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	12/03/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility did not identify resident concerns as grievances for 1 (R1) of 1 Residents reviewed for grievances.Social Worker-Q did not initiate grievances when R1's power of attorney voiced a concern R1 was being put to be too early and R1 did not receive an eye drop medication according to physician orders.Findings include:The facility's policy titled, Grievances and Complaints and last reviewed January 31, 2023, under Purpose documents To provide members and their representatives with a process to assist in writing concerns or complaints regarding the environment, missing items, or care and treatment provided by WVH (Wisconsin Veterans Homes). Under policy documents *A grievance shall be considered any circumstance thought to be unjust and grounds for a complaint and meets at least one of the following criteria: Pertains to the environment or care and treatment provided by the Homes, including missing property. Has reference to state or federal regulations, facility policies, or Member Rights and Responsibilities. Requires facility management to perform fact finding and intervention. *Any person acting on behalf, or in interest of the member, shall be considered a representative and reserve the right to file a written grievance or complaint. *All grievances and concerns shall be documented at the time of report and investigated within five business days. *Each facility shall maintain an electronic log of grievances/concerns. *The grievance process shall be posted throughout the facilities and shall include: The right to file grievances orally or in writing. The right to file grievances anonymously. The right to obtain a written decision regarding the grievance. A reasonably anticipated timeframe for completing the review of the grievance.R1's diagnoses include Alzheimer's Disease (progressive brain disorder that causes gradual cognitive decline) and dementia (loss of cognitive function that interferes with a person's daily life and activities).R1 has an activated power of attorney for healthcare.On 12/2/25, at 8:33 a.m., Surveyor reviewed the facility's grievance log from August 2025 to November 2025. Surveyor noted R1 is listed on the grievance log on 9/10/25 regarding R1's eyeglasses chipped & needs a new lens. On 12/2/25, at 9:36 a.m., Surveyor spoke with R1's POA (power of attorney) on the telephone. During this conversation R1's POA informed Surveyor she had gone to name of SW (Social Worker)-Q regarding complaints of R1 going to bed too early at 7:00 p.m. and then R1 gets up in the middle of the night. Surveyor asked R1's POA when she informed SW-Q of this. R1's POA informed Surveyor she spoke to SW-Q a couple of times. R1's POA informed Surveyor she complained R1 didn't receive eye drops as the doctor ordered. R1's POA indicated they took R1 to the eye doctor and the eye doctor said to keep R1 on the same eye medication and start new eye drops. Surveyor asked R1's POA if SW-Q filed a grievance for her regarding these concerns. R1's POA replied that's what I thought [name of SW-Q] was doing.On 12/3/25, at 8:00 a.m., Surveyor asked SW-Q if there have been any concerns brought to her attention from R1's family regarding R1. SW-Q replied ya sure, there has been lots in the last two years. Surveyor asked SW-Q if there have been any concerns in the last couple of months. SW-Q informed Surveyor she would have to look back at the grievance log there may have been a grievance for missing two hats. Surveyor asked SW-Q how the family communicates concerns to her. SW-Q informed Surveyor she talks to them in person, they call, or email. Surveyor asked if there were any concerns about R1 being put to bed too early. SW-Q replied yup they have brought that up. Surveyor asked if a grievance was initiated for this. SW-Q replied she believes so. Surveyor asked SW-Q if there were any other concerns voiced to her. SW-Q replied not really. Surveyor asked SW-Q if there were any concerns voiced to her regarding R1 missing medication. SW-Q replied ya. Surveyor asked what the missing medication was regarding. SW-Q replied eye drops he didn't receive. Surveyor asked SW-Q if she did a grievance for R1 not receiving his eye drops. SW-Q informed Surveyor she would have to look at the log as this was several months ago. Surveyor informed SW-Q Surveyor would like to see R1's grievances for going to bed to early and R1 not receiving eye drops.On 12/3/25, at 8:10 a.m., Surveyor re-reviewed the grievance log and noted on 11/8/25 R1 was on the log for two marine hats missing.On 12/3/25, at 8:41 a.m. SW-Q informed Surveyor regarding R1's missing medication they did a risk, so she didn't do a grievance. Surveyor asked SW-Q why she didn't do a grievance. SW-Q replied they did a risk. Surveyor inquired about R1's grievance for going to be early. SW-Q replied this was discussed at a care conference and the care plan was updated. Surveyor asked SW-Q if she did a grievance. SW-Q replied no.On 12/3/25, at 10:02 a.m. SW-Q and Interim Director of Nursing (IDON)-B spoke with Surveyor. IDON-B informed Surveyor they did a medication error report for R1's missing eye. Surveyor explained to IDON-B Surveyor had spoke to SW-Q regarding R1's POA voicing a complaint R1 didn't receive his eye drops & SW-Q had informed Surveyor a risk was done. Surveyor wanted to know if a

