STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525638	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Health Center	725 Butler Ave Oshkosh, WI 54901

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 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, resident and resident representative interview, and record review, the facility did not ensure appropriate supervision was in place to address wandering behavior and related concerns for 3 residents (R) (R32, R64, and R71) of 4 sampled residents. R32 wandered into residents' rooms and displayed intrusive behavior. R64, R71, and R71's Power of Attorney for Healthcare (POAHC) expressed concerns regarding R32's unwanted entry into their rooms. The facility did not provide adequate supervision or implement interventions to prevent R32 from entering residents' rooms. Findings include: The facility's Aggressive Behavior Prevention and Response policy, dated 11/26/18, indicates: .To identify causes, prevention techniques, and reaction methods for residents at risk of aggressive behavior. Performed by: All staff. Preventing Aggressive Behavior: Contributing factors: Dementia/cognitive impairment, delusions, hallucinations, situational causes and triggers, unwanted entry into bedroom; Procedure: .3. Call the Registered Nurse (RN) shift supervisor and they will respond to the area of concern. 4. Keep other residents safe .7. Once the resident is calm, the neighborhood nurse will assess the resident(s) involved for any injuries and initiate .immediate interventions to monitor physical and psychosocial status. The need for 1:1 monitoring of the resident will be assessed immediately following the incident .10. The Interdisciplinary Team (IDT) will complete a review of the incident to identify what led to the acute aggressive episode and put interventions in place to avoid reoccurrence. (Of note: When Director of Nursing (DON)-B provided the policy to Surveyor on 4/16/25, DON-B indicated the policy covered wandering behavior as well.) From 4/14/25 to 4/16/25, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] and had diagnoses including unspecified dementia with psychotic disturbance, Alzheimer's disease, generalized anxiety disorder, and delusional disorder. R32's Significant Change Minimum Data Set (MDS) assessment, dated 3/31/25, indicated R32 was severely cognitively impaired. The MDS assessment also indicated R32 wandered 1-3 days during the observation period which significantly intruded on the privacy or activities of others. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, dated 3/28/25, indicated R32 had the potential to feel overwhelmed, anxious/restless, and paranoid due to cognitive impairment and anxiety and indicated R32 may yell, shout, scream, not talk, have a hard time expressing what R32 needs, and may pace/wander throughout the neighborhood. The care plan indicated R32 was not able to distinguish between areas R32 was welcome to enter and those that R32 was not. The care plan instructed staff to provide 15 minute checks if R32 became intrusive, redirect R32 from areas where R32 was not welcome, and offer snacks or drinks (chocolate ice cream or cranberry juice) which were generally effective if R32 became resistive. R32's medical record indicated the following: ~ On 10/22/24, the facility implemented 1:1 supervision for R32 due to falls and intrusive behavior (wandering). At that time, R32 ambulated with a cane in the facility. ~ A physician note, dated 11/13/24, indicated quetiapine (an antipsychotic medication) was recently increased due to increased behaviors. R32 was also on buspirone (an anxiolytic medication) for generalized anxiety disorder. R32 continued to require 1:1 monitoring due to fall risk, pacing, and wandering into peers' rooms. ~ On 3/4/25, R32 went to the hospital due to a change in condition. R32 returned from the hospital on 3/10/25 with diagnoses including pneumonia, urinary tract infection (UTI), urinary retention, and sepsis. R32 was no longer ambulatory at that time. ~ On 3/17/25, the facility initiated a short-term care plan (STCP) that indicated: Trial (discontinue) of 1:1. The care plan instructed staff to document intrusiveness, provide 1:1 supervision as needed for increased agitation/intrusive behavior, use distraction techniques such as snacks, repositioning, fluids, walks, check and change, fidgets, etc., and update the Social Worker (SW) or RNs with concerns A Social Services note, dated 3/18/25, indicated the IDT