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	10/01/2025

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** Based on interview and record review the facility did not ensure a resident's physician was notified for 2 (R1 & R11) of 11 residents reviewed. R1's physician was not notified when R1 was screaming out in pain with minimal movement on 8/22/25. The incident report dated 8/22/25 documents the provider notification to be done the next day. R11's physician was not notified when R11 eloped on 9/11/25. Findings include: 1.) R1's diagnoses includes chronic embolism and thrombosis of right popliteal vein (vein of the lower limb), atrial fibrillation (irregular and rapid heart beat), hypertension (high blood pressure), left above knee amputation, obsessive compulsive disorder (excessive thoughts that lead to repetitive behaviors), dementia (loss of cognitive function that interferes with a persons daily life & activities) and history of traumatic brain injury (brain dysfunction caused by outside force usually a violet blow to the head). R1's nurses note dated 8/22/25 at 13:58 (1:58 p.m.) written by Registered Nurse (RN)-V documents: No new bleeding or bruising noted. Member returned from appointment with POA (Power of Attorney) at approximately 1150. The next nurses note is dated 8/22/25 at 16:18 (4:18 p.m.) written by RN-OO documents: Hall Certified Nursing Assistant (CNA) informed writer that member is screaming out in pain with minimal movement while trying to roll to L (left) side. Member refused and ordered the CNA to get out of the room and leave him be. Member had a Chiropractor appointment this AM (morning). There was no new orders from the appointment and no info (information) in report regarding new pain. (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	R1's incident note dated 8/22/25 at 17:00 (5:00 p.m.) written by RN-OO documents: Hall CNA informed writer that member is screaming out in pain with minimal movement while trying to roll to L side. Member refused and ordered the CNA to get out of the room and leave him be. Member had a Chiropractor appointment this AM. There were no new orders from the appointment and no info in report regarding new pain. Member's POA [Name] informed writer of the reason for the member's knee pain. POA stated that when she is transferring the member in and out of the van, I sometimes bump his knee or it gets stuck when I take him to his appointments. POA stated the pain is not in the member's back, it's in their knee. VITALS: FOLLOW-UP: New intervention implemented and added to TPOC (temporary plan of care). extra caution when transferring/cares. NOTIFICATIONS: Provider notification to be done next day. NOK (next of kin)/Responsible party notified this shift: 08/22/25 5:00 PM [Name] done in person. Supervisor notified in person: 08/22/2025 4:18 PM (evening) [Name] Charge RN. R1's nurses note dated 8/22/25 at 17:30 (5:30 p.m.) written by RN-OO documents: Member's POA present at this time attempting to feed member themselves as they refused dinner. POA stated that member's pain is not in their back from the chiropractor appointment today but is in the knee. POA gave permission to not move forward with attempting to bathe member. R1's nurses note dated 8/23/25 at 02:55 (2:55 a.m.) written by RN-PP documents Unit CNA reported that member is screaming and hollering in pain. Writer and other charge nurse went to member's room, assessed member 'leg. Member is complaining of right hip/knee pain. Member screaming with movement. No visible redness, swelling, bruise or any injury noted. Pedal pulse palpable. Member had Chiropractor appointment during the day. Member has been complaining of right hip/knee pain since evening per charting. Member yelled out loud when staff tried to reposition member. Member refused to be repositioned. R1's nurses note dated 8/23/25 at 04:01 (4:01 a.m.) written by RN-QQ documents: Member was restless during night. C/o (complained of) pain on rt (right) hip and rt leg 5/10. Tramadol and Tylenol given at 0400 (4:00 a.m.). R1's nurses note dated 8/23/25 at 09:40 (9:40 a.m.) written by RN Supervisor-U documents: POA [Name] on unit due to member being sent out for eval (evaluation) & tx (treatment) due to new onset of uncontrolled pain to R hip/knee. [Name] agreed it was best to have it looked at to be safe. Voiced concern that member had surgery to site years ago. R1's nurses note dated 8/23/25 at 11:18 (11:18 a.m.) written by RN Supervisor-U documents: Member picked up by [Ambulance Name] via stretcher at 1055 (10:55 a.m.) for transport to [Hospital Name] for eval & tx for uncontrolled pain to R hip/knee. Management & Admissions updated via email of hospital transfer. R1's nurses note dated 8/23/25 at 22:34 (10:34 p.m.) written by RN Supervisor-W documents: Spoke with [Name] RN for Member at [Hospital Name]. Member was admitted for Femur facture of the right leg. Member will have surgery 08/24/25. [Name] stated Member will likely spend the next week as an inpatient of the unit [Name]. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/25, at 4:25 p.m., Surveyor interviewed RN-OO. Surveyor inquired about R1's pain on the day R1 had the Chiropractor appointment. RN-OO explain she and the Certified Nursing Assistant (CNA) went in the room, the CNA was barely touching R1 and R1 was screaming out in pain. RN-OO informed Surveyor she contacted R1's POA who informed her they were at the chiropractor. RN-OO informed Surveyor she asked R1's POA when R1's POA came to the facility about R1's right knee. RN-OO informed Surveyor R1's PO told her sometimes she bumps him. RN-OO informed Surveyor this day was R1's bath day and the POA told her not to worry about bathing R1. RN-OO informed Surveyor she didn't get anything from the other nurse about R1 being in pain so when the CNA told her R1 was yelling in pain it was a shock to her. Surveyor asked RN-OO when R1 was screaming out in pain why didn't she notify R1's physician regarding the pain and for recommendations such as an increase in pain medication or having an x-ray taken at the facility. RN-OO informed Surveyor she didn't know it was an option when R1's POA told her not to notify the doctor. RN-OO informed Surveyor name of R1's POA gave her permission not to notify the doctor because she was aware of the pain. On 9/115/25, at 8:28 a.m., Surveyor asked Assistant Director of Nursing (ADON)-S when ADON-S would expect a resident's nurse to notify the doctor. ADON-S replied that's a really involved question and explained change of condition, parameters provided by physician, falls. Surveyor asked what about if a resident has signs of pain. ADON-S informed Surveyor if the resident has pain more than usual, if the treatment is not successful or there is a change of condition. Surveyor asked ADON-S what if a POA tells the nurse not to notify the MD what should the nurse do? ADON-S replied I would hope the nurse would notify the physician if there were any of these things. Surveyor informed ADON-S of R1 was yelling out in pain with minimal movement during the evening shift on 8/22/25 after R1 had been out of the facility for a chiropractors appointment and RN-OO informing Surveyor she did not notify the doctor because R1's POA told her she didn't have to. No additional information was provided as to why R1's physician was not notified of R1's pain on 8/22/25. 2.) R11 was admitted to the facility on [DATE] with diagnoses of Dementia Unspecified Severity(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), With Mood Disturbance, Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Essential (Primary) Hypertension(most common type of high blood pressure), Chronic Respiratory Failure With Hypoxia(long-term condition where the lungs are unable to adequately exchange oxygen and carbon dioxide), Insomnia(sleep disorder characterized by difficulty falling asleep), Unspecified, and Peripheral Vascular Disease(circulatory condition in which narrowed blood vessels reduce blood flow to limbs), Unspecified. R11 has an activated Health Care Power of Attorney(HCPOA) as of 1/10/24, however, there is a guardianship hearing on 10/6/25 because family no longer wants to be the HCPOA. R11's Quarterly Minimum Data Set(MDS) completed 6/26/25 documents R11's Brief Interview for Mental Status(BIMS) score is 12, indicating R11 is moderately cognitively impaired. R11's MDS documents no mood or behavior issues, including wandering. R11 requires set-up for eating. R11 is independent with hygiene, dressing, mobility, and transfers. R11 is occasionally incontinent of urine and always continent of bowel. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/25, at approximately 9:55 AM, a family member of another resident informed staff in the facility, that R11 was seen at the intersection of the 3 way stop sign. Staff went to R11. R11 stated R11 was trying to hitch hike a ride to the bank. R11 was then going to get a cab to Chicago and fly to Hawaii. Per the incomplete incident report the facility provided, R11 has been frustrated with notification of pending guardianship and wishes to move to Hawaii. R11 was moved to the memory care unit and a wander guard was placed on the metal bar under R11's chair. On 9/12/25, at 10:00 AM, Medical Doctor (MD)-L completed a monthly compliance visit. MD-L documents “no acute complaints or concerns are reported during this visit”. MD-L's documentation does not indicate that at anytime MD-L was notified of R11's elopement from the facility along with R11's continuous psychosocial verbalizations. On 9/15/25 at 3:44 PM, Nursing Home Administrator (NHA)-A stated that “no one is taking responsibility” for the incident report. Surveyor asked NHA-A what NHA-A meant by that. NHA-A stated that the expectation is that the nurse should complete the incident report at the time of the incident. This was not completed and notifications to R11's physician has not been completed. There is no documentation that R11's vitals were taken after the elopement. The incident is blank for sections mental status, predisposing environmental factors, predisposing situation factors. Surveyor notes there is no documented registered nurse (RN) assessment. The facility has not provided any statements in regard to R11's elopement from the facility. NHA-A stated the facility is still gathering statements. Surveyor shared the concern with NHA-A and Director of Nursing (DON-B) that R11's physician has not been updated in regard to R11's elopement from the facility. Surveyor shared based on documentation that MD-L completed a monthly compliance visit and does not document that MD-L was made aware of R11's elopement from the facility. NHA-A acknowledged the concern and provided no further information at this time. On 9/16/25, at 1:47 PM, Surveyor was provided documentation by the facility that the medical director was notified at 11:15 AM on 9/16/25 of R11's elopement from the facility. A body check was completed on 9/16/25. Surveyor noted that these actions were completed six days after R11's elopement. No additional information was provided as to why R11's physician was not notified of R11's elopement, when R11 eloped on 9/11/25.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents were free from abuse affecting 2 of 11 residents (R7 and R5) reviewed for abuse concerns.On 7/17/25, R6 punched R7 in the head and mouth, resulting in R7 having a bloody lip. R6 was placed on 1 on 1 supervision for a short period of time. The facility indicated they did not have the staffing to keep a person on 1 on 1 supervision long term. R6 was then put on 15-minute checks. R6 continued to demonstrate aggressive behaviors where staff needed to intervene before the behaviors escalated. On 8/27/25, R6 hit R5 multiple times over the head with a cane. R5 was sent to the hospital where R5 was diagnosed with a Traumatic Brain Injury (TBI) - subdural hematoma (a collection of blood between the brain's outer covering and the surface of the brain,) small traumatic subarachnoid hemorrhage (a bleeding that occurs in the space between the brain and the arachnoid mater, one of the membranes covering of the brain,) and acute (sudden onset of symptoms and injury) left frontal ischemia (Occurs when blood flow to brain tissue is blocked or reduced. This deprives the cells of oxygen and nutrients, causing them to begin dying within minutes,) likely traumatic (Points to a head injury as the probable cause, rather than a typical stroke from a pre-existing condition like a blood clot from atherosclerosis), per hospital documentation. R5 was returned to the facility on 8/28/25 and required follow up with neurosurgery.The facility's failure to keep R7 and R5 free from abuse created a finding of immediate jeopardy that began on 7/17/25. Surveyor notified NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the immediate jeopardy on 9/17/25 at 11:37 a.m. The immediate jeopardy was removed on 9/18/25 when the facility completed an IJ removal plan.Findings include:The facility's policy titled Prohibition and Prevention of member Abuse, Neglect, and Exploitation with a last revision date of 07/2024, documents in part, .Facility shall attempt to identify members exhibiting abusive behavior toward staff and/or other members and shall make referrals to appropriate agencies as needed.R6's most recent MDS, dated [DATE], documents R6 has a BIMS score of 4 indicating severe cognitive impairment, had wandering behaviors 1 to 3 days, no impairment in upper or lower extremities, uses a cane for mobility, and receives antipsychotic medications.R6 was admitted to the facility on [DATE] with diagnoses including Dementia with mood disturbances and psychotic disturbances. R6 is on the memory care unit following an altercation with another resident and has been receiving Behavior Psychiatric services since 09/03/2024. Surveyor noted R6 has 8 documented incidents of aggressive behaviors since receiving Behavior Psychiatric Services. On 9/15/2025, 10:33 AM, Surveyor interviewed RN-BB (Registered Nurse). RN-BB explained to Surveyor, RN-BB has worked at the facility since 2017 and worked with R6 since admission. RN-BB indicated R6 has had numerous resident to resident altercations. When R6 is on a 1:1 supervision, R6 does great but a couple days will go by after R6 comes of the 1:1 and R6 will be back in other resident rooms. RN-BB believes R6 has exhibited this repeated pattern of behavior.1. Surveyor reviewed the Facility Reported Incident involving a resident-to-resident altercation that occurred on 7/17/2025 with R7. R7 was admitted to the facility on [DATE], with diagnoses that include Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline).R7's most recent MDS, dated [DATE], documents R7 has a BIMS score of 14 indicating R7 is cognitively intact, has no behaviors, has no impairment in upper or lower extremities, and uses a walker as a mobility device.The facility's incident report documents R6 walked into R7's room and hit R7 in the mouth and head. Certified Nursing Assistant (CNA)-II was checking on residents in the dining room and noticed R6 was not in the recliner where R6 had previously been sitting. CNA-II walked toward R6's room to locate R6 and heard R7 yelling out for help. CNA-II observed R6 standing over R7. R7 was sitting in R7's recliner while R6 had ahold of R7's wrists. R7 was attempting to get R6 away from R7, using R7's legs. CNA-II was able to separate R6 and R7. CNA-II then walked R6 down the hall and informed the Nurse immediately, who then went and assessed R7. R6 was immediately placed on a 1:1 supervision. On 7/18/25, the Intradisciplinary Team (IDT) met to discuss R6 and R7's altercation and documented a stop sign will be placed across R7's door, R6 and R7 will not sit together during activities or during meals and will be kept separated in the hallways and elevators and R6 will remain on 1:1 supervision. Surveyor noted R6's Care Plan documents the follow for interventions following the 7/17/25 altercation: -A stop sign banner will be placed across the other Member's doorway.-Members will not sit together during activities, during mealtime and will be kept separated in hallways and/or elevators. All parties aware of interventions and in agreement with treatment plan. -Members will not sit together during activities, during

