

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525688	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER WI Veterans Home-Boland Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 21425 E Spring St Union Grove, WI 53182	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility did not ensure that 1 out of 4 residents (R2) reviewed remained free from sexual abuse.</p> <p>R2, a female resident with a significant history of PTSD (post-traumatic stress disorder) and a history of sexual assault was inappropriately sexually touched by R1.</p> <p>The facility's failure to keep R2 safe from and free from sexual abuse created a finding of immediate jeopardy that began on 5/6/25. Surveyor notified NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the immediate jeopardy on 5/29/25 at 3:50 p.m. The immediate jeopardy was removed on 5/30/25, however, the deficient practice continues at a scope/severity level of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.</p> <p>Findings include:</p> <p>The facility's policy last revised on July 2, 2024 and titled, Prohibition and Prevention of Member (Resident) Abuse, Neglect, and Exploitation documents:</p> <p>*All staff shall be expected to immediately report any, and all, observed or alleged abuse and other reportable incidents.</p> <p>*Immediate intervention shall be initiated to maintain member safety with all observed or suspected allegations.</p> <p>Reporting: (includes)</p> <p>1.) On observation of actual or suspected abuse, or other reportable incident, staff immediately reports the event to the RN (Registered Nurse), nursing supervisor, or facility NHA.</p> <p>2.) The RN and unit staff immediately develop a plan to maintain member safety, removing any potentially harmful agents/situations and conducts an initial evaluation of the circumstances.</p> <p>5.1) If the incident resulted in serious bodily injury, notification to local law enforcement is required within 2 hours of forming suspicion. Incidents not resulting in serious bodily injury must be reported to law enforcement no later than 24 hours after forming the suspicion.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/6/25, the facility submitted the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report (F-62617) to the state survey agency. The form indicated that on 5/6/25, Resident (R1) reached out and grabbed another resident (R2). The date and time this occurred is documented as 5/6/25 at 11:00 a.m. The report documents that the time the facility discovered the alleged abuse/mistreatment was at 3:00 p.m. on 5/6/25. This form was submitted by NHA-A.</p> <p>On 5/12/25, the facility submitted the Misconduct Incident Report (F-62447) which documented the facility became aware of a resident to resident altercation. The report documents that the date/time the incident occurred is 5/6/25 at 1:30 p.m. The report asks the facility to explain the steps taken, upon learning of the incident, to protect the affected person(s) and others from further potential misconduct.</p> <p>The facility report documents: residents placed in safe location and investigation ensued. The affected person is listed as R2, and the accused is listed as R1. The facility documented that law enforcement was not contacted or involved. Persons with knowledge of the incident are listed as Laundry Aide-C, CNA (Certified Nursing Assistant)-D and RN (Registered Nurse)-F. The report also contained a typed summary from NHA-A about the incident. Surveyor noted the following: On Tuesday, May 6, 2025, this writer (NHA-A) was informed by laundry staff member of a resident-to-resident altercation whereby a male resident (R1) placed his hand on female resident (R2) crotch as she was walking near him. At the time of the incident, the nurse on the unit was made aware and both residents were immediately separated and maintained in a safe situation. This writer (NHA-A), DON-B and ADON (Assistant Director of Nursing)-E were also informed of the situation. Both residents (R1 and R2) live in the Memory Care area of our community, and both have activated Power of Attorneys (POA). R1 has a BIMS score of 9 (moderate cognitive impairment) on 3/12/25 and R2 has a BIMS score of 1 (severely impaired cognition) as of 2/24/25. Due to the cognition deficit and dementia diagnosis, it was determined that we were not able to immediately determine the psychological or emotional harm on the female resident (R2), so a self-report was submitted to Department of Health Services of Caregiver Quality. Activated POAs for both residents were communicated with as to what the situation was and how we are going to move forward to keep our residents safe. Male resident (R1) was moved to a different unit where no female residents reside and continues on 30-minute checks to assure safe distance from female residents. We will continue to monitor his adjustment to the new room/wing for any adverse effects. Female resident's (R2) mood and behavior indicated no immediate adverse effect from this altercation. We will continue to monitor. Care plans were reviewed by nursing and updated and consent for psych services for male resident (R1) was received from POA. Female resident (R2) involved in the altercation will be monitored for psycho-social/mood and/or behavior changes because of this situation and care plan updated as needed to assure safety and well-being. No other residents were identified as being at risk because of this altercation, but again, we will continue to monitor and provide a safe and secure environment for all.