

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	

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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161</p> <p>Based on observation, interviews, and record review, the facility did not ensure 1 of 3 residents (R1) reviewed for potential sexual abuse was provided medically related social services to assist R1 in attaining or maintaining their mental and psychosocial health.</p> <p>* On 5/18/24, R1 was approached by her spouse to have sexual relations while R1 resided at the facility. The facility was made aware of R1's spouse's intentions to have sexual relations with R1 prior to 5/18/24 but took no steps on 5/18/24 to ensure that R1 could consent to having sexual relations.</p> <p>Findings include:</p> <p>R1 was admitted to the facility on [DATE] with a diagnosis that included Left Hand Contracture, Bipolar Disorder, Anxiety Disorder, Schizophrenia, Unspecified Dementia without Behavioral Disturbance, Mood Disturbance and Anxiety.</p> <p>R1's Annual MDS (Minimum Data Set) dated 3/15/24 documents a BIMS (Brief Interview for Mental Status) score of 00, indicating that R1 is severely cognitively impaired.</p> <p>Section E (Behavior) documents that R1 experiences hallucinations, delusions and experiences verbal behavioral symptoms directed towards others.</p> <p>Section GG0115 (Functional Limitation in Range of Motions) documents that R1 has impairment on both sides of her upper and lower extremities.</p> <p>R1's Behavior care plan dated as initiated 11/4/23 documents, Focus: The resident has a behavior problem calling out due to cognitive impairment, bipolar, anxiety, schizophrenia. Resident suffers from PTSD (post traumatic stress disorder) due to losing a patient while a nurse.</p> <p>R1's Intimacy and Sexual Preferences care plan dated as initiated 4/14/24 documents, Focus: Resident is married and comfortable showing affection with husband by holding hands, kissing and sexual relations. Interventions: Intimacy and Sexual Assessment to be completed on admission. Will be updated as needed with change in condition; Social worker will be available to meet with resident regarding choices.</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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's nursing note dated 5/3/24 at 3:29 PM documents, Social Services Note Text: POA (power of attorney) contacted writer to make aware he will be in tomorrow. POA would like privacy for sexual relations with wife.</p> <p>R1's nursing note dated 5/15/24 at 5:22 PM documents, Note Text: Unwitnessed Fall: Nonapparent injury. Resident observed by kitchen staff face down in front of her chair in the dining hall, nursing staff notified immediately. Resident was assessed, AOx3, denies any pain, very good spirits, no complaints. Assessed, no injury found. Hoyer sling used to help resident back to bed. Reassessed with a scrap found on her left eyebrow. Resident confused which is her baseline. Unable to explain what happened. Room well-lit. Floor dry and uncluttered.</p> <p>R1's Fall Risk Evaluation dated 5/15/24 documents, Memory and Recall Ability: In the last 7 days: recalls three out of four of the following: current season, that he/she is in a nursing home, location of room, staff names/faces. Answer: Sometimes.</p> <p>R1's nursing note dated 5/16/24 at 3:43 PM documents, Nurses Note Text: At 08:15 (AM) CNA (Certified Nursing Assistant) informed RN (registered nurse) that resident was on the floor in the dining room. Resident was noted to be laying on side on foot rest of chair. RN assessed resident, resident denied pain . Neuro checks negative, no injuries noted. Resident transferred back into chair via Hoyer, resident was relocated and monitored until notable decrease of fidgeting behavior.</p> <p>R1's Fall Risk Evaluation dated 5/15/24 documents, Memory and Recall Ability: In the last 7 days: recalls three out of four of the following: current season, that he/she is in a nursing home, location of room, staff names/faces. Answer: Sometimes.</p> <p>R1's nursing noted dated 5/18/24 at 2:59 PM documents, Note Text: Husband here this AM, complains that his wife is not ready for him at 9 am, and where is the sign for the door, writer unaware of what he actually means. Writer is assuming not ready for taking to dining room or outside. Social worker explains to writer if this sign is on door it means do not go in room that they are performing sexual acts. Husband comes out of room a few hours later states to writer I'm done now you can clean her up now and I will be back next Saturday. I go in room to check on patient she is on her left side balled up in a ball in fetal position and will not speak to me. this patient seems to be A/O x 2.</p> <p>At the time, Surveyor was unable to locate any documentation in R1's medical record that documented that facility staff assessed R1's mental status and ability to consent to sexual relations on 5/18/24.</p> <p>On 6/6/24 at 12:05 PM, Surveyor observed R1 sitting in a Broda chair. Surveyor attempted to speak with R1 but R1 did not answer Surveyor's attempts to initiate conversation.</p> <p>On 6/6/24 at 12:17 PM, Surveyor informed DON (Director of Nursing)-B and SW (Social Worker)-D of the above findings. Surveyor asked SW-D if she had assessed R1's ability to consent to sexual relations with her husband on 5/18/24, as R1 is confused at times.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>SW-D informed Surveyor that she had spoken to R1 the morning of 5/18/24 and that she thought she had documented the interaction in R1's medical record. Surveyor informed SW-D that Surveyor could not locate any assessment in R1's medical record that documented R1 was able to consent to sexual relations and that documented R1 was alert and orientated enough to make such decision. SW-D informed Surveyor that she spoke with R1 but did not complete a formal assessment on R1.</p> <p>Surveyor informed DON-B and SW-D that fall documentation on 5/15/24 and 5/16/24 (see above) documented R1 was confused as a baseline. Surveyor also noted that R1's nursing noted dated 5/18/24 documents that R1 was AO (alert and orientated) x 2 after she had engaged in intimate time with her husband.</p> <p>Surveyor asked SW-D why she had not completed an assessment of R1's ability to consent to sexual relations prior to R1's husband's arrival on 5/18/24 and why R1 was documented as being AOX 2 on 5/18/24 by nursing staff.</p> <p>SW-D informed Surveyor that she could not explain why she did not formally assess R1 and could provide no explanation why nursing staff would document that R1 was AO X 2 on 5/18/24.</p> <p>SW-D informed Surveyor that she spoke with R1 the morning of 5/18/24 and was told by R1 she wanted her husband's penis. SW-D informed Surveyor that because of this, she assumed R1 was able to consent to sexual relations with her husband.</p> <p>SW-D informed Surveyor that she would go back into R1's medical record and document this conversation.</p> <p>R1's nursing note dated 5/18/24 at 8:05 AM but written on 6/6//24 documents, Social Services Late Entry:</p> <p>Note Text: Writer met with resident in dining room, resident was eating breakfast. Resident stated her husband is coming today. Writer asked resident if she was comfortable having sexual relations with her husband. Resident replied, I want his dick. Writer left resident to eating her breakfast.</p> <p>On 6/6/24 at 3:15 PM, Surveyor informed NHA (Nursing Home Administrator)-A and DON-B of the above findings. No additional information was provided as to why the facility failed to provided medically related social services to assist R1 in consenting to sexual relations.</p>		