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not ensure all allegations involving potential abuse and/or neglect, and injury of unknown origin were thoroughly investigated for 4 (R10, R8, R14, R3 and R2) of 10 facility reported incidents reviewed involving residents. *On 7/14/25, R14 and R10 were involved in a member-to-member altercation that was not thoroughly investigated, and the facility did not conduct interviews of other members. *On 8/27/25, R8 and R14 were involved in a member-to-member altercation that was not thoroughly investigated. *On 7/10/25, allegation of abuse was submitted to the State Survey Agency involving R3. The facility did not conduct interviews of other members. *A thorough investigation was not completed for R2's injury of unknown injury. Findings Include: The facility's Prohibition and Prevention Member Abuse, Neglect, and Exploitation effective 7/2/24 documents: .All incidents shall be investigated and reported to the appropriate agency as required by the agency. .The facility shall maintain records of incidents and accompanying information to meet legal and regulatory agency requirements. 4.The nursing supervisor or facility administrator immediately initiates initial reporting and conducts a thorough investigation. 8.A list of possible witnesses is given to the nursing supervisor as soon as possible. Copies of daily schedules and staff statement forms are placed on 24-hour report board, names of staff needing to provide statements are highlighted. Cross off the highlighted names after statements are obtained. 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. 9.Interviewing the alleged victim, witnesses, accused individuals, and other members and staff. 10.The Social Worker will be involved in taking statements from the members involved in the situation and those who also could have been affected by this or a similar incident. 14.A file containing the supervisor summary, initial incident report, staff statements, any supporting documentation, and items submitted to DQA is routed to Administration for keeping; a copy goes to the facility administrator. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) R10 was admitted to the facility on [DATE] with diagnoses of Hypertensive Heart Disease(long term conditions developed from chronic high blood pressure), Cerebral Ischemia(insufficient blood flow to meet metabolic demand), Cerebral Infarction(stroke resulting in blood flow being interrupted to brain leading to brain cell damage), Dysphagia(difficulty swallowing foods), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), and Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities). R10's Quarterly Minimum Data Set(MDS) completed 8/8/25 documents R10's Brief Interview for Mental Status(BIMS) score to be 11 indicating R10 demonstrates moderately impaired cognition. R10's MDS documents no mood or behavior concerns. R10 has no range of motion impairment. R10 is set-up for eating, dependent for showers, for upper/lower dressing, mobility and transfers. R14 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Essential Hypertension(chronic condition of persistently high blood pressure), Atherosclerotic Heart Disease of the Native Coronary Artery(plaque buildup narrows the arteries that supply blood to the heart), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), Parkinson's Disease(disorder of the central nervous system that affects movement, often including tremors), Adjustment Disorder with Depressed Mood(depressed mood, tearfulness, and feelings of hopelessness in response to a stressful life event), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R14's Quarterly Minimum Data Set(MDS) completed 6/5/25 documents R14's Brief Interview for Mental Status(BIMS) score to be 12, indicating R14 demonstrates moderately impaired skills for daily decision making. R14's MDS documents no mood or behavior concerns. R14 has no range of motion impairment. R14 is independent with eating. R14 requires partial/ moderate assistance for upper body dressing and substantial/maximum assistance for lower dressing. R14 requires partial/moderate assistance for transfers and mobility. On 9/10/25, at 9:16 AM, Surveyor reviewed the facility reported incident(FRI) member-to-member altercation involving R14 and R10.It is documented that R14 is hard of hearing and did not hear R10 yelling at R14 to move R14's wheelchair resulting in R14 and R10 pulling at each other's arms and wrists. The summary documents a root cause is indicated, however, there is no documentation of what the root cause actually was and specific interventions for both R14 and R10. The facility did not obtain any other member statements to complete a thorough investigation. 2.) R8 was admitted to the facility on [DATE] with diagnoses of Hypertensive Heart Disease(long term conditions developed from chronic high blood pressure), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Osteoarthritis(degenerative joint disease), Alzheimer's(progressive disease that destroys memory and other important mental functions), and Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R8 currently has an un-activated Health Care Power of Attorney(HCPOA). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's Quarterly Minimum Data Set(MDS) completed 7/17/25 documents R8's Brief Interview for Mental Status(BIMS) score to be 14 indicating R8 is cognitively intact for daily decision making. R8's MDS documents no mood or behavior concerns. R8 has no range of motion impairment. R8 is set-up for eating, dependent for showers, and substantial/maximum assistance for upper/lower dressing, mobility and transfers. R14 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Essential Hypertension(chronic condition of persistently high blood pressure), Atherosclerotic Heart Disease of the Native Coronary Artery(plaque buildup narrows the arteries that supply blood to the heart), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), Parkinson's Disease(disorder of the central nervous system that affects movement, often including tremors), Adjustment Disorder with Depressed Mood(depressed mood, tearfulness, and feelings of hopelessness in response to a stressful life event), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R14's Quarterly Minimum Data Set(MDS) completed 6/5/25 documents R14's Brief Interview for Mental Status(BIMS) score to be 12, indicating R14 demonstrates moderately impaired skills for daily decision making. R14's MDS documents no mood or behavior concerns. R14 has no range of motion impairment. R14 is independent with eating. R14 requires partial/ moderate assistance for upper body dressing and substantial/maximum assistance for lower dressing. R14 requires partial/moderate assistance for transfers and mobility. On 9/10/25, at 9:59 AM, Surveyor reviewed the facility reported incident(FRI) member-to-member altercation involving R14 and R8. It is documented that R8 yelled for R14 to sit down in the wheelchair and R14 swung at R8. The facility documents in the summary of the incident that no contact was made between R8 and R14. A CNA's statement indicates that R8 had informed the CNA that R8 had been punched in the arm. The facility did not conduct an investigation of the statement by R8 that there may have been actual physical contact between R8 and R14. On 9/10/25, at 3:08 PM, Director of Nursing (DON)-B stated that a thorough investigation of a member-to-member altercation would consist of review of medication, who the member is, any history of behaviors, evaluate any injuries and the expectation is that a root cause analysis is conducted of the incident and implement new interventions. On 9/11/25, at 11:08 AM, Surveyor interviewed Social Worker (SW)-D in regard to the FRI process. SW-D stated that SW-D is responsible for interviewing other members when there is an allegation of abuse or neglect or member-to-member altercation. SW-D does not know why there would be no documented member interviews for the FRI involving R14 and R10. On 9/15/25, at 3:44 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and DON-B that both R8 and R14 and R14 and R10 member-to-member altercations were not thoroughly investigated. No further information has been provided by the facility at this time. 3.) R3's diagnoses includes hypertension (high blood pressure), chronic kidney disease (kidneys are damaged and cannot filter blood and waste effectively), dementia (loss of cognitive function that interferes with a persons daily life and activities), depressive disorder, and Alzheimer's Disease (progressive brain disorder that causes gradual cognitive decline). (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/10/25 the facility reported to the State agency an allegation of abuse involving R3. Surveyor reviewed the facility's reported incident and noted although multiple staff were interviewed regarding the allegation Surveyor was unable to locate evidence the facility interviewed other residents residing on R3's unit. On 9/15/25, at 8:49 a.m., Surveyor asked Director of Social Services (DSS)-D what is the process if a resident or family has an allegation of abuse. DSS-D informed Surveyor the allegation would be reported directly to the Administrator and Director of Nursing, an investigation would ensue, witness statements would be obtained, they would interview the member (resident) and the allegation would be reported to the State. Surveyor asked DSS-D if she is involved in the investigations. DSS-D replied typically not, depends on the day and time, may interview the member. Surveyor asked if other residents are interviewed. DSS-D replied ya, usually I would do a handful of interview able residents. Surveyor asked DSS-D if she was involved with R3's abuse investigation. DSS-D informed Surveyor she thinks she did member interviews. Surveyor showed DSS-D R3's facility reported incident and informed DSS-D Surveyor was unable to locate any resident interviews. DSS-D replied truthfully if not here can't say that it was done. DSS-D explained the Administrator usually asks her to interview members. They (Administrator & Director of Nursing) start the investigation and delegate. DSS-D stated that Administrator is not here any more. DSS-D stated I don't know why we wouldn't of done those. Surveyor asked DSS-D to check to see if there are any resident statements and get back to Surveyor. On 9/15/25, at 1:05 p.m., DSS-D informed Surveyor they don't have any member (resident) interviews. The facility did not conduct a thorough investigation for the abuse allegation involving R3 as the facility did not interview any residents to determine if there were any additional concerns regarding abuse. 4.) R2 was admitted to the facility on [DATE] with diagnoses that include Dementia with Psychotic Disturbance and Age related Osteoporosis. R2's Quarterly Minimum Data Set (MDS) with an assessment reference date of 7/22/25 documents under section C R2's Brief Interview Mental Status (BIMS) score was 4 indicating severe cognitive impairment for R2. R2's Nursing notes dated 6/14/25, at 7:30 AM, documents: “Writer assessed member's right shoulder, after unit nurse reported a very faint bruise, and c/o pain. Writer noticed, very faint yellow color bruise on member's right shoulder. Writer. Member appears to have pain with movement. Mild swelling present as well. Order for STAT x rays in place. ADON notified.” R2's Nursing note dated 6/14/25, at 7:10 AM, documents: “Call placed to {provider's office}. Spoke with NP (nurse practitioner) and informed that member has increased right shoulder pain with swelling, old bruising [yellowing] and limited ROM. New order received for a two view shoulder X Ray.” R2's Physician's order dated 4/11/25, at 6:03 PM, documents: “Diclofenac Sodium External Gel 1% (diclofenac sodium topical) Apply to left arm topically every 12 hours as needed for discomfort to left arm 2 grams every 12 hours.” (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's June 2025 Medication Administration Record (MAR) documents R2 receiving Diclofenac Sodium External Gel 1% as needed on 6/11/25 to the right shoulder for a pain score of 3 out of 10. (the order indicates left shoulder discomfort.) The June 2025 MAR documents R2's pain at 6:30 AM on 6/11/25 as a 2 out of 10, on 6/13/25 as 2 out of 10, and 6/14/25 as 2 out of 10. No other pain above 0 documented in June of 2025 prior to 6/11/25. No other as needed pain medications given to R2 prior to 6/11/25. R2's witness statement dated 6/15/25, at 10:45 AM, given by Licensed Practical Nurse (LPN)-N, documents: On 6/11/25 at 0750 writer applied Diclofenac Gel to members Right shoulder for complaints of discomfort. Member was sitting in a recliner in the TV room. Writer and ADON (BN) repositioned member in the chair and member stated she had pain in right shoulder. No swelling or bruising was present. R2's witness statement dated 6/15/25, at 4:37 AM, given by Certified Nursing Assistant (CNA)-MM, documents “On Thursday June 12th I toileted R2 and she complained of shoulder pain, and I reported it to nurse on PM shift.” R2's witness statement dated 6/16/25, at 07:14 AM, given by CNA-L, documents: “Yes on 6/13 PM shift. Toileting and changed clothes for bedtime. She was complaining of right shoulder pain at the time, and it was difficult for her to stand for transfers.” R2's witness statement dated 6/17/25, at 08:23 AM, given by Senior Therapist (STH)-AA, documents: “I was off on Thursday. I did a craft with her (R2) on Friday morning (6/13/25) and after she was done. She was complaining that her right upper arm was sore. Then she said she was tired and fell asleep in her wheel chair. I mentioned to a CNA (can't remember who) who was sitting there about her (R2) arm.” On 9/16/25, at 11:39 AM, Surveyor interviewed LPN-N about R2's shoulder pain on 6/11/25. LPN-N informed Surveyor that R2 had a history of arthritis and that R2 was complaining of right shoulder pain. Surveyor asked LPN-N if LPN-N reported the pain to the Supervisor. LPN-N informed Surveyor that LPN-N applied R2's as needed Voltaren gel to R2's right shoulder and did not think R2's pain needed to be reported. Surveyor asked LPN-N to verify it was the right shoulder and not the left shoulder in the order. LPN-N verified it was the right shoulder. On 6/16/25, at 12:31 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-S about R2's 6/14/25 investigation into the fractured Right clavicle. ADON-S informed Surveyor that the former Commandant had overseen the investigation and ADON-S felt it was done thoroughly. Surveyor asked ADON-S if ADON-S had any knowledge of the investigation and specifically of the witness statements documenting pain starting in R2's right shoulder on 6/11/25. ADON-S informed Surveyor he could not recall. Surveyor asked ADON-S if there were any investigation into the multiple witness statements indicating R2 had right shoulder pain on 6/11/25, 6/12/25, 6/13/25 and the right clavicle fracture was found on 6/14/25. ADON-S informed Surveyor that ADON-S did not have any knowledge of further investigation into the witness statements. On 9/16/25, at 12:30 PM a message was left with the Nurse Practitioners (NP) office, (continued on next page)

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	10/01/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/16/25, at 12:58 PM, Surveyor interviewed Nursing Home Assistant (NHA)-A about R2's right shoulder fracture discovered on 6/14/25. Surveyor asked NHA-A if NHA-A had anymore documentation from this investigation done by the previous NHA. NHA-A informed Surveyor that the Surveyor had everything that was on file for R2's 6/14/25 self-report. Surveyor showed NHA-A and Director of Nursing (DON)-B the witness statements indicating R2 had right shoulder pain starting on 6/11/25 and had received the only as needed pain medication on 6/11/25 by LPN-N. Surveyor informed NHA-A that a concern was the only charted pain for R2 in June 2025 prior to 6/14/25 was on 6/11/25, 6/13/25 and 6/14/25 the day the fracture was discovered. Surveyor asked NHA-A if there was any documentation to show any follow up by the former NHA on the witness statements documenting R2's pain started on 6/11/25. Surveyor informed NHA-A the concern that a follow up on those witness statements was not done especially when a right shoulder fracture was discovered is concerning. R2 had a significant injury discovered on 6/14/25 and evidence the injury may have started on 6/11/25 in the witness statements. Surveyor informed NHA-A these statements needed to be followed up to rule out abuse, neglect or another cause of R2's right shoulder pain. Surveyor informed NHA-A the only documented pain for R2 during the Month of June 2025 prior to 6/14/25 was on 6/11/25, 6/13/25 and 6/14/25. NHA-A informed Surveyor NHA-A would look for more information but informed Surveyor she understood the Surveyor's concern, but felt there was unlikely any more documentation. On 9/16/25, at 1:07 PM Surveyor interviewed STH-AA about R2's pain in the right upper arm on Friday 6/13/25. STH-AA informed Surveyor that R2 told STH-AA that R2's right arm hurts. STH-AA informed Surveyor that STH-AA informed the staff of the R2's pain complaint. Surveyor asked STH-AA if anyone brought R2 any pain medication or came back to assess R2. STH-AA informed Surveyor not while STH-AA was there. Surveyor asked STH-AA if anyone followed up with STH-AA on the witness statement STH-AA gave indicating R2 had right arm pain on 6/13/25 during R2's fracture investigation. STH-AA informed Surveyor no one followed up with STH-AA about STH-AA's statement indicating R2 had pain in the upper right arm on 6/13/25. No additional information was provided on why R2's 6/14/25 right clavicle fracture of unknown origin investigation was not thoroughly investigated.

