

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Randolph Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 502 S High St Randolph, WI 53956	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882</p> <p>Based on interview and record review, the facility did not ensure that all alleged violations involving misappropriation of resident funds/personal property are reported immediately to the administrator of the facility, the State agency, and to other officials, including local law enforcement, in accordance with State law through established procedures for 1 of 3 sampled residents (R3) reviewed for abuse.</p> <p>Facility did not report an incident of suspected resident theft/misappropriation of resident monetary funds to the local law enforcement.</p> <p>Evidenced by:</p> <p>The facility policy, entitled Abuse, Neglect, and Exploitation, reviewed 7/15/22, includes It is the policy of the facility to provide protection 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 . The facility will implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property . Establish policies and procedures to investigate any such allegations; and . Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention; and . Establish coordination with the QAPI (Quality Assurance Performance Improvement) program . Reporting/Response: The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies, for example law enforcement when applicable, within specified timeframes . Immediately, but no later than two hours after the allegation is made, if events that cause the allegation involve abuse or result in serious bodily injury, or not later than twenty four hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy, reviewed 8/16/22, includes: . Definitions: Crime- Section 1150 B (b) (1) of the Social Security Act provides that a crime is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township, village, or any local unit of government created by or pursuant to State law. Policy explanation and compliance guidelines: The facility will coordinate with state and local law enforcement entities to determine what actions are considered crimes in the facility's political subdivision and will work with law enforcement to determine which crimes are reported. Example of situations that would be considered crimes in all subdivisions include, but are not limited to murder, manslaughter, rape, battery, sexual abuse, theft/robbery, drug diversion ., fraud/forgery, certain cases of abuse, neglect, and exploitation . others as required by local jurisdiction and/or specific circumstances of the incident . The facility will follow policies regarding staff treatment of residents to assure the facility is doing all that is within its control to prevent occurrences of resident abuse .misappropriation of property. This includes policies for reporting such incidents .</p> <p>R3 admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction, type 2 diabetes mellitus with hyperglycemia, aphasia, anxiety disorder, post-traumatic stress disorder, and major depressive disorder.</p> <p>R3's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 4/15/25 indicates R3 is cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 5 out of 15.</p> <p>Facility Self-Reported Incident Report, submitted 4/25/25, includes Date and Time of incident: unknown. Date discovered: 4/24/25 . Summary of Incident- Law Enforcement was not contacted. The resident was asked if he would like law enforcement to be contacted and he did not feel the need to contact law enforcement . The Administrator and Social Services Director searched the resident's room for the missing funds, with the approval of the resident and his activated power of attorney. \$200 was found in a pocket of the resident's jacket, in the form of \$20 bills. The resident states that this is not the money that was missing. The resident stated to the social worker on 4/24/25 that he was missing \$60.00. In the same conversation, he told her that he was missing \$80. In the same conversation he told her he was missing \$70. When the administrator spoke with him on 4/25/25, the resident stated that he was missing \$38. The resident also stated that he had a coin purse that was approximately 3 inches long. No coin purse was found by the administrator and social worker when the residence room was searched. When the administrator spoke with the activated power of attorney, he stated that the resident had a \$20 bill in his night stand and some quarters in a green pill bottle. No \$20 bill was found in the residence night stand. The green pill bottle was found but no quarters were in the pill bottle. The resident has funds in a safe provided by the son, and that are tracked by the facility. The only withdrawal from the account was the one most recent withdrawal for \$31 that went directly to the resident. The facility is conducting resident interviews to determine if any other residents have been missing property. No other residents with missing property have been identified at this time, however, interviews are still ongoing.