STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525688	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI Veterans Home-Boland Hall	21425 E Spring St Union Grove, WI 53182

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview and record review, the facility did not ensure 1 (R6) of 1 resident's resident representative was notified when there was a need to alter medical treatment. R6's POA (Power of Attorney) was not notified when R6 started Physical Therapy (PT) to work on R6's balance. Findings include: The facility's policy titled, Orders Management with a last revision date of 5/17/2024 documents, in part: . The member or their healthcare representative will be notified of new orders and orders revised by provide/designee prior to initiation . 1.) R6 was admitted to the facility on [DATE] with diagnosis that include Alzheimer's disease, Dementia with mood disturbance, Cancer, Repeated falls and Difficulty walking. R6's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents that R6 has long and short-term memory problems, is unable to recall faces, names, location, and season, and has severely impaired cognition with making decisions. R6 wears glasses. R6 requires supervision with walking and transfers. R6 has an activated healthcare Power of Attorney (POA)-U. On 3/25/25 at 8:51 AM Surveyor interviewed POA-U. POA-U informed Surveyor that R6 started Physical Therapy in January of this year, but POA-U was not aware that R6 was in therapy until R6's therapy was almost completed. R6's Fall risk care plan initiated on 6/29/23 documents the following intervention: PT evaluate and treat as ordered or [as needed]. R6's physician order dated 1/29/25 documents: PT eval and treat. Surveyor reviewed R6's PT evaluation and Plan of treatment and noted that PT started on 1/29/25. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R6's electronic medical record. Surveyor did not locate any documentation that R6's POA was notified of physical therapy starting on 1/29/25. On 3/26/25 at 10:40 AM, Surveyor interviewed Rehab Director and Physical Therapy Assistant, (RD)-R. Surveyor asked if R6 received PT starting on 1/29/25. RD-R stated yes. RD-R stated that the therapy department is new to the facility but does remember that R6 started therapy in late January. RD-R stated that R6 had a fall and needed to be screened after the fall to determine if R6 should start therapy or not. The screen was completed and R6 was assessed to need PT for balance improvement. Surveyor asked who notifies a resident's POA to inform them of the start of therapy. RD-R stated that the Therapy department will send an email to the nurse to get the MD order for therapy, and the nurse is to notify the POA/family representative of the start of therapy. Surveyor asked if R6's POA/family was notified prior to R6 starting therapy on 1/29/25. RD-R stated No. RD-R stated that RD-R had been working with R6 for at least a few sessions. RD-R went to get R6 from R6's room and R6's family was in the room. RD-R stated that R6's family was not aware that R6 was in therapy until RD-R came to get R6 for that session. On 3/26/25 at 11:00 AM, Surveyor interviewed Registered Nurse (RN)-P. Surveyor asked what the process is if a resident needs to start PT. RN-P stated that if a resident needs PT or a PT order, the nurse will speak to the doctor to get an order. RN-P stated that the physical therapy department can also get an order for PT. Surveyor asks who notifies the POA when that order is placed. RN-P stated that the nurse will notify the POA. On 3/26/25 at 11:05 AM, Surveyor interviewed RN-Q. Surveyor asked what the process is if a resident needs to start PT. RN-Q indicated that if a resident has a fall, they automatically need to be screened by PT. Depending on the results of the screen, the resident may start PT sessions. Surveyor asked who notifies the POA or family if PT is going to start. RN-Q stated that the facility just changed therapy companies. RN-Q stated that the last company would call POA or a resident's representative, but RN-Q was not sure of the process now. Surveyor asked if a resident's POA/family should be notified prior to the start of PT. RN-Q stated the POA should be notified. On 3/26/25 at 11:45 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what the process is if a resident needs to start a PT. DON-B stated if a resident experiences a fall, PT will need to complete a screen to determine if PT is needed. Surveyor asked who should notify the POA/resident's family. DON-B indicated that nurses would update the POA of the fall. Surveyor asked if PT will then update the family/POA if the resident PT screen indicates that the resident needs to start therapy. DON-B stated that the therapy department does not notify the family/POA. DON-B stated that the facility does not have a process for notification to the POA of therapy starting. DON-B stated that it is something that would be reviewed in the morning meeting and the Therapy Department attends the morning meetings. Surveyor asked if the family/POA should be notified at the start of therapy. DON-B stated that the POA should be notified. Surveyor shared the concern that R6's family was not notified at the start of PT. DON-B stated that the family may have gotten a notification from the facilities care app. DON-B stated that the app will send a notification of anything new or changes in a resident's care. Surveyor asked if the family/POA should still be notified by facility staff. DON-B indicated the POA/family should still be notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 12:20 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern that R6 started Physical Therapy and the R6's POA was not notified. Surveyor informed NHA-A that DON-B stated that the family/POA might have known about the PT starting through a notification sent through an app. NHA-A stated that an app would not be an appropriate way to notify a family. NHA-A stated that if the family stated they were not notified, then they were not notified. NHA-A stated that NHA-A understood the concern. No additional information was provided as to why the facility did not ensure R6's POA was notified when R6 started Physical Therapy.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review, the facility did not address and resolve grievances conveyed on behalf of 2 (R5 and R6) of 2 residents reviewed for grievances. *R5 expressed care concerns. There was no documentation this was thoroughly investigated, along with an appropriate resolution. *R6's eyeglasses were found to be broken on 2/8/25 and facility staff documented that the glasses were to be sent out for repair. R6's family brought a pair of old glasses to the facility for R6 to use until his current pair of glasses was fixed. On 3/9/25, facility staff document that R6's broken glasses are still waiting to be repaired. On 3/12/25, a grievance was placed regarding R6's glasses. The grievance investigation documented that R6's original pair of broken glasses were going to be sent out for repair on 3/12/25. The glasses were not sent for repair. As of 3/26/25, the grievance has not been resolved and R6's broken glasses are still awaiting repair. Findings include: The Facility Policy titled Grievances and Complaints last reviewed January 2023 documents (in part): Policy: -A grievance shall be considered any circumstance thought to be unjust and grounds for a complaint and meets at least one of the following criteria: -Pertains to the environment or care and treatment provided by the Homes, including missing property . -Grievances or concerns regarding potential abuse, neglect, exploitation, misappropriation or property, or injury of unknown source are expected to be reported immediately and promptly investigated. -All grievances and concerns shall be documented at the time of report and investigated within five business days . Procedure .: 4. The employee assigned to investigate the grievance/complaint: 4.1 Reviews the grievance complaint. 4.2 Meets with staff, member, and or responsible party as indicated regarding the grievance/complaint to obtain comprehensive information . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4.5 Interviews staff having contact with the member during the relevant period or shift of the grievance/complaint . 5. Facility staff monitor and respond to any negative psychosocial outcomes regarding the grievance/complaint . 6. As needed, the Grievance Officer/designee and facility leadership take immediate action to prevent further violations of any member while the grievance/complaint is being investigated. Resolution 1. Within five (5) business days, the grievance is to be resolved with resolution documented. 2. The person assigned to investigate the grievance/complaint develops a written summary of the situation, including a corrective action plan. He/she reviews and documents grievance/complaint resolution and follow-up with the complainant via phone or in person; the SW (social worker) may follow-up with the member as needed . 1.) R5 has pertinent diagnoses which include Parkinson's, dementia, weakness, type 2 diabetes and chronic obstructive pulmonary disease. R5's quarterly Medicare Minimum Data Set (MDS) with an assessment reference date of 12/12/2024 indicates R5 had a Brief Interview for Mental Status score of 11 (moderate cognitive impairment). R5 is coded to make self understood and understands others. R5's MDS showed that a walker is used for mobility. On 3/12/2025, Surveyor was reviewing grievances related to abuse/neglect in conjunction with Facility Reported Incidences and discovered a grievance dated 3/5/2025 that had not been investigated. The summary of concern was that R5 met with the social worker (SW) for assessments and during the meeting expressed a concern that the night before last he used his call light to request water and the CNA (certified nursing assistant) responded by telling the member to get their own water. Member stated this happened at roughly 2 AM while member was in bed. The summary of investigation findings reads SW met with commandant and DON (Director of Nursing) to discuss concerns. Grievance given to DON to follow up with staff. Surveyor notes the Resolution and Member . Notified of Resolution sections were blank. On 3/12/25, at 3:50 PM, during the end of day meeting with the Facility, Surveyor asked DON-B and the Nursing Home Administrator (NHA)-A for the follow up information for the 3/3/25 grievance that was reported 3/5/25. DON-B stated that this had not been followed up on. On 3/13/25, at 10:28 AM, Surveyor interviewed DON-B about the grievance not being followed up on. DON-B stated that the staff and other resident interviews were done yesterday related to the grievance after it was brought to their attention. DON-B felt this should resolve the issue. Surveyor asked about the follow up with R5, DON-B stated they haven't gotten to the floor yet to talk to R5. Surveyor explained that the expectation is to act promptly on grievances and to get back to the resident. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted one Registered Nurse and two CNA were interviewed, and all denied that R5 asked them for water. Ten residents on the same unit as R5 were interviewed and none reported problems getting water as needed. On 3/13/25, at 10:51 AM, Surveyor interviewed R5 regarding the incident and R5 stated they are not going to tell on the CNA. Surveyor asked if this had any negative impact on R5 and was told it is in the past and R5 had no lasting concerns. On 3/13/25, at 11:34 AM, Surveyor informed DON-B and NHA-A there was a concern due to the delay in investigating the grievance and follow up with resident. No additional information was provided. 