</p> <p>Surveyor conducted a review of the written statements that were included with the misconduct report. On 5/6/25, a member grievance/concern form was filled out by Laundry Aide-C. The form documented that R1 and R2 were involved and that Laundry Aide-C was delivering linens, R1 had grabbed R2 in the crotch. And then R2 walked back over and R1 grabbed her in the butt. The aide stated that it has been going on for a while.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/28/25 at 11:20 a.m., Surveyor interviewed Laundry Aide (LA)-C regarding what she witnessed between R1 and R2 on 5/6/25. LA-C stated that it was early in the afternoon on 5/6/25 and she was delivering resident laundry on the unit. R2 had come over to LA-C and gave her a hug, something she would do often, and continued to walk about the hallway. R1 was seated in a chair at the table near the nursing desk. LA-C stated that when R2 walked past R1, he scooted in the chair towards R2 and grabbed her in the crotch. LA-C said to R1 you can't do that, that is not nice. R2 appeared shocked and walked away. R2 continued to walk up and down the hallway and again past LA-C. LA-C stated that when she walked past R1 again, approximately 5 minutes later, R1 grabbed R2 in the butt. LA-C said she told R1 again, that is not nice. LA-C stated that R2 was then guided over by the dining room table and R1 stayed where he was originally seated. LA-C stated she is not sure what they (unit staff) did after that. LA-C stated that she then reported what she witnessed to her boss. LA-C stated that the nurse was aware what happened as she was in the area. LA-C stated that her boss brought her down to report what she saw to DON-B and ADON-E, who then alerted NHA-A. LA-C said she gave her statement, and someone had typed it out and she signed it that day. Surveyor asked LA-C how did R2 respond to the incidents. LA-C stated that R2 appeared shocked that it happened. LA-C stated she had never seen this happen between R1 and R2 before.</p> <p>A written witness statement from CNA-D was reviewed by Surveyor. The statement, dated 5/6/25 at 4:25 p.m., documented that the incident involved R1 and R2 on 5/6/25 at approximately 7:30 a.m. CNA-D documents that on 5/6/25 at approximately 1:30 p.m., not too long after lunch, R2 was walking the hallway per usual as she does. R1 was sitting in his chair. As R2 walked by R1, R1 reached out and grabbed R2 touching her butt area. R2 exchanged words with R1. Nurse instructed R1 to not touch R2 again. To my knowledge, R1 heard her and nodded. Shortly after, then R2 continued to pace the floor and R1 touched R2 front area which caused R2 to be upset. Floor nurse then intervened and instructed R1 to move from his original sitting area to a new table out of the way of R2. Also, the behavior from R1 is not new. He has tried this before.</p> <p>On 5/28/25 at 12:07 p.m., Surveyor interviewed CNA-D regarding the incident on 5/6/25 with R1 and R2. CNA-D stated that R2 paces the hallways all day long, this is her usual thing that she does. CNA-D recalls that it was in the afternoon, after lunch, on 5/6/25 when R1 was seated in his specific spot at a table near the nurse's desk and hallway. CNA-D stated she was seated in the dining area and watched R2 walk past R1, and he tried to grab her. R2 tried to say the f-word several times and kept walking. The 2nd pass through the common area, R1 grabbed R2 in the butt. I yelled for R1 to stop and let her go. CNA-D reported to the nurse right away. The nurse got up from the desk and intervened. R2 continued to walk the hallway and a little bit later (unknown how long) R2 walked by R1 again and this time he grabbed her front area (crotch). CNA-D stated that R2 said stop aggressively. She asked R2 if she was alright and R2 just kept walking away from the area. The nurse heard the commotion and intervened again by having R1 move to the dining room table so R2 could walk freely in the common areas. CNA-D stated that the staff were told to keep R1 and R2 separated by having R1 move tables. CNA-D stated that she has seen R1 try to grab for R2 previously and R2 will yell out stop. CNA-D stated that she does not know why R1 wasn't moved after the first time he was able to grab and touch R2. CNA-D stated that the nurse was aware of the situation because she heard all of the yelling and commotion.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/12/25, a written statement was submitted from RN-F regarding the incident between R1 and R2. The statement indicates that RN-F, on May 6, 2025, was notified by Laundry Aide that R1 was attempting to touch another member (resident) inappropriately. Writer did not see incident however got up and approached both members and Laundry Aide. Writer made sure both members were separate and safe. R1 remained in his seat and the other member (R2) was on the other side of the Laundry Aide. Writer was not aware of any physical contact so writer spoke to R1 and reminded him we cannot touch others. A little while later, R2 was walking down the halls on the unit and R1 attempted to touch R2 again. Writer removed R1 to another table out of the hallway view. Again, R1 did not make contact from writers acknowledgement however due to members dementia writer was unsure if member (R1) would continue to attempt to touch other members. Member (R1) was ok with moving to a different table.