| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525613 | A. Building<br>B. Wing | 02/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Villa Marina Health and Rehab Ctr | 35 N 28th St<br>Superior, WI 54880 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, are reported immediately to other officials including the State Agency (SA) in accordance with State law through established procedures for 1 of 3 sampled residents (R). (R1)The facility did not report R1's injury of unknown origin within two hours, as the allegation involved potential abuse.The facility did not submit the misconduct incident reportwith investigation findings for R1 within five business days of discovery of the incident. The facility did not report allegation of sexual abuse to R2 within two hours to the SA.The facility did not submit the misconduct incident report with investigation findings for R2 within 5 business days of the allegationThe facility policy titled, Resident Abuse - Prevention/Investigation, dated 10/15/17, states, Villa [NAME] Health and Rehabilitation Center requires all staff to report any suspicion of abuse, neglect, exploitation or misappropriation including suspicious bruising, occurrences, patterns and trends that may constitute abuse immediately to the Administrator or designee to determine the direction of the investigation. In doing so will ensure all alleged violations involving mistreatment, neglect, or abuse or exploitation including injury of unknown source, and misappropriation of resident property are reported.R1 was admitted to the facility on [DATE], with diagnoses that included respiratory failure, heart failure, bone cancer, and pleural effusion (fluid around the lungs). R1's Minimum Data Set (MDS), dated [DATE], included a Brief Interview of Mental Status (BIMS) score of 13/15, which indicates R1 has intact cognition. R1 was dependent on staff for eating, bed mobility, transfers, and toileting and used a wheelchair for mobility and a mechanical lift for transfers. On 02/09/26, Surveyor requested and reviewed the complete self-report. The self-report noted that on 08/30/25 at around 11:00 AM, R1 was found with dark purple bruising (5 inches by 2-3 inches) on left ribs from armpit into ribcage. The final report had a submission date of 11/17/25, which is not within the 5-day reporting requirement.On 02/09/26, Surveyor reviewed facility grievances and discovered that R2 accused Registered Nurse (RN) C of trying to have sex with R2. Surveyor requested the complete investigation and found no evidence that the allegation was reported to the State Agency.R2 was admitted on [DATE] with diagnoses that include pneumonia, stroke, Lewy Body, hallucinations, amnesia, and cognitive communication deficit. R2's MDS, dated [DATE], shows a BIMS score of 14/15 indicating intact cognition, is independent with eating and bed mobility, and requires supervision/touch assistance with transfers and toileting. On 02/09/26 at 2:30 PM, Surveyor interviewed Social Worker (SW) D and asked why R1's injury of unknown origin final report was not submitted within the 5-day requirement. SW D stated that SW D is new to the position (less than 3 months) and the previous Social Worker did not ensure it was completed. Surveyor asked SW D why the sexual misconduct allegation was not reported to the State Agency. SW D stated they felt the entire investigation was completed within the 2-hour timeframe, R1 has a diagnosis of Lewy Body Dementia,<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and the police did not feel it was substantiated, therefore SW D felt it was not necessary.On 02/09/26 at 3:32 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked what the reporting expectation would be for R1's injury of unknown origin and R2's sexual misconduct report. NHA A stated that both should have been reported within 2 hours and the final report submitted within 5 days. When asked for the supporting documentation, NHA A stated R1's report to the State Agency was extremely late and they did not report R2's allegation at all which should have been reported. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not complete a thorough investigation of the alleged violation, maintain documentation that an alleged violation was thoroughly investigated, and prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation of an alleged violation is in progress for 1 of 3 residents (R) reviewed. (R2)The facility did not update R2's physician regarding the allegation of sexual misconduct by staff.The facility did not suspend accused staff of making inappropriate sexual statements while the investigation was being conducted.The facility did not re-educate staff regarding abuse/misconduct policies and procedures following the incidents for R2.The facility policy dated 10/15/17, titled, Resident Abuse-Prevention/Investigation, indicates: .2. The Director of Nursing (or designated representative such as the charge nurse on duty) will contact the Resident's physician.7. If a staff member is accused or suspected of abuse, mistreatment, neglect, exploitation or misappropriation of resident property, the facility will immediately remove that staff member from the facility and the schedule pending the outcome of the investigation.Villa [NAME] Health and Rehabilitation Center will provide ongoing staff training on the subject of Abuse, Neglect, Exploitation and Misappropriation of property, Injuries of Unknown Source, catastrophic reactions, burnout, and resident against resident aggression, as appropriate.R2 was admitted to the facility on [DATE], with diagnoses that included pneumonia, stroke, Lewy Body Dementia, hallucinations, amnesia, and cognitive communication deficit. R2's Minimum Data Set (MDS), dated [DATE], indicated that R2 scored a 14/15 on the Brief Interview of Mental Status (BIMS) which means R2 is cognitively intact. R2 is independent with eating and bed mobility but requires staff supervision for transfers and toileting.On 02/09/26, Surveyor reviewed the facility grievances and requested the investigation for R2's incident that occurred on 01/05/26. The investigation noted that R2 accused Registered Nurse (RN) C of offering sex to R2. Surveyor attempted to speak with R2; however, R2 declined due to not feeling well. Surveyor reviewed the facility investigation and R2's electronic health record and found no evidence that R2's physician was updated, RN C was not suspended pending the investigation, and ongoing education was not provided to all staff.On 2/9/26 at 2:35 PM, Surveyor interviewed Director of Nursing (DON) B, and asked for proof the physician was updated, proof that RN C was removed from the facility pending the investigation, and proof of ongoing education for all staff regarding abuse. DON B stated the doctor was not updated since their investigation and the police could not substantiate the allegation occurred. Surveyor asked if it was possible the allegation could have been a decline in R2's condition which DON B agreed it could have and agreed the doctor should have been notified. DON B reported RN C was in the office and had no resident contact, and they were able to complete the investigation within 2 hours, therefore they did not feel it was necessary for RN C to be suspended. Surveyor asked DON B how they could prove RN C was in the office and not posing a risk for other residents during the time of the investigation. DON B stated she cannot prove it because RN C was still punched in at the time. DON B voiced understanding of the importance of the accused staff to be out of work status and removed from the building. Surveyor asked why there was not on-going education for all staff regarding abuse following the incident. DON B stated she did not feel it was necessary since the allegation could not be substantiated, however agrees that re-education would be beneficial. |