49435 2.) R6 was admitted to the facility on [DATE] with diagnosis that include Alzheimer's disease, Dementia with mood disturbance, Cancer and difficulty walking. R6's Quarterly Minimum Data Set assessment dated [DATE] documents that R6 has long and short-term memory problems, is unable to recall faces, names, location, and season, and has severely impaired cognition with making decisions. R6 wears glasses. R6 requires supervision with walking and transfers. R6 has an activated healthcare Power of Attorney (POA)-U. R6's [Activities of Daily Living] care plan initiated on 9/26/23 documents the following intervention: AM routine: Encourage R6 to wear glasses full time for distance and reading. Clean glasses when dirty (date initiated 9/18/24). On 3/25/25 at 8:51 AM, Surveyor interviewed R6's POA. POA-U stated that R6 has not has his correct eyeglasses for over a month. POA-U stated that R6's glasses were broken in February and R6 has been having to use an old pair of glasses which is not the correct prescription. POA-U stated that R6 needs R6's glasses to walk and see clearly and without the correct pair, R6's fall risk is higher. POA-U stated that POA-U spoke to Social Worker (SW)-K about the glasses. POA-U stated that SW-K stated that R6's broken glasses have not been repaired and that SW-K was sorry but got busy and that is why the glasses are not fixed. R6's progress note dated 2/8/25 at 1:22 PM documents: Writer noted [R6's] broken glasses in the medication room this morning. Arm was taped on glasses. Writer placed glasses on [R6's] face. [R6's spouse] here to eat lunch with [R6] and stated nobody informed [R6's spouse] that [R6's] glasses were broken or how they broke. [R6's spouse] gave the glasses to writer this afternoon after [R6] removed them from [R6's] face. Writer sent an E mail to the [Health Unit Coordinator] requesting to have glasses sent out to Health Drive. Writer informed [R6's spouse]. [R6's spouse] states [they] will look for another pair to bring in for [R6]. R6's progress note dated 2/9/25 at 11:43 AM documents: [R6's spouse] here and brought [R6] an old pair of glasses from home. [R6] to wear until current glasses are repaired. Writer placed broken glasses in a bag with [R6's] name on it. Glasses in medication room. [Health Unit Coordinator] aware Via E mail. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's progress note dated 3/9/25 at 2:28 PM documents: [R6's family/spouse] here visiting and aware that staff was unable to locate [R6's] glasses this AM. [R6's spouse] gave [R6] another spare pair. [R6's spouse] asked writer if [R6's] initial broken pair has been sent out for repair. Writer informed the [R6's spouse] that they were returned to the unit for Health Drive to [pick up] however, Health Drive canceled. Health Drive will be here on April 2nd. [R6's spouse] states that is too long to wait. Writer sent an E mail to the social worker requesting to have them sent out for repair per family request. Surveyor reviewed the grievance log and noted a grievance placed by R6's family regarding R6's glasses. R6's Member grievance/concern document, dated 3/12/25 documents, in part: . [R6's spouse] approached [SW-K] and informed [SW-K] that [R6] is missing glasses for about a week. Attached to the grievance document is a printed email chain. On 3/12/25 at 12:10 PM, Facility staff sent an email to SW-K that documents, in part: . [facility staff] was not able to find [R6's] glasses over the weekend. The extra pair of glasses that family had brought in for [R6]. This is why they requested to have [R6's] original (broken pair) sent in for repair instead of waiting for Health Drive on 4/2/25 . On 3/12/25 at 12:32 PM, SW-K replied to the previous email which documents, in part: . [R6's spouse] did stop by about an hour or so ago and informed me that [R6's] spare pair were missing. I'm going to stop by this afternoon and grab [R6's] broken pair to be sent out today. Surveyor noted that R6's eyeglasses with the correct prescription have been broken since 2/8/25 and the glasses were going to be sent for repair. On 3/12/25, the broken glasses were still not fixed but were going to be sent for repair. On 3/26/25 at 9:10 AM, Surveyor interviewed SW-K. Surveyor asked about the grievance placed by R6's family on 3/12/25. SW-K stated that the grievance has not been resolved yet. Surveyor asked when a grievance should be resolved. SW-K stated that a grievance should be resolved within 5 business days. Surveyor asked what happened with R6's glasses. SW-K stated that R6's original glasses were broken, and the eye service was going to be in the building about 1 to 1.5 weeks later. When the glasses were broken the family brought in a spare old pair of glasses for R6 to use until the original glasses were fixed. The eye service that was coming to the facility canceled and rescheduled for 4 weeks later. In the meantime, the spare pair of old glasses was lost and the family brought in another old pair of glasses for R6 to use. Now, the eye service is coming April 2nd. SW-K stated that SW-K spoke to R6's family on 3/24/25 and asked if the family wanted the glasses sent off site to be repaired or if they wanted to wait for the glasses to be repaired at the facility on April 2nd. On 3/24/25, R6's family told SW-K that they wanted R6's glasses sent out to be repaired. On 3/25/25, R6's family told SW-K that the glasses can be fixed on April 2nd. Surveyor asked about the email sent on 3/12/25 indicating that SW-K would send the glasses out on 3/12/25 to be fixed. SW-K stated that SW-K dropped the ball on that. SW-K indicated that SW-K got busy and forgot to send the glasses out for repair. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 12:20 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concerns that R6's eyeglasses were broken on 2/8/25 and documentation stated that the glasses were going to be sent for repair. A grievance was placed on 3/12/25 about R6's glasses and staff documented that the glasses were going be sent out for repair. SW-K told Surveyor that SW-K dropped the ball on sending the glasses out for repair. The facility grievance policy states that a grievance should be resolved within 5 business days. As of 3/26/25 the glasses are still broken and R6 is wearing old glasses that are not the same prescription. NHA-A acknowledged the concern. No additional information was provided as to why the facility did not address and resolve grievances per the facility policy.

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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** 49011 Based on interview and record review the Facility did not report 2 of 4 allegations of abuse or neglect to the Nursing Home Administrator (NHA) or State Survey Agency during the required timeframe. * R4 reported potential abuse to the charge nurse which was delayed in being reported to the Nursing Home Administrator (NHA) and the state agency. * Double briefing of residents was discovered and there was a delay in the issue being reported to the Nursing Home Administrator (NHA) and the state agency. Findings include: The Facility Policy titled Prohibition and Prevention of Member Abuse, Neglect, and Exploitation last reviewed July 2024 documents (in part): Policy .: -All staff shall be expected to immediately report any, and all, observed or alleged abuse and other reportable incidents. -All incidents shall be investigated and reported to the appropriate agency as required by the agency. -Immediate intervention shall be initiated to maintain member safety with all observed or suspected allegations . -Corrective action shall be implemented for substantiated incidents following concluded investigation. Actions may include, and is not limited to, education, in-service training, disciplinary action, reassignment, or other action as determined by management depending on the incident and outcome . Procedures .: Reporting 1. On observation of actual or suspected abuse, or other reportable incident staff immediately reports the event to the RN (Register Nurse), nursing supervisor, or facility administrator . 2. The RN and unit staff immediately develop a plan to maintain member safety . 3. RN immediately reports the event to the on-duty nursing supervisor/charge nurse who notifies the facility administrator or their designee . 4. The nursing supervisor or facility administrator immediately initiates initial reporting and conducts a thorough investigation . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. The nursing supervisor/administrator, or their designee, submits all incidents meeting regulatory criteria . to the appropriate state agency as soon as possible, and no later than 2 hours after forming the suspicion that the event involved abuse or resulted in serious bodily injury, and not to exceed 24 hours from discovery if the event did not involve abuse and did not result in serious bodily injury . Alleged Mistreatment . 3. Any accused staff should be removed from working directly with members and if administrative leave is thought to be necessary, the Division Administrator and Human Resources Regional Director must approve this leave prior to beginning . 8. A list of possible witnesses is given to the nursing supervisor as soon as possible. 8.1. Copies of daily schedules and staff statement forms, WDVA 4728 and WDVA 4727, are placed on 24-hour report board; names of staff needing to provide statements are highlighted . 8.2. The RNs follow up with all staff who were on duty and may have provided any care for the affected member at time of the discovery and during the two previous shifts. 8.3. After completion, forms WDVA 4728 and WDVA 4727 are to be given directly to a supervisor or placed in a designated secure area . 1.) R4 was admitted to the facility on [DATE] and with diagnoses that include cellulitis right lower limb, urinary tract infection, contracture right and left hand, major depressive disorder, anxiety, quadriplegia, and dysphasia. R4's Quarterly Medicare Minimum Data Set (MDS) with an assessment reference date of 12/19/2024 indicated R4 had a Brief Interview for Mental Status score of 15 (cognitively intact). R4 is coded as makes self understood and understands others. R4 exhibited no behaviors during the look back period. R4 has an indwelling catheter and is frequently incontinent of bowel. Surveyor was reviewing the Facility Reported Incident dated 1/18/2025 regarding R4 reporting that he refused cares from CNA (Certified Nursing Assistant). R4 reports that cares were still completed, and that the CNA was rough while washing R4. The date discovered was listed as 1/17/2025. The Investigation Report reads on 1/16/25 R5 reported to the charge nurse that a CNA didn't listen to his requests for cares to be performed later. R4 stated that the CNA washed him up anyway and was not gentle with his bottom and groin area. R4 stated that he told her to stop but the CNA continued until cares were completed. R4 expressed that he didn't like the way he was treated. R4 stated that the CNA was a good worker, but he no longer wanted the CNA to work with him. R4 also stated that he didn't want to get the CNA in trouble and didn't want the matter taken any further. The charge nurse updated the CNA that R4 no longer wanted the CNA working with him anymore. The incident was reported to the NHA (Nursing Home Administrator) on 1/17/25 and the investigation began. Surveyor notes the incident happened 1/16/25, was reported to the NHA on 1/17/2025 and the Department of Health Services Form, F-62617, was not submitted to the State Survey Agency until 1/18/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25, at 2:09 PM, Surveyor interviewed Social Worker (SW)-K regarding the incident and the SW-K interview with R4 on 1/22/25. Surveyor asked if there had been other problems with CNA-M who was involved in this incident. SW-K stated that yes SW-K had heard other things come up. One year ago, there was an issue and R4 requested CNA-M not be R4's aid. SW-K could not remember what the issue was though. Surveyor asked if it is common for residents to ask for an aid not to care for them and was told it is kinda rare. SW-K stated that R4 is a very reasonable person, not grumpy, has wits about them. On 3/12/25, at 2:59 PM, Surveyor interviewed Registered Nurse (RN)-J who was working that evening. RN-J stated