STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525430	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Rehab Ctr	14400 Cty Hwy B Sparta, WI 54656

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47657 Based on record review and interview, the facility did not conduct a thorough investigation of a resident-to-resident altercation by interviewing all residents who were in area at time of incident, did not provide follow up supervision for 48 hours per facility report to protect other residents, and did not provide staff education following an incident for 1 of 4 residents (R1). This is evidenced by: The facility policy, entitled Misconduct Investigation & Reporting last reviewed on 08/23/11 and states in part under section 14 of policy: All resident witnesses/victims should be interviewed as part of the investigation. Nursing or Social Services will assess the resident(s) and make official entries in client charts indicating any behavioral, emotional or changes from their baseline and recommend follow-up or longer if deemed necessary. R1 was admitted to facility on 03/21/21 and has diagnosis of cerebral vascular accident and aphasia. R1's quarterly Minimum Data Set completed on 06/19/24 indicated that R1 has a Brief Interview for Mental Status (BIMS) score of 6 (moderate cognitive impairment). On 08/20/24 at 8:45 AM, Surveyor reviewed facility investigation that occurred on 05/27/24 of a resident-to-resident altercation. R1 had turned off the TV in the resident living room while other residents were watching it and went back to own room. The TV was turned back on and R1 came back out of own room and got upset at inability to locate the TV remote. R1 threw items off the dining table and grabbed another resident's hand and squeezed it. On 08/20/24 at 8:50 AM, Surveyor requested evidence to support that the facility put interventions into place to prevent further resident abuse from occurring while the investigation was in progress. Surveyor asked for interviews conducted with residents that were witnesses to the event to thoroughly collect evidence to allow the facility to determine what actions are necessary (if any) for the protection of residents and education provided to staff following the incident of the findings. On 08/20/24 at 12:39 AM, Surveyor interviewed Nursing Home Administrator (NHA) A who stated interviews with residents that were witnesses to the event did not occur. The facility did not have evidence of R1's increased supervision for 48 hour per facility report and did not provide education to staff following the incident to prevent further potential abuse.

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	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** 49353 Based on interview and record review, the facility did not ensure adequate supervision to reduce risk of wandering/elopement for 1 of 3 residents (R) reviewed (R1). R1 left the facility without staff's knowledge and was not added to the facility's Wanderer's List for increased supervision after incident per facility policy. This is evidenced by: The facility's policy titled, Wanders-Identification, Observation, and Possible Search For, with most recent revision dated 08/2022 stated in part that required follow up following a wandering/elopement event nursing staff must include resident on Wanderer's List. R1 was admitted to the facility on [DATE] with pertinent diagnoses of hemiplegia (impaired body function) on right side due to cerebral infarction (blood clot in brain) and aphasia (impaired speech). R1's most recent quarterly Minimum Data Set (MDS) dated [DATE] indicated no verbal, physical, or wandering behaviors noted. R1's Brief Interview of Mental Status (BIMS) score was 06 indicating severe cognitive impairment. R1's care plan, dated 07/17/24 (implemented after elopement), states: Problem: Activities of Daily Living/Functional Safety Interventions: Wheelchair to be positioned next to head of bed locked related to self-transfer. If R1 is upset/angry about something, staff to initiate 15-minute checks until anger/upset is resolved. No care plan interventions for wandering/elopement risk for R1 were noted. Surveyor reviewed facility's self-report incident of R1 wandering from facility without supervision that occurred on 07/17/24. Surveyor reviewed R1's medical record for wandering/elopement risk assessment. No risk assessment noted. No prior incidents of elopement or exit seeking noted in the medical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following the event the care plan was updated to include implemented safety interventions of 15-minute safety checks and placement of wheelchair next to bed for safety. The Interdisciplinary Team (IDT) met to review incident and determined that R1 was upset about a chair being moved in his room causing R1 to become upset and purposefully leave facility. The IDT determined that R1 was not previously considered at-risk for wandering, had not displayed exit seeking behaviors prior to this incident, and was determined not be at-risk for wandering in the future. The IDT ultimately decided to discontinue the 15-minute safety checks with the exception of re-starting safety checks if R1 becomes agitated/upset again, the facility did not to add R1 to facility's wanderer's list. The facility determined through their investigation the use of other safety supervision interventions (such as a Wanderguard) were unnecessary. On 08/20/24, Surveyor reviewed facility's wanderer's list for residents identified as at-risk for wandering/elopement. R1 was not included on this list. On 08/20/24 at 12:37 PM, Surveyor interviewed Director of Nursing (DON) B and Nursing Home Administrator (NHA) A regarding wandering/elopement risk assessment procedure and R1 not being listed on wanderer's list. Surveyor asked if there was a policy for wandering/elopement risk assessment. DON B stated having no written policy, but current practice is that newly admitted residents are informed of any prior wandering/elopement incidents or at-risk behaviors from transferring facility, if applicable. Additionally, all new admissions are monitored for 72-hours for mood and behavior. This information is assessed by the IDT to determine safety risks (i.e. wandering) and the care plan will be updated with safety interventions. All residents are then routinely monitored by nursing staff documenting any change in mood or behavior which is then assessed during routine IDT meetings or immediately if nurse recognizes a risk to safety. Each resident is assessed individually by the IDT for appropriate safety interventions and not all residents at-risk for wandering will have a Wanderguard applied, as was the case with R1. DON B stated R1 had never showed signs of wandering or exit seeking prior to this event and therefore was never determined to be a risk. DON B and NHA A stated that R1 was assessed by the IDT not to be not appropriate for the wanderer's list or for use of a Wanderguard as this would upset R1 being questioned by staff every time R1 was observed roaming the facility grounds outside of R1's unit and restrict his rights. Surveyor asked DON B and NHA A the purpose of having the wanderer's list. DON B and NHA A both stated that the individuals on the list were at-risk for wandering and provide a picture for quick recognition by staff to intervene if observed attempting to wander or elope. Surveyor asked why R1 was not added to wanderer's list after the wandering event. DON B and NHA A stated that they felt appropriate post-incident safety measures were implemented at the time and it was not necessary, but now recognize R1 should have been added to the list.