

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525653	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2024
NAME OF PROVIDER OR SUPPLIER  Virginia Highlands Care and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  W173 N10915 Bernies Way Germantown, WI 53022	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</b></p> <p>Based on staff and resident interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when they did not ensure allegations of abuse and misappropriation were reported to the State Agency (SA) or local law enforcement for 3 residents (R) (R3, R4, and R9) of 11 sampled residents.</p> <p>Director of Nursing (DON)-B was informed of a resident-to-resident altercation between R3 and R4 on 6/17/24 in which R3 sustained a physical injury. The facility did not report the allegation of abuse to the SA or local law enforcement.</p> <p>The facility did not report an allegation of misappropriation of property for R9 to the SA or local law enforcement.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect and Exploitation policy, dated January 2023, states it is the policy of the facility 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 .IV. Identification of Abuse, Neglect and Exploitation: A. The facility will have written procedures to assist staff in identifying the different types of abuse-mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services .B. Possible indicators of abuse include, but are not limited to: .3. Physical injury of a resident of unknown source .VII. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. On 7/17/24, Surveyor reviewed an incident report, dated 6/17/24 and completed by DON-B, that indicated R3 swung a call light in R4's room and sustained a laceration on the left forehead and left eyebrow. R4 was not affected by the incident and R3 was removed from the room. R3's injuries were assessed and treated. An interview with Certified Nursing Assistant (CNA)-C indicated CNA-C heard yelling, entered R4's room, and saw R3 swing the call light next to R4's bed. CNA-C removed R3 from the room. An Interdisciplinary Team (IDT) review indicated R3 sustained two small lacerations on the face. During the struggle for the call light, R3 was hit. CNA-C was the only eyewitness to the event. Additional staff statements were not obtained because CNA-C was the only employee directly involved.</p> <p>On 7/17/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] for a Hospice respite stay and had diagnoses including Alzheimer's disease, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, anxiety disorder, and major depressive disorder. R3's Minimum Data Set (MDS) assessment, dated 6/22/24, had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated R3 had severely impaired cognition. R3's medical record indicated R3 had an activated Power of Attorney for Healthcare (POAHC).</p> <p>On 7/17/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, unspecified severity with mood disturbance, major depressive disorder, and generalized anxiety disorder. R4's MDS assessment, dated 5/22/24, had a BIMS score of 11 out of 15 which indicated R4 had moderately impaired cognition. R4's medical record indicated R4 had an activated POAHC.</p> <p>On 7/17/24 at 1:45 PM, Surveyor interviewed CNA-C who confirmed CNA-C worked with R3 on 6/17/24. CNA-C stated CNA-C answered R4's call light and observed R3 in R4's room. CNA-C removed R3 from R4's room and closed the door. CNA-C went to do something else and noticed R4's call light was on again. CNA-C answered the call light and again observed R3 in R4's room. R3 was holding the smaller end of the call light which had been pulled from the wall and R4 was holding the longer end of the call light and swinging it around (which was contradictory to what the incident report stated). CNA-C stated R3 was bleeding from the head. CNA-C stated R4 asked if R4 clocked R3 good and asked CNA-C to keep R3 out of R4's room. CNA-C removed R3 from the room. CNA-C stated CNA-C was not asked to provide a statement. CNA-C confirmed CNA-C did not witness how the injury occurred because R3 was already bleeding when CNA-C entered the room.</p> <p>On 7/17/24 at 2:59 PM, Surveyor reviewed the above information with Nursing Home Administrator (NHA)-A who indicated DON-B was unavailable for interview. NHA-A did not deny the findings or that the facility did not report the resident-to-resident altercation as required.</p> <p>49563</p> <p>2. On 7/17/24, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] with diagnoses including biliary acute pancreatitis without necrosis, diabetes, and hypothyroidism. R9's MDS assessment, dated 7/13/24, had a BIMS score of 15 out of 15 which indicated R9 had intact cognition. R9's medical record indicated R9 was responsible for R9's healthcare decisions.</p> <p>On 7/17/24 at 12:40 PM, Surveyor interviewed R9 who stated approximately six to seven months ago a wallet that contained R9's debit card and \$16.00 went missing and wasn't found. R9 reported the missing wallet. Four staff searched R9's room but were unable to find the wallet.</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 7/17/24 at 1:40 PM, Surveyor interviewed NHA-A who stated NHA-A was not aware of R9's missing wallet and was unable to find a grievance or investigation for the missing wallet.</p> <p>On 7/17/24 at 2:25 PM, Surveyor interviewed CNA-D who confirmed R9 mentioned the missing wallet several months ago but CNA-D was not aware of any details.</p> <p>On 7/17/24 at 2:40 PM, Surveyor interviewed Social Services Assistant (SSA)-E who was not aware of R9's missing wallet. SSA-E reviewed grievance logs from September of 2023 to the present but was unable to find documentation regarding the missing wallet.</p> <p>On 7/17/24 at 2:55 PM, Surveyor interviewed Regional Director (RD)-F who stated RD-F recalled R9's missing wallet and was told there would be an investigation and report by the former NHA. RD-F verified reports to the SA and local law enforcement were not completed for the suspected misappropriation of resident property.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</b></p> <p>Based on staff and resident interview and record review, the facility did not ensure allegations of abuse and misappropriation were thoroughly investigated for 3 residents (R) (R3, R4, and R9) of 11 sampled residents.</p> <p>Director of Nursing (DON)-B was informed of a resident-to-resident altercation between R3 and R4 on 6/17/24 in which R3 sustained a physical injury. The facility did not thoroughly investigate the allegation of abuse.</p> <p>R9 reported R9's wallet, debit card, and cash were missing. The facility did not thoroughly investigate the allegation of misappropriation.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect and Exploitation policy, dated January 2023, indicates an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for the investigation include: 1. Identifying staff responsible for the investigation. 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering with or destroying evidence; 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.</p> <p>1. On 7/17/24, Surveyor reviewed an incident report, dated 6/17/24 and completed by DON-B, that indicated R3 swung a call light in R4's room and sustained lacerations on the left forehead and left eyebrow. R4 was not affected by the incident and R3 was removed from the room. R3's injuries were assessed and treated. An interview with Certified Nursing Assistant (CNA)-C indicated CNA-C heard yelling, entered R4's room, and saw R3 swing the call light next to R4's bed. CNA-C removed R3 from the room. The incident report did not include additional resident and staff interviews or a determination on possible resident-to-resident abuse.</p> <p>On 7/17/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] for a Hospice respite stay and had diagnoses including Alzheimer's disease, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, anxiety disorder, and major depressive disorder. R3's Minimum Data Set (MDS) assessment, dated 6/22/24, had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated R3 had severely impaired cognition. R3's medical record indicated R3 had an activated Power of Attorney for Healthcare (POAHC).</p> <p>A progress note, dated 6/17/24, indicated R3 was in R4's room and sustained lacerations on the left forehead and left eyebrow. The areas were cleaned with no signs or symptoms of pain. A message was left for the Nurse Practitioner at 3:30 PM. R3's emergency contact and DON-B were also notified. R3's medical record did not contain any additional documentation related to the incident.</p> <p>(continued on next page)</p>

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