</p> <p>The facility is also collecting statements from staff who were notified of the missing funds. The facility is also interviewing staff at our facility to determine if they have seen the money in the resident's room, or if they have any indication that the money was taken from the resident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Investigation Summary, dated 4/29/25, includes Resident was admitted to the facility on [DATE] . He has an activated power of attorney . Description of Incident: On 4/24/25 Licensed Practical Nurse C, Social Services Director D, Housekeeper F, and Housekeeper E were notified that R3 was missing monetary funds that were kept in his room. R3 initially shared . it was \$60 missing. In the same conversation he noted it was \$80 missing, and later in the conversation noted that \$70 was missing. The administrator was notified that the resident was missing monetary funds that were kept in his room. R3 shared with the administrator that \$31 was unaccounted for. The Administrator and Social Services Director searched for the funds in the resident's room with permission from the resident, while the resident was in the room. The search of the room was unsuccessful in finding the monetary funds. R3 was notified that the center would be submitting a report to the state on the incident, asked if he felt someone had taken the funds, and asked if he would like law enforcement to be notified. R3 stated that he did not want to notify law enforcement. Results of investigation: the administrator and social services director performed random resident interviews for residents residing in all sections of the skilled nursing facility to determine if any other residents were missing monetary funds or other items of personal property. The administrator also obtained statements from staff who were notified of the missing funds on 4/24/25. The administrator spoke with the residents power of attorney . and the power of attorney notified the administrator that there was a \$20 bill in the top drawer of his night stand and some quarters in a green bottle in the top shelf. It was found that the resident pulled \$31.00 from his funds that his power of attorney leaves in the facility safe for the resident if he needs or wants it. It cannot be determined if these funds were used by the resident or if the funds were in his room. These funds were unable to be located. The power of attorney noted that he would not like law enforcement to be notified. The power of attorney was notified that the administrator submitted a report to the state and would be performing an investigation in house to hopefully determine the cause of the missing funds. Conclusion: Based on interviews and the investigation the facility cannot establish that there is any evidence of non-compliance. After an exhaustive search and thorough investigation, it could not be determined if money was ever in the residence possession, if money was taken from the residence room, if so, by whom, and how much was actually missing. The facility will continue to closely monitor resident and resident activity that may indicate theft of resident property. The resident has been reminded that his monetary funds can be kept in the safe at the facility for safekeeping. The resident is content with the results of this investigation and will be informed if any further information is found.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility Self-Reported Incident Report, submitted 4/30/25, includes Date occurred- (unknown) . Date discovered- 4/24/25 . The administrator and social services director searched the resident's room for the missing funds, with the approval of the resident and his activated POA. R3 initially shared with Social Services Director D that it was \$60 missing. In the same conversation he noticed it was \$80 missing, and later in the conversation noted that \$70 was missing. When the administrator spoke with him, the resident stated that he was missing \$38. When the administrator spoke with the activated power of attorney ., he stated that the resident had a \$20 bill in his nightstand and some quarters in a green pill bottle. No \$20 bill or quarters were found in the resident's nightstand. The facility conducted staff and resident interviews and gathered some staff statements. After an exhaustive search and thorough investigation, it could not be determined if money was ever in the resident's possession, if money was taken from the resident's room, if so, by whom, and how much was actually missing . The resident was initially upset by the encounter. However, shortly after, the resident expressed that it was just a little bit of money. I am not worried about it. The resident expressed that he would not like law enforcement to be notified and that he was not concerned over the incident. The resident's son (Power of Attorney) also expressed that he is not upset by the incident, and that he would not like law enforcement to be notified. Upon learning of the incident, the administrator and social services director interviewed numerous residents to identify if any other residents were missing personal property. The administrator and social services director also received written statements from the staff who were notified of the incident and interviewed other staff to determine if any staff members have seen money in the resident's room. It was found that no staff members interviewed had seen money in the resident's room.</p> <p>On 5/6/25 at 11:00 AM NHA A (Nursing Home Administrator) indicated R3 thought someone may have taken his money and she never reported it to local law enforcement.</p> <p>On 5/6/25 at 11:39 AM NHA A indicated stealing is a crime. NHA A indicated it was only \$20 and R3 and his power of attorney did not want the facility to call local law enforcement. NHA A indicated she was not sure how much money missing would warrant a call to local law enforcement. NHA A indicated the facility has never coordinated with the local law enforcement to create a policy and procedure for reporting crime in their jurisdiction. NHA A indicated she does not need family or resident's permission to follow the facility abuse policy and procedures. NHA A indicated she understands that the local law enforcement is a resource for the residents and by calling them, she would be giving the local law enforcement a chance to decide whether they would conduct an investigation on behalf of the resident, or if they would just document it, or if they would not get involved at all. NHA A indicated by not calling local law enforcement to report, the resident is denied the resource of having local law enforcement involved.</p>		