

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525630	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER New Glarus Home		STREET ADDRESS, CITY, STATE, ZIP CODE 600 2nd Ave New Glarus, WI 53574	

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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436</p> <p>Based on interview and record review, the facility did not ensure the residents right to receive visitors of his or her choosing at the time of his or her choosing for 2 of 6 residents (R1 and R4).</p> <p>R1's medical record banner states R1's son, daughter, and daughter-in-law cannot visit. The facility posted a sign at the nurses' station indicating R1's son, daughter, and daughter-in-law are not allowed to visit.</p> <p>R4's medical record banner states R4 cannot receive visits from FM E (Family Member). The facility posted a sign at the nurses' station indicating R4 is not allowed visits from FM E.</p> <p>This is evidenced by:</p> <p>The facility Residents' Rights handout, undated, states, in part: .You retain the ability to exercise any rights that you do not delegate to a representative .You have the right to spend private time with visitors. The facility must permit your family, your representative(s), your physician, a representative of the state, and your Long-Term Care Ombudsman to visit you at any time .</p> <p>The facility provided an untitled and undated handout with headings of Dignity, Privacy, Grievances, Access, Notification and Transfer of Discharge that states, in part: You have the right to: .Private and unrestricted visits and communication with any person of your choice .</p> <p>Example 1</p> <p>R1 admitted to the facility on [DATE] with diagnoses including vascular dementia, relationship distress with spouse or intimate partner, and depression.</p> <p>R1's 11/20/24 Brief Interview for Mental Status (BIMS) score is 13, indicating R1 is cognitively intact.</p> <p>R1's comprehensive care plan, printed on 12/17/24, includes the following:</p> <p>-Special Instructions: ***Per R1's POA H (Power of Attorney) [Wife Name] - Son [FM G (Family Member)], daughter in law [Name] & daughter [Name] are not allowed to visit or take R1 out of the facility***Please call Administrator, [NHA A] if they are in the building or trying to take him out***</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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Focus: I have the following Advanced Directives on record Healthcare POA (Power of Attorney) .</p> <p>Goal: My Advanced Directives are in effect, and they will be carried out in accordance with my wishes on an ongoing basis .</p> <p>Interventions: My appointed health care representative will make all my health care decisions if I am incapacitated .</p> <p>-Focus: Per POA H: Son, daughter, and daughter in law are not to visit resident or take him out of facility at any time</p> <p>Goal: Son, daughter, and daughter in law will not visit resident or take him out of facility. They are allowed to send presnt's [sic] and cards.</p> <p>Interventions: Staff will ask son, daughter, and daughter in law to leave. If they do not leave staff are to call administrator.</p> <p>R1's Durable Power of Attorney for Health Care and Living Will dated 6/12/24, states, in part: .This advance directive form is an official document where you can write down your preferences for your health care. If someday you can't make health care decisions for yourself anymore, this advance directive can help guide the people who will make decisions for you.</p> <p>R1's Advance Directive Certification dated 7/28/22 states, in part: We certify that the principal is unable to receive and evaluate information effectively or to communicate decisions to such an extent that the principal lacks the capacity to manage his or her health care decisions.</p> <p>Of note, the activation of the Power of Attorney for Health Care only allows the POA to make health care decisions. This means the POA does not have authority to restrict R1's visitors.</p> <p>The facility posted sign at the nurses' station states: R1 was found to be incapacitated on 7/28/22. Power of Attorney is [Name]. I [POA H] do not want [FM G, daughter, and daughter in law] to be visiting R1 at the facility or taking R1 out of the facility.</p> <p>The first signature line was signed by POA H on 11/14/24. The second signature line was signed by SS F (Social Services) on 11/14/24.</p> <p>Handwritten at the bottom of the sign states: [POA H] is aware that we cannot monitor this 24/7. Signed by POA H on 11/14/24.