</p> <p>On 5/29/25 at 10:45 a.m., Surveyor interviewed RN-F regarding the incident that happened between R1 and R2. RN-F confirmed that she was working on day shift 5/6/25. RN-F stated that she did not observe anything happen between R1 and R2. RN-F stated that she also was not told that R1 touched R2, only that he had attempted to touch her. RN-F stated that when she first heard that R1 had tried to touch R2 she stated that the two residents need to be separated, and staff should be on high alert. RN-F stated that she had been busy doing charting and passing medications at the time. RN-F stated that the first report came from the laundry aide that R1 was trying to touch R2. RN-F stated that she then asked where was R2. R2 was walking in the hallway as she always does. RN-F stated that she told staff to just monitor the 2 residents. RN-F stated that awhile later, she heard the aide say to R1 NO so she got up from the nurse's desk and R1 was sitting in the same spot he was previously and R2 had already walked away down the hallway. RN-F stated that she was again told that R1 tried to touch R2, so she said we must move R1. RN-F said that they moved R1 to a table near the window facing the TV and out of the walkway. RN-F stated that nothing happened after that. RN-F stated that she emailed her statement to the NHA, as she works part time and was not back at the facility for a few days. RN-F stated that she had never witnessed R1 try to touch R2 like that before.</p> <p>On 5/29/25 at 1:50 p.m., Surveyor interviewed RN-H regarding the incident between R1 and R2 on 5/6/25. RN-H stated that the incident happened on his shift as he worked 2nd shift on 5/6/25. RN-H stated that when he was getting report at the beginning of his shift from the 1st shift nurse, he received a rough description of what happened between R1 and R2. Then ADON-E came up to the unit and stated that he was not happy about the whole situation. Surveyor asked what that meant. RN-H stated it was maybe because it took too long to report it. RN-H stated he was instructed to document the incident in the electronic record. RN-H stated that he felt this incident was kind of building up between R1 and R2. He has witnessed R1, on a number of occasions, try to reach out and grab R2's hands. R1 would want to look at R2's tattoos closer. RN-H stated that R1 has Parkinson's and R2 walks very quickly so he was surprised that R1 was able to make contact with R2. RN-H stated that R2 would walk by R1 500 times a day because that is all she did was pace the unit. RN-H stated R1 would watch R2 walk by and sometimes would yell out Hey to get her attention. It didn't seem to bother R2 at all. R1 does not talk much and R2 has a lot of difficulty making her needs verbally known. RN-H stated he was instructed to put R1 in 1 to 1 supervision until he could get the incident documented in the medical chart. DON called the families and notified them of the situation. RN-H stated that after the reports were written, he believed R1 was then on 30-minute checks.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Surveyor noted discrepancies within the facility's investigation regarding the incident that occurred on 5/6/25 between R1 and R2. The written summary provided by NHA-A documents that there was only 1 time where R1 touched R2 inappropriately on 5/6/25. Both witness statements from Laundry Aide-C and CNA-D state that R2 was touched 2 different times, 1 time in the crotch area and 1 time in the butt by R1. Both witness statements state different times that these incidents occurred. The summary indicates that nurse was aware of the incident and separated R1 and R2 to maintain a safe situation, although R1 was able to grab and touch R2 a second time. The time between these 2 incidents is not reflected in any of the witness statements, only that R2 had walked away after the 1st incident and sometime later walked by R1 again and he grabbed her. NHA-A first identified the incident as happening at 11:00 a.m. on 5/6/25 and not discovered by the facility staff until 3:00 p.m. on 5/6/25. The 2nd submitted report to the state agency indicates the incident occurred at 1:30 p.m. on 5/6/25. The written statement from Laundry Aide-C does not indicate a time of occurrence, although the statement from CNA-D states the time of the occurrence was 7:30 a.m. on 5/6/25. The written statement from RN-F does not indicate what time she was notified or what time she took corrective action to keep the residents safe. Surveyor also noted that the facility did not thoroughly investigate this incident by interviewing all staff who may have had knowledge of this incident. A review of the schedule for 5/6/25 shows that 5 staff members were working on the unit for the morning shift (6:30 am-3:00 PM) in addition to Laundry Aide-C being on the unit returning resident clothing.</p> <p>Surveyor conducted further review of R1's medical record for further clarification of the incidents between R1 and R2. The following was noted:</p> <p>R1's nursing note dated 5/6/25 at 4:27 p.m. documents: Writer called POA to give update on member behavior of reaching out to touch female members. Left message to call back. This note was written by DON-B.