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	525688	A. Building B. Wing	10/01/2025

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility did not provide adequate evidence of a proper discharge for 1 of 3 residents (R6) reviewed for discharge and transfers.*The facility's physician did not document the specific needs for R6 that cannot be met at the facility, the facility's attempts to meet R6's needs, and the services available at the receiving facility to meet R6's needs for R6 to have an appropriate discharge.Findings:On 8/27/25, R6 was sent out to the hospital for a mental health evaluation from an appointment with R6's neurologist.At the time of R6's discharge, R6 was on the following medications per R6's Medication Administration Record:Risperidone 0.5mg two times per day and Duloxetine 60mg once per day.In a progress note dated 8/27/25 at 12:30 PM, Director of Social Services-D documented: This writer called member's guardian to inform them of the member to member that occurred today. This guardian presented as upset as evidenced by guardian raising their voice stating that this facility cannot discharge him as he is a veteran and has nowhere else to go. This writer informed guardian that they are not looking to discharge this member at this time, this writer is only calling to update this guardian of the incident that occurred. This guardian stated that this member is violent and will kill her if he comes home. This guardian repeatedly told this writer that this member cannot come home. This writer stated that the IDT needs to talk and discus next steps such as getting this member evaluated. This POA apologized for being upset with this writer and noted that they understand this facility has done everything they can to help this member and she feels badly that this incident occurred.A progress note dated 8/27/25 at 2:58 PM documents Nursing Supervisor-HH spoke with the nurse at the Milwaukee VA to discuss and give report and why R6 was sent to emergency room (ER). Nursing Supervisor-HH indicated R6 has had violent behaviors/aggression and assaults to peers and needs to be admitted for medication management. Nursing Supervisor-HH indicated the nurse unavailable at time for report to and information was left to give Nursing Supervisor-HH a call when available.Surveyor reviewed the Facility provided document, titled Notice of Transfer, dated 8/27/25 which included representative notification, reason and bed hold policy.On 8/29/25, at 11:11 AM, the Facility mailed R6's family member a Discharge Notice via certified mail.Surveyor reviewed the Facility provided document, titled Discharge Notice dated 8/29/25 and documents the R6 is being discharged from the Facility due to the Facility being unable to fully meet the care needs due to unpredictable and uncontrollable behaviors related to unspecified diagnoses. Documenting OMB will work with the facility and guardian, towards an alternative placement. The anticipated date of discharge of R6 is on or before 09/29/25.On 9/11/25, at 9:32 AM, Surveyor interviewed R6's family member. R6's family member explained that on 7/30/25 R6's family member spoke with Director of Social Services-D regarding R6 being in the hospital and indicated there was not a plan to discharge R6 from the Facility. R6's family member reached out to the facility on 9/3/25, via email, asking about updates on R6 and if R6 has returned to the Facility. Director of Social Services-D replied via email and informed R6's family member R6 was still at the hospital. On 9/4/25, R6's family member received the 30-day notice via mail, indicating the Facility could not take R6 back due to aggression and after 10 days, R6 would have to pay $723.00 per day to hold a bed at the Facility. R6's family member became tearful speaking with Surveyor about R6's aggressive behaviors at home and toward family members, expressing frustration of being unable to care for R6 at home and being afraid of R6. R6's family member explained R6 being 100% service connected, the financial concerns/struggles when considering paying for R6's bed hold, and it was unknown how long R6 would remain in the hospital. Once receiving the 30-day notice, R6's family member reached out to the Facility, expressing safety concerns if R6 had to return home and being unable to care for R6 safely.On 9/7/25, at 7:07 PM, NHA-A emailed the State Agency to provide additional information regarding the Facility Reported Incident regarding R6, which documents, on 9/4/25, R6's family member left a message with Director of Social Services-D being upset to receive the 30-day notice and requesting to speak to Director of Social Services-D. NHA-A documents, DON-B visited R6 at the hospital on 9/3/25 and found R6 to be heavily sedated, on a alternate diet, with a urinary catheter and receiving several new psychiatric medications for behaviors which explained R6 appearing sedated. NHA-A, DON-B and Director of Social Services-D met with the Medical Director-RR. Medical Director-RR recommended reassessing R6's necessary psychiatric medications if R6 was to return to the Facility, removing most new medication causing sedation and placed on a 1:1 supervision for a minimum of 48 hours to stabilize R6 at baseline. It was recommended R6 remain in the hospital over the weekend and return to the Facility early next week. The Facility then met with R6's

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	525688	A. Building B. Wing	10/01/2025

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility did not provide 5 residents (R4, R7, R11, R12 and R15) of 11 residents reviewed with the necessary cares and services to promote quality of life and assist residents to maintain their highest practicable level of physical, mental, and psychosocial well-being. *The facility did not provide R7 with the sense of safety within the Facility from R6. R7 indicated being in fear of R6, a resident who displayed escalating aggressive behaviors. R7 was assaulted by R6 and was assessed as experiencing Post-Traumatic Stress Syndrome (PTSD) as a result. R6 went on to assault R5 a few weeks later. The facility did not have a plan to effectively monitor R6. * The facility failed to provide R4 a sense of satisfaction with oneself, the environment, and the care received. R4 has continually expressed dissatisfaction with the living at the facility. R4's dissatisfaction with the facility has caused R4's behavior of planning unsafe ways of leaving the facility. R4's loss of a friend was not addressed in R4's plan of care potentially triggering unsafe behaviors by R4. *The facility was aware of R11's previous attempts and continued expressions of wanting to leave the facility and did not implement interventions to keep R11 safe while residing at the facility as evidenced by R11's [DATE] elopement from the facility. The facility did not identify R11's signs of distress exhibited by R11's expressions of wanting to leave the facility and attempting to elope. R11's care plan does not document person-centered interventions. Medically related social services has not been provided to R11 resulting in a deterioration in R11's psychosocial well-being. *R12 documents during a statement following a resident-to-resident altercation, that R12 did not feel safe at the Facility with R6 wandering “in here.” *R15 expressed being fearful of closing R15's eyes at night due to R14 wandering into R15's room. R15 expressed not being able to defend R15's self from R14 and wanting to purchase a water gun to deter R14 from entering R15's room. This pervasive disregard for residents' quality of life created a finding of immediate jeopardy that began on [DATE]. The Facility was notified of the immediate jeopardy on [DATE] at 11:37 AM. The immediate jeopardy was removed on [DATE] when the facility implemented an immediate jeopardy removal plan. Findings include: 1.) On [DATE], R6 was the aggressor in a resident-to-resident altercation with R7. On [DATE], R6 had another resident -to-resident altercation where R6 is the aggressor. A statement from R7, dated [DATE], documents R7 does not feel safe at the Facility with R6 around. R12's statement, dated [DATE], documents the resident feels unsafe when R6 wanders in “here.” (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], at 6:46 PM, a progress note, by Registered Nurse (RN)-BB, documents R6 exhibiting severe anxiety/restlessness, ignoring redirection, staff shut all doors on unit, R6 would just open the doors to enter resident rooms, another resident in the hallway due to not wanting to be alone in the room with R6. R6 requiring 1:1 interaction with staff but management continues to deem R6 only needing 15-minute checks. Staff finding it difficult to tend to other residents and prevent resident to resident altercations Surveyor noted a progress note by PhD (Doctor of Psychiatry)-DD, dated [DATE], documents R7 is experiencing acute PTSD symptoms following recent assault by R6. R7 reports being “frightened and surprised” by the assault with fears R6 will return and hurt R7 again. PhD-DD documents R7's anxiety symptoms are currently heightened due to the recent assault and expressing fear in R6's return. 2.) R4 was admitted to the facility on [DATE] with diagnoses that include COPD, Dementia with Mood Disturbance, Dementia with Moderate Anxiety, PTSD, Multiple Sclerosis- and MVI (motor vehicle incident) with quadriplegia. R4 was placed under protective placement via a court order on [DATE]. R4's Determination and Order on Petition for Guardianship Due to Incompetency document dated [DATE] 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. Protectively placed: indicating the ward is totally incapable of providing the wards own care or custody as to create a substantial risk of serious harm to the ward or others. Serious acts may be acts of overt acts or acts of omission.” R4 has an elopement history with multiple planned elopements from appointments. The most recent prior to [DATE] was dated [DATE] when R4 eloped from the hospital and was found at a hotel approximately seven hours later. A later investigation found R4 planned the elopement and had saved money to go to a different location and to live independently R4's Last Brief Interview for Mental Status (BIMS) was completed in June of 2024 with R4 scoring 15 indicating intact memory. R4 refuses to participate in the BIMS process. R4's minimum data set (MDS) with an assessment reference date of [DATE] documents under section GG that R4 uses a manual wheelchair and once seated can wheel independently at least 150 feet. R4's Discharge Care Plan initiated on [DATE] 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. R4's medications include Sertraline 50 mg daily started [DATE]. (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R4's Psychiatry progress note dated [DATE], at 2:42 PM, documents: “Pt is [AGE] year-old male seen today for follow up psychiatric evaluation. Pt seen for yelling, restiveness with cares and medications, anxiety and agitation. Pt will refuse cares/meds at times from certain staff, then report that he was not offered/given the cares/meds. Pt dismissive of exam today. Pt will discuss with staff and practitioners when he wants per staff report. Overall behaviors improved since rx (medication) sertraline….” R4's nursing note dated [DATE], at 12:54 PM, documents: “Writer attempted to recheck members blood pressure due to reading this morning. Member stated Get the fuck out! Get the fuck out! writer will notify physician. Supervisor aware. Member is on blood pressure medications as well. Plan of care continues. ” R4's Incident Report dated [DATE], at 2:30 PM documents: “Incident description” Member was seen returning from the gazebo outside onto the unit. Member had 4 fluid filled blisters on his face. Immediate action taken, Description: member was monitored. Member did not report pain or discomfort from the Sunburn. The physician was called. Nurse notified physician and received orders Aloe. Aloe received. Member offered aloe. Member agreed and was applied. Mental Status oriented to Person. Oriented to situation. Oriented to place. Oriented to time. Predisposing factors: other. Predisposing Physiological factors: none. Predisposing Situation factors: Active exit seeker. Other info: Member prefers to be non-compliant. Member enjoys being outside in the sun. member does not like to wear sunscreen. (Historical Temperature was 84 degrees). R4's nursing note dated [DATE], at 1:00 PM, documents: “Register Nurse (RN) and Assistant Director of Nursing (ADON) went outside to assess member's forehead. Member refused. Was using abusive language and left the area where he was outside. RN and ADON notified member we were going back inside. Member's face is normal color, and he has a hat down over his forehead”. R4's elopement nursing note dated [DATE], at 2:48 PM, documents: Member left out the unit at 12:30 with water in hand. Declined sunscreen, had hat on. At approximately 1:30 member was not seen at the gazebo. Staff immediately went to look at {….Hall} and outside. Staff coming in for second shift alerted writer member was rolling towards Highway C. Writer and aid jumped in personal vehicle and drove towards member to check on safety. Member seen close to Wisconsin Southern Center State sign, Writer and aid got out and spoke with member. Member stated, “I don't want to be here, I want to go to [NAME]”. Writer called 911 when member appeared not to stop. Member agreed to come back to facility. Staff rolled member to safe location and called transport to pick him up to drive back to {….Hall}. New intervention implemented and added to TPOC (care plan). Provider notified this shift: [DATE] 2:45 PM. Family/Guardian notified [DATE] 2:45 PM. Supervisor notified via phone [DATE] 2:00 PM. (Historical Temperature was 86 degrees). (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