</p> <p>R1's progress note dated 11/15/24 at 11:32 AM, written by SS F, states: Residents POA [Name] met with writer and stated that per her wishes that their son [Name] and his wife [Name] and their daughter [Name] are no longer allowed to visit Resident in the facility or take the Resident out of the facility. Document signed by POA and uploaded to [Electronic Health Record] labeled POA Visitor wishes. This was also put into [Electronic Health Record] under Special Instructions. [Name of POA] was made aware that we cannot monitor this 24/7. Writer and Administrator called [FM G] and [Daughter] to inform them of the POA's wishes. [FM G] stated that he would let his wife [Name] know.</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/17/24 at 10:27 AM, Surveyor interviewed R1 regarding visitations. R1 indicated he would like to visit with his son, daughter, and daughter in law.</p> <p>On 12/17/24 at 10:10 AM, Surveyor spoke with FM G (Family Member, R1's son). FM G indicated the facility called him and said FM G, R1's daughter and daughter in law were no longer allowed to come to the facility to visit R1 because of POA H's wishes. FM G indicated he would like to visit with his dad.</p> <p>Example 2</p> <p>R4 admitted to the facility on [DATE] with diagnoses including dementia, mild cognitive impairment, and depression.</p> <p>R4's comprehensive Minimum Data Set (MDS) assessment dated [DATE] has a Brief Interview for Mental Status (BIMS) score of 10, indicating R4 has moderate cognitive impairment.</p> <p>R4's Power of Attorney for Health Care Document, dated 9/2/21, signed by R4, states, in part: .you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to make those decisions personally . Designation of Health Care Agent .If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate POA O to be my health care agent for the purpose of making health care decisions on my behalf. If he or she is ever unable to unwilling to do so, I hereby designate FM E (Family Member) to be my alternate health care agent .</p> <p>R4's Power of Attorney for Health Care Statement of Incapacity, dated 6/21/24, states, in part: I have personally examined R4 and certify that the patient meets the statutory definition of incapacity, in that the patient is unable to receive and evaluate information effectively or to communicate decisions to such an extent that the patient lacks the capacity to manage his or her health care decisions .</p> <p>Of note, the activation of the Power of Attorney for Health Care only allows the POA to make health care decisions. This means the POA does not have authority to restrict R4's visitors.</p> <p>On 8/20/24, the facility mailed a letter to FM E that states, in part: I am writing to inform you that the Power of Attorney for R4 has requested that you do not visit with her while she is a resident of the facility. This is a request we are legally obligated to honor, and we respectfully request that you refrain from visiting the [Facility Name] .</p> <p>R4's comprehensive care plan printed on 12/17/24 states in part:</p> <p>-Special Instructions: Per POA, FM E cannot have contact with resident-Contact Administrator, if FM E will not leave when asked by staff .</p> <p>-Focus: I have the following Advanced Directives on record healthcare POA .</p> <p>Goal: My advanced directives are in effect, and they will be carried out in accordance with my wishes .</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions: My appointed health care representative will make all my health care decisions if I am incapacitated.</p> <p>On 12/17/12 at 10:03 AM, Surveyor interviewed CNA K (Certified Nursing Assistant) regarding visitations. CNA K indicated POA O requested FM E not be allowed to visit R4. CNA K stated there is a picture of FM E at the nurses' station and staff were instructed to ask her to leave and if FM E does not leave, staff are to call the administrator.</p> <p>On 12/17/24 at 10:13 AM, Surveyor interviewed LPN L (Licensed Practical Nurse) regarding visitations. LPN L indicated if R4 requested to see FM E, LPN L would talk to the DON (Director of Nursing) first because R4's POA does not want FM E to visit.</p> <p>On 12/17/24 at 10:19 AM, Surveyor interviewed CNA M regarding visitations. CNA M indicated FM E could not visit R4. CNA M indicated if R4 requested to visit with FM E, CNA M would have to speak with SS F because CNA M is unsure of the rules.</p> <p>On 12/17/24 at 10:36 AM, Surveyor interviewed CNA I regarding visitations. CNA I indicated residents can have visitors unless the POA or chart says different. CNA I indicated if there were visitation restrictions, a sign would be posted at the nurses' station.</p> <p>On 12/17/24 at 10:42 AM, Surveyor interviewed LPN N regarding visitations. LPN N indicated residents can have visitors unless the POA doesn't want them to. LPN N indicated a note would be posted at the nurses' station indicating any restrictions on visitation.