</p> <p>R1's nursing note dated 5/6/25 at 5:15 p.m. documents: Member (R1) noted to reach out and grab fellow member R2 in a purposeful and inappropriate physical contact with member's genital/buttock area. Member (R1) has attempted to reach out and grab R2 in the past but has not targeted such areas and been successful. This note was written by RN-H who worked the 2nd shift on 5/6/25.</p> <p>R1's Incident note dated 5/6/25 at 5:19 p.m. documents: Follow-up: new intervention implemented and added to Treatment Plan of Care. Seating situation permanently changed. This note was written by RN-H.</p> <p>Surveyor reviewed R1's plan of care and noted it was updated with the following:</p> <p>On 5/6/25, the care plan was updated stating that R1 has actual problem of reaching out for inappropriate touching of other members. Interventions added on this date included:</p> <p>During non-meal hours R1 should be encouraged to be in the area over by the other male residents due to repeated reaching out in inappropriate manners to other residents.</p> <p>Encourage R1 to sit in the common area and not in hallway to prevent reaching out to females.</p> <p>5/7/25 30-minute checks to ensure that when member is seated in common area that he is with other male members and not in common walkway areas utilized by pacing members.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>5/8/25 targeted behavior is inappropriate touching of female staff or members.</p> <p>R1's IDT (interdisciplinary team) note dated 5/7/25 documents: Summary of discussion (late entry): met to discuss incident. All proper parties notified. Interventions: 30-minute checks to ensure that when member (R1) is seated in common area that he is with other male members and not in common walkway areas utilized by pacing members. During non-meal hours, R1 should be encouraged to be in area over by the other male members. Encourage member (R1) to sit in the common area and not in hallway to prevent reaching out to females. Monitor member (R1) behavior around female members. This note was written by ADON- E.</p> <p>R1's nursing note dated 5/7/25 at 1:38 p.m. documents: Per ADON-E, Member (R1) is on 30-minute checks. ADON-E updated members (R1) care plan. Member (R1) currently off the unit and out of the building with activity staff. Surveyor did request to see evidence that the 30-minute checks were being completed. The facility provided documentation with 30-minute checks starting at 1:40 p.m. on 5/7/25 until R1 moved to a different unit on the afternoon of 5/8/25.</p> <p>R1's communication note dated 5/7/25 at 4:30 p.m. documents: This writer met with member's (R1) POA and discussed a psychiatry referral for member. This POA was agreeable to transition R1 to see the in-house psychiatrist for a more integrated care approach instead of R1 going out to see a psychiatrist outside of this facility. This POA signed off on this consent. This writer and POA discussed R1's recent behavior towards female on the unit and inappropriately touching the female. This writer and POA discussed moving this member to a new unit, without females, as an intervention. This POA was agreeable to this idea, should the facility feel that it was in everyone's best interest. This note was written by SW (Social Worker)-G. Surveyor noted that although SW-G obtained consent for R1 to see the in-house psychiatrist for a more integrated approach, R1 did not actually have the initial Psychiatry evaluation until 5/19/25.</p> <p>R1's behavior note dated 5/7/25 at 10:29 p.m. documents: Member (R1) did not make contact; member emerged from his room with his walker and attempted to grab R2's arm however R2 walked away too quickly for R1 to make contact with her. Member noted to have 1 attempt to reach to and grab member (R2). This member (R1) did express great remorse to the writer and volunteered a promise to never do it again. Note written by RN-H.</p> <p>On 5/29/25 at 1:50 p.m., Surveyor interviewed RN-H. RN-H confirmed that on 5/7/25, he observed R1 come out of his room with his walker and try to grab R2 as she was walking by. R1 didn't really make contact, just grazed R2's arm. There is a speed difference in R1 and R2, she is fast to move. RN- H stated that he believed R1 was definitely interested in R2, although he doesn't show much interest in anything else.</p> <p>R1's communication note dated 5/8/25 at 12:00 p.m. documents: This writer called members (R1) POA and left a voice mail message. This writer informed POA of members (R1) room move to a new unit as an intervention to member's inappropriate touching towards a female peer on current unit. Note written by SW-G.