discussed discontinuing R32's 1:1 on 3/17/25. Since R32 returned from the hospital, R32 was no longer ambulatory but attempted to self-propel a wheelchair. Nursing staff would transition R32 to a peddler Broda chair for comfort and mobility. Concerns with R32's behavior had decreased since R32 was less mobile and R32 had not been intrusive with peers. R32's 1:1 supervision was discontinued on 3/17 PM shift and R32 transitioned to 15 minute checks for 48 hours. A progress note, dated 3/23/25 at 9:21 PM, indicated R32 was on 15 minute checks, was not able to be redirected, and was intrusive while self-propelling a wheelchair around the neighborhood. A behavior assessment, dated 3/23/25, indicated R32 wandered aimlessly, had hallucinations, and significantly intruded on the privacy or activity of others. Interventions included 1:1 activity, reorientation, reassurance, offer a snack, and toileting. R32's behavior had not changed since the last assessment. A progress note, dated 3/25/25 at 8:36 AM, indicated a STCP was initiated on the 3/23/25 PM shift for increased agitation with cares and biting staff. Staff were instructed to immediately report further biting/agitation to the nurse. Fifteen minute checks were continued. Charting from 3/24/25 indicated R32 rested comfortably in bed the majority of the AM and PM shifts. R32 continued to be irritated with cares but was calm afterward. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From 4/14/25 to 4/16/25, Surveyor reviewed R71's medical record. R71 was admitted to the facility on [DATE] and had diagnoses including dementia, major depressive disorder, generalized anxiety disorder, and difficulty in walking. R71's MDS assessment, dated 1/29/25, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R71 had moderate cognitive impairment. R71 had an activated POAHC who visited daily. On 4/14/25 at 11:30 AM, Surveyor interviewed R71 and POAHC-L. R71 and POAHC-L expressed concerns about a resident (R32) who wandered into R71's room. R71 and POAHC-L indicated (R32) previously had a staff with (R32) at all times, however, staff were no longer with (R32) who entered R71's room uninvited. R71 informed Surveyor that R71 did not have a call light (per choice) recently when R71 was in R71's recliner. R71 indicated (R32) entered R71's room and touched R71's toe. R71 yelled for help and staff finally came. POAHC-L indicated sometimes (R32) enters R71's room when POAHC-L is visiting. POAHC-L stated POAHC-L tries to get (R32) out of the room. R71 indicated R71 witnessed (R32) be mean to staff and is not sure what (R32) will do when (R32) enters R71's room. R71 indicated it is scary to have to live like that. R71 and POAHC-L indicated staff are aware that (R32) wanders into rooms and have removed (R32) from R71's room. R71 and POAHC-L indicated staff had not talked to them about implementing interventions to deter (R32) from entering R71's room. From 4/14/25 to 4/16/25, Surveyor reviewed R64's medical record. R64 was admitted to the facility on [DATE] and had diagnoses including dementia and cerebrovascular disease. R64's MDS assessment, dated 1/22/25, had a BIMS score of 11 out of 15 which indicated R64 had moderate cognitive impairment. On 4/15/25 at 10:15 AM, Surveyor interviewed R64 who was sitting in a chair in R64's room. R64 indicated last week (R32) entered R64's room and waved both hands at R64. R64 indicated R64 thought (R32) wanted to fight R64 or live with R64. R64 activated the call light and staff responded. R64 indicated R64 does not like it when (R32) enters R64's room but indicated staff respond right away. R64 indicated R64 does not like it when people sneak up on R64 because R64 is a nervous person, is small, and cannot fight anyone if R64 needs to. On 4/15/25 at 10:17 AM, Surveyor observed R32 wandering in the hallway with no staff present. R32 slowly self-propelled a wheelchair down the hallway and entered a room on the left side of the hallway. Approximately one minute later, staff walked down the hallway, observed R32 in the room, and backed R32's wheelchair out of the room. Surveyor noted the resident whose room R32 entered was asleep on the bed. On 4/15/25 at 1:19 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-H who worked the PM shift on R32's unit. CNA-H confirmed R32 wanders on the unit regularly, continues to enter residents' rooms, and is difficult to redirect at times. CNA-H indicated a few residents express concerns when R32 is in their room. CNA-H indicated R32 has not been aggressive toward other residents, just toward staff during cares. When asked if R32 had entered R71's room, CNA-H indicated R32 tried to get in R71's bed and was difficult to redirect. (R71 was not in bed at the time.) CNA-H indicated CNA-H has shut residents' doors, however, R32 opens doors easily. On 4/15/25 at 1:58 PM, Surveyor interviewed RN-J who confirmed R32 enters residents' rooms regularly. RN-J had not received any resident concerns regarding R32 and indicated when RN-J was on the unit, R32 was easily redirectable. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 2:01 PM, Surveyor interviewed CNA-K who worked on R32's unit the last two days. CNA-K indicated R32 was often in residents' rooms, however, no residents expressed concerns in the last two days. Surveyor reviewed progress notes for R32 since R32's 1:1 supervision was discontinued on 3/17/25. The progress notes did not indicate whose rooms R32 entered or was removed from. Surveyor also reviewed R64 and R71's progress notes which did not indicate R32 was found in either of their rooms. On 4/16/25 at 10:14 AM, Surveyor interviewed Unit Manager (UM)-I who indicated R32 was removed from 1:1 supervision when R32 returned from the hospital. UM-I was not aware residents expressed concerns that R32 wandered into their rooms. UM-I indicated R32 resides on a dementia unit and needs to be allowed to wander, however, interventions should be implemented to address the residents' concerns. Surveyor and UM-I discussed safety for R32 if R32 enters someone's space uninvited. UM-I indicated if residents express concerns, staff should report the concerns to the nurse or shift supervisor. UM-I indicated UM-I and the Social Worker communicate so the team can address any concerns appropriately. UM-I was unsure if staff followed-up with residents when R32 was removed from their rooms. On 4/16/25 at 12:10 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated since R32 was not ambulatory when R32 returned from the hospital, the IDT trialed a removal of 1:1 supervision and monitored R32 and staff's reactions. DON-B indicated R32 was not aggressive toward peers and stated R32 was only aggressive during cares. DON-B was not aware that residents expressed concerns regarding R32 wandering into their rooms. When Surveyor informed DON-B that staff indicated residents had expressed concerns about R32 wandering into their rooms, DON-B indicated staff should communicate with the IDT so the concerns can be addressed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and spread of communicable disease and infection. This practice had the potential to affect more than 4 of the 88 residents residing in the facility. The facility did not track last symptoms of illness and return to work dates for 3 staff (Certified Nursing Assistant (CNA)-D, CNA-E, and Licensed Practical Nurse (LPN)-F) during a gastrointestinal illness (GI) outbreak. R10 was on enhanced barrier precautions (EBP). LPN-F did not wear a gown or goggles while administering a tube feeding for R10 and while flushing R10's enteral tube. In addition, LPN-F did not complete hand hygiene prior to exiting R10's room. R37 was on EBP. Registered Nurse (RN)-G did not wear gloves during cares for R37. Findings include: The Facility's Acute Illness Policy and Procedure-Staff, dated 2/2024, indicates: To prevent the spread of illness within the facility by restricting staff with acute illness from working. Procedure for staff experiencing gastrointestinal (GI) illness: Symptoms include (minimum of 2 episodes of vomiting or loose stools); Acute onset of vomiting; Acute, explosive loose diarrhea; Low grade fever, nausea, chills, body aches, fatigue, abdominal cramping in addition to vomiting and diarrhea .1. Staff should call in according to the Employee Sick Call policy if they are experiencing acute GI illness symptoms of fever, vomiting, diarrhea and should be removed from the schedule. 2. Staff with GI symptoms must call scheduling daily to update on symptoms. 