</p> <p>On 12/17/24 at 10:58 AM, Surveyor interviewed MT J (Medication Technician) regarding visitations. MT J indicated residents could have visitors unless there was a situation where you would need to call the POA for approval.</p> <p>On 12/17/24 at 11:32 AM, Surveyor interviewed SS F regarding visitations and POA decision making abilities. SS F indicated that POA's care notified of medication consents, medication changes, care plan conferences and call to update them on everything. SS F indicated residents maintain their rights even if they have an activated POA. Surveyor asked if the POA has the authority to restrict who is able to visit with a resident and SS F indicated she did not know if the POA could make that decision or not.</p> <p>On 12/17/24 at 2:22 PM, Surveyor interviewed DON B regarding visitations and the decision-making authority POAs have. DON B indicated POAs have authority over finances and health care depending on the type of POA. DON B indicated POA for either finances or healthcare does not have the authority to restrict resident's visitors. DON B indicated it is the resident's rights to see whomever they want.</p> <p>On 12/17/24 at 2:53 PM, Surveyor interviewed NHA A regarding visitations and POA authority on decision making. NHA A indicated the POA should do what is in the best interest of the resident and the decisions should align with what the resident wants. NHA A indicated the POA has decision making authority in regard to finances or healthcare depending on the type of POA. NHA A indicated it is the residents' right to visit with whomever they want and a POA does not have the authority to restrict visitors.</p>		

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<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** 41788</p> <p>Based on interview and record review, the facility did not ensure that residents were free from sexual abuse perpetrated by a resident for 1 of 6 sampled residents (R2).</p> <p>R3 was found in R2's room sitting on the edge of the bed with R2's Depends unfastened and fondling R2 between the butt cheeks.</p> <p>Evidenced by:</p> <p>The facility policy titled, Abuse, Neglect, and Exploitation Policy & Procedures, dated 2/25/23, states, in part: .</p> <p>Policy Statement: It is the policy of New Glarus (referred to as the facility herein) to provide protections 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.</p> <p>Definitions: .</p> <p>Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology .</p> <p>Sexual Abuse is non-consensual sexual contact of any type with a resident.</p> <p>Procedure:</p> <p>1. The facility will develop and implement written policies and procedures that:</p> <p>a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.</p> <p>b. Establish policies and procedures to investigate any such allegations; and</p> <p>c. 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 .</p> <p>III. Prevention of Abuse, Neglect, and Exploitation</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves:</p> <p>A. Establishing a safe environment that supports .establishing policies and protocols for preventing sexual abuse .</p> <p>D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.</p> <p>E. Ensuring the health and safety of each resident .</p> <p>VI. Protection of Resident</p> <p>The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include .</p> <p>C. Increased supervision of the alleged victim and residents.</p> <p>D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator .</p> <p>G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.</p> <p>VII. Reporting/Response</p> <p>A. The facility will have written procedures that include:</p> <p>1. Reporting of all alleged violations to the Administrator, state agency . within specified timeframes:</p> <p>a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .</p> <p>R3 admitted to the facility on [DATE] and has diagnoses that include vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain).</p> <p>R3's Admission Minimum Data Set (MDS) Assessment, dated 11/11/24, shows that R3 has a Brief Interview for Mental Status (BIMS) score of 5 indicating R3 has severe cognitive impairment.</p> <p>R3's Care Plan, dated 11/17/24, states, in part:</p> <p>Focus: The resident has a behavior problem (agitation, anxious, irritability, sexually inappropriate, potential to become aggressive) r/t (related to) dementia and depression. Date Initiated: 11/17/24. Revision on: 11/20/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Goal: The resident will have fewer episodes of: Anxiousness, irritability, sadness, aggressive, sexually inappropriate behavior by review date. Date Initiated: 11/17/24. Revision on: 11/20/24. Target Date: 2/10/25.