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/29/25 at 11:46 a.m., Surveyor interviewed SW (Social Worker)-G regarding the incident between R1 and R2. SW-G stated that she does not recall how she found out about the inappropriate touching between R1 and R2. SW-G stated that she did not conduct any interviews with R1 or R2 immediately following the incident. SW-G stated that she did speak with R1's POA regarding having a psych evaluation and this was over the phone on 5/7/25. R1's POA did give consent to the evaluation and a room change. Surveyor asked SW-G why R1 did not have his initial psych evaluation until 5/19/25. SW-G stated she wasn't exactly sure but believes the in-house Psychiatrist was out on vacation and only comes to the facility every Monday. Surveyor asked SW-G when R1 moved rooms to a different unit on a different floor. SW-G stated that R1 moved in the afternoon of 5/8/25. Surveyor asked SW-G why R1 wasn't moved on 5/7/25 after the POA gave permission. SW-G stated she doesn't know why there was a delay in moving R1, maybe they didn't have a room ready or the manpower to move his belongings. Surveyor asked SW-G if she was aware that R1 attempted to grab R2 again after coming out of his room on 5/7/25. SW-G stated she was not aware of this. SW-G stated that interventions were put in place for 30-minute checks for R1 but not for R2. Staff were to be looking for any reactions to the incident from R2 and chart them in the electronic medical record. The delay in moving R1 created a very vulnerable situation and did not protect R2 from further sexually inappropriate touching. Given R2's extensive history of multiple trauma, especially sexual assault, this left R2 to be very vulnerable and any reasonable person would have the potential to respond to the actions of R1 in a negative way.</p> <p>On 5/28/25 at 10:49 a.m., Surveyor interviewed NHA-A in regard to the incident between R1 and R2 on 5/6/25. Surveyor stated to NHA-A that upon reviewing the written summary, it only identifies that R1 touched R2 inappropriately one time. The written witness statements document that R1 touched R2 twice. NHA-A stated that she thought it all happened at the same time. Surveyor asked NHA-A if she was aware what time the incidents happened because the facility's report documents 11:00 a.m., 1:30 p.m., witness statement says 7:30 am, and another states after lunch. NHA-A stated she does not recall what time she was notified and did not know the times of the incidents. NHA-A confirmed that the police were not called per the policy within 24 hours. NHA-A was asked what was done to protect the residents. NHA-A stated that R1 and R2 were separated. Surveyor asked if R1 and R2 were separated for safety, why was R1 able to touch R2 inappropriately a second time. NHA-A stated that NHA-A thought it all happened at the same time.</p> <p>On 5/28/25 at 2:28 p.m., Surveyor interviewed DON-B regarding the incident between R1 and R2 on 5/6/25. DON-B stated that she was made aware initially by ADON-E that the laundry aide had witnessed R1 touch R2 inappropriately. DON-B stated that she instructed ADON-E to gather interviews with any witnesses and find out where the incident happened. DON-B stated that she was not involved in the investigation because she was out of the facility for the next week immediately following the incident. DON-B stated that she was very concerned about R2 given her traumatic history with abuse and having flashbacks. DON-B stated that immediately following the incident, R1 was put on 15-minute checks and staff were to keep an eye on both R1 and R2 for any changes in behaviors. When R1 is out of his room, he is to sit in a more supervised area. DON-B is not aware of any other times where R1 inappropriately touched R2 or the other female residents on the unit.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/28/25 at 2:52 p.m., Surveyor interviewed ADON-E regarding the incident that occurred with R1 and R2 on 5/6/25. ADON-E stated he could not give a time of when he was notified but remembers the girl from laundry came into the conference room and told us she witnessed R1 touch R2 inappropriately. ADON-E stated that R1 had grabbed R2 in the crotch and then also grabbed her in the butt. ADON-E stated he immediately notified NHA-A because the issue needed to be addressed right away. ADON-E stated that an investigation began immediately and put R1 and R2 on 15-minute checks, if he remembers correctly. ADON-E stated that there were no behavioral changes to R2, and staff was keeping the 2 residents separated. Surveyor asked ADON-E what type of behaviors that the staff was monitoring for R2 to determine if she had been affected by this situation. ADON-E said they are watching all behaviors but could not give specifics for either resident.</p> <p>Surveyor noted that facility staff were aware that R1 had made several attempts to touch R2 as she would walk past him, although many thought it was harmless in intent. On 5/6/25, R1 was seated in a stationary chair at a table near the nurse's desk when R2 walked by. R1 grabbed R2 in the crotch, making R2 yell out stop and quickly walking away from the area. Staff told R1 that this was not nice of him and not to do it again. R1 remained seated in the same chair at the same table when R2 walked by again sometime later. R1 then grabbed R2 in the butt. R2 tried to swear at R1 and quickly walked away again. Staff determined that an immediate intervention was to move R1 to an area away from the walking path of R2. After NHA-A, DON-B, and ADON-E became aware of the situation, an investigation began and R1 was placed on 30 minute checks. DON-B thought it was 15 minute checks, but there was no evidence of this. R1's plan of care was updated with the interventions of having his seat moved when in the common area and staff are to observe him every 30 minutes. In the meantime, the afternoon of 5/7/25, R1 was able to walk out of his room and attempt to grab at R2 as she walked by in the hallway. R1 was moved to another unit on a different floor 2 days after the incident.