

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525562	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Vernon Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Fairlane Dr Viroqua, WI 54665	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview, and policy review, the facility failed to ensure residents (R) were free from physical abuse for 1 (R22) of 3 residents reviewed for abuse out of 18 sample residents. R15 threw a metal spoon and hit R22 on the back of the head during an activity.</p> <p>Findings include:</p> <p>Review of R15's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnosis including unspecified dementia.</p> <p>Review of R15's significant change "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 07/07/24 located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated the resident was severely cognitively impaired. Further review revealed R15 exhibited physical and verbal behaviors towards others.</p> <p>Review of R15's Care Plan, located under the "Care Plan" tab of the EMR and dated 08/26/24, revealed a care plan related to altered behaviors and that resident strikes out. Interventions in place were to watch for signs of increasing anxiety and agitation.</p> <p>Review of R22's "Admission Record," located in the "Profile" tab of the EMR, revealed R22 admitted to the facility on [DATE] with diagnosis including Alzheimer's disease.</p> <p>Review of R22's quarterly "MDS" with an ARD of 09/04/24 and located in the EMR under the MDS tab revealed the facility a BIMS score of 13 out of 15 which indicated the resident was cognitively intact.</p> <p>Review of R15's Incident report, dated 08/25/24 at 10:00 AM, provided by the facility revealed there was an incident with R15 during activities. No additional description was listed.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525562	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Vernon Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Fairlane Dr Viroqua, WI 54665	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R15's Incident Summary dated 08/25/24 at 10:00 AM completed by Activities Assistant 1 (ACT) revealed ACT1 removed R15 from the group circle in the activity room due to R15 trying to hit another resident. (It did not identify the resident) It further documented while ACT1 was trying to redirect R15 with magazines, R15 tried to hit ACT1 with a spoon but was unsuccessful. R15 kept talking to ACT1 and then moved her chair to see in the direction of the group of other residents and then threw the spoon at another resident.</p> <p>During an interview on 11/18/24 at 2:33 PM, ACT1 stated Certified Nurse Aide 1 (CNA) brought R15 into the activities room from the dining room. ACT1 stated R15 already had a spoon with her when she came to activities. She stated that CNA1 placed R15 beside other residents. She said R15 seemed off, appeared upset and had an angry face. R15 was sitting beside R22 and R15 attempted to hit R22 on her arm with the spoon but she was unable to reach her. ACT1 further stated she moved R15 to another table in the activity room. She gave R15 some magazines to read and she seemed fine, but she did not take the spoon away from R15. A short time later R15 turned her wheelchair around in the direction of the other resident and was mumbling something and she threw the spoon. She did not see the spoon being thrown but she heard the noise it made when it hit the ground, and she heard R22 say Ouch. Continued interview revealed she looked up and saw R22 who appeared upset. ACT1 stated she asked R22 if she was okay, and she stated yes. At that time, she took R15 out of the activity room and reported it to Licensed Practical Nurse 1 (LPN), who took R15 with her while she filled out an incident report and wrote a statement.</p> <p>During an interview on 11/18/24 at 2:59 PM, LPN1 stated back in August, ACT1 reported to her during an activity that R15 became upset and threw a spoon at R22. She took R15 to the nurse's station after it happened to keep an eye on her. She stated she was aware that R15 had another incident in the past of hitting another resident. She stated R15 should not have been allowed to take a metal spoon out of the dining room. She said no residents are allowed to take utensils out of the dining room.</p> <p>During an interview on 11/19/24 at 12:12 PM the Director of Nursing (DON) stated the facility substantiated the incident that occurred between R15 and R22. She stated staff witnessed the incident when R15 threw a spoon at R22 and hit her in the head. She stated ACT1 should have intervened and notified a nurse as soon as she observed R15 trying to hit R22 on the arm.</p> <p>Review of the facility's policy titled Resident Abuse revised 01/15/24 revealed, the facility believes all residents have the right to be free from abuse including metal, verbal, and sexual: neglect, maltreatment, exploitation, corporal punishment, involuntary seclusion, and misappropriation of property.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525562	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Vernon Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Fairlane Dr Viroqua, WI 54665	