</p> <p>Interventions:</p> <ul style="list-style-type: none"> -Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 11/17/24. -Anticipate and meet the resident's needs. Date Initiated: 11/17/24. -Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Date Initiated: 11/17/24. -Explain all procedures to the resident before starting and allow the resident time to adjust to changes. Date Initiated: 11/17/24. Revision on: 11/17/24. -If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Date Initiated: 11/17/24. -Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 11/17/24. -Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations. Document behavior and potential causes. Date Initiated: 11/17/24. -Praise any indication of the resident's progress/improvement in behavior. Date Initiated: 11/17/24. <p>Note: No new interventions were put into place on or after 11/26/24.</p> <p>R2 was admitted to the facility on [DATE] and has diagnoses that include vascular dementia. R2's Quarterly MDS Assessment, dated 8/6/24 shows that R2 has a BIMS score of 5 indicating R2 has severe cognitive impairment.</p> <p>The Facility Self Report dated 11/26/24, states, in part: .</p> <p>Summary of Incident:</p> <p>Allegation type: Other: Reportable incident that is not misconduct related.</p> <p>Name - Affected Person: R2</p> <p>Name of Accused Person: R3 .</p> <p>Is Date and time when occurred known? NO</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Date occurred .: BLANK.</p> <p>Time occurred: BLANK.</p> <p>Is occurred date and time estimated: BLANK.</p> <p>Date discovered: 11/26/24.</p> <p>Brief Summary of Incident: On [DATE], at 9:15 am, it was reported to NHA A (Nursing Home Administrator), Interim Administrator, that R3 was found sitting on the edge of the bed of R2. CNA (Certified Nursing Assistant) stated that R2's brief was pulled down; R3 was sitting on the bed touching R2 in his private area. R3 was extremely confused at the time of the incident; R2 remained asleep through the incident. R3 was immediately removed. R2 did not have any s/sx (signs/symptoms) of pain or emotional disturbances. R3 was assisted in wheelchair to dining room and placed on 15-minute checks. R2's assessment was negative for skin and pain. Both residents have activated POAs (Powers of Attorney). R3's BIMS 5/15 and R2's BIMS 3/15. Neither resident is interviewable. POAs and physicians were notified. Police Department is being contacted. Statements being taken. Investigation has begun.</p> <p>Person Preparing This Report:</p> <p>Name: NHA A .</p> <p>Report Submitted Date: 11/26/24 10:39:49 AM .</p> <p>R2 & R3 - Resident to Resident Altercation 11/26/24, Investigation Summary, states, On [DATE], at 9:15 am, it was reported to NHA A, Interim Administrator, that R3, resident, was found sitting on the edge of the bed of R2. CNA P and CNA D stated that R2's brief was pulled down; R3 was sitting on bed touching R2 in his private area. R3 was extremely confused at the time of the incident. RN C (Registered Nurse) was called to the 400 wing and assessed both residents and R3 was immediately removed. R2 did not have any s/sx (signs/symptoms) of pain or emotional disturbances. R3 was assisted in wheelchair to dining room and placed on 15-minute checks. R2's assessment was negative for skin and pain. RN C notified DON B (Director of Nursing). Both residents have activated POAs R3's BIMS 5/15 and R2's BIMS 3/15. Neither resident is interviewable. POAs and physicians were notified. Police Department is being contacted. Statements being taken. Investigation has begun .</p> <p>Care Plans were reviewed/updated as appropriate. Other residents on secure 400 wing were interviewed .</p> <p>RN C's statement, dated 11/26/24, states, in part: .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At approximately 4:30 AM, CNA P working on the 400-hall called myself over to 500 hall and asked me to come over to the unit. Once I arrived, I saw R3 from room [421] sitting on the edge of R2's bed accompanied with the 2 CNAs working. The CNAs told me that R3 would not get up and leave the room. At which time I got R3's wheelchair and offered him a snack and drink which he was agreeable to and let us assist him into the wheelchair and out to the dining area. Once R3 was situated, CNA P told me that she found R3 in the room with R2, whose brief was pulled down, sitting on the bed, and touching R2 in his private area. CNA P also said that as she was leaving the room to call me, R3 slapped her on the butt and said, Now you get out of here. R3 seemed extremely confused at the time of the incident and was easily redirected when I arrived. R2 remained asleep through the incident and did not have any s/sx of pain or emotional disturbances. R3 was immediately placed on 15-minute checks .