that R4 told them that they did not want CNA-M to work with them anymore. RN-J told the charge nurse who went and talked with R4. RN-J stated that R4 did not elaborate on what the issue was. When asked if there were any problems with CNA-M it was stated not really with cares, guys here like her. There are no performance issues, CNA-M gets work done and does what needs to. Surveyor asked if R4 complained and was told not usually but is particular about how things are done. On 3/12/25, at 3:05 PM, Surveyor interviewed R4 regarding the incident. R4 stated they were in the middle of a two week bout of being sick with covid, it was the 7th day. R4 explained to CNA-M that they did not want brief changed at that time, just wanted to lay flat. CNA-M stated they were going change it now and was forceful this time. R4 stated they asked CNA-M to contact the nurse to come see R4, this was round 6:30 PM but the nurse didn't come in until after 8:30 PM. R4 stated this is the second time they have had a problem with CNA-M, the first time was about a year ago. The past issue was R4 put on call light and got no response so R4 went out to look for someone. CNA-M was stirring something they had just taken out of the microwave. R4 asked why no response and was told CNA-M didn't hear the call light. With this recent issue R4 states CNA-M denied at first, then apologized. On 3/12/25, at 3:34 PM, Surveyor interviewed the charge nurse on duty, RN-O, who stated they got a complaint that R4 did not want CNA-M as aid anymore. CNA-M and R4 have a history. RN-O stated that R4 was sleeping due to covid and not feeling well. R4 was soaking wet but wanted to be left alone. CNA-M stated it is time to change because CNA-M had tried before and R4 refused. When RN-O talked to R4, RN-O gave two choices. CNA-M could apologize or RN-O would escalate to the supervisors. RN-O felt R4 was irritable due to covid. RN-O stated CNA-M had not been R4's aid for a period of time before too. Surveyor notes in the investigation of this event a Record of Conversation/Notice form was included for CNA-M. The Reason for Conference is checked as Policy/Work Rule Violation. The Description of issues resulting in conversation and notice is discussed R4's concern grievance form 1/16/25 pm shift. On 3/13/25, at 9:07 AM, Surveyor interviewed Registered Nurse (RN)-N regarding the reporting of abuse or neglect. RN-N stated that they would get a statement from the member, report incident to the supervisor, then get witness statements. On 3/13/25, at 9:13 AM, Surveyor interviewed RN-L regarding the reporting of abuse or neglect. RN-L stated they would immediately remove the CNA from care of resident, update the supervisor and get witness statements. Surveyor notes a voicemail was left for CNA-M on 3/13/25, at 11:05 AM, a return call was not received. (continued on next page)

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	525688	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25, at 10:03 AM, Surveyor interviewed Director of Nursing (DON)-B regarding the delay of the charge nurse reporting the incident, DON-B stated need to look into that. Surveyor asked if there were other issues with CNA-M and DON-B replied not that they were aware of. On 3/13/25, at 10:55 AM, DON-B got back to Surveyor that they had no idea on delay in reporting by RN- O. As for the delay in reporting to the state agency it was the previous commandant and DON-B can't speak to that. On 3/13/25, at 11:34 AM, Surveyor informed DON-B and Nursing Home Administrator-A of the concern related to the delay in reporting to management and to the state agency of the allegation of abuse. No additional information was provided. 2.) Surveyor was reviewing the Facility Reported Incident dated 1/7/2025 regarding While assisting CNA (Certified Nursing Assistant) to help resident member stand, Charge Nurse discovered member was double briefed and after talking with CNA learned there were many members double briefed from 1st shift onto 2nd shift. Further investigation determined the double briefing was occurring on other nursing units and shifts as well . Surveyor notes the incident was discovered 12/25/24, was reported to the Nursing Home Administrator (NHA)-A on 12/26/24 via email and the Department of Health Services Form, F-62617, was not submitted to the State Survey Agency until 1/7/25. On 3/13/25, at 9:07 AM, Surveyor interviewed Registered Nurse (RN)-N regarding the reporting of abuse or neglect. RN-N stated that they would get a statement from the member, report incident to the supervisor, then get witness statements. On 3/13/25, at 9:13 AM, Surveyor interviewed RN-L regarding the reporting of abuse or neglect. RN-L stated they would immediately remove the CNA from care of resident, update the supervisor and get witness statements. On 3/13/25, at 10:05 AM, Surveyor interviewed Director of Nursing (DON)-B regarding the delay of charge nurse reporting the issue of double briefing. Per DON-B staff did not know it was neglect so were slow to report. Email was used because they did not know it was neglect. DON-B cannot speak to why the former NHA-A was late reporting the issue to the state agency. On 3/13/25, at 11:34 AM, Surveyor informed DON-B and Nursing Home Administrator-A of the concern related to the delay in reporting to management and to the state agency of the allegation of neglect. No additional information was provided.

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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** 36161 2.) R3 was admitted to the facility on [DATE] with diagnoses that includes atrial fibrillation, restless and agitation, vascular dementia, dysphagia and osteoarthritis. The facility's incident self-report dated 2/13/25 documents, Resident has bruise of unknown source on his right inner forearm .Weekly body check done and it was noted there was bruising of unknown origin to right inner and outer forearm. 15 x 12 cm (centimeter) dark purple to inner forearm and yellowing to outer right forearm and surrounding purple bruising; Conclusion: R3 is unable to be interviewed due to cognitive impairment. R3 had an unwitnessed fall with injury on 2/6/25 where he fell on his right side. R3 sustained a laceration to R3's right forehead. R3 was sent out to receive medical treatment and returned on 2/6/25. R3 was placed on 15-minute checks for a temporary intervention. R3 has a fall mat on the floor of his bedside. R3 has not had any other falls since this event and is closely monitored by staff post fall. NHA (Nursing Home Administrator) corelates the bruising to R3's right forearm with the unwitnessed fall on 2/6/25. Surveyor noted that the above incident self-repot only included two staff statements from staff who worked with R3 on 2/13/25. Surveyor could not locate any other staff statements from staff who worked with R3 days prior to when R3's injury of unknown origin was identified. On 3/12/25 at 10:41 AM, Surveyor requested from DON (Director of Nursing)-B any additional staff or resident statements that were collected for R3's injury of unknown origin that was discovered on 2/13/25. DON-B informed Surveyor she would review the investigation and let Surveyor know. On 3/12/25 at 3:29 PM, DON-B informed Surveyor that there were no other staff or resident statements involving R3's injury of unknown origin on 2/13/25. Surveyor asked DON-B with the facility did not interview and or obtain staff statements from any other staff members who had worked with R3 prior to 2/13/25. DON-B informed Surveyor that she could not provide an answer as to why the facility did not interview and or obtain staff statements from any other staff members who had worked with R3 prior to 2/13/25. No additional information was provided as to why the facility did not thoroughly investigate R3's injury of unknown origin dated 2/13/25. 49011 Based on interview and record review, the Facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment were thoroughly investigated, staff member removed to prevent further incidence, or all staff education provided for 2 (R4 and R3) of 4 allegations of abuse or neglect reviewed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* R4 made an allegation of abuse that was not acted on by the staff member being removed from contact with residents or all staff education provided to prevent further abuse. *R3 had an injury of unknown origin that was not thoroughly investigated. Findings include: The Facility Policy titled Prohibition and Prevention of Member Abuse, Neglect, and Exploitation last reviewed July 2024 documents (in part): Policy .: -All staff shall be expected to immediately report any, and all, observed or alleged abuse and other reportable incidents. -All incidents shall be investigated and reported to the appropriate agency as required by the agency. -Immediate intervention shall be initiated to maintain member safety with all observed or suspected allegations . -Corrective action shall be implemented for substantiated incidents following concluded investigation. Actions may include, and is not limited to, education, in-service training, disciplinary action, reassignment, or other action as determined by management depending on the incident and outcome . Procedures .: Reporting 1. On observation of actual or suspected abuse, or other reportable incident staff immediately reports the event to the RN (Register Nurse), nursing supervisor, or facility administrator . 2. The RN and unit staff immediately develop a plan to maintain member safety . 3. RN immediately reports the event to the on-duty nursing supervisor/charge nurse who notifies the facility administrator or their designee . 4. The nursing supervisor or facility administrator immediately initiates initial reporting and conducts a thorough investigation . 5. The nursing supervisor/administrator, or their designee, submits all incidents meeting regulatory criteria . to the appropriate state agency as soon as possible, and no later than 2 hours after forming the suspicion that the event involved abuse or resulted in serious bodily injury, and not to exceed 24 hours from discovery if the event did not involve abuse and did not result in serious bodily injury . Alleged Mistreatment . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Any accused staff should be removed from working directly with members and if administrative leave is thought to be necessary, the Division Administrator and Human Resources Regional Director must approve this leave prior to beginning . 8. A list of possible witnesses is given to the nursing supervisor as soon as possible. 8.1. Copies of daily schedules and staff statement forms, WDVA 4728 and WDVA 4727, are placed on 24-hour report board; names of staff needing to provide statements are highlighted . 8.2. The RNs follow up with all staff who were on duty and may have provided any care for the affected member at time of the discovery and during the two previous shifts. 8.3. After completion, forms WDVA 4728 and WDVA 4727 are to be given directly to a supervisor or placed in a designated secure area . 