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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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R4's Psychiatric note dated [DATE], at 9:53 PM, documents: Reason: Adjustment disorder with Depression and Anxiety. R4, [AGE] years old male seen today for follow up psyche visit. Start time 10 AM end time 10:30 AM record review/consultation with staff 10 minutes, face- to -face with patient 20 minutes. This clinician was asked to see R4 by his Family Member. Attempts have been made over the past several months; however, he has refused services. Records indicate that last weekend he eloped twice, when found, he stated that he wanted to go to [NAME] as they have in his opinion, better physical therapy. He cooperated with staff and got in their car and returned to the facility. If R4 does not have a wander guard at this time, that should be considered. R4 was angry and frustrated. He did not wish to engage in individual therapy despite wanting to leave the facility and knowing that talking to the staff and cooperation could assist him in being accepted in another facility. He was verbally aggressive during the session and stated that no one could help him. He is oriented x 3. Due to his self-isolation and verbal aggressiveness, therapy will be attempted within the coming 2 weeks…. On [DATE], at 12:00 PM, Surveyor interviewed R4 about R4's elopement and [DATE] sunburn incident. Surveyor asked if R4 membered leaving the building in July. R4 informed Surveyor that R4 remembered leaving. R4 informed Surveyor “I was going to [NAME]”. Surveyor asked R4 why R4 wanted to leave. R4 informed Surveyor that “I don't like it here, I keep escaping” and that R4 has always planned on leaving. R4 informed Surveyor that R4 didn't believe the facility was trying to help him. R4 informed Surveyor that R4 was finally going to an assisted living next week Tuesday and that they won't treat him like a baby like they do here. Surveyor asked R4 why R4 had been out so long on [DATE] causing R4 to get a bad sunburn. R4 informed Surveyor the R4 was sad that day. R4 didn't seem like R4 wanted to continue. Surveyor asked if the Surveyor could come back later. R4 agreed. On [DATE], at 9:58 AM, Surveyor continued the interview with R4. Surveyor asked R4 if R4 could tell Surveyor about why R4 felt he needed to leave the facility. R4 informed Surveyor that R4 was going to [NAME] to the hospital because the Social Workers here won't help him. R4 informed Surveyor that R4 could have been in [NAME] but they didn't evaluate him because the Social Worker didn't help set it up. R4 informed Surveyor the Social Worker at [NAME] Hospital would help him. Surveyor asked R4 what route R4 took. R4 informed Surveyor that R4 wheel himself down the road from the Gazebo then down the main road towards the highway. R4 informed Surveyor they must have finally noticed I wasn't there, and they came after me. R4 informed Surveyor “I escaped in Milwaukee before; I had to do something”. R4 informed Surveyor that the family member was stealing from him and that they were not helping him get out here. R4 informed Surveyor They treat me like a baby here Surveyor asked R4 if R4 was being monitored by staff. R4 informed Surveyor the staff was not monitoring him but that after he left, they sure are now. Surveyor asked R4 if R4 had any provisions like water for the trip. R4 informed Surveyor that R4 was in Vietnam and knew how to pack a [NAME] sack. R4 informed Surveyor he had cloths and water with him. Surveyor asked R4 if he was planning to leave now. R4 informed Surveyor he was being transferred to an assisted living next week Tuesday and was happy about that. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor asked R4 how long R4 was out on [DATE] when R4 received the Sunburn of R4's forehead. R4 informed Surveyor that R4 like to be in the Sun and often is outside tanning. R4 informed Surveyor the R4 was outside from about noon to after 3:00 PM maybe 3:20 PM. Surveyor asked why R4 was outside long enough to get burned. R4 informed Surveyor the R4 was thinking about R4's friend who died and R4 was very sad and didn't want to come inside. R4 informed Surveyor that R4 wanted to sit by himself outside for as long as possible. R4 informed Surveyor that R4 has a new friend now like R4 who wants to escape from here. R4 informed Surveyor my friend has escaped 3 times already. Surveyor asked R4 if the facility or social services had spoken to R4 about why he was sad and why he was outside for so long. R4 informed Surveyor that no one has spoken to me about anything about that day. R4 informed Surveyor that the social worker wouldn't help him anyway. On [DATE], at 2:12 PM Surveyor interviewed RN-V, Surveyor asked RN-V about R4's behaviors when R4 goes outside. RN-V informed Surveyor R4 refuses to sign out and refuses Sunscreen and other measures to protect R4 from injury. Surveyor asked RN-V about R4's friend that passed away and that R4 told the Surveyor that R4 stayed outside to long because R4 was sad on [DATE] over the death of R4's friend. RN-V informed Surveyor that R4 and the resident who passed away last February 2025 were close and went outside together. They often took their shirts off and had tanning contests despite warnings of Sun exposure by staff. RN-V informed Surveyor that R4 was impacted by the other member's death and that RN-V had informed Administration this was one of the concerns RN-V had for R4's behaviors. On [DATE], at 12:42 PM, Surveyor interviewed Director of Social Service (DSS)-D about R4. Surveyor asked DSS-D about R4's statement to Surveyor about a friend who passed away this year. DSS-D informed Surveyor that R4's friend at the facility passed away in February or 2025. Surveyor informed DSS-D that R4 informed the Surveyor that is why R4 had sat outside so long on [DATE] and that it still seems to trouble R4, and no one has spoken to R4 about it. DSS-D informed Surveyor they have spoken. Surveyor asked if DSS-D documented that conversation as Surveyor could not locate it and there is nothing in the care plan addressing it. DSS-D informed Surveyor it would be in the social service progress notes. Surveyor asked DSS-D how interventions and member care plans were assessed for the most meaningful and effective actions, especially triggers for behaviors that are implemented for each member. DSS-D informed Surveyor that the Interdisciplinary Team (IDT) reviewed the members care plan and implemented the interventions needed. Surveyor asked DSS-D if DSS-D could explain how that process works in the IDT meetings. DSS-D informed Surveyor the members charts were reviewed and the departments had input from their staff. Surveyor informed DSS-D that during an interview with R4 informed Surveyor the R4 has never stopped wanting to leave. Surveyor asked if DSS-D was aware R4 has never stopped wanting to leave. DSS-D acknowledged that R4 wanted to leave. Surveyor acknowledged to DSS-D that now the R4 is leaving R4 seems to be satisfied with the move to an assisted living. Surveyor asked DSS-D back before R4's elopement R4 had an elevation in behaviors of being resistive to cares and medications as noted by the psychiatry note on [DATE], and with R4's elopement history, was it safe or a good idea for R4 to have no meaningful psychosocial or proactive elopement/safety interventions in place except a 2-hour safety check placed on [DATE]. DSS-D informed Surveyor “no, probably not.” (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor asked NHA-A and DON-B for the process the IDT team used to develop, evaluate and implement safety and elopement interventions. Surveyor informed NHA-A that most of what the Surveyor noticed were safety checks, and motion lights. Surveyor requested any system the IDT team used to implement interventions and evaluate triggers for behaviors and the success of the interventions. DON-B informed Surveyor that ADON-S charted under the IDT notes in the point click care system. Surveyor informed DON-B these notes were sparse and basic and did not show the thought process behind the reason for the interventions or any analysis of the interventions being discontinued. NHA-A informed Surveyor she would look to see what the process involved and get back to the Surveyor. (Note: Surveyor noted there was no IDT meeting on R4 from [DATE] until after R4's [DATE] Sunburn incident.) Surveyor did not note any interventions documented in R4's safety plan of care for potential behavior triggers related to R4's sadness over R4's friend or the possibility R4 was not leaving on the anticipated day of Tuesday [DATE]. On [DATE], at 8:52 AM, Surveyor interviewed DON-B about members who are elopement risks. Surveyor asked DON-B if there was any more information about the processes for implementing interventions for members especially with risk factors such as dealing with psychosocial issues, elopement concerns or behaviors that might lead to injury like R4 staying outside too long and developing blistering sunburns. Surveyor informed DON-B that R4 was seen for behavior increases on [DATE] by psychiatric services and Surveyor did not note any care plan changes. DON-B informed Surveyor that DON-B did not find a policy or procedure for IDT care plan intervention implementation and evaluation. On [DATE]. At 3:24 PM, Surveyor gave serious concerns to NHA-A and DON-B from Surveyor's investigation as of [DATE]. Surveyor informed NHA-A that the facility did not evaluate the root causes of R4's [DATE] elopement and [DATE] blistering sunburn injury. The facility failed to implement meaningful and effective care interventions for R4 to keep R4 safe. R4's incident on [DATE] had no investigation on when or why R4 left the building and never asked R4 why R4 was outside for so long. R4 informed Surveyor that R4 was sad, and R4 went outside around 12:00 PM and did not come back into the building until around 3:20 PM. R4 informed Surveyor that he was sad thinking about his friend who had passed away. R4 informed Surveyor that no one has asked R4 anything about the [DATE] sunburn incident. R4 had a psychiatric consult on [DATE] asked for by R4's family because of increasing behaviors of refusing cares. Staff informed Surveyor that R4 had a history of refusing sunscreen and protective measures when in the sun before the [DATE] incident where R4 received a blistering sunburn. No psychosocial or proactive interventions were documented or discussed by the IDT team responsible for care plan interventions, and no proactive interventions to keep R4 safe from these behaviors were placed in R4's care plan until after R4 ended up with a blistering sunburn on R4's forehead. No root cause analysis except comments: “member prefers to be non-compliant” “Member enjoys being in the sun” and “Member refuses sunscreen” Nothing about R4's sadness over the loss of R4's friend or interventions related to R4's feelings of loss that may have triggered the behavior. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor asked NHA-A if NHA-A would agree that R4 had nothing proactive in R4's plan of care for elopement and safety until after R4 almost made it almost a mile away to a highway in a wheelchair. NHA-A and DON-B agreed that the Surveyor was correct there was nothing proactive in place for R4's elopement concerns prior to R4's [DATE] elopement. NHA-A informed surveyor that a WanderGuard and closer monitoring of R4 are in place now. NHA-A informed Surveyor that the NHA-A had initiated training of the staff and NHA-A found that the staff believed R4 was R4's own person and could make all his own decisions. NHA-A informed surveyor the staff were not aware of R4's cognitive impairment. R4's Physicians order dated [DATE], at 06:30 AM documents, “Member cannot sign himself out (even to the grounds of the facility). He has recently left the property after signing himself out to the gazebo. Member must be always accompanied outside (by a staff member of a volunteer). All behaviors, including attempted elopements need to be documented and interventions immediately put into place. Member may use the courtyard for 1W (Memory Care) if he prefers. If member is in courtyard, must be placed on 15-minute checks.” No new psychosocial interventions in R4's safety care plans implemented to address R4's feelings of loss or potential disappointment with R4's transfer timeline. 3.) R11 was admitted to the facility on [DATE] with diagnoses that inclide Dementia Unspecified Severity (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), With Mood Disturbance, and Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R11 has an activated Health Care Power of Attorney (HCPOA) as of [DATE], however, there is a guardianship hearing on [DATE] because family no longer wants to be the HCPOA. R11's Quarterly Minimum Data Set (MDS) completed [DATE] documents R11's Brief Interview for Mental Status (BIMS) score is 12, indicating R11 demonstrates moderately impaired skills for daily decision making. R11's MDS documents no mood or behavior issues, including wandering. R11's main locomotion is by standard wheelchair. R11's Kardex, instructions to nursing staff was updated [DATE]. The Kardex documents: Safety -[DATE] Encourage member to ask for help with computer -Alert on call nurse or DON or ADON for all incidents (escalated behaviors, attempts at elopement) -R11 has a wander guard on R11's wheelchair because R11 tries to tear it off R11's arm/leg -R11 now lives in memory care R11 refused wander guard [DATE] -Redirect R11m when voicing need to leave facility to go to the bank. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Roam Alert wander band to R11's wheelchair R11's comprehensive includes the following applicable problems: 1.Safety Elopement: R11 at risk of elopement due to cognitive losses, Dementia high risk for elopement [DATE] R11 was waiting outside “for a ride to his bank”. 15-minute safety checks initiated for R11 whereabouts. R11 declines wearing roam alert device bracelet [DATE] 15-minute checks discontinued [DATE] Roam alert device on R11's wheelchair Initiated [DATE] Interventions: -Monitor my behaviors to determine: duration, frequency, intensity, and patterns. Consider any changes that may have occurred such as: a room change, change in cognitive status, medication changes, new staff, or termination of treatment program. Initiated [DATE] -Alert on call nurse or DON or ADON for all incidents (escalated behaviors, attempts at elopement) Initiated [DATE] -R11 has a wander guard on R11's wheelchair because R11 tries to tear it off R11's arm/leg Initiated [DATE] -R11 now lives in memory care Initiated [DATE] 2.Coping/Trauma Informed Care Plan: I am at risk for ineffective individual coping due to R11's diagnosis of Major Depressive Disorder, Recurrent Unspecified. Adjustment to nursing home. R11 referred to in-house psychologist on [DATE] Triggers: R11 breathing issues forced R11 to stop R11's construction in R11's 40s. When R11's breathing bothers R11, R11 can feel triggered. Initiated [DATE] Interventions: -Administer medications as ordered. Monitor/document for side effects and effectiveness. Initiated [DATE] -Arrange for psych consult, follow up as indicated. R11 referred to in-house psychologist [NAME] [DATE]. Initiated [DATE] (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Assess/screen for post traumatic events and history of trauma, using nursing home appropriate screening tools, such as the LEC-5. Initiated [DATE] -R11 has deep breathing techniques to use when R11's breathing is bothering R11. R11 also enjoys socializing and being around family and friends. Initiated [DATE] -Discuss feelings around change and loss, facilitate R11's expression of these feelings. Initiated [DATE] -Encourage R11 to talk about how R11 is feeling to family, friends, or staff; remind R11 to utilize R11's support system if R11 is feeling down. Initiated [DATE] -Please watch R11 for the signs and symptoms which may indicate R11 feeling sad or depressed such somnolence, social isolation, increased sadness, frequent weeping, anger, refusal of cares, decreased appetite, weight loss/gain. Initiated [DATE] Starting [DATE], the facility completed an elopement assessment every day, sometimes multiple times a day until [DATE] triggering multiple times of a score of 10 or more indicating R11 must have a safety plan put into place. Surveyor notes a safety plan was not put into place at this time for R11. R11's current physician orders document R11 is on Duloxetine 20 mg 1 capsule at bedtime for pain in left foot. Surveyor notes that Duloxetine can be used to treat Major Depressive Disorder, Generalized Anxiety, and chronic pain. Surveyor notes there is no documentation how R11's Duloxetine has impacted R11's diagnosis of Major Depressive Disorder. The facility has not been monitoring for signs of symptoms of depression and/or behaviors related to the Duloxetine because the facility is stating the facility is treating R11 with Duloxetine for pain. The facility has no current accurate documentation of signs and symptoms related to R11's diagnosis of Major Depressive Disorder because the facility has not monitored R11's behaviors. Surveyor reviewed R11's electronic medical record (EMR) and notes the following progress notes: On [DATE], Director of Social Services (DSS)-D documented R11 had coat on stating R11 wanted to leave the building, order a cab, go to their bank and get a debit card. R11 stated that R11 wanted to complete an online purchase from a store of potato chips and other snacks. Placed on 15 checks. On [DATE], Registered Nurse (RN)-BB documented R11 voicing R11 wanted to leave and was hard to redirect. Making multiple statements about leaving on Monday and will have to be shot to be stopped. Stating is waiting for debit card so R11 can work R11's way to California and cross the border to Mexico for some new lungs. Stated the lungs would be from drug dealers that the Mexicans kill. R11 stated that R11 is too old to get new lungs in the US and that is why R11 has to go to Mexico for them. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor notes there is root cause analysis by DSS-D or any interventions put in place for R11. On [DATE], Registered Nurse (RN)-CC documented R11 voicing the want to leave. R11 stating “you can't keep me here. I'm not a prisoner.” R11 wanting to go outside. R11 attempting to go to 2nd floor elevators and not easy to redirect. Surveyor notes there is no follow-up by DSS-D on how R11 is feeling and what psychosocial concerns R11 has. On [DATE], Registered Nurse (RN)-G documented R11 making multiple statements about leaving on Monday and R11 will have to be shot to be stopped. Surveyor notes there is no documentation DSS-D met with and provided support to R11 in regard to the intense feelings R11 was expressing. On [DATE], it is documented that 30-minute checks were discontinued for R11. On [DATE], it is documented that a referral to psychology was initiated. On [DATE], R11 was evaluated by Psychology (PhD)-DD with the goal for psychotherapy to address cognitive distortions, improve reality orientation, and enhance coping skills. R11 was to be seen for six individual psychotherapy sessions, each 30 minutes in duration, over the coming three months. R11 has not been seen since [DATE] by PhD-DD. On [DATE], Registered Nurse (RN)-EE documented R11 voiced to a staff member he had intentions of escaping during the planned facility shopping trip tomorrow [DATE]. R11 stated “I am going to escape and go to the bank, get a debit card, buy a plane ticket and I am going to buy a house in Hawaii and a plane ticket.” …”Called and reported to Interim commandant, DON, and ADON were notified. ”… No documentation after this was voiced by R11 of any interventions put into place. Surveyor notes there is no documentation that DSS-D completed a root/cause analysis of R11's expressions. On [DATE], Activity Aide (AA)-FF documented R11 was waiting outside “for a ride to his bank”. Nursing aware. 15-minute checks initiated. On [DATE], another elopement assessment was completed with a score of 16, indicating R11 is high risk for eloping. Surveyor notes that an elopement care plan with a safety plan was not implemented until [DATE]. R11 had multiple previous verbalizations of wanting to leave the facility. On [DATE], 15-minute checks were implemented. (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The only intervention on R11's care plan added on [DATE] was to monitor behaviors to determine: duration, frequency, intensity, and patterns. Consider any changes that may have occurred such as: a room change, change in cognitive status, medication changes, new staff, or treatment of treatment program. On [DATE], Nursing Supervisor (NS)-HH documentation states 15-minute checks discontinued, however, Surveyor notes that staff continued to document 15 minute checks were in place. On [DATE], 15-minute checks were discontinued as documented by NS-HH. On [DATE], RN-BB documents R11 is expressing that R11's kids are taking R11 to court and trying to take all R11's money and that R11's children were handing over their HCPOA to a guardian. R11 is upset and unreceptive to redirection. Surveyor notes on [DATE] the coping trauma informed care plan was initiated. On [DATE], at 7:45 AM, R11 initiated conversation with Surveyor who was observing two other Residents on the unit. Surveyor notes R11 was very focused on leaving, the upcoming court hearing, and wanting to get to the bank so R11 can pay a lawyer for the upcoming court hearing. On [DATE], at about 9:55 AM. R11 was found out of the facility, down at the 3 way stop sign. Staff were alerted by a family membe

