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	02/15/2023

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 32767 Based on staff interview and record review, the facility did not ensure assessments, interventions, and increased monitoring were implemented after a statement of suicidal ideation was verbalized by 1 Resident (R) (R69) of 5 residents reviewed for behavioral and emotional well-being. Licensed Practical Nurse (LPN)-I wrote a progress note that indicated R69 voiced a statement of suicidal ideation. LPN-I did not update the facility's Interdisciplinary Team (IDT), therefore, assessments, interventions and increased monitoring were not implemented and R69's psychologist/psychiatrist was not informed. Findings include: From 2/13/23 through 2/15/23, Surveyor reviewed R69's medical record and noted R69 had diagnoses to include Alzheimer's disease and anxiety disorder. LPN-I documented during staff intervention of R69's elopement attempt on 12/15/22, R69 stated, I should just go die in a snow bank. R69's Patient Health Questionnaire (PHQ)-9 (depression severity assessment) scores remained in the minimal depression range between 9/28/22 and 1/25/23 and decreased from 4 to 1 (lower score is less severe on 30 point scale). Surveyor noted R69's medical record did not contain a suicide prevention care plan, an assessment on the date of the statement, or increased monitoring following the statement. R69 met with psych on 12/20/22. The visit note documented R69 had no suicidal ideation. During the course of survey, LPN-I, who documented the 12/15/22 progress note, was not available for an on-site interview and did not respond via telephone. On 2/14/23 at 11:41 AM, Surveyor interviewed Social Worker (SW)-F regarding R69's 12/15/22 statement of suicidal ideation. SW-F denied awareness of R69's statement. SW-F stated the facility's practice was for staff to report statements of suicidal ideation to the unit manager, Registered Nurse (RN)-G, and/or report the incident to SW-F, who were members of the IDT. SW-F stated when SW-F is notified of suicidal ideation, SW-F assesses the resident to determine the urgency of a psychology visit. The urgency level either results in a phone call for an urgent visit or placement of the resident on the list for the next scheduled psych visit. SW-F also stated the IDT would create a short-term care plan. SW-F verified R69 had a psych visit on 12/20/22. SW-F stated SW-F and RN-G usually rounded with psych and SW-F would have informed psych of R69's suicidal ideation if SW-F was aware. (continued on next page)

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/23 at 12:15 PM, Surveyor interviewed RN-G regarding R69's suicidal ideation statement. RN-G denied awareness prior to Surveyor's investigation. RN-G stated there was an expectation that suicidal ideation statements be reported up the chain of command. RN-G verified suicidal ideation statements always required follow-up.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32767 Based on observation, staff interview, and record review, the facility did not ensure food was stored, and served under sanitary conditions. This practice had to potential to affect 94 of 98 residents. (Four residents were exclusively fed via tube). Staff did not identify and address the main kitchen warewashing machine (dishwasher) internal surface temperature monitoring device did not reach the required 160 degrees Fahrenheit (F) since July of 2022. Staff did not date foods and beverages that were time and temperature controlled for safety upon opening and did not discard outdated items in accordance with food safety practices. Findings include: On 2/13/23 at 8:52 AM, Dietary Manager (DM)-H stated the facility used the Food and Drug Administration (FDA) Food Code as its standard of practice. Dishwasher Internal Temperature FDA Food Code 2022 documented at 4-703.11 After being cleaned, equipment food-contact surfaces and utensils shall be sanitized in: .(B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under SS 4-501.15, 4-501.112, and 4-501.113 and achieving a UTENSIL surface temperature of 71oC (160oF) as measured by an irreversible registering temperature indicator On 2/13/23, during an initial kitchen tour beginning at 8:52 AM, Surveyor reviewed the main kitchen dishwasher monitoring logs and noted the internal surface temperature was not reaching 160 degrees F. DM-H and Surveyor reviewed dishwasher documentation which revealed the dishwasher internal surface temperature stopped reaching the required minimum 160 degrees F in July 2022. DM-H explained DM-H referred to the FDA Food Code requirement at 4-501.112(A) which documented the maximum temperature of the sanitizing rinse is 194 degrees F when DM-H reviewed the dishwasher monitoring logs. Surveyor reviewed the FDA Food Code 4-703.11(B) with DM-H at that time. On 2/14/23 at 1:24 PM, Surveyor observed an internal surface temperature monitoring device run through dishwasher and reach the required minimum temperature of 160 degrees F. DM-H stated the facility determined the internal surface temperature monitoring device which registered temperatures below the required minimum was discovered by staff