STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastview Health and Rehabilitation Center	729 Park St Antigo, WI 54409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff and resident representative interview and record review, the facility did not notify a Power of Attorney for Healthcare (POAHC) of a change in condition for 1 resident (R) (R1) of 1 sampled resident. R1 had bruising on the legs and buttocks from multiple falls and behaviors. R1's POAHC (POAHC-E) was not notified of the injuries. Findings include: The facility's Notification of Changes policy, dated August 2024, indicates: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification .The facility must inform the resident, consult with the resident's physician, and or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 1. Accidents: a. Resulting in injury . On 5/13/25, Surveyor reviewed R1's medical record. R1 had diagnoses including nontraumatic subarachnoid hemorrhage, Lewy body dementia, depression, and history of falls. R1's Minimum Data Set (MDS) assessment, dated 4/13/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R1 was severely cognitively impaired. R1 had an activated POAHC for healthcare decisions. R1's medical record contained the following progress notes: ~ A progress note, dated 3/31/25 at 8:38 AM, indicated R1 had a small bruise bruise on the right outer buttock by the hip possibly from a fall on 3/28/25. The note did not indicate POAHC-E was notified. ~ A progress note, dated 3/31/25 at 10:44 AM and written by Director of Nursing (DON)-B, indicated new orders were received. POAHC-E was updated on R1's behaviors and would come sit with R1 in a of couple hours. The note did not indicate POAHC-E was notified of the bruising. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ A progress note, dated 4/1/25 at 4:45 AM, indicated R1 was found on the floor next to R1's bed. R1 hit, pinched, and kicked staff. R1 was assisted off the floor by two staff and refused the Hoyer lift. R1 had a large bruise on the right hip with minimal swelling. The physician was updated via fax. The note indicated staff would update POAHC-E in the morning because POAHC-E requested not to be called again that night. The note did not indicate POAHC-E was notified of the bruising. Surveyor reviewed R1's fall investigations and skin assessments. A skin assessment completed on 3/31/25 as well as a fall investigation and skin assessment completed on 4/1/25 indicated the bruising was consistent with multiple falls and behaviors. POAHC-E was not notified of the bruising. On 5/13/25 at 10:11 AM, Surveyor interviewed POAHC-E who was not aware of R1's bruises until R1 was sent to the emergency room (ER) on 4/13/25 where POAHC-E observed the bruising. POAHC-E was updated by the facility regarding R1's most recent falls on 3/29/25, 3/31/25, 4/1/25, and 4/13/25. POAHC-E was not notified of the bruising on R1's buttocks and legs which were in various stages of healing. POAHC-E indicated they were distressed that they were not notified of the injuries. POAHC-E was with R1 at the ER following the fall on 3/31/25 and stated bruising was not present at that time. On 5/13/25 at 2:21 PM, Surveyor interviewed DON-B who thought nursing staff were going to update POAHC-E. DON-B reviewed R1's medical record and found no documentation that indicated POAHC-E was notified of the bruising. DON-B confirmed DON-B did not notify POAHC-E of the bruising on 4/1/25. DON-B confirmed the facility did not have documentation that indicated POAHC-E was notified of the injuries R1 sustained from multiple falls.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident representative interview, and record review, the facility did not ensure fall interventions were implemented for 1 resident (R) (R1) of 3 sampled residents. R1 had a history of falls and sustained multiple falls in the facility. The facility did not implement fall interventions or safety measures to prevent future falls or injury. Findings include: The facility's Fall Reduction Policy, revised 7/1/19, indicates: Purpose: To provide an environment that remains as free of accident hazards as possible. To identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries .to promote a systematic approach and monitoring process for the care of residents who have fallen and/or those who are determined to be at risk .2. Each resident will be evaluated for risk of falls using a fall risk upon admission, readmission, upon a significant change of condition, quarterly, and following each fall. 3. Residents with a a fall risk assessment score greater than 10 should be considered at high risk for falling. 4. Identified risk factors should be discussed in documentation and addressed in the resident's care plan to assure individualized interventions to reduce the risks are implemented. 5. Residents identified to be at high risk for falling along with interventions to manage that risk will be communicated to caregivers via the care planning process .7. Document in the clinical record a summary of the fall including, but not limited to, assessment, intervention, and resident response .12. The care plan should be reviewed after every fall and updated with a new intervention, when applicable. On 5/13/25, Surveyor reviewed R1's medical record. R1 had diagnoses including nontraumatic subarachnoid hemorrhage, Lewy body dementia, depression, and history of falls. R1's Minimum Data Set (MDS) assessment, dated 4/13/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 10 which indicated R1 was severely cognitively impaired. R1 had an activated Power of Attorney for Healthcare (POAHC). R1's medical record indicated R1 was admitted to the facility for rehabilitation due to a fall from a standing position that resulted in a traumatic subdural hemorrhage. R1 was assessed for falls risk on 3/22/25 with a score of 15 which indicated R1 was at high risk for