</p> <p>Email from DON B (Director of Nursing) to NHA A (Nursing Home Administrator) sent Tuesday December 3, 2024, 12:16 PM, states, On November 26, 2024, at 6:17 AM, I received a phone call from RN C regarding an incident involving two residents on the 400-wing, R3 and R2. She reported the staff was alerted by a call light going off in R2's room and found R3 touching R2 inappropriately after having removed R2's depends. Staff immediately removed R3 from the room. They did cares on R2 and reapplied depend. The staff said R2 slept through the entire incident. I asked RN C to have staff monitor R3, so he didn't return to R2's room. She assured me this would be done. I also asked her to write up a statement and give it to me when I got to work between 7:45 and 8 am. I reported this to NHA A on 11/26/24 at 9am.</p> <p>Abuse, Neglect, and Exploitation Policy and Procedure Training from 12/6/24 provided to Surveyor shows 117 staff out of 175 received this training.</p> <p>On 12/17/24 at 10:57 AM, Surveyor interviewed CNA D and asked CNA D to tell Surveyor about the incident that occurred on 1/26/24 between R2 and R3. CNA D indicated R3 and R2's rooms were adjoined by a bathroom. R3 had gotten up and walked through the bathroom into R2's room. CNA D indicated she knew this because CNA D and CNA P were sitting at the kitchen table and would have seen R3 if he would have been out in the hallway. CNA D indicated hearing movement and both CNA D and CNA P went to check and found R3 sitting on R2's edge of the bed. R2's depend was unfastened on one side and R3 was fondling R2's bottom with his hand between R2's butt cheeks. CNA D asked R3 what he was doing and informed R3 that R2 was a man. CNA D indicated R3 asked, That is a man? CNA D indicated R2 was full of BM (bowel movement) and R3's hand had BM all over it. CNA P moved R3 to his room into his recliner while CNA D stayed with R2 and cleaned R2 and applied a depend. CNA D indicated R2 was awake when both CNAs entered the room. Surveyor asked if R2 appeared to be scared or upset with what happened, and CNA D indicated no. CNA D indicated the CNAs called RN C right away, when RN C arrived CNA D indicated she left the room and CNA P stayed and took over. Surveyor asked if CNA D had received abuse training and CNA D indicated before she started at facility which was 90 days prior.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525630	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER New Glarus Home		STREET ADDRESS, CITY, STATE, ZIP CODE 600 2nd Ave New Glarus, WI 53574	
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>On 12/17/24 at 11:53 AM, Surveyor interviewed RN C and asked RN C to tell Surveyor about the incident that occurred on 11/26/24 between R2 and R3. RN C indicated CNA D & CNA P called RN C around 4:00 AM. RN C indicated when she arrived to R2's room, R2 was sleeping in his bed and R3 was sitting on the edge of R2's bed. CNAs reported R3 would not leave R2's room. RN C offered R3 a snack trying to get R3 out of R2's room. RN C retrieved R3's wheelchair and R3 did get into wheelchair. RN C took R3 out to the dining room and gave him a snack then went back into R2's room when CNAs informed her they had entered R2's room to find R3 sitting on edge of R2's bed with R2's depend unfastened and R3 was fondling R2 in R2's private parts. RN C indicated the CNAs informed her R2 slept through the incident. RN C indicated she assessed R2's mental status and pain. Surveyor asked if RN C assessed R2's skin at that time and RN C indicated no due to R2's brief was on. RN C asked the CNAs if they had seen anything different when they cleaned R2 up. CNAs indicated no. RN C indicated she started R3 on 15-minute checks immediately. RN C indicated R3 was confused, and she assessed his needs and checked neuros (neurological checks). RN C indicated everything checked out ok. Surveyor asked when RN C had received abuse training and she indicated she was agency and received abuse training before she could pick up a shift at facility. RN C could not recall when abuse education was received.