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** 37590</p> <p>Based on record review, document review, interviews, and policy review, the facility failed to timely report an allegation of verbal abuse to the State Agency (SA) for 1 of 3 residents (R33) reviewed for abuse out of a total sample of 18 residents.</p> <p>Findings include:</p> <p>Review of the facility's Grievance Log for September 2024 revealed a grievance dated 09/17/24 that indicated R33 reported that Certified Nurse Aide 5 (CNA) had verbally abused her.</p> <p>Review of R33's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab revealed admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, heart failure, and chronic obstructive pulmonary disease (COPD).</p> <p>Review of the EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/04/24 under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact.</p> <p>Review of the facility's investigative file revealed that CNA6 (Certified Nursing Assistant) and CNA5 entered R33's room on 09/14/24 to answer her call light. R33 requested to be removed from the bedpan. CNA5 began to yell at R33. CNA7 came across the hall and stated that she heard CNA5 yelling at R33. The investigation documented that CNA6 reported to RN1 the verbal abuse on 09/15/24. However, Registered Nurse 1 (RN) did not report to the Social Service Director (SSD) or Director of Nursing (DON) until 09/17/24 the allegation of verbal abuse. On 09/17/24, the SA and Local Law Enforcement were notified.</p> <p>Review of the facility's policy titled Resident Abuse revised 01/15/24 revealed, Nursing Home Administrator will determine whether or not the alleged incident or offense is reportable. Reportable incidents are to be reported immediately, and not to exceed 24 hours with the exception of suspicion of serious bodily injury which will be reported immediately, but no later than 2 hours after forming the suspicion.</p> <p>During an interview with the DON on 11/19/24 at 04:14PM, she confirmed that she and the SSD work as the facility's Abuse Coordinators. She was asked why the facility failed to report the incident timely to the SA regarding R33's allegation of abuse and she stated that she was not made aware of the situation until the day it was reported 09/17/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525562	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Vernon Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Fairlane Dr Viroqua, WI 54665	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview, and policy review, the facility failed to thoroughly investigate an incident of resident-to-resident abuse for 1 of 3 residents (R22) reviewed for abuse out of 18 sample residents.</p> <p>Findings include:</p> <p>Review of R15's "Admission Record," located in the "Profile" tab of the EMR, revealed R15 admitted to the facility on [DATE] with diagnoses of unspecified dementia, anxiety disorder and depression.</p> <p>Review of R15's significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/07/24, revealed a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicated severe cognitive impairment. Further review revealed R15 exhibited physical and verbal behaviors towards others.</p> <p>Review of R22's "Admission Record," located in the "Profile" tab of the EMR, revealed R22 admitted to the facility on [DATE] with diagnosis of Alzheimer's disease.</p> <p>Review of R22's quarterly "MDS" with an ARD (Assessment Reference Date) of 09/04/24 revealed a BIMS (Brief Interview of Mental Status) score of 13 out of 15, which indicated no cognitive impairment.</p> <p>Review of R15's Incident Summary dated 08/25/24 at 10:00 AM completed by Activities Assistant 1 (ACT) revealed ACT1 removed R15 from the group circle in the activity room due to R15 trying to hit another resident. (It did not identify the resident). The summary further stated while ACT1 was trying to redirect R15 with magazines and that R15 tried to hit ACT1 with a spoon but was unsuccessful. R15 kept talking to ACT1 and then moved her chair in the direction of the group of other residents. R15 threw a spoon at another resident.</p> <p>During an interview on 11/18/24 at 2:33 PM, ACT1 stated that Certified Nurse Aide 1 (CNA) brought R15 into the activities room from the dining room and that R15 was carrying a spoon. R15 was seated beside R22 and R15 attempted to hit R22 on her arm with the spoon but she was unable to reach her. ACT1 moved R15 to another table in the activity room. A short time later R15 turned her wheelchair around in the direction of the other resident and was mumbling something. R15 threw the spoon. ACT1 stated that she didn't see the spoon being thrown but she heard the noise it made when it hit the ground, and she heard R22 say Ouch.</p> <p>During an interview on 11/19/24 at 12:12 PM, the Director of Nursing (DON) confirmed that she did not interview any staff or other residents who were witnesses to the incident. The DON stated that she should have completed a thorough investigation by conducting the interviews.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525562	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Vernon Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Fairlane Dr Viroqua, WI 54665	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled Resident Abuse revised 01/15/24 revealed, the facility believes all residents have the right to be free from abuse including mental, verbal, and sexual: neglect, maltreatment, exploitation, corporal punishment, involuntary seclusion, and misappropriation of property. The policy of the facility is to investigate any suspicious events of the above nature. The investigation will include interviewing alleged victim(s) and witnesses. Interviewing other residents to determine if they have been abused. Interview staff that work same shift as the accused and interview staff who worked other shifts to determine if they are aware of an injury or incidents. Interview family or others who may know about any injury, incident, or significant care issues.