STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525664	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamilton Health Services	1 Hamilton Dr Two Rivers, WI 54241

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793 Based on staff interview and record review, the facility did not ensure an allegation of abuse was reported to Nursing Home Administrator (NHA)-A and the State Agency (SA) for 2 residents (R1 and R2) of 4 sampled residents. On 5/23/24, R1 entered R2's room, threw a Styrofoam cup full of coffee creamers at R2, and verbally threatened R2. Staff did not report the allegation of abuse to NHA-A and the facility did not report the allegation of abuse to the SA. Findings include: The facility's Abuse, Neglect, and Exploitation policy, revised 7/15/22, states the facility will report all alleged violations to the Administrator, State Agency, Adult Protective Services and all other required agencies (e.g., law enforcement when applicable) within a specified timeframe: 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. On 6/24/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, epilepsy, schizoaffective disorder, bipolar disorder, insomnia, and anxiety. R1's Minimum Data Set (MDS) assessment, dated 5/20/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R1 had intact cognition. R1's admission care plan stated R1 was at risk for behaviors related to schizoaffective disorder and bipolar mental illness. R1 refused medications and had inappropriate physical and verbal behaviors. The care plan contained interventions to call family members, administer medications as ordered, provide supervision in social gatherings/recreation programs, and remain calm and avoid angry reactions if behaviors were exhibited. On 6/24/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including diffuse large B-cell lymphoma, lymphedema, and encounter for palliative care. R2's MDS assessment, dated 5/24/24, had a BIMS score of 15 out of 15 which indicated R2 had intact cognition. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R2's medical record related to an incident that occurred between R1 and R2 on 5/24/24. A progress note, dated 5/23/23 at 12:15 PM, indicated R1 was aggressive and threatening toward staff. Registered Nurse (RN)-F observed R1 leave R2's room and state, I'm going to kick your ass. R2 reported to RN-F that R1 entered R2's room and threw a Styrofoam cup full of coffee creamers at R2. On 6/24/24 at 12:14 PM, Surveyor interviewed R2 who verified R1 threw a Styrofoam cup full of coffee creamers at R2 on 5/23/24 for no apparent reason. R2 stated R2 did not know R1 and wondered why R1 would do something like that. On 6/24/24 at 12:23 PM, Surveyor interviewed NHA-A who verified the resident-to-resident altercation between R1 and R2 was not reported to NHA-A or Director of Nursing (DON)-B until the morning of 5/24/24. NHA-A also verified the incident was not reported to the SA.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793 Based on staff interview and record review, the facility did not ensure an allegation of abuse was thoroughly investigated for 2 residents (R) (R1 and R2) of 4 sampled residents. On 5/23/24, R1 entered R2's room and threw a Styrofoam cup full of creamers at R2. The incident was not thoroughly investigated to ensure further abuse was prevented and resulted in another allegation of abuse involving R1 and R2 on 5/24/24. Findings include: The facility's Abuse, Neglect, and Exploitation policy, revised 7/15/22, states the facility will initiate an investigation for allegations or suspicions of abuse, including: 1. Identify staff responsible for the investigation; 2. Exercise caution in handling evidence that could be used in a criminal investigation (e.g., not destroying evidence); 3. Investigate different types of alleged violations; 4. Identify and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s); 5. Focus the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Provide complete and thorough documentation of the investigation. On 6/24/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, epilepsy, schizoaffective disorder, bipolar disorder, insomnia, and anxiety. R1's Minimum Data Set (MDS) assessment, dated 5/20/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R1 had intact cognition. R1's admission care plan indicated R1 was at risk for behavior related to schizoaffective disorder and bipolar mental illness. R1 refused medications and had inappropriate physical and verbal behavior. The care plan contained interventions to call family members, administer medications as ordered, provide supervision in social gatherings/recreation programs, and remain calm and avoid angry reactions if behaviors were exhibited. On 6/24/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including diffuse large B-cell lymphoma, lymphedema, and encounter for palliative care. R2's MDS assessment, dated 5/24/24, had a BIMS score of 15 out of 15 which indicated R2 had intact cognition. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R2's medical record related to an incident that occurred between R2 and R1 on 5/24/24. A progress note, dated 5/23/23 at 12:15 PM, indicated R1 was aggressive and threatening toward staff. Registered Nurse (RN)-F observed R1 leave R2's room and state, I'm going to kick your ass. R2 reported to RN-F that R1 entered R2's room and threw a Styrofoam cup full of coffee creamers at R2. On 6/24/24 at 12:14 PM, Surveyor interviewed R2 who verified R1 had thrown a Styrofoam cup full of coffee creamers at R2 on 5/23/24 for no apparent reason. R2 stated R2 did not know R1 and wondered why R1 would do something like that. On 6/24/24 at 12:23 PM, Surveyor interviewed NHA-A regarding the resident-to-resident altercation between R1 and R2 on 5/23/24. NHA-A verified the incident between R1 and R2 on 5/23/24 was not reported to administration or the SA and was not thoroughly investigated to prevent further abuse from occurring.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793 Based on observation, staff and resident interview, and record review, the facility did not provide adequate supervision for 1 resident (R) (R1) of 4 sampled residents. The failure to supervise R1 led to R1 being able to verbally and physically abuse another resident, R2. On 5/23/24, staff observed R1 exit R2's room and state, I'm going to kick your ass. R2 reported to staff that R1 had thrown a Styrofoam cup of coffee creamers at R2. Following the incident, the facility did not implement any interventions to ensure the safety of R1, R2, or other residents. On 5/24/24, Licensed Practical Nurse (LPN)-D observed R1 in the hallway outside R2's room. R1 appeared agitated and was repeatedly stating, Shut the f*** up. LPN-D did not attempt to redirect R1 or implement any interventions to supervise R1 before LPN-D left the area. R1 then entered R2's room, threw a basket full of items which hit R2 in the forehead, and stated, That's what you get you f****** bitch. R2 was tearful and incurred redness and swelling on R2's forehead. Findings include: The facility's Abuse, Neglect, and Exploitation policy, revised 7/15/22, states the facility will ensure the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect; B. Possible indicators of abuse include . Verbal abuse of a resident overheard or inappropriate verbal conduct overheard; Physical abuse of a resident observed .Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include .Increased supervision of the alleged victim and residents and room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. On 6/24/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, epilepsy, schizoaffective disorder, bipolar disorder, insomnia, and anxiety. R1's most recent Minimum Data Set (MDS) assessment, dated 5/20/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R1 had minimal cognitive impairment. On 6/24/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including diffuse large B-cell lymphoma, lymphedema, and encounter for palliative care. R2's Quarterly MDS assessment, dated 5/24/24, had a BIMS score of 15 out of 15 which indicated R2 had intact cognition. R1's admission care plan indicated R1 was at risk for behaviors related to schizoaffective disorder and bipolar mental illness. R1's behaviors included refusing medications and inappropriate physical and verbal behaviors. R1's care plan contained interventions to call family members, administer medications as ordered, provide supervision in social gatherings/recreation programs, and remain calm and avoid angry reactions if behaviors are exhibited. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's admission documentation contained a physician order, dated 8/24/23, from R1's previous facility that stated to monitor R1 for behaviors including biting, hitting, kicking, spitting, cussing, racial slurs, and aggression. R1's medical record indicated the following: ~ On 2/7/24, R1 was agitated, displayed behaviors toward staff, and refused medications. ~ On 3/10/24, R1 struck out at a Certified Nursing Assistant (CNA) during cares. ~ On 3/27/24, R1 yelled in the hallway I'm going to beat someone's ass one day! and threatened a CNA because R1's lunch tray was late. ~ During an activity on 4/1/24, R1 told other residents to shut up and used foul language toward staff and residents. ~ On 4/7/24, R1 called a CNA names and swore at them. ~ On 4/14/24, R1 threw a cup at a CNA and swore at them. ~ When Director of Nursing (DON)-B entered R1's room on 4/14/24 and asked if R1 threw items at a CNA, R1 threw items at DON-B ~ On 4/28/24, R1 threw snacks in the hallway and swore at staff. ~ On 5/9/24, R1 swore at staff and made racist comments. R1's care plan was not updated to reflect R1's increased behaviors toward residents and staff. ~ On 5/23/24, staff observed R1 swear and complain in the dining room. R1 was redirected to R1's room while staff prepared R1's meal tray. When staff brought the meal tray to R1's room, staff observed R1 leave R2's room and say, I'm going to kick your ass. R2 stated R1 entered R2's room, picked up a Styrofoam cup full of coffee creamers from R2's bedside table, and threw the cup at R2. R2 asked, Why would (R1) do that? I don't even know (R1). The facility did not implement increased supervision or any interventions for R1 or R2 following the incident. ~ On 5/24/24 at 4:30 PM, LPN-D observed R1 in the hallway outside of R1 and R2's rooms. R1 repeatedly stated, Shut the f*** up. When LPN-D asked if R1 was okay, R1 told LPN-D to shut the f*** up and stop talking to me like that. LPN-D then exited the area and left R1 and R2 unsupervised. ~ On 5/24/24 at 4:45 PM, staff heard yelling from R2's room and observed R1 in R2's room. R2 stated R1 entered R2's room, picked up a wicker basket full of remote controls and personal items from R2's bedside table, threw the basket at R2's head, and yelled, That's what you get you f******* bitch. R2 was crying and had redness and swelling on R2's forehead. R1 was removed from R2's room and immediately placed on 1:1 supervision. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	~ On 5/24/24, the police interviewed R1 and R2 regarding the incident. Per the police report, R1 was charged with battery (willful and unlawful use of force or violence upon the person of another). R2 told the police that was not the first time R1 had done something like this. ~ On 5/30/24, R1 was seen by a psychiatric Nurse Practitioner (NP) who indicated R1's 1:1 supervision could be discontinued. ~ On 6/4/24, R1 made inappropriate loud comments about another resident's weight. ~ On 6/5/24, R1 yelled and swore at staff about the mess in R1's bed. On 6/24/24 at 11:45 A.M., Surveyor interviewed R2 regarding the incident with R1. R2 reports that R2 was unsure why R1 did that. R2 stated that R2 was not afraid to leave R2's room and was continuing to participate in activities in the facility. On 6/24/24 at 1:30 PM, Surveyor interviewed LPN-D regarding R1's current supervision. LPN-D verified R1 was not on increased supervision when R1 was out of R1's room. LPN-D stated it was best to leave (R1) alone until (R1) calms down. On 6/24/24 at 1:45 PM, Surveyor interviewed CNA-E regarding R1's current supervision. CNA-E verified R1 was not on increased supervision when R1 was out of R1's room. CNA-E stated the interventions in R1's care plan to redirect R1 when aggravated were sometimes effective. On 6/24/24 at 2:10 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding R1's current supervision. NHA-A verified R1 was not on increased supervision related to behaviors.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on staff interview and record review, the facility did not ensure physician visits were completed timely for 2 residents (R) (R2 and R4) of 5 sampled residents. R2 was admitted to the facility on [DATE]. R2 was not seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. R4 was admitted to the facility on [DATE]. R4 was not seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Findings include: The facility's Leadership Policies and Procedures indicates: VI: Medical Services: .2. The physician visits the patient/resident according to the following guidelines: Every months for three months and every 60 days thereafter, or more often as clinically driven. 1. On 7/8/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including large cell lymphoma, lymphedema, and encounter for palliative care. R2's Minimum Data Set (MDS) assessment, dated 5/24/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 had intact cognition. R2 did not have an activated power of attorney for healthcare (POAHC). R2's medical record indicated R2 was seen by the facility's physician for medical care and oversight in conjunction with palliative care providers. R2 was seen by the physician for an initial visit on 11/17/23 and monthly visits on 12/8/23, and 1/4/24. R2 was not seen again by a physician or Nurse Practitioner (NP) until 3/27/24. 2. On 7/8/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, chronic pain syndrome, chronic vascular disorders of intestines, type 2 diabetes with diabetic peripheral angiopathy, pressure ulcer of left heal unstageable, peripheral vascular angioplasty status with implants and grafts, chronic obstructive pulmonary disorder (COPD), and bipolar disorder. R4's MDS assessment, dated 6/26/24, had a BIMS score of 10 out of 15 which indicated R4 had moderate cognitive impairment. R4 did not have an activated POAHC. R4's medical record indicated R4 was seen by the facility's physician for an initial visit on 9/27/23. R4 was seen by an NP in October of 2023 and December of 2023. R4's medical record did not indicate R4 was seen by a physician every 30 days for the first 90 days after admission. On 7/8/24, Surveyor requested any additional physician visits for R2 and R4 from [NAME] President of Success (VPS)-C. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/8/24 at 12:35 PM, Surveyor interviewed VPS-C who stated the information Surveyor obtained through R2 and R4's medical records was correct regarding physician visits for both residents. VPS-C stated VPS-C contacted the physician's group and requested any additional documentation for visits conducted for R2 in February of 2024 and for R4 in October, November and December of 2023. VPS-C verified R4's visits in October and December of 2023 were completed by an NP. On 7/8/24 at 1:15 PM, VPS-C approached Surveyor and stated R2's physician's group stated a visit for R2 was on the schedule in February of 2024, but there was no documentation to confirm the visit occurred. VPS-C stated the physician would enter a note in R2's medical record shortly. VPS-C confirmed R4 was not seen by a physician in October, November or December of 2023 and was unsure why it was overlooked by the facility and the physician's group. VPS-C also confirmed R4 was not seen by a physician every 30 days for the first 90 days after admission.