</p> <p>The facility's failure to keep a resident free from sexual abuse created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The facility removed the jeopardy on 5/30/25, however, the deficient practice continues at a scope/severity level of D (potential for more than minimal harm/isolated) as the facility continues to implement the following action plan:</p> <ul style="list-style-type: none"> - Identified RN was suspended pending completion of investigation. - All staff have been in-serviced by their next scheduled shift on prohibition and prevention of member abuse, neglect, and exploitation with reporting expectations. - IDT team was educated on the process of trauma assessments, identification of the need for a trauma care plan and the necessitation of ongoing monitoring and auditing of interventions success. - All staff will be in-serviced by next scheduled shift assigned training regarding identifying trauma triggers and mitigation strategies. - Abuse screening was completed by a sampling of members. - All new admissions will be assessed and anyone who triggers for trauma needs will have those needs care planned by the IDT team, interventions will be evaluated and adjusted if needed monthly for 3 months and then quarterly results of assessments and interventions of new admissions will be reviewed in QAPI. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>No additional information was provided.</p>

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<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder (PTSD), received appropriate treatment and services to correct the assessed problem or attain the highest practical mental and psychosocial well-being for one (R2) of 4 residents reviewed.</p> <p>*R2's social history documents R2 experiencing trauma as an adult including sexual assault and having war related trauma resulting in a diagnosis of Post Traumatic Stress Disorder(PTSD). R2's Life Events Checklist for DSM-5(LEC-5) indicates R2 has a history of trauma and R2's comprehensive care plan was not individualized with known triggers, person-centered interventions, and/or goals related to R2's past history of trauma. Based on R2's history of trauma, R2 is vulnerable and on 5/6/25, the facility did not protect R2 from unwanted sexual contact from R1.</p> <p>Findings Include:</p> <p>Surveyor noted that the facility was not able to provide a policy and procedure for trauma informed care.</p> <p>The facility's Facility Assessment Tool dated May 2024 documents:</p> <p>.Psychiatric/Mood Disorders-psychosis, impaired cognition, mental disorder, depression, bipolar disorder, schizophrenia, PTSD, anxiety disorder, behavior that needs interventions . as a category of Residents that the facility is able to provide the care and meet the needs of Residents in that category. Currently the facility has an average of 23 requiring behavioral health needs.</p> <p>The facility documents mental health and behavior services are provided by:</p> <p>.manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities .</p> <p>Competencies Include:</p> <p>.Caring for Residents with mental and psychosocial disorders, as well as Residents with a history of trauma and/or PTSD, and implementing non-pharmacological interventions.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>1.) R2 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder(PTSD)(a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), Personal History of Physical and Sexual Abuse, Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), Recurrent, Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities), Personal History of Other Mental and Behavioral Disorders, Dementia, Severe, With Mood Disturbance(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), and Early Onset Alzheimer's Disease(progressive disease that destroys memory and other important mental functions).</p> <p>R2's Quarterly Minimum Data Set(MDS) completed 5/13/25 documents R2's short and long term memory is impaired and demonstrates severely impaired skills for daily decision making. R2's MDS documents R2 has no depressive or behavioral symptoms. R2's MDS documents R2 has clear speech, is understood, and understands. R2 requires set-up for eating, supervision for mobility, and substantial/maximum assist for transfers. R2 is dependent for showers. R2 has no range of motion impairment and R2 is independent with ambulation.</p> <p>R2's current physician orders document R2 is receiving:</p> <ul style="list-style-type: none"> -Aripiprazole 5 mg 1 tablet in morning for dementia with mood disturbances -Busipirone HCl 10 mg every morning and at bedtime for anxiety -Duloxetine HCl 60mg 2 capsules in morning for PTSD, Depression, Mental Health to PTSD, Chronic and Major Depressive Disorder <p>R2's current Treatment Administration Record(TAR) documents R2's targeted behaviors are:</p> <ul style="list-style-type: none"> -Behavioral Disturbances -Crying -Restless -Anxiety <p>The facility is monitoring R2's targeted behaviors each shift. Surveyor reviewed R2's TAR for month of May and noted that from May 1-May 28, R2's targeted behaviors on 2nd shift occurred 12-18 times compared to 1st and 3rd shift where the targeted behaviors were 0-3 occurring. Surveyor also noted that R2's TAR does not document non-pharmalogical interventions put into place for staff to implement when R2 is demonstrating behavioral disturbance, crying, restless, and/or anxiety.