STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525292	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Health Services	516 26th Ave Monroe, WI 53566

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on interviews, record review, facility document review, and review of the facility's policy, the facility failed to ensure residents were free from misappropriation of property for one of three sample residents (Resident (R) 1) reviewed for misappropriation. Findings include: Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 07/15/22, revealed It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent .The facility will have written procedures that include .analyzing the occurrence to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes may be needed to prevent further occurrences .training of staff on changes made and demonstration of staff competency after training is implemented. Review of R1's undated Resident Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE] with diagnosis that included chronic respiratory failure, muscle weakness, and diabetes mellitus. Review of R1's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/13/24 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating the resident was cognitively intact. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Misconduct Incident Report provided by the facility, documented that the incident was discovered 12/24/24, that R1's phone was missing and said that a housekeeper took it. Patient was worried about her phone. Police were called and [R1] did not want to pursue it with the police. The Administrator was called immediately, and the housekeeper was suspended immediately. Police called. Certified Nursing Assistant (CNA) 1 wrote a witness statement on 12/24/24 that stated, R1 turned her call light on and I answered it .she then asked about her phone saying the house keeper put her phone in her pocket. The actions taken by the Administrator stated, On 12/24/2024 at 1300 [1:00 PM], the administrator was notified that [R1's] phone was missing. [R1] made a comment that she thought it might be the [Housekeeper (HSK) 2] as she thinks she saw her put it in her pocket. [HSK2] was immediately suspended. Staff immediately started searching for it and the police were called. The police started interviewing [R1]. [R1] told the police officer that she did not want anything done. Police Officer . called the administrator and stated that, 'he would not proceed because [R1] did not want anything done' .The Assistant Director of Nursing (ADON) was interviewing staff and searching for the phone. Staff searched the grounds and around cars and saw the phone in [HSK3's] passenger seat. [HSK2] was outside waiting for a ride from [HSK3] and walked with staff to her co-worker's [HSK3] vehicle because she received rides to work and saw the phone was under a package of Kleenex in the front seat, she asked that we not tell [HSK3]. The phone was returned to [R1] immediately. The conclusion documented that, Between staff and resident interviews .[HSK2] was scheduled in [R1's] hallway .[R1] saw housekeeper put it in her pocket. The phone was found with staff and [HSK2] present, in the car that she rode in. [Facility] and the .police department are unable to substantiate the theft of the phone, but due to the evidence provided in the investigation, we are terminating [HSK2]. During an interview on 01/17/25 at 9:45 AM, CNA1 said that she remembered R1 was upset about someone who had cleaned her room and had taken and put something into her pocket, and now she could not find her phone. She said she helped the resident search her room, but it could not be found. She said a lot of staff were looking in her room to find it, but they could not. CNA1 said she reported it and wrote her statement and gave it to management. She said it was the end of her shift and went home. She said she heard the phone was found in the housekeeper's car. She stated she was not aware of any other residents expressing similar concerns. During an interview on 01/17/25 at 10:10 AM, HSK1 said that she completed a regular background check when she applied to the housekeeping company and had received abuse training. She could not recall if she had received any after the incident with R1, but believed it was after the last facility survey. During an interview on 01/17/25 at 10:26 AM, the Housekeeping Manager (HSKM) said she did the hiring for the housekeeping staff. She said the process to check for references, and background checks were done by her company, which was separate from the facility itself. She said she was not at the facility that day, but the Administrator told her what happened. She said she called HSK2 who said she did not do it. HSKM said R1 had stated she saw HSK2 take her phone. She said the District Manager of her company had called her to discuss the situation, and that they were doing their own investigation. She stated that since the incident she did not believe there had been any reeducation or training on abuse that she could recall. She stated the facility used Relias and her company used a separate system, but she could not recall any since the misappropriation of property. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/17/25 at 11:36 AM, the Director of Nursing (DON) said that although he was not at the facility during the incident, he was informed. He said the facility did the self-report and education. He confirmed they interviewed other residents, and none had concerns. He said they sent the report to the contracted housekeeping company that HSK2 worked for, since she was not a direct employee. During an interview on 01/17/25 at 11:39 AM, the Regional Administrator said he was involved in the termination of the employee. He stated they could not 100% confirm she took the phone, but the evidence suggested that she took it. He confirmed that the contract company she worked for was now handling it. During an interview on 01/17/25 at 12:05 PM, R1 said that she saw HSK2 in her room and put her cell phone into HSK2's pocket. She said she told the staff, and they found the phone in HSK2's friend's car. She said she knew HSK2 took it, but she did not know why. She said the police came in and asked her if she wanted to press charges. She stated she did not. She said she wanted the housekeeper to come and apologize, but she did not. R1 said it was an unfortunate situation, and she just wished she knew why HSK2 did it. During an additional interview on 01/17/25 at 12:20 PM, the Regional Administrator said there were no additional findings of missing property, and if there was it would be on the grievance log. There were none reported. During an interview on 01/17/25 at 12:27 PM, the ADON said it was Christmas Eve in the afternoon and the girls reported to her that R1 could not find her cell phone. She stated they looked everywhere in her room. She stated staff came back and said they could not find it. She stated R1 was very adamant that she saw HSK2 take it. She said she talked to HSK2 who swore she did not take it. She stated HSK2 was carpooling with HSK3. She said she called the Director of Nursing then to see what to do, because she knew there had to be an investigation, and get statements. She stated HSK2 finished her work before HSK3 and went to the car she was carpooling with HSK3, because she had access to it when she was on breaks. She stated that HSK2 came and told her that she saw a phone on the car seat and had taken a picture of it. ADON said she did not know what R1's phone looked like, so another staff member validated that it was hers. She said she had brought HSK3 into the office and asked her about the phone and said she had not taken it; it was not hers. She stated she was not aware of what had happened. ADON said she told the Administrator and Director of Nursing, and they told her to call the police, and get statements. ADON stated when the police came, they interviewed R1, and she said the same thing. She stated R1 got her phone back and identified HSK2 because she could recall what she looked like. She said that the Housekeeping Manager was their supervisor, and she was told to handle it on her end. She said that since then there had been additional education on abuse, and they had the nursing staff sign and review. During an interview on 01/17/25 at 12:40 PM, the Administrator said the Director of Nursing had nursing meetings, talked with every new hire, and that there was also online training that the staff received to go over all the abuse training. He said they also did in-services for abuse and talked about it, that it was ongoing. He confirmed that housekeeping services was a contracted company and that the Housekeeping Manager was to provide abuse education to her staff as well. A review of the abuse training on 12/26/24 revealed the HSKM had attended, but not the housekeeping staff. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/17/25 at 12:49 PM, HSKM said she had brought in the available training that was completed for her housekeeping staff. She confirmed that none of the housekeeping staff had received abuse reeducation since the incident. A review of the housekeeping staff training revealed none of the staff had received abuse training since the incident with HSK2 and R1. During a concurrent interview on 01/17/25 at 12:52 PM with the Administrator, Regional Administrator, and DON, they confirmed the misappropriation of R1's property had occurred, and that they had provided retraining on abuse to the facility staff. They confirmed HSKM had attended this reeducation, and that she would have been responsible for educating the housekeepers since they were a contracted company.