falls. R1's baseline care plan, initiated on 3/21/24, indicated R1 was confused, incontinent of bowel and bladder, independent with transferring and bed mobility, and required assistance with ambulation. Surveyor noted R1's baseline care plan did not contain any falls interventions. R1's comprehensive care plan did not contain any fall interventions until 3/28/25. R1's medical record indicated R1 fell at the facility on 3/22/25 (two falls), 3/23/25, 3/29/25, 3/31/25, 4/1/25, and 4/13/25. Surveyor reviewed R1's fall investigations and noted the following: ~ R1 had an unwitnessed fall on 3/22/25 at 9:30 PM. R1 was found sitting on the floor and got R1's self up from the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ R1 had an unwitnessed fall on 3/22/25 at 11:30 PM. R1 was found rolling on the floor and got R1's self up from the floor. ~ R1 had an unwitnessed fall on 3/23/25 at 12:15 AM. R1 was found crawling on the floor and got R1's self up from the floor. Surveyor noted there were no fall interventions or safety measures implemented to prevent injury or future falls after R1's falls on 3/22/25 and 3/23/25. A fall investigation indicated R1 was seen in the emergency room (ER) on 3/23/25 at 1:00 PM per POAHC-E's request. R1 was admitted to the hospital and diagnosed with gallstones. R1 returned to the facility on 3/28/25. On 5/13/25 at 10:11 AM, Surveyor interviewed POAHC-E who indicated R1 had a history of falls and was diagnosed with a nontraumatic subarachnoid hemorrhage and admitted to facility for rehabilitation. POAHC-E expressed concern that fall interventions and safety measures were not added to R1's care plan upon admission despite R1's history of falls with injuries. POAHC-E indicated R1 had several falls at the facility but no new interventions were discussed or added to R1's care plan until after the fall on 3/28/25. POAHC-E indicated R1 had multiple falls shortly after admission to the facility but was not assessed by a physician until POAHC-E requested R1 be seen in the ER on [DATE] due to R1's history of falls with hemorrhage. POAHC-E stated falls may have been prevented if fall interventions were implemented upon admission. On 5/13/25 at 2:21 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R1 was placed on 15-minute checks following the first fall on 3/22/25 and indicated all new admissions are put on 15-minute checks for the first 72 hours. DON-B verified 15-minute checks were not an individualized fall intervention for R1 and confirmed fall interventions were not implemented for R1 upon admission. DON-B reviewed R1's medical record and confirmed there were no fall interventions implemented for R1 following multiple falls. DON-B also verified R1's baseline care plan did not contain fall interventions in accordance with the facility's policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure the accurate administration of medication for 1 resident (R) (R7) of 13 sampled residents. R7 had an admission order to hold clopidogrel (Plavix) prior to an appointment to have a urinary stent removed. The facility missed the appointment and the order to hold medication on R7's discharge instructions and After Visit Summary (AVS) from the hospital. Findings include: On 5/14/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including acute kidney injury, bladder cancer, complicated urinary tract infection (UTI), and atrial fibrillation. R7's Minimum Data Set (MDS) assessment, dated 3/31/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R7 was not cognitively impaired. R7 discharged from the facility on 3/31/25. Surveyor reviewed R7's Discharge Summary and After Visit Summary (AVS) from R7's hospital stay prior to admission. Surveyor noted the AVS, dated 3/26/25, was scanned into R7's medical record on 3/26/25. The AVS indicated R7 should follow-up with the urologist for stent removal on 4/1/25 and the oncologist and nephrologist. R1 should follow-up with Physician (PH)-C in 1 week. The Discharge Summary contained an order to stop Plavix on 3/29/25 pending stent removal. Surveyor reviewed R7's Medication Administration Record (MAR) and noted an order for clopidogrel bisulfate (Plavix) oral tablet 75 milligrams (mg) give 1 tablet by mouth one time a day for (atrial fibrillation). The MAR indicated R7 received the medication from 3/27/25 through R7's discharge on [DATE]. The medication was not stopped on 3/29/25 per the order on R7's hospital Discharge Summary. Surveyor noted R7's medical record did not indicate R7 had a stent removal appointment on 4/1/25. On 5/14/25 at 1:45 PM, Surveyor interviewed Admissions Director (AD)-D who confirmed the stent removal appointment and hold medication order were missed. AD-D indicated AD-D usually gets paperwork from the hospital and can access the hospital's system. AD-D indicated AD-D did not see the appointment or medication hold and stated Director of Nursing (DON)-B (who confirms the orders) did not see a paper copy of the orders. AD-D indicated when the facility realized the error, they changed their process to ensure all nurses see a paper copy of scanned items so nothing is missed. AD-D indicated the education was a conversation between staff and there was no signed documentation of the education. On 5/14/25 at 1:41 PM, Surveyor interviewed DON-B who confirmed R7's appointment and Plavix hold order were missed on R7's admission orders. DON-B indicated DON-B did not know about the appointment until R7's family indicated to staff that R7 had an appointment. DON-B indicated some of R7's paperwork was scanned into R7's medical record without DON-B seeing a paper copy of it. DON-B indicated the facility changed their process as a result of the error to ensure AD-D makes paper copies of all scanned admission records so DON-B and the nurses see them. DON-B confirmed the education was a conversation between a few staff and indicated formal education was not completed.