</p> <p>R2's Social Service Interview completed 2/25/25 by Social Worker (SW)-G documents R2 served in the Iraq War and was in Afghanistan as part of the United States Army.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Social History completed 3/5/25 by SW-G documents R2 was living at an assisted living facility prior to admission to the facility. R2 was a supply specialist for the Army for 32 years. 15 years of active duty and 17 years in the reserves. R2 divorced from R2's husband in 2015 and they have 2 children, who the youngest is being raised by R2's husband. R2 has 3 other children, 1 of whom R2 gave up for adoption. R2 struggled with alcohol use in the past and has PTSD since 2002 after a long deployment in Afghanistan. R2 was raped and has anxiety. Information was provided by R2's daughter to SW-G.</p> <p>R2's LEC-5 completed by SW-G documents the following trauma:</p> <ul style="list-style-type: none"> -2. Fire or explosion-happened to R2, R2 witnessed it, part of R2's job -3. Transportation accident-happened to R2 -5. Exposure to toxic substance-happened to R2, part of R2's job -6. Physical Assault-happened to R2 -7. Sexual Assault-happened to R2 -9. Other unwanted or uncomfortable sexual experience-happened to R2 -10. Combat or exposure to war-zone-R2 witnessed, part of R2's job -13. Severe human suffering-R2 witnessed, part of R2's job -14. Sudden violent death-R2 learned about it -17. Any other very stressful event or experience-R2 gave a child up for adoption <p>SW-G also documented that R2 saw a little child get killed in Afghanistan. The child was strapped with a bomb. R2 experienced multiple times witnessing violent deaths as part of R2's military deployments. SW-G also documented that R2 struggled with R2's PTSD symptoms more so in the past. R2 can have sun downing around 6 PM.</p> <p>Surveyor reviewed R2's comprehensive care plan. Surveyor noted that there is no care plan in place for R2's past history of multiple trauma that is individualized with known triggers and person-centered interventions. Any information related to R2's multiple traumas related to R2's PTSD that SW-G obtained as documented in R2's social history and LEC-5 was not addressed further with a person-centered approach to include R2's triggers and person-specific interventions.</p> <p>Surveyor noted that R2's care plan includes an intervention initiated on 2/11/25 that states R2 is to have female caregivers due to history of trauma.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/12/25, the facility submitted the Misconduct Incident Report (F-62447) which documented the facility became aware of a resident to resident altercation. The report documents that the date/ time the incident occurred is 5/6/25 at 1:30 PM. The report asks the facility to explain the steps taken, upon learning of the incident, to protect the affected person(s) and others from further potential misconduct. The facility documented residents placed in safe location and investigation ensued. The affected person is listed as R2, and the accused is listed as R1. The facility documented that law enforcement was not contacted or involved. Persons with knowledge of the incident are listed as Laundry Aide (LA)-C, CNA (certified nursing assistant)- D and RN (registered nurse) (RN)- F. The report also contained a typed summary from Nursing Home Administrator (NHA)-A about the incident. Surveyor noted the following: On Tuesday, May 6, 2025. This writer (NHA)- A) was informed by laundry staff member (LA)-C of a resident-to-resident altercation whereby a male resident (R1) placed R1's hand on female resident (R2) crotch as R2 was walking near R1.</p> <p>Surveyor conducted a review of the written statements that were included with the misconduct report. On 5/6/25, a grievance/concern form was filled out by Laundry Aide (LA)-C. The form documented that R1 and R2 were involved and that while LA-C was delivering linens, LA-C witnessed R1 grab R2 in the crotch. And then R2 walked back over and R1 grabbed R2 in the butt. LA-C stated that it has been going on for a while.</p> <p>On 5/6/25, R2's comprehensive care plan was updated that R2 had actual incident of being targeted with inappropriate physical contact from other member as well as a target of previous attempts to make inappropriate contact. 2 interventions were implemented on 5/6/25:</p> <ul style="list-style-type: none"> -Ensure that R1 is seated on the far side of the day room and not in the pathway of R2's frequent pacing pathway. -Ensure R2 is redirected away from R1 who may continue to take opportunities to reach out to touch R2. <p>On 5/7/25, R1 was able to walk out of R1's room and attempt to grab at R2 as R2 walked by in the hallway as documented by the facility.