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525562	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Vernon Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Fairlane Dr Viroqua, WI 54665	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440</p> <p>Based on observation, interview, record review, and policy review, the facility failed to develop a person-centered care plan to include pertinent diagnoses and care areas for 2 residents (R28 and R59) of 18 sampled residents.</p> <p>Findings include:</p> <p>Review of R28's Admitting and Discharge Record located in the electronic medical record (EMR) under the Face Sheet tab, revealed an admitted [DATE] with diagnosis of malignant carcinoid tumor of the ileum.</p> <p>Review of R28's admission Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 09/04/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R28 was cognitively intact. Review of the Care Area Assessments (CAAs) revealed urinary incontinence, psychotropic drug use, and pain were triggered by the MDS and had a checkmark for Addressed in Care Plan.</p> <p>Review of R28's EMR under the Care Plan tab revealed no mention of pain, incontinence, and psychotropic drug use in the Care Plan.</p> <p>Review of R28's Guidelines for Daily Care, located in R28's room revealed no plan of care for pain, incontinence, and psychotropic drug use.</p> <p>On 11/19/24 at 1:17 PM, MDS Coordinator (MDSC) said the interdisciplinary team determined what went on the comprehensive care plan. A Registered Nurse (RN) worked on the admission and was responsible to start the care plan. The MDSC stated that she reviewed the care plan and updated it as needed. She stated that R28's care areas were expected to be on the care plan. The MDSC verified R28's Care Plan did not address the care areas.</p> <p>Example 2</p> <p>Review of R59's Admitting and Discharge Record located in the EMR under the Face Sheet tab, revealed an admitted [DATE] with diagnosis of unspecified dementia.</p> <p>Review of R59's EMR under the Nurses Notes tab revealed a 10/01/24 Nurse Notes which indicated, It was reported from staff that resident has been wandering into other residents' room on 300 wing, disturbing other residents. Per IDT (Interdisciplinary Team), alarm will be placed on door to notify staff of residents whereabouts at night and encourage resident from wandering into other rooms.</p> <p>Review of R59's quarterly MDS located in the EMR under the MDS tab with an ARD of 10/16/24, revealed a BIMS score of 7 out of 15, indicating severe cognitive impairment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525562	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Vernon Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Fairlane Dr Viroqua, WI 54665	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R59's Care Plan in the EMR under the Care Plan tab revealed an approach, dated 10/28/24, door alarm on door at night only under the self-care deficit problem. The Care Plan did not document that R59 wandered.</p> <p>Review of R59's Guidelines for Daily Care, located in R59's room revealed it did not mention R59's wandering or use of an alarm.</p> <p>During an observation on 11/17/24 at 9:21 AM, a motion sensor alarm was mounted to the top of R59's door frame.</p> <p>During an interview on 11/18/24 at 9:49 AM, LPN3 stated the alarm over the door was in place because R59 was confused and started to wander into other residents' rooms.</p> <p>During an interview on 11/18/24 at 2:10 PM, Certified Nurse Aide 3 (CNA) stated she used the care cards located inside the residents' closets and daily report to know how to care for the residents.</p> <p>During an interview on 11/19/24 at 9:00 AM, the Assistant Director of Nursing (ADON) stated the floor nurses were instructed to update the Care Plan for new infections. For other care items, the MDS nurse was responsible.</p> <p>During an interview on 11/19/24 at 12:49 PM, CNA4 reported she used a paper located in residents' closets which stated how to provide care.</p> <p>During an interview on 11/19/24 at 1:02 PM, Licensed Practical Nurse 3 (LPN) said that she only updated the care cards in the residents' rooms with changes.</p> <p>On 11/19/24 at 1:17 PM, MDS Coordinator (MDSC) stated she thought the nurses had updated R59's care plan when he began wandering. MDSC verified the care plan did not contain any wandering behavior.</p> <p>During an interview on 11/19/24 at 3:07 PM, the Director of Nursing (DON) stated that RNs were responsible for the care plans and that the MDSC was expected to check them when completing the MDS assessments. The DON expected triggered care areas and pertinent diagnoses were addressed on the care plan. The DON stated that changes, such as wandering behavior, were also expected to be on R59's care plan.</p> <p>Review of the facility's policy titled, Development - Implementation and Maintaining Comprehensive Care Plans, updated 06/01/22, revealed, RN and other interdisciplinary team members will create an overall care plan reflecting the individual needs, strengths, and preferences of the resident . The care plan should continue to reflect resident's individual needs, strengths and preferences. It will be evaluated and revised with quarterly, annual, and significant change status assessments, and as needed with changes in resident condition and functioning. The care plan should show evidence of the resident's triggered areas Care Area Assessments (CAAs) . The care plan should be followed by all staff providing care to the resident. Portions of the care plan pertinent to the CNAs should be located inside the resident closet door.</p>		