1.) R4 was admitted to the facility on [DATE] and has pertinent diagnoses which include cellulitis right lower limb, urinary tract infection, contracture right and left hand, major depressive disorder, anxiety, quadriplegia, and dysphasia. R4's Quarterly Medicare Minimum Data Set (MDS) with an assessment reference date of 12/19/2024 indicated R4 had a Brief Interview for Mental Status score of 15 (cognitively intact). R4 is coded as makes self understood and understands others. R4 exhibited no behaviors during the look back period. R4 has an indwelling catheter and is frequently incontinent of bowel. Surveyor was reviewing the Facility Reported Incident dated 1/18/2025 regarding R4 reporting that he refused cares from CNA (Certified Nursing Assistant). R4 reports that cares were still completed and that the CNA was rough while washing R4. The Investigation Report reads on 1/16/25 R5 reported to the charge nurse that a CNA didn't listen to his requests for cares to be performed later. R4 stated that the CNA washed him up anyway and was not gentle with his bottom and groin area. R4 stated that he told her to stop but the CNA continued until cares were completed. R4 expressed that he didn't like the way he was treated. R4 stated that the CNA was a good worker, but he no longer wanted the CNA to work with him. R4 also stated that he didn't want to get the CNA in trouble and didn't want the matter taken any further. The charge nurse updated the CNA that R4 no longer wanted the CNA working with him anymore. The incident was reported to the NHA (Nursing Home Administrator) on 1/17/25 and the investigation began. On 3/12/25, at 2:09 PM, Surveyor interviewed Social Worker (SW)-K regarding the incident and the SW-K interview with R4 on 1/22/25. Surveyor asked if there had been other problems with CNA-M who was involved in this incident. SW-K stated that yes SW-K had heard other things come up. One year ago, there was an issue and R4 requested CNA-M not be R4's aid. SW-K could not remember what the issue was though. Surveyor asked if it is common for residents to ask for an aid not to care for them and was told it is kinda rare. SW-K stated that R4 is a very reasonable person, not grumpy, has wits about them. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25, at 2:59 PM, Surveyor interviewed Registered Nurse (RN)-J who was working that evening. RN-J stated that R4 told them that they did not want CNA-M to work with them anymore. RN-J told the charge nurse who went and talked with R4. RN-J stated that R4 did not elaborate on what the issue was. When asked if there were any problems with CNA-M it was stated not really with cares, guys here like her. There are no performance issues, CNA-M gets work done and does what needs to. Surveyor asked if R4 complained and was told not usually but is particular about how things are done. On 3/12/25, at 3:05 PM, Surveyor interviewed R4 regarding the incident. R4 stated they were in the middle of a two week bout of being sick with covid, it was the 7th day. R4 explained to CNA-M that they did not want brief changed at that time, just wanted to lay flat. CNA-M stated they were going change it now and was forceful this time. R4 stated they asked CNA-M to contact the nurse to come see R4, this was around 6:30 PM but the nurse didn't come in until after 8:30 PM. R4 stated this is the second time they have had a problem with CNA-M, the first time was about a year ago. At that time, R4 put on call light and got no response so R4 went out to look for someone. CNA-M was stirring something they had just taken out of the microwave. R4 asked why no response and was told CNA-M didn't hear the call light. This recent issue R4 states CNA-M denied at first, then apologized. On 3/12/25, at 3:34 PM, Surveyor interviewed the charge nurse on duty, RN-O, who stated they got a complaint that R4 did not want CNA-M as aid anymore. R4 and CNA-M have a history. RN-O stated that R4 was sleeping due to covid and not feeling well. R4 was soaking wet but wanted to be left alone. CNA-M stated it is time to change because CNA-M had tried before and R4 refused. When RN-O talked to R4, RN-O gave two choices. CNA-M could apologize or RN-O would escalate to the supervisors. RN-O felt R4 was irritable due to covid. RN-O stated CNA-M had not been R4's aid for a period of time before too. Surveyor notes R4 has a catheter so unclear why would be soaking wet. Surveyor notes in the investigation of this event a Record of Conversation/Notice form was included for CNA-M. The Reason for Conference is checked as Policy/Work Rule Violation. The Description of issues resulting in conversation and notice is discussed R4's concern grievance from 1/16/25 pm shift. On 3/13/25, at 9:07 AM, Surveyor interviewed Registered Nurse (RN)-N regarding the reporting of abuse or neglect. RN-N stated that they would get a statement from the member, report incident to the supervisor, then get witness statements. On 3/13/25, at 9:13 AM, Surveyor interviewed RN-L regarding the reporting of abuse or neglect. RN-L stated they would immediately remove the CNA from care of resident, update the supervisor and get witness statements. Surveyor notes a voicemail was left for CNA-M on 3/13/25, at 11:05 AM, a return call was never received. On 3/13/25, at 10:03 AM, Surveyor interviewed Director of Nursing (DON)-B regarding CNA-M being removed from caring for residents to which DON-B responded CNA-M was removed from caring for that resident. Surveyor asked if there were other issues with CNA-M and DON-B replied not that they were aware of. Surveyor asked if education was provided to staff other than the CNA involved, DON-B will need to get back to Surveyor. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes this was the second issue between R4 and CNA-M and the Facility failed to remove CNA-M to protect all residents this CNA has contact with. Surveyor notes per the investigation summary the NHA did not interview the CNA involved until 1/23/25. On 3/13/25, at 11:25 AM, DON-B got back to Surveyor that no staff education can be found. On 3/13/25, at 11:34 AM, Surveyor informed DON-B and Nursing Home Administrator-A of the concerns related to the CNA not being removed from cares of all residents during the investigation and that all staff were not educated on resident right to refuse cares. DON-B stated that CNA-M was removed from care of R4. No additional information was provided.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 36161 Based on interview and record review, the facility did not ensure that 2 (R2 & R1) of 2 residents reviewed received adequate supervision to prevent accidents. * R2 had expressed his desire to live independently and not stay at the facility. R2 also has a history of elopements as well as leaving medical appointments early. R2 was sent to a hospital appointment with a transportation company and not accompanied by staff or provided with supervision. R2 eloped from the hospital and was found at a hotel approximately seven hours later. A later investigation found R2 planned the elopement and had saved money to go to a different location and to live independently. The failure to provide adequate supervision to prevent R2 from eloping created a finding of Immediate Jeopardy that began on 03/06/2025. The Nursing Home Administrator (Administrator-A) and Director of Nursing (DON-B) were notified of the immediate jeopardy on 3/13/2025 at 1:22 PM. The immediate jeopardy was removed and corrected on 3/14/2025. The deficient practice continues at a scope and severity of a G (Actual Harm/Isolated) due to the following example: The facility failed to put a system in place to monitor R1's safety when R1 left the building unattended. R1 was found outside by staff arriving to the facility for their assigned second shift. R1 was transferred to the hospital for evaluation and was diagnosed with dehydration, heat exposure, and renal insufficiency. Findings include: 1.) R2 was admitted to the facility on [DATE] with diagnoses that include COPD, Dementia with Mood Disturbance, Dementia with Moderate Anxiety, PTSD, and mild cognitive impairment. R2 was placed under protective placement via a court order on 11/17/23. R2's Discharge Care Plan initiated on 5/6/22 documents, DISCHARGE PLANS: Long-term stay anticipated at this SNF r/t (related to) I'm no longer able to reside at home d/t (due to) eviction from apartment, my history of falling at home. I voice wanting to leave the facility to go and live independently but I am unrealistic about my abilities. I refuse to have [NAME] County come out and do discharge options counseling. The VA (Veterans Affairs) spinal cord unit has encouraged me to talk to the county as the VA does not have a discharge option. R2's Safety Care Plan initiated on 2/17/23 documents, SAFETY: I am at risk for becoming a danger to myself by trying to leave the facility unsafely. Under the Interventions is documented: If resident leaves the facility and cannot be redirected to stay, and he has no safe plan for returning home: 1. Contact the Supervisor to update what is happening. 2. Call 911, report we need assistance with resident who is trying to leave the facility without a plan and his safety is a concern. 3. A staff person should follow resident and reapproach him to return to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The safety care plan does not address proactive measure to prevent R2 from eloping even though the 5/6/22 discharge plan indicates R2 speaks about wanting to leave the facility. There was no evidence that an elopement care plan was put into place prior to 3/6/25. Surveyor reviewed nursing/progress notes for R2 and noted the following: R2's psychiatric progress notes dated 4/5/23 document, We also discussed the recommendation for activation of his DPOAHC (Durable Power of Attorney for Health Care) and continued placement in a supervised living environment that can assist with medication administration, meal preparation and transportation. The veteran again disagreed with these recommendations, stating, This is bullshit! He discontinued the appointment and left the examiner's office . R2's nursing note dated 6/13/23 documents, Social Services Progress Note Text: Member was scheduled for an appointment at [name of hospital] Urology around 824am with Transtar transport. Hospital called at 2pm that member did not make it to the appointment. Member has not returned to the facility. Writer attempted to call member-phone disconnected. Writer and HUC called Transtar- confirmed patient was dropped off at [name of hospital] around 930am and they have not picked him up. Facility conducted campus and building search for member. Facility notified Zablock campus security. Writer called local law enforcement and APS per member safety plan. Surveyor noted that after the above event in June 2023, R2 was referred for protective placement. R2's evaluation for protective placement dated 10/24/23 documents, On June 13, 2023, the [NAME] County Human Services Department received a referral on behalf of R2 requesting Emergency Chapter 54/55 Guardianship and Protective Placement .The referral also stated that on June 13, 2023, R2 had a urology and spinal cord injury appointment at [hospital] name in Milwaukee, Wisconsin. While at the [hospital name], R2 reportedly eloped from the hospital. It was reported that R2 was picked up at the facility by Transtar. R2 was then dropped off around 9:30 AM at [hospital name]. It was reported that R2 had an appointment at 10:00 AM but did not attend the appointment. At 2:00 PM that afternoon, [hospital name] alerted the facility that R2 had missed his appointment. R2 was eventually located at the hospital hiding from staff. R2's Determination and Order on Petition for Guardianship Due to Incompetency document dated 11/17/23 documents, This individual is found to be incompetent because other like incapacities .The court transfers to the guardian of the person the power to exercise in full the ability to receive medical or treatment records of the individual; make decisions related to mobility and transfer- Partial Transfer. The individual retains the power with Guardian consent. On 3/7/24, R2 has an appointment at the VA. R2's appointment visit notes dated 3/7/24 that documents: Pick up at 930 AM. Resident returned from VA lab, Va x-ray .well after 6:00 PM. On 3/13/25 at 8:50 AM, Health Unit Coordinator (HUC) -W informed Surveyor that when she spoke to the hospital via telephone, she was informed that R2 did not attend the 3/7/24 appointment. Surveyor asked HUC-W if there was any information as to where R2 went on 3/7/24 as R2 did not attend the appointment. HUC-W informed Surveyor that there was no information as to where R2 went on 3/7/24 when R2 did not attend the appointment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's psychiatric note dated 4/16/24 documents, Resident has been isolating in his room. He frequently refuses cares. Resident repeatedly stated, I hate it here, I don't care