</p> <p>On 12/17/24 at 2:15 PM, Surveyor interviewed DON B (Director of Nursing) and asked regarding the incident on 11/26/24 with R2 and R3, and what was put into place to ensure residents' safety from R3. DON B indicated at the time of the incident R2 and R3 were separated and staff were to keep an eye on R3. Surveyor asked what that includes specifically and DON B indicated staff was to make sure R3 did not go back into R2's room and to always monitor R3's whereabouts. Surveyor asked if R3 was on 1:1 to ensure staff knew R3's whereabouts and DON B indicated no. Surveyor asked DON B if staff were documenting R3 was being monitored and DON B indicated no. Surveyor asked DON B if anything was put into place for other residents' safety. DON B indicated not that she was aware of. Surveyor asked if there should have been, and DON B indicated yes. Surveyor asked DON B if R3 or R2's Care Plans had been updated after the incident. DON B indicated the last time R3's Care Plan was revised was 11/20/24; no updates or new interventions were put into place regarding 11/26/24's incident. Surveyor asked if DON B would expect a new intervention to be placed after incident and DON B indicated yes. DON B indicated no interventions were put into place for R2 after the incident and there should have been. Surveyor asked DON B if R3 was put on 15-minute checks immediately after the incident, and DON B indicated she could not find anything in R3's medical record indicating R3 was placed on 15-minute checks or showing R3 is currently on 15-minute checks. Surveyor asked DON B if she would expect all staff to receive abuse education after an incident such as what occurred between R2 and R3. DON B indicated yes.</p> <p>(continued on next page)</p>		

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(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>On 12/17/24 at 2:53 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked when an abuse allegation should be reported to the State Agency. NHA A indicated within 2 hours. Surveyor asked NHA A if the incident from 11/26/24 involving R2 & R3 was reported within 2 hours. NHA A indicated the facility was looking at this as a resident-to-resident altercation and as an isolated incident. Surveyor had NHA A look at time report that was submitted to state and the time incident occurred and asked if it was submitted within 2 hours. NHA A indicated the incident could be considered abuse and it was not submitted within the 2 hours. Surveyor asked NHA A if education was provided to all staff after this incident and NHA A indicated NHA A felt it was an isolated incident that wouldn't involve all staff in the rest of the building. NHA A indicated she considered the incident to be a resident-to-resident altercation. Surveyor asked NHA A if education was provided to RN C and DON B due to the reporting time frames. NHA A indicated there was an email to DON B, but nothing documented for RN C. Surveyor asked NHA A if reporting abuse in the required 2 hours is part of abuse training. NHA A indicated yes abuse training should have been given to all staff due to the reporting factor of this incident. NHA A provided staff education on abuse from 12/6/24. Surveyor informed NHA A it would be looked at. Surveyor asked NHA A as of today have there been any interventions put into place to prevent this incident from happening again, NHA A indicated no.</p> <p>On 12/17/24 at 3:15 PM, DON B walked in NHA A's office while Surveyor was conducting the interview. NHA A asked DON B if at this time anything was put into place to prevent this incident from occurring again between R2 and R3 and DON B indicated no. DON B indicated nothing has been done to closely monitor R3 and R2 to prevent this from occurring again.</p> <p>No protections were put into place to prevent an incident from occurring again between R3 and R2 after staff found R3 in R2's room fondling R2 between the butt cheeks.</p>		

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(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** 41788</p> <p>Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law though established procedures for 1 of 6 abuse investigations (R3) reviewed.</p> <p>Facility became aware of an abuse allegation on 11/26/24 at 4:30 AM and was not reported to State Agency until 11/26/24 at 10:39 AM.</p> <p>Evidenced by:</p> <p>The facility policy entitled, Abuse, Neglect, and Exploitation Policy & Procedures, dated 2/25/23, states, in part: .</p> <p>Policy Statement: It is the policy of New Glarus (referred to as the facility herein) is to provide protections 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.</p> <p>Definitions: .</p> <p>Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology .</p> <p>Sexual Abuse is non-sensual sexual contact of any type with a resident.</p> <p>VII. Reporting/Response</p> <p>A. The facility will have written procedures that include:</p> <p>1. Reporting of all alleged violations to the Administrator, state agency . within specified timeframes:</p> <p>a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .</p> <p>The Facility Self Report dated 11/26/24, states, in part: .