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure a resident (R14) with hearing impairment received proper treatment and assistive devices for 1 (R14) of 1 residents reviewed for assistive devices.Findings include:Surveyor requested a policy or procedure from the facility for residents requiring assistive devices for hearing, vision, and/or dental. Surveyor was notified that the facility had no policy or procedure for assistive devices.R14 was admitted the facility on 2/12/2020 with diagnoses of Dementia (progressive decline in thinking, communication, speech, and memory that interfere with daily life), Cognitive Communication Deficit (communication deficit from decline in memory, problem-solving, or attention), Post-Traumatic Stress Disorder (PTSD) (difficulty living day to day life due to experiencing a traumatic event), Adjustment Disorder with Depressed Mood (loss of interest in activities that were once enjoyable). R14's Quarterly Minimum Data Set (MDS) completed 6/5/25 documents a Brief Interview for Mental Status (BIMS) score to be a 12, indicating that R14 is moderately cognitively impaired. R14's MDS also documents that R14 does not wear hearing aids and hears with minimal difficulty.Surveyor reviewed annual MDS completed 9/24/2024 - section B, that documents R14 has minimal hearing deficit and does not wear hearing aids. In this section, a CAA is triggered and RN-P documents .member has minimal difficulty hearing, no hearing aids.R14's care plan initiated 9/18/21 documents that R14 has a communication problem r/t (related to) cognitive impairment, Hard of hearing. Under the interventions section it documents:- Ensure hearing aid(s) left and right is in place. collect at HS (hour of sleep)R14's Kardex as of 9/10/25, instructs nursing staff on dressing/Splint care, documents:- Ensure hearing aid(s) left and right is in place. Collect at HS (night) to be stored in the medication room.R14 physician order dated 2/29/2020 to 2/3/2025 documents an order for R14 to wear hearing aids.Surveyor noted that R14 did not have a current physician order to be wearing hearing aids. However, Surveyor noted that in R14's TAR (Treatment Administration Record) there was an order for nursing staff is to document the application and/or removal of hearing aids. Facility staff had been documenting that R14 had his hearing aids put in the morning and removed at bedtime from 2/29/2020 to 2/3/2025.On 7/14/2025, R14 had an altercation with another resident, the facility completed an investigation and identified the root cause is R14 being hard of hearing.On 9/10/2025, at 8:59 AM, Surveyor observed R14 sitting in the common area watching television (TV) away from R8 and R10. Surveyor noted that R14 appeared well groomed, had glasses on but Surveyor did not observe R14 to be wearing any hearing aids. On 9/10/2025, at 10:53 AM, Surveyor observed R14 in common area watching TV. R14 is separated from R8 and R10. Surveyor observed R14 to not have any hearing aids in R14's ears.On 9/10/2025, at 11:04 AM, Surveyor interviewed certified nursing assistant (CNA)- H about R14's hearing aids and ability. CNA- H stated R14 hears from the right ear better but is unsure if R14 has hearing aids. CNA-H looked around R14's room and did not locate any hearing aids and stated the members will have a pouch or a container for the hearing aids.On 9/11/2025, at 8:44 AM, Surveyor observed R14 sitting in the main common area separated from R8 and R10. Surveyor observed R14 to not have any hearing aids in R14's ears.On 9/11/2025, at 9:29 AM, Surveyor interviewed Family Member (FM) -K regarding R14's hearing aids. FM -K stated the hearing aids were lost about a year ago and that is the last time Family-K is aware that R14 had hearing aids. FM -K stated that a grievance was not filed to their knowledge. FM -K stated that R14 would sometimes take the hearing aids out and the staff would keep them so they would not get lost. FM -K stated that R14 would benefit from having the hearing aids.On 9/11/2025, at 11:30 AM, Surveyor observed R14 sleeping in the common area in a recliner with a blanket on R14. Surveyor observed R14 to not have any hearing aids in R14's ears.On 9/11/2025, at 12:44 PM, Surveyor observed R14 separated from R8 and R10. Surveyor observed R14 to not have any hearing aids in R14's ears.On 9/11/2025, at 1:21 PM, Surveyor interviewed Director of Social Services (DSS)-D regarding the grievance process. DSS-D states DSS-D is the grievance officer for this facility, a list of grievance officials can be found on each floor, and this grievance process is reviewed upon admission. DSS-D states if a family member reports an issue to the nurse or other staff, then the staff member is responsible for filing the grievance and processing it to DSS-D.On 9/11/2025, at 1:43 PM, Surveyor observed R14 in R14's room watching TV. Surveyor noted that the TV was extremely loud and can be heard from several rooms away. Surveyor asked R14 if the TV could be turned down for interview. R14 agreed and Surveyor observed the TV volume setting had been set to 100, which is the. volume setting the maximum the TV can be set to.Surveyor asked R14 if R14 has hearing aids. R14 stated yes and that the

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	525688	A. Building B. Wing	10/01/2025