as defective and replaced by a new monitoring device. Time and Temperature Foods (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	FDA Food Code 2022 documented at 3-501.17(B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety On 2/13/23, during an initial kitchen tour beginning at 8:52 AM, Surveyor observed and DM-H verified the main kitchen walk-in refrigerator contained a one gallon container of lemon juice, delivery dated 10/4/22, which was open and undated. Food Keeper (foodsafety.gov) indicated lemon juice is good for two months in the refrigerator once opened. DM-H and Surveyor toured the household kitchenettes and noted the following Resident (R) specific foods in refrigerators were open and undated: R350 - 12 ounce (oz) jar of marinated herring R9 - 64 oz apple juice Surveyor observed and DM-H verified a household kitchenette freezer contained a Ziploc bag with 8 pancakes and an obvious build-up of ice particles in the bag and on the pancakes. The bag was marked with a use-by date of 1/20/23. DM-H verified all food products must be date marked at the time of opening and items past use-by dates should be discarded timely.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 42248 Based on staff interview and record review, the facility did not ensure medical records contained documentation related to influenza immunizations for 3 Residents (R) (R10, R22 and R55) of 5 residents reviewed for immunizations. R10's medical record did not contain documentation indicating the facility offered or administered the influenza immunization for the 2022/2023 season. R22's medical record did not contain documentation indicating the facility offered or administered the influenza immunization for the 2022/2023 season. R55's medical record did not contain documentation indicating the facility offered or administered the influenza immunization for the 2022/2023 season.Findings include: The facility's Influenza Immunization Policy, dated 02/2018, contained the following information: The facility has developed policies and procedures that ensure that - (i) Before offering the influenza immunization, each resident or the resident representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident representative has the opportunity to refuse immunization; (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (v) The resident or resident representative will be re-offered the influenza vaccine with increased levels of influenza-like illness within the building or in the community. The facility's Seasonal Influenza Vaccination Procedure - Residents, dated 09/2022 contained the following information: 2. RN Neighborhood Supervisors: .Inform Infection Preventionist of any refusals *Refusals must be approached three times and documented in ECS (electronic medical record) for each encounter . The facility's Informed Consent - Influenza Immunization document, dated 02/2018, contained the following information: Procedure: 1. Prior to the annual vaccination date, which is determined by the QAA (Quality Assessment and Assurance) Committee sometime each fall usually after October 1st): a. Give competent resident a consent form and a copy of the most current VIS (Vaccine Information Sheet) from CDC (Centers for Disease Control and Prevention.) b. Mail consent forms and VIS forms to the resident representative of incompetent/incapacitated residents. 2. Forward completed consent to the RNNS (Nurse Supervisor)/Infection Preventionist. On 2/15/23, Surveyor reviewed R10, R22, and R55's medical records for documentation related to their influenza vaccination status and documentation for the 2022/2023 influenza season. R10, R22, and R55's medical records contained the following: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. R10 was admitted to the facility in September of 2012. The most recent influenza consent/declination document in R10's medical record was signed and dated 11/1/20. 2. R22 was admitted to the facility in April of 2021. The most recent influenza consent/declination document in R22's medical record was signed and dated 4/6/21. 3. R55 was admitted to the facility in June of 2017. The most recent influenza consent/declination document in R55's medical record was signed and dated 9/26/19. On 2/15/23, Surveyor interviewed Registered Nurse Manager/Quality Assurance & Infection Control (IP)-C. IP-C stated IP-C had a log that contained documentation of all resident immunizations. IP-C stated IP-C would provide Surveyor a copy of the consent/declination forms. On 2/16/23 via e-mail, IP-C provided Surveyor with additional information which included progress notes related to influenza immunization consents and declinations as follows: R10 late entry dated 2/16/23 at 8:26 AM; R22 late entry dated 2/16/23 at 8:22 AM; R55 late entry dated 2/16/23 at 8:24 AM. On 2/16/23 at 2:02 PM via e-mail, IP-C stated IP-C documented the attempts on 2/16/23. IP-C attached the copies of the original consents that were sent to R10's, R22's, and R55's powers of attorney (POAs) on 9/22/22 and 12/1/22. IP-C stated IP-C did not see the documents in the chart but had the original copies with original logs that IP-C prepared at the start of the influenza season.