anymore. His sister is attempting to relocate him closer to where she lives in La Crosse; however, that has been problematic. R2's Annual MDS dated [DATE] documents that R2 has short and long term memory problems. The MDS documents a PHQ-9 mood assessment score of 6, indicating that R2 has mild depression. Section GG documents that R2 has no impairment to R2's upper or lower extremities, uses a wheelchair for mobility purposes, is able to self-propel, and is independent wheeling himself at least 150 feet. R2's Psychosocial Well-being CAA (Care Area Assessment) dated 2/4/25 documents under the care plan considerations section, Member self-isolates in their room. Member does not often participate in activities. Member often refuses to participate in assessments with staff and daily cares. Staff assessments were completed, which rated member to be a 06 on the PHQ9 scaled, indicating mild depression. Despite R2's care planned interventions and R2's failure to show for appointments on 6/13/23 and 3/7/24, R2 was assessed for elopement risk on 2/4/25 and deemed to not be at risk for elopement with a score of 6. The elopement risk assessment documents that a score over 10 requires an elopement care plan. R2's nursing note dated 3/6/25 documents, Member was transported out of facility at [Name of hospital] Milwaukee for his ultrasound appointment by TranStar around 1300 (1:00 p.m.). Facility received call from Transtar Driver that when driver went back to pick member up from [name of hospital] Hospital after appointment, he was unable to locate member. Call placed to [name of hospital] hospital; staff confirmed that member never attended his appointment. Police was alerted by Hospital staff. [NAME] County Sheriff's office was informed by DON. Guardian [name] informed @ 1810 (6:10 p.m.). Police informed that silver alert was issued for member. Member was safely located by Milwaukee police approximately around 2130 (9:30 p.m.). Member was brought back to facility by unknown transportation service around 2330 (11:30 p.m.). Member wheeled his wheelchair to his unit with smiling face. Member refused body check and vitals and helped to go to bed by staff. The facility's self-report and investigation dated 3/6/25 documents, Trans star transportation picked up resident at 1:30 PM for a 2:30 PM ultrasound appointment at [hospital]. At 5:30 PM ADON (assistant director of nursing) was informed that resident was not at the designated spot at [hospital] for post appointment pickup. Call was placed to doctor's office, and it was made known that resident did not check in for his 2:30 PM ultrasound appointment. Timeline as follows: 5:30 PM- 9:52 PM 1. ADON informed DON. 2. DON called hospital and doctors office to inquire about resident. 3. Guardian, Regional Administrator and Administrator were notified. 4. DON called resident's cell phone (no answer). (continued on next page)

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	525688	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. DON called County Sheriffs office, County informed local sheriff. 6. Silver Alert issued. R1 was dropped off at hospital in Milwaukee at approximately 2:00 PM for appointment. Resident however did not go to said appointment. Resident left hospital on his own and was found at 9:13 PM at [NAME] Milwaukee Fairfield (hotel) Inn. On 3/7/25R2 was interviewed by Charge nurse. Resident stated that he planned the events yesterday. He stated that he had slowly been saving cash. He also stated that he was hoping to pay cash for a cab to the [NAME] VA because he likes that hospital better than the one in Milwaukee. When asked about why he tried what he did he stated that he was unhappy and feels like he lives in a prison. He also stated that he doesn't like the PT department here because they tell him that he can't walk and that they treat him like a kid. R2 was asked about how he felt while he was out last night and he stated that he wasn't cold nor scared. Charge nurse stated that he was in good spirits and laughing about the events of last night. R2's statement documented that the elopement was planned, R2 saved $900 prior to the elopement, and that R2 wanted to pay for a cab with cash and wanted to go to [NAME] as R2 likes that hospital. R2's nursing note dated 3/7/25 and completed by RN (Registered Nurse)-V documents, Resident frequently non-compliant with care plan for safety, has history of leaving scheduled medical appointments. R2's elopement care plan documents, I am at risk of elopement r/t Dementia with mood disturbance. 3/06 Member eloped from [Name of Hospital] Hospital from his appointment, silver alert was issued, member was located safe by Police. Interventions: Member is to have a companion ride along for all appointments to the VA. Q (every) checks 30 minutes. On 3/12/25 at 1:51 PM, Surveyor interviewed RN-V regarding R2's nursing note dated 3/7/25. Surveyor asked RN-V if R2 had eloped previously. RN-V informed Surveyor that R2 had eloped previously and/or had left appointments early, and that Surveyor should review R2's nursing notes. Surveyor asked RN-V why R2 was allowed to go appointments alone if he had eloped previously. RN-V informed Surveyor that RN-V did not know why R2 went to appointments alone as he had previously eloped. On 3/12/25 at 1:53 PM, Surveyor spoke with R2 about R2's elopement attempt. Surveyor asked R2 why R2 eloped from the facility. R2 informed Surveyor that R2 planned to go to the hospital in [NAME] as R2 hated living at the facility and that SW (Social Worker)-K did not help him get placement to live near [NAME]. R2 informed Surveyor that R2 planned to elope during his appointment as R2 had done it previously and R2 was aware that the facility did not send him with an escort. R2 informed Surveyor that R2 still wanted to leave the facility and had saved money to leave at R2's last appointment. R2 informed Surveyor that R2 felt extremely frustrated as SW-K did not speak with R2 and did not help R2 in any way to obtain another place to live. Resident believes that his sister gets his hopes up and it doesn't happen. Resident spends his days alone, playing chess on his computer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/13/25 at 9:07 AM, Surveyor interviewed SW -K regarding R2's elopement and placement services. SW-K informed Surveyor that R2 had been offered placement services approximately 6 months prior to R2's elopement attempt but that the placement did not go through. SW-K informed Surveyor that she had not spoken to R2 since and stated that SW-K has attempted to speak with R2 but that R2 has refused to speak with SW-K. Surveyor asked SW-K if SW-K was aware that R2 was unhappy living at the facility and asked why no other placement services had been attempted for the last 6 months. SW-K informed Surveyor that SW-K was aware that R2 was unhappy living at the facility and stated that SW-K could not provide a reason as to why placement services had not been offered to R2 for the last 6 months. SW-K informed Surveyor that R2 refuses to speak with SW-K. Surveyor asked SW-K if SW-K had reached out and spoken with R2's guardian to again attempt to provide placement services for R2. SW-K informed Surveyor that SW-K had not reached out or spoken to R2's guardian for approximately 6 months. On 3/13/25 at 9:30 AM, Surveyor informed DON (Director of Nursing)-B of the above findings. Surveyor asked DON-B if DON-B was aware that R2 had previously eloped during an appointment at the hospital. DON-B informed Surveyor that DON-B was not aware that R2 had previously eloped from appointments. Surveyor asked DON-B if DON-B was aware that R2 did not make an appointment on 3/7/24. DON-B informed Surveyor that DON-B was not aware that R2 did not make an appointment on 3/7/24. Surveyor asked DON-B why R2 was allowed to go to appointments without an escort or supervision as R2 had previously attempted to elope while at appointments. DON-B informed Surveyor that DON-B was not aware of previous elopement attempts and stated that DON-B could not provide any information as to why R2 was allowed to go to appointments without an escort or supervision. The failure to provide adequate supervision to prevent R2 from elopement created a reasonable likelihood for serious harm, thus resulting in a finding of Immediate Jeopardy that began on 03/06/2025. The Nursing Home Administrator (Administrator-A) and Director of Nursing (DON-B) were notified of the immediate jeopardy on 3/13/2025 at 1:22 PM. The immediate jeopardy was removed on 3/14/2025 when the facility completed the following: - Affected resident continues to have periodic onsite checks (q (every) 2 hrs) in alignment with resident rounding policy. - All Staff will be educated regarding elopement on their very first shift in their work unit after 3.13.2025. - R2's care plan has been updated to require attendant at each external appointment/outing. Facility has made contact with the Guardian who is agreeable to a care plan meeting on March 17, 2025 @ 4:00 PM to discuss possible placement in the community, as this is what the member expressed a desire to do. - Facility has reviewed court determined member rights restrictions and has updated R2's care plan to reflect any/all court order rights and/or removals. - Member's care plan has been updated to include 2 hour checks whether member is in the building or anywhere on the premises. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Facility reviewed Member rounds policy and member elopement policy. The policies remain appropriate. - DON, ADONs and or designated licensed staff will audit weekly, for one month, member rounding and safety checks on all residents. If no concerns noted, will perform audit every two weeks for one month. If no concerns, will perform audits monthly for three months. If no concerns, random audits will be done. - All Audits will be reviewed during the facility's QAPI meetings. Facility will ensure attendant goes to every off-site appointment the member has, attendant will be identified in the appointment note in the EHR (Electronic Health Record). The deficient practice continues at a scope/severity of G (actual harm/isolated) as evidenced by: 51016 The facility's policy and procedure titled, Member Rounds, with a last revision date of January 7, 2025, documents: Rounding shall be defined as nursing staff accounting for all members assigned to their unit frequently using the 4 Ps of rounding and purpose. It should be understood rounding is not every 2 hours as that is merely an absolute minimum: rounding is a continual event. One round should flow into the next round, this is how rounding reduces fall, skin breakdown, and other accidents and injuries. - Walking rounds shall occur at AM (morning) into PM (afternoon) and PM into NOC (night) shift change with CNA (Certified Nursing Assistant) staff from oncoming and outgoing shifts. - A walking round shall be considered when staff physically walk the unit to observe each member and their status, any noted change of the member shall be promptly reported to the on-duty nurse. 