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** Based on observation, interview, and record review the facility did not ensure 6 (R2, R11, R4, R3, R8, and R10) of 7 residents received adequate supervision to prevent accidents from falls and elopements * R2 has had 15 falls since 1/9/25. On 1/17/25 R2 fell. A fall risk assessment on 1/17/25 indicates R2 is at low risk for falls. On 3/5/25 the facility completed another fall risk assessment and was assessed to be high risk for falls. R2 fell on 4/1/25, 4/3/25, & 4/7/25. R2's fall risk assessment dated [DATE] assesses R2 as low risk for falls. R2's fall risk assessment dated [DATE] and subsequent fall risk assessments assess R2 as high risk for falls. On 4/3/25 R2 was transferred to the hospital and diagnosed with a traumatic hematoma of the forehead. The facility did not thoroughly investigate R2's falls on 4/1/25, 4/3/25, & 4/7/25, did not determine if prior interventions were in place and did not determine a root cause of these falls to prevent further falls. On 4/9/25 R2 fell. R2 was transferred to the hospital on 4/9/25 and admitted on this date with diagnoses of Subdural Hematoma, Hematoma, Subarachnoid hemorrhage, T12 fracture and UTI. R2's hospital Discharge summary dated [DATE] documents She will need Keppra for 4 weeks for seizure prophylaxis. Following hospitalization R2 sustained falls on 4/16/25, twice on 4/29/25, 5/8/25, 5/10/25, 5/26/25, 6/24/25, 7/19/25, 7/25/25, & 8/18/25. With the exception of R2's fall on 7/19/25 the facility did not thoroughly investigate R2's falls, did not consistently obtain staff statements, and did not determine the root cause of R2's falls to help prevent further falls. *R11 was assessed as being high risk for elopement. On 3/26/25 R11 had a coat on stating wanted to leave the building, order a cab, and go to the bank for a debit card. On 4/12/25 R11 voiced he wanted to leave. On 7/8/25 R11 voiced to a staff member he had intentions of escaping during a planned facility shopping trip. R11 stated he was going to escape, go to the bank, get a debit card, buy a plane ticket and was going to buy a house in Hawaii. On 9/11/25 R11 was found out of the facility, down the road at the three way stop sign. Facility staff was unaware R11 had left the facility and was made aware by another resident's family member. The facility was aware of R11's previous attempts and continued expression of wanting to leave but did not implement interventions to keep R11 safe. *The facility failed to put a system in place to monitor R4's safety when R4 left the building unattended. On 6/28/25 R4 came in from the outdoors with 4 blisters from sunburn on R4's forehead. R4 was found outside by staff arriving to the facility for their assigned second shift. On 7/27/25 R4 had traveled in R4's wheelchair . 9 miles on the road almost making it to a highway C a well-traveled local class A highway. The facility's failure to provide adequate supervision, to thoroughly investigate R2's falls and determine a root cause and its failure to prevent R11 and R4 from eloping from the facility led to a finding of immediate jeopardy (IJ) that began on 4/9/25. Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were informed of the immediate jeopardy on 9/16/25 at 3:31 p.m. The immediate jeopardy was removed on 10/7/25 when the facility implemented and IJ removal plan. The deficient practice continues at a scope and severity of a D (potential for harm/isolated) based on the following examples of additional noncompliance not at the level of immediate jeopardy: (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*On 5/25/25 R3 had an unwitnessed fall from R3's bed. The facility did not thoroughly investigate R3's fall and did not determine a root cause to help prevent further falls. On 8/18/25 R3 had an unwitnessed fall and was discovered on the floor next to R3's bed. R3 was transferred to the emergency room and on 8/19/25 R3 underwent surgery for a closed right hip fracture. The facility did not conduct a thorough investigation of R3's fall on 8/18/25. *R8 rolled out of bed on 2/28/25 and 4/11/25 both related to trying to reposition in bed as documented. The intervention to have a body pillow in place was to be implemented after the 2/28/25 incident. There is no documentation this was implemented. R8 rolled out of bed on 4/11/25 and the fall checklist documents that R8 has expressed a refusal of the body pillow. The facility did not implement an alternative intervention after refusing the body pillow in relation to the 2/28/25 incident resulting in R8 rolling out of bed again on 4/11/25. *R10 fell on 1/17/25 on the way to the bathroom. No intervention was put into place. R10 fell on 1/28/25 trying to get into wheelchair. No root/cause analysis as to why R10 was trying to get into the wheelchair. R10 fell on 2/16/25 attempting to get to the bathroom again. No interventions was put into place. On 8/10/25, R10 fell out of the recliner. There is no root/cause analysis and no intervention was put into place. Findings include: The facility's policy, titled “Member Falls” and last revised January 2025 under Policy documents: All members shall have a care plan addressing their fall risk and predisposing factors… Interventions implemented to prevent falls shall be individualized for the member and relevant to the root cause of a recent fall. Interventions that are generalized and are not relevant to the reason the member fell are not appropriate…. Under Procedure for Fall Care and Follow Up documents ….5. The Registered Nurse (RN) initiates fall documentation in the electronic record through risk management. 5.1 If the member has multiple falls, each fall is a new entry. A repeat unwitnessed fall or fall with head injury, restarts the neurological assessment schedule. 6. Additional information related to the member's fall is required to be documented as an incident assessment note in the member's chart. 7. The RN attempts to determine root cause of fall through member and staff interview, all known information is documented in the electronic record. 7.1 Review the members care plan, Kardex, and orders to determine if the plan was provided as written and if total plan of care addresses the root cause. 8. Implement a relevant intervention to prevent recurrence, considering the root cause of the incident…. 1.) R2 is [AGE] years old with diagnoses which includes Alzheimer's Disease (progressive brain disorder that causes gradual cognitive decline), dementia, anxiety disorder (group of mental health conditions characterized by excessive & persistent worry, fear, and nervousness that can interfere with daily life) depressive disorders, delusional disorders (a belief or altered reality that is persistently held despite evidence or agreement to the contrary), hypertension (high blood pressure), and diabetes mellitus (high blood sugar). R2 has had 15 falls since 1/9/25. R2's at risk for falls care plan initiated 4/14/25 & revised 9/10/25 documents the current following interventions: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*High Risk: I am at an increased risk for falls based on my screening evaluation; this means that I have several predisposing factors which increase my risk for falls. Remind me to be safe and to call for assistance. Initiated 2/15/23. *Be Aware: I take medications that may cause e to have low blood pressures, remind me to change positions slowly. Initiated 2/15/23. *Arrange my environment to minimize my risk for falls; ensure my space is free of clutter and my furniture is securely against the walls. Initiated 2/15/23. *Orient me to the facility and my surroundings often as I can become confused, and this increases my risk for falls. Initiated 2/15/23. *Make sure I have everything I need and the call light close by. Initiated 2/16/23. *Member not to open brake away doors to assist with helping members to the unit. Initiated 11/5/24. *Keep door open when in room. Initiated 4/4/25. *Provide additional assistance with cares. Initiated 4/6/25. *Staff to assist member with AM cares. Initiated 4/16/25 & revised 6/25/25. *Utilizing a body pillow while member is in bed for safety and fall prevention. Initiated 4/20/25 and revised 5/5/25. *Utilize scoop mattress. Initiated 4/29/25 & revised 5/2/25. *Monitor and redirect member when in peers' personal space. Make sure non-slip material is placed in w/c or recliner before I sit down to prevent me from sliding. Initiated 4/29/25 & revised 6/25/25. *Encourage member to stay in common area. Include member in activities taking place on unit. Initiated & revised 5/8/25. *When member appears agitated or restless, toilet member. Initiated 5/9/25. * NOC (night) get up prior to leaving shift & bring to day room for supervision. Initiated 5/10/25 & revised 8/12/25. *Body pillow in place while member is in bed. Initiated 5/19/25 & revised 5/20/25. *PT (physical therapy) Eval (evaluation) and treat. Follow up with Ortho 6 weeks. Initiated 6/15/25 & revised 7/28/25. *Staff to monitor and supervise member when she is awake and sitting reclined in the recliner in dayroom. Initiated 5/26/25 & revised 6/25/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Member has individualized wheelchair set up by therapy. Chair to be in slight reclined position when not eating meals. Upright for meals. Initiated 6/25/25. *Member to have shoes on properly, heels to be in shoes correctly, not waking on back of shoes Initiated & revised on 6/25/25. *Motion sensor in room on at all times. Initiated & revised 6/25/25. *Leave sensor alarm on at all times. Initiated 6/25/25. *Member to wear shoes or grippy socks when standing up or transferring with staff. Initiated & revised 6/25/25. *Member to wear gripper socks while in bed every shift. Initiated 6/25/25. *Member to wear hip protectors during day on in AM with cares upon rising and off at HS (hour sleep) for prevention, size medium. Initiated 6/25/25. *To make sure member has items within reach when sitting in dining room table to avoid injury. Initiated 7/8/25. *Another motion sensor in members room near the door in front of bathroom entrance. Her current motion sensor is positioned above her bed and does not activate until there is motion just past the foot board of her bed, need detection for door and bathroom entrance. Initiated 7/21/25 and revised 9/10/25. *Maintenance to install another motion sensor in members room near door in front of bathroom entrance. Initiated 7/21/25. *Second motion sensor placed in room to cover bathroom entrance. Sensor to be on at all times and verified every shift for functionality. Initiated & revised 7/23/25. *Tels in for anti-roll backs for W/C. Initiated 7/28/25. *Member is not to be left alone when in the restroom. Initiated 8/12/25. *Member wants blinds to be closed when she goes to bed for sleeping. Initiated 8/19/25. The following are fall Interventions initiated and resolved/cancelled: *PT/OT (physical therapy/occupational therapy) eval and treat. Initiated 2/15/23 and revised & cancelled 4/11/25. *NP (Nurse Practitioner) ordered CBC (complete blood count), BMP (basic metabolic panel), UA (urinalysis). Initiated 12/4/23 and revised & cancelled 8/23/24. *Member to be 15-minute checks. If member sustains fall while on 15 min checks member will become 1:1. Initiated 4/9/25 & revised and cancelled 4/13/25. (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Encourage me to take rest periods often as I may tire when I am ambulating with staff. Initiated 4/14/25 and revised & cancelled 6/25/25. *Member on 15 min (minute) check staff monitoring for safety due to high fall risk. Initiated & resolved on 4/16/25. *Motion sensor placed in member's room to alert staff when Member is attempting to transfer, toilet or ambulate independently. Initiated 4/16/25 & resolved on 6/25/25. *Member on 1:1 for safety and fall prevention. Initiated 4/17/25 & resolved 4/28/25. *Member to have untucked body pillow on the outer edge of the bed for protection against falls. Initiated 4/16/25 & revised and resolved 5/5/25. *Toileting program; at risking around mealtimes, and before bed. Staff to assist Member to toilet before 5AM if awake. Initiated 4/28/25 & resolved 6/25/25. *Member is 1:1. Initiated 4/29/25 & resolved 5/9/25. *Place Dycem in my w/c or recliner to prevent me from sliding out of chair. Initiated 4/29/25 and revised & cancelled 6/25/25. *Member to wear hip protector for safety. Initiated 4/30/25 & resolved 6/17/25. *Order pommel cushion for wheelchair to allow proper alignment for member when sitting in wheelchair. Initiated 5/2/25 and revised & cancelled 6/25/25 *Ordering small W/C (wheelchair) for Member. Initiated & resolved on 5/21/25. *Member is on 15 minute checks on night shit for fall prevention. Initiated 5/21/25 and revised & resolved 6/13/25. *Walking: 2ww (wheeled walker), gait belt, 2nd person to follow with wheelchair, ambulate 100-300 ft (feet) to and from meals and as needed when member has extra energy to prevent falls Initiated 5/25/25 & revised and cancelled 7/28/25. *When member is awake sitting in the recliner, don't put recliner in the reclined position. Initiated 5/25/25 and revised & cancelled 6/25/25. *Fall Prevention: 30-minute checks. Initiated 6/13/25 & revised and resolved 8/21/25. *Encourage member to wear gripper socks while in bed every shift. Initiated 6/18/25 and revised & resolved on 6/25/25. *Staff to make sure that member has gripper socks on at bedtime. Initiated 6/25/25 and revised & cancelled 6/25/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*The resident requires limited assist of two staff members and gait belt for transfers. Initiated 6/25/25 & resolved 7/28/25. *Tels request for maintenance to install another motion sensor in members room near the door in front of bathroom entrance. Initiated 7/19/25 & revised and resolved 7/23/25. *Pt (patient) will receive frequent cues/reminders to ask for help if needing assistance. Initiated 7/25/25 and revised & cancelled 7/28/25. *Pt will receive frequent cues/reminders to ask staff for assistance before trying to self-ambulate. Initiated 7/25/25 and revised & cancelled 7/28/25. R2's fall CAA (care area assessment) dated 12/30/24 under analysis of findings for nature of problem/condition documents Member has a dx (diagnosis) of Alzheimer's Disease, dementia, anxiety, wandering, cognition is severely impaired. Receives scheduled antidepressant medication. Has had 5 falls in last year. Hx (history of) falls d/t (due to) UTI (urinary tract infection) is up ad lip/ambulatory. Should have proper footwear on, currently being treated by psych due to behaviors/increase in packing while looking for labor and delivery. R2's fall risk assessment dated [DATE] has a score of 8 which indicates low risk for falls. FALL R2's nurses note dated 1/17/25 at 07:15 (7:15 a.m.) written by Registered Nurse (RN)Supervisor-W documents Member was found sitting with legs out on the floor. Member was towards the foot of the bed. Member was fully dressed with nothing on the feet. Lamp was on in the room. Member stated they had a fall and bumped their head. Denied any other pains. Assessed member. Minimal help back into bed after placing shoes on feet. Member states bump to back of head. Assessment no abrasion, no bump, no indication of pain when touching, denied PRN (as need) pain relief medication. Neuro check was negative. BP (blood pressure) was elevated at 188/84. Check and hour and half later 170/82. All other vitals WNL (within normal limits). Lungs clear, BS (bowel sounds) all quads. (quadrants). Mentation at baseline. Updated supervisor and provider. Vitals BP 170/82, 1/17/25 05:17 (5:17 a.m.), Position: sitting l (left) arm, P (pulse) 68 – 1/17/25 0325 (3:25 a.m.), pulse type regular. T (temperature) 97.7 1/17/25 0325 Route: forehead (non-contact), R (respirations), O2 (oxygen) 95% -1/17/25 0325 Method: room air. Pnl (pain level) 1- 1/17/25 0235. Pain scale Pain ad. Follow up new intervention implemented and added to TPOC (temporary plan of care) wear shoes or gripper socks while ambulating/walking. Surveyor reviewed R2's fall investigation which includes an incident audit report for date of incident 1/17/25 03:10 (3:10 a.m.) and two fall/incident witness statements. Surveyor noted the facility's fall investigation was not thoroughly investigated as the investigation does not include when R2 was last toileted, how was R2 positioned in bed etc, if previous interventions were in place at the time of the fall and does not include a root cause. R2 ‘s care plan was not revised with the new intervention to wear shoes or gripper socks while ambulating. R2's fall risk assessment dated [DATE] has a score of 18 which indicates high risk for falls. (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R2's quarterly MDS (minimum data set) with an assessment reference date of 3/11/25 has a BIMS (brief interview mental status) score of 4 which indicates severe cognitive impairment. R2 is assessed as requiring set up or clean up assistance for eating, toileting hygiene, rolling left & right, and chair/bed to chair transfer. R2 is assessed as being independent for toilet transfer. R2 is occasionally incontinent of urine and frequently incontinent of bowel. R2 has fallen since prior assessment, one fall with no injury. FALL R2's nurses note dated 4/1/25 at 10:15 a.m. and written by Licensed Practical Nurse (LPN)-N documents CNA was giving member a shower. Member was standing in the shower, went to step out of the shower on a towel on the floor, fell and struck her head. CNA assisted member onto the shower chair and placed the call light on. See progress note for entire fall assessment. R2's nurses note dated 4/1/25 at 10:49 a.m. and written by LPN-N documents Certified Nursing Assistant (CNA) placed call light to shower room on to report that member fell on the floor. Writer entered tub room at 1015 member was sitting on the shower chair. CNA states member was stepping out on the shower, a towel was on the floor for member to step onto. Member fell and struck the back of her head on the shower wall. CNA informed writer that CNA assisted member back onto the shower chair. No redness or bruising noted to buttock or back. Writer did assess members head, no redness or injury at this time. Member unable to state what happened, was asking for under ware (sic)/clothing. Writer sent e mail to Assistant Director of Nursing (ADON) and charge nurses per fall check off sheet. ADON not in office. Writer obtained V.S. (vital signs) and did neuro check. Neuro check is negative bilateral pupils are large, round and reactive to light. Hand grasps are strong and equal. Call placed to [Name of medical group]. Writer spoke to [Name] NP and informed of fall wand that member struck her head, no visible injury. Informed that member has an order for prn (as needed) Voltaren gel no other blood thinners. New order received to send member to ER (emergency room) for eval due to her age. Call placed to members son [Name] and let a voice message requesting a return call. R2's nurses late entry nurses note dated 4/1/25 at 1700 (5:00 p.m.) documents Member returned from ER. ER called to get [Name] Pharmacy information to send antibiotic prescription for Member. Information was given to [Name] ER and prescription was sent to [Name] Pharmacy from [Name] ER. R2's fall risk assessment dated [DATE] has a score of 8 which indicates low risk for falls. R2's IDT (interdisciplinary team) note dated 4/2/25 at 9:53 a.m. & created on 4/3/25 at 17:56 (5:56 p.m.) written by ADON-S documents Met to discuss fall in shower. Intervention to provide shower stool/chair of appropriate size for member. Surveyor reviewed the facility's fall investigation for R2's fall on 4/1/25 which included an incident report, neuro assessments on 4/1/25 at 10:15 a.m. & 17:15 (5:15 p.m.) and 4/2/25 at 9:43 a.m., an incident audit report for incident date 4/1/25 10:15 a.m. and CNA-VV's fall/incident witness statement. Surveyor noted the facility did not conduct a thorough investigation as the facility did not investigate why CNA-VV placed a bath blanket on the floor, why did CNA-VV get R2 off the floor without being assessed by a Registered Nurse (RN) and did not determine the root cause. R2's care plan was not revised with an appropriate size shower stool/chair. FALL (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R2's nurses note dated 4/3/25 at 10:30 a.m. and written by LPN-N documents Writer was called to members room at 1030 per CNA. CNA states “Member is on the floor.” Writer went to room, member sitting a few feet away from door to her room. Member dressed with shoes on sitting on buttocks. Member noted with a large, raised bruise to the middle to her forehead. Member stated to writer “It happened so quick.” Member stated she fell in the bathroom. Member did have a BM (bowel movement) in the bathroom in her room. Writer informed ADON [initials] that member was on the floor. ADON did see member in her room. [Name] NP was on the unit NP did see member, noted bump to forehead and gave order to send to ER for an evaluation. Members ROM (range of motion) per usual. Member continuing to deny pain and discomfort. Body check was done, no other apparent injuries. Member was assisted to toilet to change clothing that was soiled. Writer placed call to members son [Name] who is members HC POA (healthcare power of attorney). Son is aware of fall, head injury and order to send to ER for an evaluation per NP who was in building and assessed member. [Name] Ambulance was called and cannot transport. [Name] Ambulance will transport member to [Hospital Name] for an evaluation due to head injury. R2's nurses note dated 4/3/25 at 18:49 (6:49 p.m.) written by RN Supervisor-W documents Member returned from [Name] ED (emergency department) at 1700 (5:00 p.m.). Member was diagnosed with acute cystitis without hematuria, traumatic hematoma of forehead, and fall. Member was started on ciprofloxacin 500mg (milligrams) tab (tablet) for acute cystitis. Member baseline mentation. R2's fall risk assessment dated [DATE] has a score of 12 which indicates high risk. R2's IDT note dated 4/4/25 at 10:41 a.m., created on 4/6/25 at 1447 (2:47 p.m.) and written by ADON-S, documents: Met to discuss fall. Intervention: Encourage member to stay in common area. Provide additional assistance with cares. Keep door open when in room. POA and physician notified of fall. Surveyor reviewed the facility's fall investigation for R2's fall on 4/3/25 which consisted of an incident report dated 4/3/25, neuro assessments dated 4/3/25 at 9:51 a.m., 10:35 a.m., 21:44 (9:44 p.m.), 4/4/25 at 05:15 (5:15 a.m.), 17:37 (5:37 p.m.), and 4/6/25 at 04:06 (4:06 a.m.) & 17:12 (5:12 p.m.). An incident audit report dated 4/3/25 10:30 a.m. and CNA-VV's fall/incident witness statement. Surveyor noted the facility did not thoroughly investigate R2's fall as there is no evidence the facility investigated whether prior interventions were in place. The facility did not clarify CNA-VV's statement regarding the last time staff interacted with R2 which was 10:22 a.m. when walking R2 to her bed & the last time R2 was toileted is documented as 10:25. The facility did not determine a root cause to help prevent further falls. Surveyor noted R2's fall care plan was revised on 4/4/25 & 4/6/25. R2's nurses note dated 4/4/25 at 14:44 (2:44 p.m.) written by RN-O documents Bruise to forehead remains, purple/red in color. Writer noted 2 new bruises developing to members right eye moving up into eyebrow and bridge of nose. Nose bruise 1.5 x .3 and eye bruise measures 2.5 x 1 cm (centimeter). Member had fall with head injury on 4/3. Bruises purple/red in color. Member denies pain/discomfort to area. FALL (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R2's nurses note dated 4/7/25 at 22:35 (10:35 p.m.) written by RN-QQ documents Staff found member sitting on the floor near her bed. Member said that she hit her head. Noted a small bump and redness on the occipital area, measures 2.5 x 1.5cm. No c/o (complaint of) pain. Neuro check and ROM per baseline. VSS (vital signs stable). No loss of consciousness. R2's fall risk assessment dated [DATE] has a score of 12 which indicates high risk. R2's nurses note dated 4/8/25 at 01:40 (1:40 a.m.) written by RN-QQ documents [Name] ambulance brought the member back to floor from [Hospital Name] ER. No new orders received. R2'S IDT note dated 4/8/25 at 10:05 a.m. documents Met to discuss 4/7/25 fall. Floor was reported to be dry when the member fell despite commenting she slipped. Med review completed by pharmacy – members fall do not appear to be associated with orthostatic hypotension as BP (blood pressure) is not abnormally low upon incident. BS (blood sugar) do not appear to be low. Possible transient torsades with cipro and quetiapine but unlikely. Unsteadiness could be attributed to active UTI (urinary tract infection). Culture from hospital shows susceptible to current antibiotic. Also discussed possible Vitamin D deficient or related to GDR (gradual dose reduction). Surveyor reviewed the facility's fall investigation for R2's fall on 4/7/25 which consists of an incident report dated 4/7/25, neuro assessment dated [DATE] at 22:35 (10:35 p.m.), 4/8/25 at 11:00 a.m., & 20:28 (8:28 p.m.), an incident audit report dated 4/7/25 at 22:35 (10:35 p.m.) and five fall/incident witness statements. Surveyor noted the facility did not thoroughly investigate R2's fall as there is no evidence the facility investigated whether prior interventions were in place, how R2 was in bed prior to the fall, and did not address R2's footwear when R2 indicated the floor was slippery. The facility did not determine a root cause to help prevent further falls. R2's falls care plan was not revised until after R2 sustained another fall on 4/9/25. FALL R2's nurses note dated 4/9/25 at 07:45 (7:45 a.m.) written by RN/Education-KK documents Member had transferred herself to the bathroom to toilet. It appears she had a bowel movement and possible stood up to pull her brief and pants up and lost her balance. Neuro check seems to be baseline, and no new injuries found on body check. Member was cleaned up transferred to toilet and clean close sic (clothes) put on. No signs or expression of pain. Member to be 15 min (minute) checks per IDT team. R2's fall risk assessment dated [DATE] has a score of 15 which indicates high risk. R2's IDT note dated 4/9/25 at 09:57 (9:57 a.m.) written by ADON-S documents IDT met to discuss 4/9 fall. Interventions: 15 minute checks and motion sensor put in room. POA, DON and NP notified. Concerns about multiple falls discussed. Call placed to physician for orders included concerns of possible sepsis given multiple recent diagnosis of infection and BP reported below baseline. New orders received from NP. Results will be reviewed and member will be seen tomorrow by NP. Surveyor noted the new orders are for Stat CBC (complete blood count) and BMP (basic metabolic panel). R2's nurses note dated 4/9/25 at 16:13 (4:13 p.m.) written by RN-BBB documents Writer spoke with [Name of Medical Group] and spoke with [Name] NP about member's STAT CBC and received no new orders with instructions to continue pushing fluids. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R2's nurses note dated 4/9/25 at 18:04 (6:04 p.m.) written by RN-BBB Writer spoke with on-call [Name] NP to report STAT BMP results, writer received order to send member to emergency room for treatment of acute kidney injury based on elevated BUN (blood, urea, nitrogen) (39), elevated creatinine (1.46) and reduced eGFR (estimated glomerular filtration rate) (33). R2's nurses note dated 4/9/25 at 23:30 (11:30 p.m.) written by RN-QQ documents Member is admitted to [Hospital Name] with diagnoses of Subdural Hematoma, Hematoma, Subarachnoid hemorrhage, T12 fracture and UTI. Surveyor reviewed the facility's fall investigation for R2's fall on 4/9/25 which consists of an incident report dated 4/9/25. Under other info (information) documents Member lives on memory care unit and is (sic) severe dementia. She has recently had and tx (treatment) for Pneumonia and now UTI. Due to her age and deconditioning, confusion and lack of safety awareness she is high risk for falls. Neuro assessments dated 4/9/25 at, 05:45 (5:45 a.m.), 08:13 (8:13 a.m.) and 17:37 (5:37 p.m.), an incident audit report dated 4/9/25 at 07:45 (7:45 a.m.) and one staff statement by CNA-VV which documents As I went to do morning cares on [R2's initials] I walked in to her sitting on her bathroom floor with her brief and pants down to her knees. She had toilet paper in her hand and turned to her left side almost in a seated fetal position trying to wipe her bottom. Surveyor noted the facility did not conduct a thorough investigation as there is no evidence as to who last saw R2, when was she toileted, were prior interventions in place and did not determine a root cause to help prevent further falls. Surveyor noted the facility did not conduct a thorough investigation and did not determine the root cause of R2's four falls prior to R2's fall on 4/9/25. R2 transfer to the hospital and R2 was diagnosed with a Subdural Hematoma, Hematoma, Subarachnoid hemorrhage, & T12 fracture. R2's hospital Discharge summary dated [DATE] under diagnosis documents Traumatic subdural with intracranial bleed. Dementia with behavioral disturbance with some delirium. Essential hypertension. Urinary tract infection present on admission. Frequent falls. Under Hospital Course documents Patient is a [AGE] year-old female with dementia with power of attorney activation with frequent falls who comes in with a fall consequence of subdural hematoma and intracranial bleed. patient was monitored CT did not show worsening bleeding.