3. Staff must be removed from the schedule until 48 hours after the last incident of vomiting and/or diarrhea. The facility's Infection Control; Enhanced Barrier Precautions policy, dated 1/2025, indicates: Enhanced Barrier Precautions (EBP) expand the use of personal protective equipment (PPE) to include the use of gowns and gloves (face protection should also be used if there is a potential for splashes or sprays) during all high-contact resident care activities that provide an opportunity to transfer multidrug-resistant organisms (MDROs) to staffs' hands and clothing .Enhanced barrier precautions will be used for residents with any of the following: open wounds requiring dressing, indwelling urinary catheters, . feeding tubes .4. Staff will don a gown and gloves (face protection should also be used if there is a potential for splashes and sprays) prior to performing any of the following: .Device care or use: .feeding tubes .wound care .5. Once the above have been completed, PPE should be removed and disposed of and hand hygiene should be performed. 1. On 4/15/25, Surveyor reviewed the facility's infection surveillance and staff line list for a GI outbreak that started on 12/18/24. The staff line list included names, last worked dates, dates and times of onset of symptoms, symptoms, lab results, dates and times of last symptoms, well dates, and return to work dates. During the outbreak from 12/18/24 to 2/26/25, the staff line list did not include last symptom dates for staff who called in sick during that time period. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/15/25 at 10:50 AM, Surveyor interviewed Infection Preventionist (IP)-C who indicated call-in sheets are used to identify staffs' last symptom and when they can return to work. Surveyor asked to review the call-in sheets for 3 employees who had return to work dates that were 2 days after their initial call-in day with symptoms. ~ CNA-D called in sick on 12/16/24 with symptoms of nausea, vomiting, and abdominal cramps. CNA-D returned to work on 12/18/24. There was no date listed for CNA-D's last symptom. ~ CNA-E called in sick on 12/21/24 with symptoms of nausea and vomiting. CNA-E returned to work on 12/23/24. There was no date listed for CNA-E's last symptom. ~ LPN-F called in sick on 12/26/24 with symptoms of nausea and vomiting. LPN-F returned to work on 12/28/24. There was no date listed for LPN-F's last symptom. IP-C indicated IP-C could not provide call-in documentation for last symptoms for CNA-D, CNA-E, and LPN-F. IP-C indicated the facility's procedure is for the employee to call back when their symptoms have resolved and return to work 48 hours after the resolution of symptoms. IP-C indicated the facility's policy was not followed for CNA-D, CNA-E, and LPN-F. IP-C was not sure when CNA-D, CNA-E, and LPN-F's symptoms resolved. 2. On 4/16/25, Surveyor reviewed R10's guidelines for daily cares, dated 4/15/25, which indicated R10 was on EBP due to an enteral tube. On 4/15/25 at 9:10 AM, Surveyor observed LPN-F complete a tube feeding flush and administer R10's tube feeding. LPN-F completed hand hygiene, entered R10's room, and donned gloves. LPN-F did not don a gown or goggles prior to entering the room. LPN-F attached R10's tube to the gastric button, opened the clamp, and flushed the tube with water. LPN-F then attached R10's tube to an extension tube and started R10's tube feeding. LPN-F then removed gloves and exited R10's room. LPN-F did not complete hand hygiene prior to exiting the room. On 4/15/25 at 1:30 PM, Surveyor interviewed LPN-F and Director of Nursing (DON)-B regarding PPE and hand hygiene. LPN-F verified LPN-F did not wear a gown and goggles during R10's flush and tube feeding. LPN-F indicated LPN-F was aware of the need to wear a gown and goggles during the flush and tube feeding due to R10's EBP status. LPN-F also verified LPN-F did not complete hand hygiene before exiting R10's room. DON-B indicated R10 was on EBP due to an enteral tube and catheter and indicated staff should follow the facility's EBP policy. 3. On 4/16/25, Surveyor reviewed R37's guidelines for daily cares, dated 4/16/25, which indicated R37 was on EBP due to wounds. On 4/16/25 at 8:27 AM, Surveyor observed RN-G complete wound care for R37. RN-G washed hands, donned gloves and a gown, and completed wound care for R37's legs and left wrist. RN-G then removed RN-G's gown and gloves. Without cleansing hands and applying clean gloves, RN-G applied tubigrips to R37's legs, put on R37's socks, picked up a lift pad off the floor, and disposed of soiled bandages and the lift pad. R37 then sanitized hands and exited R37's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/25 at 8:41 AM, Surveyor interviewed RN-G regarding EBP and PPE. RN-G verified RN-G did not wear gloves while applying R37's tubigrips and socks and when RN-G disposed of R37's soiled bandages and lift pad. RN-G indicated RN-G should wear gloves at all times during cares for R37.