2.) R1 was admitted on [DATE] with diagnoses that include repeated falls, dependence on other enabling machines and devices, unspecified Cranial Injury, Cognitive Communication Deficit, Post Traumatic Stress Disorder, and Encephalopathy. R1's Quarterly Minimum Data Set (MDS) with an assessment reference date of 04/26/2024, documents a BIMS (Brief Interview for Mental Status) score of 10, indicating moderately impaired cognition for R1. Section GG (Functional Abilities and Goals) documents R1's self-care as needing maximal assist with toileting, dressing, bathing, indicating that facility staff provides more than half the effort for R1's self-care. Section GG also documents R1's mobility as dependent on staff for transfers, requires substantial/maximal assist using a manual wheelchair, indicating that facility staff provides more than half the effort for R1's wheelchair mobility. R1's Care Area Assessment (CAA) dated 05/10/24 documents under the analysis of findings section: R1 requires assistance with toilet use, has had a decline in condition and now requires use of a full body lift for transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted R1's care plan titled Potential Wandering was implemented for R1 on 7/12/24 after R1's 7/12/24's incident resulting in R1 being hospitalized for dehydration, heat exposure, and heat exhaustion. Under the interventions section it documents: Roam Alert. Under the goals section it documents: R1 will use the sign in/out form when leaving the unit. R1's nursing noted dated 7/12/24, at 03:30 PM, documents: Writer Licensed Practical Nurse (LPN)-D was called from receptionist that member (R1) was found stuck outside in the parking lot by staff coming into work. Writer LPN-D went to reception area and member (R1) was sitting in his w/c not responding, body very warm, very red in the face. Charge nurse went and gotten cold water for member (R1) to drink cool cloths to applied on member. Member brought up to 2nd floor 2 west and vital signs taken. Charge nurse continue to cool member (R1) down with cold water to drink and changing clothes for new cool cloths. Members (R1) not opening eyes, member (R1) is shaking his head yes and no. C/O nausea. Member (R1) continues to be non-verbal. Member (R1) was outside for about 1 hour and 15min. R1's nursing note dated 07/12/24, at 10:00 PM, documents: At 1530 (3:30 PM), writer Registered Nurse (RN)-C was walking into the building and noticed R1 sitting in his wheelchair near the outer corner of the car circle in front of [facility]. Writer RN-C called out R1's name a few times with no response, writer RN-C then walked up to member (R1) and noted that his face, neck, and arms were red, skin very warm to touch and member (R1) did not reply. Writer RN-C brought member (R1) inside the front entrance and receptionist called the unit LPN (Licensed Practical Nurse) to come down to also assess member (R1). Writer then went to grab member ice water and cold wet cloths. Member (R1) brought up to the unit and ADON (Assistant Director of Nursing) also present, placed fan facing member (R1) and ice-cold wet cloths to his forehead, back of neck, arms and armpits to help cool him down. Unit LPN took member vitals and continued to try to arouse him, facial grimacing noted with sternal rub, after a few minutes member then nodding his head when asked if he felt nauseated, not opening his eyes and no verbal response, member able to drink 2 cups of ice water with encouragement, member did say soda, skin slowly less red but still warm, unit LPN called NP (Nurse Practitioner) at 1545 (3:45 PM) and NP stated to continue to monitor him and if no improvement in mentation in 30 minutes send to ER (emergency room) for Evaluation. At 1605 (4:05 PM) Power of Attorney called and then 911 to send R1 to hospital. 911 paramedics here and IV (Intravenous) inserted and normal saline IV started, blood sugar 120, R1 transferred to stretcher with Hoyer lift and R1 out to Hospital at 1630 (4:30 PM). R1 returned to the facility on 2010 (8:10 PM) with Dx (diagnosis) of dehydration, heat exposure/exhaustion and renal insufficiency and was given IV fluids, labs and imaging done- ECG (Electrocardiogram) and CXR (chest x-ray)- no new orders received. Member in bed watching TV and ate noodles and drank the broth, requested orange soda. Roam Alert bracelet and device applied to members rt wrist (#F0341C) per ADON instruction for safety, POA (Power of Attorney) is aware and agreeable. Writer questioned R1 and asked what he was doing outside on the opposite side of the drive circle, and R1 stated I went out there to find a good spot to get some sun and a tan, but I got stuck and then I fell asleep. Next thing I know I was at the hospital with the paramedics shaking me up, I won't be doing that anymore .Roam Alert Device with bracelet applied to R1's right wrist for safety precautions due to R1 being found outside in sun and heat. Tag #F0341C exp 8/2027. R1 must have escort when going outside. Surveyor noted that the outside temparature according to the National Weather Service on 7/12/24 was 82 degrees Farenheit. R1's hospital after visit summary documents: Today's visit you were seen by (Doctor) Diagnoses: Dehydration; Heat exposure; Renal insufficiency. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/12/25, at 02:05 PM, Surveyor interviewed Receptionist-H regarding R1's 7/12/24 incident resulting in R1's hospitalization for dehydration, heat exposure, and renal insufficiency. Surveyor asked if Receptionist-H was working 7/12/24 the day when R1 was found outside by RN-C. Receptionist-H informed Surveyor that Receptionist-H was working on 7/12/24. Surveyor asked Receptionist-H if Receptionist-H remembered when R1 went outside. Receptionist-H informed Surveyor that Receptionist-H had no recollection of when and how R1 got outside. Surveyor asked Receptionist-H if R1 typically received help getting off the unit. Receptionist-H informed Surveyor R1 typically went off the unit and out of the building and came back independently. Surveyor asked Receptionist-H how the facility monitored the safety of R1 and other unsupervised residents after they exit the building to head outdoors. Receptionist-H informed Surveyor a sign in and out book that was started after R1's elopement incident on 7/12/24. Receptionist-H informed Surveyor that all residents must now sign in and out of the building. Surveyor asked Receptionist-H if Receptionist-H knew of any staff checking on R1 after R1 went outside on 7/12/24. Receptionist-H informed Surveyor that Receptionist-H did not remember seeing anyone check on R1. Surveyor asked Receptionist-H what the current protocol for resident's leaving the building unsupervised. Receptionist-H informed Surveyor the facility uses a sign in and out book. Surveyor asked Receptionist-H what the protocol prior to R1's 7/12/24 incident was. Receptionist-H informed Surveyor the facility always kept track of appointments and outings, and that after R1's 7/12/24 incident all unsupervised and supervised resident's leaving the building for any reason must sign in and out On 3/13/25, at 8:21 AM, Surveyor interviewed Receptionist-H regarding the facility monitoring protocol of unsupervised residents exiting the building to head outdoors. Surveyor asked Receptionist-H to explain the protocol put in to monitor unsupervised residents exiting the building to head outdoors. Receptionist-H informed Surveyor the residents sign into and out of the book. Any receptionist working will track all the times a resident exits the building and when a resident returns. The receptionist will write it in the book if the resident does not write it in themselves. Surveyor asked Receptionist-H who keeps an eye on the unsupervised residents outside on the facility grounds. Receptionist-H informed Surveyor the people working the reception desk will visualize where the residents are outside. Receptionist-H informed Surveyor the front desk will check on a resident frequently to make sure while the resident is outside is okay. Receptionist-H informed Surveyor all the receptionists keep a close eye out throughout the day to make sure the receptionist can see the resident through the windows. Receptionist-H informed Surveyor if a resident starts to move out of view, they will call the unit or go out and redirect the resident back into a visible location. Surveyor asked Receptionist-H if the facility had any safety monitoring protocols for unsupervised residents exiting the building to head outdoors prior to 7/12/24. Receptionist-H informed Surveyor the facility did not have a protocol to monitor unsupervised residents exiting the building to head outdoors prior to 7/12/24. Receptionist-H informed Surveyor the facility did keep track of resident's leaving and coming back from all appointments and family outings prior to 7/12/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/12/25, at 01:10 PM, Surveyor conducted a phone interview with CNA-E regarding R1's 7/12/24 incident resulting in R1's hospitalization for dehydration, heat exposure, and renal insufficiency. Surveyor asked CNA-E if CNA-E remembered the incident with R1 on 7/12/24. CNA-E informed Surveyor that CNA-E did not remember R1 or the incident. CNA-E informed Surveyor that CNA-E was working the other second floor unit most of the time. Surveyor asked CNA-E what the facility's expectation was for staff to monitor the safety of residents leaving the unit or building unsupervised. CNA-E informed Surveyor that staff is supposed to round every 2 hours, but most residents do not stay out that long. Surveyor asked CNA-E how CNA-E would know what length of time a resident was gone. CNA-E informed Surveyor that if a resident hadn't come back for some time staff would notice and go look for them. CNA-E informed Surveyor that CNA-E was not familiar with R1 and had no further information for the Surveyor. On 3/12/25 at 01:12 PM Surveyor conducted a phone interview with CNA-F regarding R1's 7/12/24 incident resulting in R1's hospitalization for dehydration, heat exposure, and renal insufficiency. CNA-F informed Surveyor CNA-F's shift started at 2:30 PM. CNA-F informed Surveyor CNA-F didn't see R1 in the parking lot when coming in for the shift. CNA-F informed Surveyor CNA-F remembered R1 coming back into the facility. CNA-F remembered R1 was lethargic and redden in the face. Surveyor asked CNA-F if R1 routinely went outside without supervision. CNA-F informed Surveyor that R1 went outside without supervision. Surveyor asked CNA-F what the facility's expectation of staff was to monitor the safety of residents like R1 going outside unsupervised. CNA-F informed Surveyor the expectation is to do rounds on all residents, there is no expectation to check on the independent residents like R1 who go off the unit, as those residents will come back to the unit on their own. CNA-F informed Surveyor that staff will check on residents that are fall risks or a wander risks. CNA-F informed Surveyor that staff wouldn't let a resident go out independently if that resident was at risk for injury. CNA-F informed Surveyor the staff will go with a resident if the resident is a fall risk or wander concern. CNA-F informed Surveyor R1 wasn't a fall risk or a wander risk and could be independent going outside. CNA-F informed Surveyor R1 was not the type of resident that needed to be supervised. CNA-F informed Surveyor that R1 would normally sit in the front lobby or go downstairs to the vending machines to get a soda. CNA-F informed Surveyor that R1wasn't at risk and R1 went outside frequently. CNA-F informed Surveyor R1 always came back in the facility on R1's own, so staff would not have checked on R1. Surveyor asked CNA-F if there is no policy or procedure for unit staff to check on unsupervised residents considered independent, then who would be responsible to check to make sure there are no medical or safety concerns when a resident is off the unit or outside CNA-F informed Surveyor the front desk will check on the residents and often the activities staff will check on the residents outside. Surveyor asked CNA-F if CNA-F was informing the Surveyor that R1 didn't need to be monitored off the unit or outside. CNA-F informed Surveyor that R1 went outside frequently and safely and didn't need to be monitored by the unit staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/12/25, at 02:49 PM, Surveyor interviewed LPN-D regarding R1's 7/12/24 incident resulting in R1's hospitalization for dehydration, heat exposure, and renal insufficiency. Surveyor asked LPN-D to provide details on the 7/12/24 incident with R1. LPN-D informed Surveyor that the day R1 was found in in the parking lot, LPN-D arrived that day to work a scheduled PM shift. Surveyor asked LPN-D what time LPN-D started work on 7/12/24. LPN-D informed Surveyor that LPN-D came in a little before the 2:30 PM shift start time. Surveyor asked LPN-D when the last time LPN-D saw R1 prior to R1 being found in the parking lot on 7/12/24. LPN-D