</p> <p>Summary of Incident:</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>Allegation type: Other: Reportable incident that is not misconduct related.</p> <p>Name- Affected Person: R2</p> <p>Name of Accused Person: R3 .</p> <p>Is Date and time when occurred known? NO</p> <p>Date occurred .: BLANK.</p> <p>Time occurred: BLANK.</p> <p>Is occurred date and time estimated: BLANK.</p> <p>Date discovered: 11/26/24.</p> <p>Brief Summary of Incident: On [DATE], at 9:15 am, it was reported to NHA A, Interim Administrator, that R3, resident, was found sitting on the edge of the bed of R2. CNA (Certified Nursing Assistant) stated that R2's brief was pulled down; R3 was sitting on the bed touching R2 in his private area. R3 was extremely confused at the time of the incident; R2 remained asleep through the incident. R3 was immediately removed. R2 did not have any s/sx (signs/symptoms) of pain or emotional disturbances. R3 was assisted in wheelchair to dining room and placed on 15-minute checks. R2's assessment was negative for skin and pain. Both residents have activated POAs (Power of Attorney). R3's BIMS 5/15 and R2's BIMS 3/15. Neither resident is interviewable. POAs and physicians were notified. Police Department is being contacted. Statements being taken. Investigation has begun.</p> <p>Person Preparing This Report:</p> <p>Name: NHA A (Nursing Home Administrator)</p> <p>Report Submitted Date: 11/26/24 10:39:49 AM .</p> <p>RN C's statement, dated 11/26/24, states, in part: .</p> <p>At approximately 4:30 AM, CNA P working on the 400-hall called myself over to 500 hall and asked me to come over the unit. CNA P told me that she found R3 in the room with R2, whose brief was pulled down, sitting on the bed, and touching R2 in his private area.</p> <p>An email from DON B (Director of Nursing) to NHA A (Nursing Home Administrator) sent Tuesday, December 3, 2024, 12:16 PM, states, On November 26, 2024, at 6:17 AM, I received a phone call from RN C (Registered Nurse) regarding an incident involving two residents on the 400-wing, R3 and R2. She reported the staff was alerted by a call light going off in R2's room and found R3 touching R2 inappropriately after having removed R2's depends. Staff immediately removed R3 from the room. They did cares on R2 and reapplied depend. The staff said R2 slept through the entire incident. I asked RN C to have staff monitor R3, so he didn't return to R2's room. She assured me this would be done. I also asked her to write up a statement and give it to me when I got to work between 7:45 and 8 am. I reported this to NHA A on 11/26/24 at 9am.</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>On 12/17/24 at 2:53 PM, Surveyor interviewed NHA A and asked when an abuse allegation should be reported to state. NHA A indicated within 2 hours. Surveyor asked NHA if the incident from 11/26/24 involving R2 and R3 was reported within 2 hours. NHA A indicated the facility was looking at this as a resident-to-resident altercation and as an isolated incident. Surveyor had NHA A look at time report that was submitted to state and the time incident occurred and asked if it was submitted within 2 hours. NHA A indicated the incident could be considered abuse and it was not submitted within the 2 hours.</p>		

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<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** 41788</p> <p>Based on interview and record review, the facility failed to thoroughly investigate an accusation of physical abuse for 1 of 6 residents (R3) reviewed for abuse.</p> <p>R3 was found in R2's room sitting on edge of bed with R2's depends unfastened, fondling R2 between the butt cheeks. Facility did not put anything in place to prevent this from happening again. Facility did not provide abuse education to all staff.</p> <p>Evidenced by:</p> <p>The facility policy entitled, Abuse, Neglect, and Exploitation Policy & Procedures, dated 2/25/23, states, in part: .</p> <p>Policy Statement: It is the policy of New Glarus (referred to as the facility herein) is to provide protections 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.</p> <p>Definitions: .</p> <p>Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology .</p> <p>Sexual Abuse is non-sensual sexual contact of any type with a resident.</p> <p>Procedure:</p> <p>1. The facility will develop and implement written policies and procedures that:</p> <p>a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.</p> <p>b. Establish policies and procedures to investigate any such allegations; and</p> <p>c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention; and .</p> <p>III. Prevention of Abuse, Neglect and Exploitation</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves:</p> <p>A. Establishing a safe environment that supports .establishing policies and protocols for preventing sexual abuse .