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on interview and record review, the facility did not ensure that 5 of 15 residents reviewed (R6, R14, R15, R12 and R11) received medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. * R6 has had 13 episodes of aggressive behaviors toward staff and other residents since 7/26/24, On 7/17/25, R6 punched another resident in the mouth. On 8/25/25, R6 hit R5 on the head with R6's cane, resulting in a traumatic brain injury for R5. The facility did not identify and seek ways to support R6's psychosocial and behavioral needs by reevaluating and assessing R6's behaviors. The facility did not identify and promote non-pharmacological approaches to care that met the mental and psychosocial needs of R6 and did not assess and identify possible transition of care services for R6 The facility's failure to provide R6 with necessary medically related social services, created a finding of immediate jeopardy that began on 7/17/25. Surveyor notified NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the immediate jeopardy on 9/17/25 at 11:37 a.m. The immediate jeopardy was removed on 10/7/25 when the facility implemented an immediate jeopardy removal plan. The deficient practice continues at a scope and severity of a E (pattern/potential for harm) for the following examples: *The facility did not reevaluate R14's behaviors in order to implement proper, person-centered interventions related to R14's psychosocial and behavioral needs. *The facility did not ensure R15's stop sign banner was in place to keep R14 from entering the room while R15 is in R15's room and did not follow up with R15's psychosocial needs following incident on 9/23/25. *Facility Social Worker did not follow up with R12 following R12's statement on 8/27/25 of feeling unsafe at the facility while R6 was at the facility. * Facility staff did not keep R11 from eloping from the facility. Facility staff did not update psychotherapy with R11's increased frustration or verbalizations of wanting to leave and feeling like a prisoner and did not address alternative placement or a less restrictive environment with R11 based on R11's continued verbalizations of wanting to leave the facility. Findings include: (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's document titled “WISCONSIN VETERANS HOME Union Grove- Facility Assessment, ” with a certification expiration date of November 25, 2025, documents in part, based on the resident assessment, the Facility accepts and provides for residents with Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (i.e., Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder and behavior that need interventions. The decision to admit a resident is based on the following: does the Facility have sufficient staff to provide care for the resident, staff with the skill set to provide quality care, equipment and supplies need, additional staff training required and number of bed available. “Services and Care We Offer Based on our Resident's Needs. Mental Health and Behavior 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”. Under “Provide person-centered/directed care: Psycho/social/spiritual support ,“ the facility documents “Find out what resident's preferences are and routines are. what upsets him/her and incorporate this information into the care planning process. Record and discuss treatment and care preferences.” The facility documents “Caring for residents with mental and psychosocial disorders, and implementing nonpharmacological interventions is part of the Facility's competencies. 1.) R6 was admitted to the facility on [DATE] with diagnoses including Dementia (a general term for a group of conditions that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life) with mood disturbances and psychotic disturbances, Anxiety, Delirium, and Major Depressive Disorder Adjustment Disorder. R6's most recent MDS, dated [DATE], documents R6 has a BIMS score of 4 indicating severe cognitive impairment, had wandering behaviors 1 to 3 days, no impairment in upper or lower extremities, uses a cane for mobility and receives antipsychotic medications. Surveyor noted R6 has had 13 incidents of escalating aggressive behaviors since 7/26/24. a. On 6/9/25, R6 had a resident-to-resident altercation where R6 was the aggressor. No root cause analysis was completed. Surveyor noted a progress note dated 6/10/25, by Director of Social Services-D, which documents Director of Social Services-D met with R6 to discuss the incident, indicated R6 did not recall the incident, is in a good mood, does not have any concerns and remains on 1:1 supervision at that time. Surveyor noted Director of Social Services-D did not assess if current behavior interventions are effective for R6 or if any new interventions needed to be implemented. On 09/16/2025, at 12:24 PM, Surveyor interviewed Director of Nursing (DON)-B. DON-B indicated that upon DON-B's arrival to the facility, DON-B noted root cause analyses were not being done and DON-B began implementing them. DON-B indicated R6 was put on temporary 1:1 supervision as an immediate intervention and expects Director of Social Services-D to be completing the root cause analysis and following up, as well as the intradisciplinary team (IDT). b. A progress note, dated 6/14/25, documents R6 started swinging R6's cane at staff. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 6/16/25, documents, R6 was seen by Psych Nurse Practitioner-JJ who documents “patient has a history of physical altercations and is involved in numerous aggressive acts, indicating a high potential for aggressive behavior. Inappropriate behavior toward staff suggests poor impulse control and potential risk. The patient's difficulty with redirection further increases the risk of problematic behaviors. Close monitoring and intervention strategies are necessary to manage these risks.” Surveyor noted no documentation indicating clarification on what Psych Nurse Practitioner-JJ meant by “Close monitoring and intervention strategies are necessary to manage these risks” or what the facility is doing to manage R6's risks or mention of R6 swinging cane at staff on 6/14/25. A progress note, dated 6/17/25, documents the IDT met on 6/16/25 for “Mind over meds behavior management meeting” and discussed R6's medications and behaviors. c. Surveyor reviewed R6's progress notes from the facility's Electronic Health Record, and noted on 7/1/25, R6 used R6's cane to hit a staff member in the stomach when redirection of wandering was attempted. The facility's document titled “Care Plan Report” for R6 documents R6 has a potential for behaviors with an initiation date of 7/1/25 and documents the following interventions: - A stop sign banner will be placed across the other Member's doorway. Members will not sit together during activities, during mealtime and will be kept separated in hallways and/or elevators. All parties aware of interventions and in agreement with treatment plan. Surveyor noted that the above intervention was related to member-to-member interactions despite the 7/1/25 incident involved R6 striking a staff member with his cane and not a member. - PT to evaluate if Member is safe ambulating without cane - Members will not sit together during activities, during mealtime and will be kept separated in hallways and/or elevators. - Administer medications as ordered. Monitor/document for side effects and effectiveness. - Anticipate and meet the resident's needs. - Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by. - Close supervision for increased behavior and safety - Explain all procedures to the resident before starting and allow the resident time to adjust to changes. - If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. - Member to be toileted Q2 hours - Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. - Pharmacy medication review - Provide a program of activities that is of interest and accommodates residents status. - Safety: 15-minute checks for Member whereabouts on unit. Surveyor noted no documented root cause analysis was completed. A progress note, dated 7/2/25, documents, Director of Social Services-D met with R6 for follow up regarding incident with staff member. Director of Social Services-D documented R6 did not recall the incident and expressed R6 does not feel R6 used R6's cane inappropriately. Director of Social Services-D documented R6 stated feeling calm and neutral in R6's mood and denied concerns. A progress note, dated 7/2/25, documents, the IDT met to discuss the incident, R6 on 30-minute safety checks, and implemented a new intervention of Physical Therapy assessing R6 for the need of a cane as a mobility device. On 9/11/25, at 9:13 AM, Surveyor interviewed Physical Therapy (PT) Director-J who indicated R6 was evaluated on 7/3/25 for the need of R6's cane. PT Director-J indicated it was determined R6 required R6's cane for mobility but was given a smaller, lighter cane on 8/27/25. On 7/7/25, R6 was evaluated by Psych Nurse Practitioner-JJ who documents “Risk Assessment Patient has a history of physical altercations and is involved in numerous aggressive acts, indicating a high potential for aggressive behavior. Inappropriate behavior towards staff suggests poor impulse control and potential risk. The patient's difficulty with redirection further increases the risk of problematic behaviors. Close monitoring and intervention strategies are necessary to manage these risks.” Surveyor noted no behavior interventions implemented or evaluated for effectiveness. d. A progress note, dated 7/13/25, documents, R6 attempted to take a box of tissues from a table where other residents were sitting. The residents became upset, telling R6 not to take their tissues. R6 became agitated and appeared to want to strike peers. Staff intervened and gave R6 a box of tissues. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/15/25, PhD (Doctor of Psychology)-DD documented “Staff reports that there have been no aggressive behaviors noted for the past few weeks.” R6 continues to minimize aggressive behaviors and is not able to identify triggers for actions. Positive reinforcement should be given for appropriate behaviors. Identifying triggers has been difficult at this time; however, attempts should be made to identify aggressive moods, comments, or physical changes that might signify potential acting out behaviors. Surveyor noted at least 2 incidents of aggressive behaviors documented for R6 from 7/1/25 to 7/15/25 which PhD-DD seems unaware of. e. A progress note, dated 7/17/25, documents R6 punched another resident in the head and mouth. A root cause analysis documents R6 is confused and went down the wrong hallway and went into the room in the same area as R6's room, R6 thought someone was in R6's room and punched them. Surveyor reviewed the Facility Reported Incident involving the resident-to-resident altercation that occurred on 7/17/2025. The facility's incident report documents R6 walked into R7's room and hit R7 in the mouth and head. Certified Nursing Assistant (CNA)-II was checking on residents in the dining room and noticed R6 was not in the recliner where R6 had previously been sitting. CNA-II walked toward R6's room to locate R6 and heard R7 yelling out for help. CNA-II observed R6 standing over R7. R7 was sitting in R7's recliner while R6 had ahold of R7's wrists. R7 was attempting to get R6 away from R7, using R7's legs. CNA-II was able to separate R6 and R7. CNA-II then walked R6 down the hall and informed the Nurse immediately, who then went and assessed R7. R6 was immediately placed on a 1:1 supervision. A progress note, dated 7/18/25, documents, The IDT met to discuss the incident. The IDT documents, R6 is confused, entered another resident's room and became aggressive when asked to leave. R6 became agitated and hit the other resident in the face. Interventions documents, R6 was placed on a temporary 1:1 supervision, R6 was not to sit with the other resident during meals, activities and will be kept separate in hallways/elevators and a stop sign would be placed across the other resident's doorway. On 9/15/25, at 1:06 PM, Surveyor interviewed DON-B. DON-B indicated that after R6 punched the other resident in the mouth family members and other residents expressed being fearful of R6 and uneasy around R6. DON-B indicated that this is when the facility began to realize R6 required more services then the facility could provide to keep other residents safe. DON-B informed Surveyor that the facility has sent R6 to the hospital for evaluations, but nothing is founded. DON-B believes the facility has been attempting to find alternative placement for R6 but would need to clarify with Director of Social Services-D. DON-B indicated they kept other residents safe by initiating a temporary 1:1 supervision for R6 and were monitoring R6's behaviors. On 9/15/2025, at 1:51 PM, Surveyor interviewed Director of Social Services-D regarding finding placement for R6. Director of Social Services-D indicated that R6's family member has expressed in the past about R6 going home to the reservation, but no other attempts to find alternative placement were looked into. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted on 7/21/25, R6 was evaluated by Psych Nurse Practitioner-JJ. Psych Nurse Practitioner-JJ evaluation documents: R6 had recent physical altercation with peer. R6 entered peers' room, possibly mistaking it for R6's, and struck peer. R6 last seen 7/7/25 where it was noted R6 was improving since re-increase risperidone after failed gradual dose reduction. R6 with significant history of physical and verbal aggression, sexual inappropriateness, generalized anxiety disorder, dementia with anxiety, mood disorder, and insomnia. Staff reports R6 has had a history of both physical and verbal aggression towards staff and peers. Surveyor noted the assessment and plan documented the following:-recent physical aggression-Plan: increase vpa (valproic acid), continue duloxetine, emotional support -Insomnia-well controlled-Plan: continue emotional support - Recent physical aggression-Plan: increased vpa, consider change to SSRI in future; continue emotional support-increase vpa ER 500; taper and DC namenda; continue emotional support; follow up next rounds” A progress note, dated 7/21/25, documents: Director of Social Services-D attempted to meet with R6 to follow up regarding the incident on 7/17/25 but R6 was sleeping. A progress note, dated 7/22/25, documents: Director of Social Services-D met with R6 to discuss the resident-to-resident incident on 7/17/25 and documents the following: “This writer met with member to talk about a recent member to member where this member hit member (R7) in the face multiple times after entering their room. This member did not recall the situation. This member does not recall hitting anyone or entering anyone else's room. When asked what makes this member upset, they stated “kids.” This member talked about kids making him upset as they are not aware of who they are, and they are dummies and have no respect. This member went on to state that he does not like being instigated or being told what to do. This member shared he becomes agitated by this. This member then started to discuss a doll and stated, “She is not real.” This member shared that those kids are toys, and they like to argue a lot. This member mentioned that “She can't understand what we are talking about because she is just a doll.” Surveyor noted Director of Social Services-D did not evaluate R6's current interventions or assess effectiveness of current interventions. A progress note, dated 7/24/25, documents R6 was glaring at particular residents, writer became concerned enough to “briskly” walk toward R6 to intervene. f. A progress note dated 8/1/25, by RN-BB, documents R6 had multiple attempts to interact with a resident R6 had an altercation with, redirection was causing R6 to become “agitated/irritated” and began pushing staff. A progress note, dated 8/21/25, documents Director of Social Services-D met with R6 to conduct an Annual Minimum Data Set assessment. Director of Social Services-D indicated R6 is currently on 15-minute checks for safety, wanders off unit usually redirectable by staff, no traumatic events in the assessment period, an updated LEC-5 (The Life Events Checklist is a self-report measure designed to screen for potentially traumatic events in a respondent's lifetime). would be completed and R6 is satisfied with living arrangements. (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Trauma informed Care plan was initiated on 8/25/25 for R6. g. A progress note dated 8/25/25, at 6:46 PM, by RN-BB, documents: R6 exhibiting severe anxiety/restlessness, ignoring staff redirection, all doors were shut on hallway but R6 kept opening other resident's doors, another resident stayed in the hallway due to not wanting to be alone in the room with R6, R6 requiring nearly 1:1 supervision but management deems R6 as 15 minute checks. A progress note dated 8/25/25, at 8:07 PM, by RN-BB documents: R6 continuing to display severe anxiety/restlessness, going into other resident rooms, unsuccessful redirection and making other residents feel unsafe. On 9/15/2025, at 1:51 PM, Surveyor interviewed Director of Social Services-D regarding R6's escalating behaviors and what was done for R6 to prevent further incidents. Director of Social Services-D indicated that Director of Social Services-D has met with R6's family member and went over trauma informed care interventions on 8/25/25 but indicated that was done due to needing a facility wide audit on trauma informed care, which every resident received. Director of Social Services-D indicated it was not a direct response to R6's behaviors. On 9/16/25, at 12:24 PM, Surveyor interviewed DON-B. DON-B indicated R6's behaviors were discussed in IDT meetings, DON-B began initiating root cause analyses and indicated Director of Social Services-D was not following up on the Social Services side. Surveyor expressed the concern regarding lack of Social Services involvement in R6's care. The facility's failure to provide R6 with necessary medically related social services, created a finding of immediate jeopardy that began on 7/17/25. Surveyor notified NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the immediate jeopardy on 9/17/25 at 11:37 a.m. The immediate jeopardy was removed on 10/7/25 when the facility implemented the following: NHA educated Social Worker on the following policies: - Definition of F745 Medically related social services from CMS - Members Behavior Policy - Member to Member altercation policy - Care planning policy - Trauma informed Care Policy - Root Cause Analysis process - Member mood assessment policy - Member discharge policy - Member at risk for elopement or unsafe wandering policy (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	SDC/Designee educated Staff on - Member Behavior policy, Member to member altercation policy, care planning policy and member at risk for elopement or unsafe wandering policy. Education was started 9-18-2025 and completed on 10/7/25 - Social worker attended the Wisconsin Nursing Home Social Workers Association fall conference 10/2-10/3/2025. - Social Worker/Designee to follow up with members or POA-HC or Guardian in discharge planning per member discharge policy for members wishing to discharge from facility. - Nurse Managers/Designee to complete elopement assessment for members due for quarterly assessment or with current change of condition warranting updated elopement assessment. - Social worker will establish a mentorship relationship with a licensed clinical social worker at the Wisconsin Veterans Home at King with weekly mentorship meetings. Facility will also pursue professional services for social services consulting. - The facility implemented a system/procedure to review every behavior event, resident -to resident altercations, and elopements during morning clinical which included reviewing assessment and care plan interventions for appropriateness. - Social Worker/Designee will review progress notes 5 x per week in clinical meeting auditing for members with increased behaviors, exit seeking, wishes to discharge and trauma. Those members identified will be adequately assessed and interventions put in place. Findings will be reported to QA for further recommendations. - Social Service Director and Administrator to conduct weekly meeting to review Medically Related Social Services concerns and establish process for addressing concerns. The deficient practice continues at a scope and severity of a E (pattern/potential for harm) for the following examples: 2.) R14 was admitted to the facility on [DATE] with diagnoses that include Adjustment Disorder (a mental health condition characterized by emotional and behavioral symptoms that develop in response to a significant life stressor), Presbyopia (a common age-related condition that affects the eye's ability to focus on near objects), Dementia (a general term for a group of conditions that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life) and Post-Traumatic Stress Disorder (PTSD) (A disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event.) R14's Quarterly Minimum Data Set (MDS), dated [DATE], documents in part, R6 has a Brief Interview for Mental Status (BIMS) score of 12 indicating R14 has moderate cognitive impairment, no behaviors, has no impairment in upper or lower extremities, uses a walker and wheelchair for mobility and receives antidepressant medication. (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R15 was admitted to the facility on [DATE], with diagnoses including depression. R15's admission MDS, dated [DATE], documents BIMS score of 15 indicating R15 is cognitively intact, has impairment in lower extremities on one side and uses a wheelchair for mobility. Surveyor noted R15 is care planned for Trauma Informed Care, initiated 9/9/25 and documents “. Depressive disorder, recurrent severe without psychotic features. Member was referred to in-house psychiatrist on 3/11/25 and inhouse psychologist on 4/14/25” On 9/30/25, during the extended survey at the facility, Surveyor reviewed the facility's grievance log and noted a grievance from R15 regarding R14 entering into R15's room on multiple occasions, with the most recent time resulting in R14 removing R14's clothing while in R15's room. Surveyor reviewed the facility provided document titled, “Member Grievance/Concern,” dated 9/23/25, by Social Worker (SW)-C, which documents R14 keeps going into R15's room and this has occurred 6 times in 12 days. This has been occurring after dinner and before bed, and on occasion R14 wanders into R15's room with pants and underwear down. R14 was placed on a temporary 1:1 overnight. Resolution of the complaint documents, R15 has a stop sign banner in front of R15's door to stop R14 from going into R15's room and indicated SW-C followed up with R15 with no concerns. On 9/30/25, at 9:54 AM, Surveyor observed R15's door open, the stop sign banner hanging next to the door and was not across the doorway. Surveyor interviewed R15. R15 informed Surveyor of the concerns regarding R14 coming into R15's room and R15 expressed those concerns to Director of Social Services-D. R14 has come into R15's room [ROOM NUMBER] times in 12 days. R15 indicated a stop sign banner is supposed to stop R14 from entering R15's room but it does not do any good when it's not put up and seems to only go up when R15 is not in R15's room. R15 explained being afraid to shut R15's eyes at night due to R14 coming into R15's room. R15 indicated wanting to buy a squirt gun to defend R15's self against R14 but does not want to get in trouble or hurt R14. R15 explained that R15 cannot defend R15's self, due to having a bum leg. R15 explained R14's behavior as strange and uncomfortable. R15 began to get choked up talking about the incident; R15 explained that R15 informed Director of Social Services-D, who came and spoke with R15, but has not spoken to R15 since. Surveyor noted no new interventions were implemented for R14 or R15 following this incident. On 9/30/25, at 11:10 AM, Surveyor interviewed Director of Social Services-D. Director of Social Services-D indicated Director of Social Services-D did not complete LEC-5s following the incident with R14 and R15 and care plans were not assessed or updated, interventions were not assessed for effectiveness and indicated that should have been done when the situation occurred and at follow up. Director of Social Services-D indicated that R14 was placed on a temporary overnight 1:1 supervision following the incident. No other interventions were implemented, and current interventions were not assessed. On 9/30/25, at 3:02 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A indicated that NHA-A was going to make a change to the plan of correction that LEC-5s were going to be done annually instead of quarterly, but should still be completed in between with any traumatic events, indicating R14 and R15 should have been reassessed following the incident. NHA-A indicated that R14 and R15 should have interventions evaluated. NHA-A indicated that the stop sign banner should be up while residents are in their rooms to prevent other residents from going into other resident rooms. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3.) On 8/27/25, R6 was involved in a resident-to-resident altercation resulting in R5 sustaining a traumatic brain injury after being hit over the head with R6's cane. During the resident-to-resident investigation, Surveyor noted a statement by R12 indicating R12 did not feel safe in the facility with R6. On 9/30/25, at 2:36 PM, Surveyor interviewed Director of Social Services-D regarding follow up with R12's statement following the resident-to-resident altercation. Director of Social Services-D informed Surveyor that Director of Social Services-D has not followed up with R12 regarding R12's statement of feeling unsafe with R6 around. Surveyor noted there were no immediate interventions implemented and no social services assessment following R6's increased behaviors on 8/25/25 prior to the assault on 8/27/25. 4.) R11 was admitted to the facility on [DATE] with diagnoses of Dementia Unspecified Severity (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), With Mood Disturbance, Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), Chronic Obstructive Pulmonary Disease (lung disease that blocks airflow and make it difficult to breathe), Essential (Primary) Hypertension (most common type of high blood pressure), Chronic Respiratory Failure With Hypoxia (long-term condition where the lungs are unable to adequately exchange oxygen and carbon dioxide), Insomnia (sleep disorder characterized by difficulty falling asleep), Unspecified, and Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to limbs), Unspecified. R11's Quarterly Minimum Data Set (MDS) completed 6/26/25 documents R11's Brief Interview for Mental Status (BIMS) score is 12, indicating R11 demonstrates moderately impaired skills for daily decision making. R11's MDS documents no mood or behavior issues, including wandering. R11's main locomotion is by standard wheelchair. R11 is independent with dressing, mobility, and transfers. R11's Kardex (instructions to nursing staff) was updated 9/15/25. The Kardex documents: Safety -1/25/25 Encourage member to ask for help with computer -Alert on call nurse or DON or ADON for all incidents (escalated behaviors, attempts at elopement) -R11 has a wander guard on R11's wheelchair because R11 tries to tear it off R11's arm/leg -R11 now lives in memory care -R11 refused wander guard 4/25/25 -Redirect R11 when voicing need to leave facility to go to the bank. -Roam Alert wander band to R11's wheelchair R11's comprehensive care plan includes the following applicable problems: (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Safety Elopement: R11 at risk of elopement due to cognitive losses, Dementia high risk for elopement 7/10/25 R11 was waiting outside “for a ride to his bank”. 15-minute safety checks initiated for R11 whereabouts. R11 declines wearing roam alert device bracelet 8/4/25 15-minute checks discontinued 9/11/25 Roam alert device on R11's wheelchair Initiated 7/10/24 Interventions: -Monitor my behaviors to determine: duration, frequency, intensity, and patterns. Consider any changes that may have occurred such as: a room change, change in cognitive status, medication changes, new staff, or termination of treatment program. Initiated 7/10/25 -Alert on call nurse or DON or ADON for all incidents (escalated behaviors, attempts at elopement) Initiated 9/11/25 -R11 has a wander guard on R11's wheelchair because R11 tries to tear it off R11's arm/leg Initiated 9/11/25 -R11 now lives in memory care Initiated 9/11/25 2.Coping/Trauma Informed Care Plan: I am at risk for ineffective individual coping due to R11's diagnosis of Major Depressive Disorder, Recurrent Unspecified. Adjustment to nursing home. R11 referred to in-house psychologist on 6/10/25 Triggers: R11 breathing issues forced R11 to stop R11's construction in R11's 40s. When R11's breathing bothers R11, R11 can feel triggered. Initiated 9/9/25 Interventions: -Administer medications as ordered. Monitor/document for side effects and effectiveness. Initiated 9/9/25 -Arrange for psych consult, follow up as indicated. R11 referred to in-house psychologist 6/10/25. Initiated 9/9/25 -Assess/screen for post traumatic events and history of trauma, using nursing home appropriate screening tools, such as the LEC-5. Initiated 9/9/25 -R11 has deep breathing techniques to use when R11's breathing is bothering R11. R11 also enjoys socializing and being around family and friends. Initiated 9/9/25 (continued on next page)