informed Surveyor LPN-D saw R1 when coming in for LPN-D's shift just before 2:30 PM. Surveyor asked LPN-D what R1 was doing at the time LPN-D observed R1. LPN-D informed Surveyor R1 was in the front lobby talking about wheeling outside. Surveyor asked LPN-D how they determined the time frame of 1 hour and 15 minutes R1 was outside. LPN-D informed Surveyor the time 2:15 PM when LPN-D saw R1 in the lobby and the time 3:30 PM when RN-C found R1 was a 1 hour and 15 minutes. Surveyor asked LPN-D if R1 could wheel himself outside. LPN-D informed Surveyor that R1 does wheel down to lobby and outside for short distances. Surveyor asked LPN-D how often staff are expected to check on unattended residents that leave the unit or go outside of the building. LPN-D informed Surveyor that the Certified Nursing Assistants (CNAs) are good at letting LPN-D know when a resident has left the unit. Surveyor asked LPN-D if the protocol was the CNAs just know when a resident has left the unit and been gone too long. LPN-D informed Surveyor the staff will notice if a resident has been gone too long. Surveyor asked LPN-D how staff knew what time a resident left the unit. LPN-D informed Surveyor the staff will notice if a resident is leaving the unit. LPN-D informed Surveyor if a resident doesn't come back for some time, staff would let LPN-D know or go and look for them. Surveyor asked LPN-D how would staff know what time an unsupervised resident left the building once the resident was downstairs. LPN-D informed Surveyor the staff know the residents and when the residents are gone for too long a period, and the front desk staff would inform the units if a resident went outside to long. Surveyor asked LPN-D if there were any protocols for resident safety checks in the facility. LPN-D informed Surveyor the facility staff will do rounding every [TRUNCATED]

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49011 Based on interview and record review, the facility did not complete a performance review at least once every 12 months for 1 Certified Nursing Assistant (CNA) reviewed. This deficient practice has the potential to affect all 62 residents who reside in the facility. CNA-M last had a performance review completed 11/14/23 for the performance period of 11/1/2022 to 10/31/2023. Findings include: The Facility Policy titled Performance Evaluation Policy issued April 24, 2004, documents (in part): Introduction: It is the policy of the Wisconsin Department of Veterans Affairs that every supervisor will provide performance reviews for his or her staff as outlined in this policy. The performance review is conducted on a regular basis in order to . A performance review must be completed at least annually for all permanent employees . While reviewing a Facility Reported Incident pertaining to abuse, Surveyor requested the employee file for the named staff member (CNA-M). Surveyor discovered that the last performance evaluation in the file was for the performance period of 11/1/2022 to 10/31/2023, signed off as completed on 11/14/23. On 3/12/25, at 3:50 PM, during the end of day meeting with Facility, Surveyor asked Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B if there was a performance evaluation done for CNA-M since 2023 . The response was probably not with all the changes in administration. Surveyor asked them to please check. On 3/13/25, at 11:34 AM, Surveyor spoke with NHA-A and DON-B regarding concerns that a performance evaluation was not completed in over a year for CNA-M. DON-B shared that CNA-M was off two times in 2024 for medical leave. Surveyor noted this did not alleviate the need for an annual performance review. No additional information was provided as to why the performance for CNA-M was not performed on a yearly basis.

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	525688	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0745 Level of Harm - Actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on interview and record review, the facility did not ensure that 1 (R2) of 6 residents reviewed received medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. * R2 eloped from the facility during a hospital appointment. R2 eloped from the hospital and was found at a hotel room approximately seven hours later. R2 had voiced and made it known to facility staff that R2 wanted to leave the facility and R2 was not provided with discharge/placement services. Findings include: 1.) R2 was admitted to the facility on [DATE] with diagnoses that includes COPD, Dementia with Mood Disturbance, Dementia with Moderate Anxiety, PTSD and mild cognitive impairment. R2's Annual MDS dated [DATE] does not documents that R2 has short and long term memory problems. The MDS documents a PHQ-9 mood assessment score of 6, indicating that R2 has mild depression. Section GG documents that R2 has no impairment to R2's upper or lower extremities and documents that the resident uses a wheelchair for mobility purposes as is able to self-propel and is independent wheeling himself at least 150 feet. R2's Psychosocial Well-being CAA dated 2/4/25 documents under the care plan considerations section, Member self-isolates in their room. Member does not often participate in activities. Member often refused to participate in assessments with staff and daily cares. Staff assessments were completed, which rated member to be a 06 on the PHQ9 scaled, indicating mild depression. R2's Discharge Care Plan initiated on 5/6/22 documents, DISCHARGE PLANS: Long-term stay anticipated at this SNF r/t I'm no longer able to reside at home d/t eviction from apartment, my history of falling at home. I voice wanting to leave the facility to go and live independently but I am unrealistic about my abilities. I refuse to have [NAME] County come out and do discharge options counseling. The VA (Veterans Affairs) spinal cord unit has encouraged me to talk to the county as the VA does not have a discharge options. R2's Safety Care Plan initiated on 2/17/23 documents, SAFETY: I am at risk for becoming a danger to myself by trying to leave the facility unsafely. Under the Interventions it documents: If resident leaves the facility and cannot be redirected to stay, and he has no safe plan for returning home:1. Contact the Supervisor to update what is happening. 2. Call 911, report we need assistance with resident who is trying to leave the facility without a plan and his safety is a concern. 3. A staff person should follow resident and reapproach him to return to the facility. Despite this R2's care plan interventions, R2 was assessed for elopement risk on 2/4/25 and deemed to not be at risk for elopement with a score of 6. The elopement risk assessment documents that anything over 10 requires an elopement care plan. Surveyor noted that R2 did not have a care plan for elopement developed until 3/8/25. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	R2's elopement care plan documents, I am at risk of elopement r/t Dementia with mood disturbance.3/06 Member eloped from [Name of Hospital] Hospital from his appointment, silver alert was issued, member was located safe by Police. Interventions: Member is to have a companion ride along for all appointments to the VA. Q (every) checks 30 minutes. R2's nursing note dated 3/6/25 documents, Member was transported out of facility at VA Hospital Milwaukee for his ultrasound appointment by TranStar around 1300. Facility received call from Transtar Driver that when driver went back to pick member up from VAMC Hospital after appointment, he was unable to locate member. Call placed to [NAME] hospital; staff confirmed that member never attended his appointment. VA Police was alerted by Hospital staff. [NAME] County Sheriff's office was informed by DON. Guardian [name] informed @ 1810. VA Police informed that silver alert was issued for member. Member was safely located by Milwaukee police approximately around 2130. Member was brought back to facility by unknown transportation service around 2330. Member wheeled his wheelchair to his unit with smiling face. Member refused body check and vitals and helped to go to bed by staff. The facility's self-report and investigation dated 3/6/25 documents, Trans star transportation picked up resident at 1:30 PM for a 2:30 PM ultrasound appointment at [hospital]. At 5:30 PM ADON (assistant director of nursing) was informed that resident was not at the designated spot at [hospital] for post appointment pickup. Call was placed to doctor's office, and it was made known that resident did not check in for his 2:30 PM ultrasound appointment. Timeline as follows: 5:30 PM- 9:52 PM 1. ADON informed DON. 2. DON called hospital and doctors office to inquire about resident. 3. Guardian, Regional Administrator and Administrator were notified. 4. DON called resident's cell phone (no answer). 5. DON called County Sheriffs office, County informed local sheriff. 6. Silver Alert issued. R1 was dropped off at hospital in Milwaukee at approximately 2:00 PM for appointment. Resident however did not go to said appointment. Resident left hospital on his own and was found at 9:13 PM at [NAME] Milwaukee Fairfield (hotel) Inn. Summary of events and Interview: On March 6th, 2025 Trans star transportation picked up resident at 1:30p for a 2:30 p ultrasound appt at VAMC. At 5:30 p ADON was informed that resident was not at the designated spot at VAMC for post appointment pickup. Call was placed to Dr. office, and it was made known that resident did not check in for his 2:30p ultrasound appointment. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	Upon learning this, Guardian, Administrator, Regional Director of Operations, [NAME] County Sheriffs, and Milwaukee County Sheriffs were all notified. Shortly after this (at approximately 7:08p) the DVA Informed us that the resident was last seen on camera arriving for his appointment at approximately 2:06p. At approximately 7:18 p a Silver Alert was issued for missing resident. At 9:13 a call was received that the resident was found safe and sound in a [NAME] Milwaukee Fairfield Inn. At 9:45 DON called DVA for update and was informed that the resident did not want to leave the hotel. After a call was placed to the resident by his sister/guardian, resident agreed to come back to the facility. Resident was returned to Union Grove VA safely and in good spirits. On March 7th, 2025, Resident was interviewed by Charge nurse. Resident stated that he planned the events yesterday. He stated that he had slowly been saving cash. He also stated that he was hoping to pay cash for a cab to the [NAME] VA because he likes that hospital better than the one in Milwaukee. When asked about why he tried what he did he stated that he was unhappy and feels like he lives in a prison. He also stated that he doesn't like the PT department here because they tell him that he can't walk and that they treat him like a kid. Resident was asked about how he felt while he was out last night and he stated that he wasn't cold nor scared. Charge nurse stated that he was in good spirits and laughing about the events of last night. R1's statement documented that the elopement was planned, R1 saved $900 prior to the elopement and that R1 wanted to pay for a cab with cash and wanted to go to [NAME] as R1 likes that hospital. R2's nursing note dated 3/7/25 and completed by RN (Registered Nurse)-V documents, Resident frequently non-compliant with care plan for safety, has history of leaving scheduled medical appointments. On 3/12/25 at 1:51 PM, Surveyor interviewed RN-V regarding R2's nursing note dated 3/7/25. Surveyor asked RN-V if R2 had eloped previously. RN-V informed Surveyor that R2 had eloped previously and or had left appointments early, and that Surveyor should review R2's nursing notes. Surveyor asked RN-V why R2 was allowed to go appointments alone if he had eloped previously. RN-V informed Surveyor that RN-V did not know why R2 went to appointments alone as he had previously eloped. On 3/12/25 at 1:53 PM, Surveyor spoke with R2 about R2's elopement attempt. Surveyor asked R2 why R2 eloped from the facility. R2 informed Surveyor that R2 planned to go to the hospital in [NAME] as R2 hated living at the facility and that SW-K did not help him get placement to live near [NAME]. R2 informed Surveyor that R2 planned to elope during his appointment as R2 had done it previously and R2 was aware that the facility did not send him with an escort. R2 informed Surveyor that R2 still wanted to leave the facility and had saved money to leave at R2's last appointment. R2 informed Surveyor that R2 felt extremely frustrated as SW-K did not speak with R2 and did not help R2 in anyway obtain another place to live. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	R2's nursing note dated 6/13/23 documents, Social Services Progress Note Text: Member was scheduled for an appointment at VAMC Urology around 824am with Transtar transport. Hospital called at 2pm that member did not make it to the appointment. member has not returned to the facility. Writer attempted to call member- phone disconnected. Writer and HUC called Transtar- confirmed patient was dropped off at VAMC around 930am and they have not picked up up. Facility conducted campus and building search for member. Facility notified Zablock campus security. Writer called local law enforcement and APS per member safety plan. Surveyor noted that after the above event, R2 was referred for protective placement. R2's evaluation for protective placement dated 10/24/23 documents, On June 13, 2023, the [NAME] County Human Services Department received a referral on behalf of R1 requesting Emergency Chapter 54/55 Guardianship and Protective Placement .The referral also stated that on June 13, 2023, R2 had a urology and spinal cord injury appointment at [hospital] name in Milwaukee, Wisconsin. While at the [hospital name], R2 reportedly eloped from the hospital. It was reported that R2 was picked up at the facility by Transtar. R2 was the dropped off around 9:30 AM at [hospital name]. It was reported that R2 had an appointment at 10:00 AM but did not attend the appointment. At 2:00 PM that afternoon, [hospital name] alerted the facility that R2 had missed his appointment. R2 was eventually located at the hospital hiding from staff. R2's Determination and Order on Petition for Guardianship Due to Incompetency document dated 11/17/23 documents, This individual is found to be incompetent because other like incapacities .The court transfers to the guardian of the person the power to exercise in full the ability to receive medical or treatment records of the individual; make decisions related to mobility and transfer- Partial Transfer. The individual retains the power with Guardian consent. R2's psychiatric progress notes dated 4/5/23 documents, We also discussed the recommendation for activation of his DPOAHC (Durable Power of Attorney for Health Care) and continued placement in a supervised living environment that can assist with medication administration, meal preparation and transportation. The veteran again disagreed with these recommendations, stating, This is bullshit! He discontinued the appointment and left the examiner's office. He stated that he did not have paperwork with him for the examiner to complete this visit. Surveyor continued to search for possible elopement episodes that were documented in R2's medical record. R2's visit notes dated 3/7/24 that documents: Pick up at 930 AM. Resident returned from VA lab, Va x-ray . well after 6:00 PM. When writer asked for the blue folder, the resident stated Member stated loudly I don't have that folder. They don't use that; they use one of those as Member pointed to his laptop. Writer looked around the room as Member talked and could not see the folder. Member stated, I never had one03-08-24: Huc (health unit coordinator) retrieving progress notes from appointment. Surveyor was unable to locate any visit notes for R2's visit to the hospital on 3/7/24. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	On 3/12/25 at 2:48 PM, Surveyor interviewed HUC-W regarding R2's hospital visit on 3/7/24. HUC-W informed Surveyor that HUC-W was not at the facility when this even occurred but stated that HUC-W would reach out to the hospital in Milwaukee and find out if R2 attended the 3/7/24 appointment. HUC-W informed Surveyor that HUC-W was not aware of the possibility that R2 did not attend his appointment on 3/7/24 for his appointment. On 3/13/25 at 8:50 AM, HUC-W provided Surveyor with a print of the hospital that documented no information available for R2's 3/7/24 appointment. HUC-W informed Surveyor that when she spoke to the hospital via telephone, she was informed that R2 did not attend the 3/7/24 appointment. Surveyor asked HUC-W if there was any information as to where R2 went on 3/7/24 as R2 did not attend the appointment. HUC-W informed Surveyor that there was not information as to where R2 went on 3/7/24 when R2 did not attend the appointment. R2's social services communication note dated 12/28/23 and completed by SW (Social Worker)-K, documents, This guardian inquired what next steps needed to be taken to transition this member to a facility that is closer to La [NAME], which is near the guardian. This writer shared that they will see what next steps are and get back to guardian. This writer explained that they will be out of the office 12/29/23 to 1/2/24 and will connect with this guarding again in the new year. This writer understood and this phone call came to an end. R2's social services communication note dated 4/2/24 and completed by SW-K, documents, This writer spoke with member guardian, [name]. This member guardian updated this writer that they have been working to figure out a new living arrangement for this member. This guardian shared that they were [NAME] to get this member an apartment with a private caretaker, however, that fell through. This guarding stated that they are starting over with looking at facilities and other living arrangements. R2's social services communication note dated 4/12/24 and completed by SW-K, documents, This writer called members guarding to discuss Healthdrive and R2's placement. This guarding expressed that they are pausing the look for a new placement for this member while they work to apply for Medicaid. R2's psychiatric note dated 4/16/24 documents, Resident has been isolating in his room. He frequently refuses cares. Resident repeatedly stated, I hate it here, I don't care anymore His sister is attempting to relocate him closer to where she lives in La [NAME]; however, that has been problematic. Resident believes that his sister gets his hopes up and it doesn't happen. Resident spends his days alone, playing chess on his computer. R2's social services communication note dated 5/2/24 and completed by SW-K, documents, This writer spoke with member regarding member's discharge to a new facility. This member has expressed that R2 would like to move closer to his sister in the [NAME] area. This writer spoke with member recently regarding an CBRF (Community Based Residential Facility) that was found in the Warren's area. This writer informed the member that there is a double room available and this member would need to share with a roommate. This member was unsure if he would like to have a roommate or not. After further discussion, this member felt that a roommate would not be a bad idea and that he could possibly move to a single room should one open up. This writer discussed the cost of the new living arrangement, which this member understood. This writer will get in touch with members guardian/POA to initiate next steps in this process. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	R2's social services communication note dated 6/12/24 and completed by SW-K documents, This writer met with member to discuss this members desire to discharge from the facility. Member has expressed wanting to be closer to R2's sister in [NAME], WI. A CBRF placement was located for this member in [NAME], WI . This member denied wanting a single room at this CBRF. R2's psychiatric note dated 11/19/24 documents, Resident presented as agitated with limited interaction with others. Staff reports that he has been refusing medications and been verbally abusive to staff. During this session, a housekeeper attempted to come in his room to clean; he became angry, ordering and demanding him to leave. He insists that his door be closed at all times. It was difficult eliciting more than a few words in response to questioning. There was no eye contact present. He denied suicidal ideation or intent. Goal: Monitor resident's comfort level with his living arrangement and address any concerns that may arise. Patient continues to isolate, spending most time in his room. Does not participate in resident activities or interact often with other residents. No longer requests to leave the facility or move closer to family. R2's social services communication note dated 7/22/24 and completed by SW-K, documents, This member and guarding were working with the ADRC in finding placement closer to this members guardian near [NAME]. One option was found, however, this member declined wanting to move at the time. Currently, this member is expressing that they are not interested in moving closer to their guardian any longer and would like to remain at the facility. On 3/13/25 at 9:07 AM, Surveyor interviewed SW-K regarding R2's elopement and placement services. SW-K informed Surveyor that R2 had been offered placement services approximately 6 months prior to R2's elopement attempt but that the placement did not go through. SW-K informed Surveyor that she had not spoken to R2 since and stated that SW-K has attempted to speak with R2 but that R2 had refused to speak with SW-K. Surveyor asked SW-K is SW-K was aware that R2 was unhappy living at the facility and asked why no other placement services had been attempted for the last 6 months. SW-K informed Surveyor that SW-K was aware that R2 was unhappy living at the facility and stated that SW-K could not provide a reason as to why placement services had not been offered to R2 for the last 6 months. SW-K informed Surveyor that R2 refuses to speak with SW-K. Surveyor asked SW-K if SW-K had reached out and spoken with R2's POA to again attempt to provide placement services for R2. SW-K informed Surveyor that SW-K had not reached out or spoken to R2's POA for approximately 6 months. Surveyor asked SW-K why SW-K had not followed up or provided discharge/placement services for R2 in the last six months. SW-K informed Surveyor that SW-K was not aware that R2 was an elopement risk and could not provide an answer as to why SW-K had not worked with or followed up with R2 regarding discharge/placement services in the last six months. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	On 3/13/25 at 9:30 AM, Surveyor informed DON (Director of Nursing)-B of the above findings. Surveyor asked DON-B if DON-B was aware that R2 had previously eloped during an appointment at the hospital. DON-B informed Surveyor that DON-B was not aware that R2 had previously eloped from appointments. Surveyor asked DON-B if DON-B was aware that R2 did not make an appointment on 3/7/24. DON-B informed Surveyor that DON-B was not aware that R2 did not make an appointment on 3/7/24. Surveyor asked DON-B why R2 was allowed to go to appointments without an escort or supervision as R2 had previously attempted to elope while at appointments. DON-B informed Surveyor that DON-B was not aware of previous elopement attempts and stated that DON-B could not provide any information as to why R2 was allowed to go to appointments without an escort or supervision. Surveyor asked DON-B why SW-K had not provided discharge/placement services for R2 in the last six months. DON-B informed Surveyor that DON-B could not provide an answer as to why SW-K had not worked with or followed up with R2 regarding discharge/placement services in the last six months. No additional information was provided as to why R2 was not provided with medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of R2.