</p> <p>D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.</p> <p>E. Ensuring the health and safety of each resident .</p> <p>VI. Protection of Resident</p> <p>The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include .</p> <p>C. Increased supervision of the alleged victim and residents.</p> <p>D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator .</p> <p>G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.</p> <p>VII. Reporting/Response</p> <p>A. The facility will have written procedures that include:</p> <p>1. Reporting of all alleged violations to the Administrator, state agency . within specified timeframes:</p> <p>a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .</p> <p>The Facility Self Report dated 11/26/24, states, in part: .</p> <p>Summary of Incident:</p> <p>Allegation type: Other: Reportable incident that is not misconduct related.</p> <p>Name- Affected Person: R2</p> <p>Name of Accused Person: R3 .</p> <p>Is Date and time when occurred known? NO</p> <p>Date occurred .: BLANK.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Time occurred: BLANK.</p> <p>Is occurred date and time estimated: BLANK.</p> <p>Date discovered: 11/26/24.</p> <p>Brief Summary of Incident: On [DATE], at 9:15 am, it was reported to NHA A, Interim Administrator, that R3, resident, was found sitting on the edge of the bed of R2. CNA (certified nursing assistant) stated that R2's brief was pulled down; R3 was sitting on the bed touching R2 in his private area. R3 was extremely confused at the time of the incident; R2 remained asleep through the incident. R3 was immediately removed. R2 did not have any s/sx (signs/symptoms) of pain or emotional disturbances. R3 was assisted in wheelchair to dining room and placed on 15-minute checks. R2's assessment was negative for skin and pain. Both residents have activated POAs (Power of Attorney). R3's BIMS 5/15 and R2's BIMS 3/15. Neither resident is interviewable. POAs and physicians were notified. Police Department is being contacted. Statements being taken. Investigation has begun.</p> <p>On 12/17/24 at 2:15 PM, Surveyor interviewed DON B (Director of Nursing) and asked regarding the incident on 11/26/24 with R2 and R3, what was put into place to ensure residents' safety from R3. DON B indicated at the time of the incident R2 and R3 were separated and staff were to keep an eye on R3. Surveyor asked what that includes specifically and DON B indicated staff was to make sure R3 did not go back into R2's room and to always monitor R3's whereabouts. Surveyor asked if R3 was on 1:1 to ensure staff knew R3's whereabouts and DON B indicated no. Surveyor asked DON B if staff were documenting R3 was being monitored and DON B indicated no. Surveyor asked DON B if anything was put into place for other residents' safety. DON B indicated not that she was aware of. Surveyor asked if there should have been, and DON B indicated yes. Surveyor asked DON B if R3 or R2's Care Plans had been updated after incident. DON B indicated the last time R3's Care Plan was revised was 11/20/24; no updates or new interventions were put into place regarding 11/26/24's incident. Surveyor asked if DON B would expect a new intervention to be placed after incident and DON B indicated yes. DON B indicated no interventions were put into place for R2 after the incident and there should have been. Surveyor asked DON B if R3 was put on 15-minute checks immediately after the incident, and DON B indicated she could not find anything in R3's medical record indicating R3 was placed on 15-minute checks or showing R3 is currently on 15-minute checks. Surveyor asked DON B if she would expect all staff to receive abuse education after an incident as this between R2 and R3. DON B indicated yes.</p> <p>On 12/17/24 at 2:53 PM, Surveyor interviewed NHA A (Nursing Home Administrator) Surveyor asked NHA A if education was provided to all staff after this incident and NHA A indicated NHA A felt it was an isolated incident that wouldn't involve all staff in the rest of the building. NHA A indicated she considered the incident to be a resident-to-resident altercation. Surveyor asked NHA A as of today has there been any interventions put into place to prevent this incident from happening again, NHA A indicated no.</p> <p>On 12/17/24 at 3:15 PM, DON B walked in NHA A's office while Surveyor conducting the interview. NHA A asked DON B if at this time if anything was put into place to prevent this incident from occurring again between R2 and R3 and DON B indicated no. DON B indicated nothing has been done to closely monitor R3 and R2 to prevent this from occurring again.</p>		