</p> <p>On 5/29/25, at 11:46 AM, SW-G informed Surveyors, SW-G does not know why there was a delay to transfer R1 to another room to another unit of the facility. R1 was not transferred until 5/8/25. The delay in moving R1 created a very vulnerable situation and did not protect R2 from further sexual inappropriate touching. Given R2's extensive history of multiple trauma, especially sexual assault, left R2 to be very vulnerable and any reasonable person would have the potential to respond to the actions of R1 in a negative way. Surveyor notes the facility's investigation of the incident between R1 and R2 indicate staff were aware that R1 was actively seeking R2 out and obsessed with R2. Based on R2's past trauma of sexual assault, the facility had not developed any person-centered interventions for R2 or were aware of any person specific triggers to be aware of that may indicate R2 was responding in a negative way to R1's unwanted attention or physical advances.</p> <p>R2 was first evaluated for an initial psychiatric evaluation by Psych NP (NP)-I on 4/21/25. NP-I documents that R2 is tearful and has anxious pacing on the unit and R2 reports dreams of service resulting in tearfulness. R2 was evaluated on 5/5/25 for follow-up by NP-I. NP-I documents R2 has delusions defined by flashbacks related to service due to PTSD.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor noted that R2 was not evaluated by NP-I after the incident of R1 sexually inappropriately touching R2. Further, NP-I has not been asked by the facility to participate in developing a person-centered care plan to identify R2's triggers and implement person-specific interventions.</p> <p>On 5/29/25, at 10:52 AM, Surveyor interviewed Registered Nurse (RN)-F in regards to R2. RN-F stated R2 has trauma. RN-F informed Surveyor that R2 had been raped multiple times by peers in the Army while overseas. R2 did not deal with it upon return home and now has a diagnosis of Alcohol Induced Dementia. RN-F stated that R2 is able to answer yes and no questions appropriately.</p> <p>On 5/29/25, at 11:41 AM, Surveyor interviewed SW-G. SW-G stated that SW-G did not make any attempt to obtain previous mental health hospital records from veteran hospitals. Surveyor notes R2's admission signed consent included for the facility to obtain mental health records as it is indicated R2 had previous stays at 2 different military hospitals for mental health issues. Surveyor asked SW-G what is SW-G's understanding of R2's trauma/PTSD. SW-G stated all SW-G knows is that R2 was in Afghanistan and has different sexual abuse but that is the extent. SW-G stated SW-G does not know anything specific in regards to R2's past. SW-G informed Surveyor that SW-G is not the best person to ask about R2's usual behavior pattern as SW-G is not on the unit frequently. SW-G confirmed SW-G did not update NP-I about the incident between R1 and R2 and did not follow-up with R2 or R2's Health Care Power of Attorney about the incident.</p> <p>On 5/29/25, at 12:32 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-J. CNA-J stated that R2 mumbles a lot and paces all day. CNA-J indicated R2 can answer yes/no questions appropriately. CNA-J stated that CNA-J was not surprised that the incident occurred between R1 and R2. CNA-J was told when CNA-J started employment at the facility that R1 likes to touch women and can be sexually inappropriate. He is touchy.</p> <p>On 5/29/25, at 1:45 PM, Assisted Living RN (RN)-K confirmed that R2 had lived at the assisted living from September of 2024 until February of 2025. RN-K stated the assisted living is predominantly female. RN-K informed Surveyor that R2 was very fearful of men during R2's stay at the assisted living. RN-K stated the assisted living sent over a lot of information on R2 including a care plan.</p> <p>On 5/29/25, at 2:07 PM, Surveyor interviewed RN-H. RN-H confirmed RN-H works the unit that R2 resides on, on a regular basis. RN-H does not know what R2's triggers are. RN-H stated R2 cries a lot but RN-H wishes he knew why. RN-H is aware that R2 has a past history of sexual trauma. RN-H will complete assessments of R2 including taking vitals, listening to stomach, and completing skin checks.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/29/25, at 3:50 PM, Surveyor shared the following concerns with NHA-A and Director of Nursing (DON)-B. Surveyor shared that R2's most documented behaviors occurred on the second shift when a regular male nurse worked on a consistent basis. Surveyor informed that the facility that it had not investigated if the behaviors could be correlated to the fact that R2 was being treated by a male nurse and this may be a trigger for R2. The facility not completing a thorough assessment of R2's multiple past trauma and related PTSD and no implementation of a person-centered care plan to address R2's PTSD, past trauma in order to reduce R2's triggers and initiate specific interventions was shared. Surveyor shared that R2 did not receive services to assist R2 in attaining the highest practicable mental and psychosocial well-being. Surveyor shared R2 did not receive appropriate person-centered and individualized treatment and services to meet R2's assessed needs. Surveyor shared that trauma informed care includes investigating the coping skills of R2 who has a history of trauma and PTSD, so assessment of R2's symptoms and implementation of care strategies should be highly individualized for R2.</p> <p>No additional information was provided by the facility as to why the facility did not ensure that R2, who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder (PTSD), received appropriate treatment and services to correct the assessed problem or attain the highest practical mental and psychosocial well-being.</p>		