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	525688	A. Building B. Wing	10/01/2025

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Discuss feelings around change and loss, facilitate R11's expression of these feelings. Initiated 9/9/25 -Encourage R11 to talk about how R11 is feeling to family, friends, or staff; remind R11 to utilize R11's support system if R11 is feeling down. Initiated 9/9/25 -Please watch R11 for the signs and symptoms which may indicate R11 feeling sad or depressed such as somnolence, social isolation, increased sadness, frequent weeping, anger, refusal of cares, decreased appetite, weight loss/gain. Initiated 9/9/25 Starting 3/26/25, the facility completed an [NAME]

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview and record review, the facility did not ensure that all facility staff received required Effective Communication program training for 7 of 8 facility staff that was reviewed. This has the potential to affect the 71 Residents who reside at the facility and have the potential to receive care from Certified Nursing Assistants (CNA) and Licensed Practical Nurses (LPN) and Food Service Assistants (FSA). Findings Include:On 09/30/24, at 12:35 AM, Surveyor reviewed CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZ completed trainings for the past year and noted there was no documentation that CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZ received training on the facility's effective communication program which outlined and informed staff of the elements and goals of the facility's Effective Communication program. On 9/30/24, at 1:09 PM, Surveyor requested missing training of the facility's Effective Communication program which outlined and informed staff of the elements and goals of the facility's Effective Communication program from NHA (Nursing Home Administrator)-A for CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZSurveyor was informed by NHA-A and Director of Nursing (DON)-R they had to call human resources and the education company to try to locate these missing education documentation for CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZ. On 09/30/25, at 01:54 PM, DON-R informed Surveyor that the facility is still attempting to locate the missing documentation for the above employees by 10/1/25 in the morning for Surveyor.On 09/30/25, at 03:02 PM, Nursing Home Administrator (NHA)-A confirmed the facility has not provided CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZ with the mandatory Effective Communication training. NHA-A informed Surveyor the facility was working on providing Effective Communication training to all staff because the Effective Communication training had never been included in the facility's training process.No additional information was provided as to why the facility did not ensure that CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZ received the required Effective Communication program training.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on interview and record review, the facility did not ensure that all facility staff received required Quality Assessment and Performance Improvement (QAPI) program training for 7 of 8 facility staff that were reviewed. This has the potential to affect the 71 Residents who reside at the facility and have the potential to receive care from Certified Nursing Assistants (CNA) and Licensed Practical Nurses (LPN) and Food Service Assistants (FSA).Findings Include:On 09/30/24, at 12:35 AM, Surveyor reviewed CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZ completed trainings for the past year and noted there was no documentation that CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZ received training on the facility's QAPI program which outlined and informed staff of the elements and goals of the facility's QAPI program. On 9/30/24, at 1:09 PM, Surveyor requested training of the facility's QAPI program which outlined and informed staff of the elements and goals of the facility's QAPI program from NHA (Nursing Home Administrator)-A for CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZSurveyor was informed by NHA-A and Director of Nursing (DON)-R they had to call human resources and the education company to try to locate missing education documentation for CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZ. On 09/30/25, at 01:54 PM, DON-R informed Surveyor that the facility is still trying to have the missing documentation by 10/1/25 in the morning for Surveyor.On 09/30/25, at 03:02 PM, Nursing Home Administrator (NHA)-A confirmed the facility has not provided CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZ with the mandatory QAPI training. NHA-A informed Surveyor the facility was working on providing QAPI training to all staff because the QAPI training was never included in the facility's training process.No additional information was provided as to why the facility did not ensure that CNA-TT, CNA-VV, CNA-WW, CNA-XX, LPN-I, LPN-N, and FSA-ZZ received the required Quality Assessment and Performance Improvement program training.