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility did not ensure a resident's unaccounted for narcotic medication was reported to the local police. This was observed with 1 of 3 Facility Reported Incidents (FRI) reviewed.R2's narcotic medication was discovered unaccounted for and was not reported to the local police. The facility's policy and procedure titled Prohibition and Prevention of Member Abuse, Neglect, and Exploitation date 7/2/2024. The Policy documents: The Facility shall comply with Section 1150B [42 U.S.C. 1320b-25} Reporting to Law Enforcement of Crimes Occurring in Federally Funding Long-term Care Facilities. All incidents shall be investigated and reported to the appropriate agency as required by the agency.Findings include:Surveyor reviewed a Facility Reported Incident (FRI) regarding R2's missing narcotic medication. The FRI investigation documents there was a missing tablet of Hydrocodone 5/325 milligrams. This was discovered missing on 9/5/2025 through an audit. The medication was missing on 8/16/2025. The FRI investigation does not indicate the local police were notified. The FRI investigation documents the facility was unable to determine what happened to the missing narcotic. The local police were not contacted regarding the missing narcotic medication.On 12/2/25, at 10:34 AM, Surveyor interviewed Interim Director of Nurses (IDON) -B. The IDON-B did not have any additional information the local police were contacted.On 12/2/25, at 3:09 PM, at the facility exit meeting with Nursing Home Administrator (NHA)-A, Assistant Nursing Home Administrator (ANHA)-C and IDON-B. Surveyor shared the concerns with the local police were not contacted for the missing narcotic. No further information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 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 interview and record review the Facility did not ensure quality of care was provided for 1 (R1) of 6 Residents. R1's ophthalmology consult on 9/8/25 includes documentation under Blepharoconjunctivitis OS (left eye) to continue polymyxin- trimethoprim one drop four times a day to left eye. The facility did not continue this order and discontinued the eye drops on 9/8/25. R1 did not receive polymyxin- trimethoprim one drop four times a day to left eye according to physician orders.Findings include:R1's diagnoses include Alzheimer's Disease (progressive brain disorder that causes gradual cognitive decline), dementia (loss of cognitive function that interferes with a person's daily life and activities), central corneal ulcer (open sore on the cornea caused by an infection or other condition), left eye and conjunctivitis (inflammation of the eye's conjunctiva most caused by viruses, bacteria or allergies).R1's nurses note dated 9/4/25, at 8:30 a.m., and written by Licensed Practical Nurse (LPN)-J documents Left eye, sclera remains pink, left eye swollen. Eye drop instilled as ordered. Small amount of dry drainage noted around eye. Left eye cleansed. Writer informed ADON (Assistant Director of Nursing) that eye drop order is complete on Friday [tomorrow] and eye still is not clear. ADON states he will follow up.R1's nurses note dated 9/5/25, at 11:40 a.m., and written by Registered Nurse (RN)-I documents POA (Power of Attorney) called regarding the need for transportation for member to get to and from a 3:15 Ophthalmology appointment in [NAME] on Monday, 9/8. Writer reached out to leader of transportation staff to see if we could accommodate.R1's order note dated 9/5/25, at 12:55 p.m., and written by RN-I documents Polymyxin B-Trimethoprim Ophthalmic Solution 10000-0.1 Unit/ML (milliliter)-% (Polymyxin B-Trimethoprim) Instill 1 drop in left eye every 4 hours for conjunctivitis for 7 days. Start Date: 9/5/2025 End Date: 9/12/2025 POA notified and expressed agreement.Surveyor reviewed R1's September MAR (medication administration record) and noted an order date of 9/5/25 Polymyxin B-Trimethoprim Ophthalmic Solution 10000-0.1 Unit/ML-% (Polymyxin B-Trimethoprim) Instill 1 drop in left eye every 4 hours for conjunctivitis for 7 days. The D/C (discontinue) date is 9/8/25. Surveyor noted although the order was for 7 days R1's Polymyxin B-Trimethoprim Ophthalmic Solution 10000-0.1 Unit/ML-% was discontinued 4 days later. R1 received this eye drop medication on 9/5/25 at 1600 (4:00 p.m.) & 2000 (8:00 p.m.), 9/6/25 & 9/7/25 at 0000 (12:00 a.m.), 0400 (4:00 a.m.), 0800 (8:00 a.m.), 1200 (12:00 p.m.), 1600, & 2000, and 9/8/25 at 0000, 0400, 0800, 1200, & 1600.R1's nurses note dated 9/8/25, at 8:01 a.m., and written by LPN-J documents Atb (antibiotic) eye drop instilled into left eye. Sclera remains pink, dry drainage present around eye. Writer gently cleansed eye. Writer also cleansed left cheek biopsy site. Sutures remain intact, skin pink, no bleeding or drainage. Vaseline applied f/b (followed by) band aides. Remains on ATB post-surgical procedure of removal of cancer. Is afebrile.Medical Doctor (MD)-L's consultation note dated September 8, 2025, includes documentation of Blepharoconjunctivitis OS (left eye) Treatment Regimen Comprehensive: Start erythromycin ointment every 12 hours to eyelids apply twice daily to LEFT EYE. Continue polymyxin-trimethoprim one drop four times a day to LEFT EYE.R1's nurses note dated 9/8/25, at 14:37 (2:37 p.m.), written by RN-K documents Appointment on: 09/08/2025 with out to [Name] hosp (hospital) for eye appointment with wife and daughter [Name]. Facility transporting member. All current orders sent with member. Order changes: valacyclovir 500 mg (milligrams) tablet, one pill twice daily for 10 days. Erythromycin 5mg/gram (0.5%) eye ointment, apply 1/4 inch to L (left) eye twice daily. Follow up appt (appointment) 09/16/2025 at 2:15 PM. Follow-up appointment: Follow up with [MD-L] on 09/16/2025 at 2:15 PM. Provider notified at 09/08/2025 4:38 PM Member notified. NOK (next of kin)/Legal Rep (representative) notified 09/08/2025 4:30 PM.Surveyor reviewed R1's September MAR and noted R1 did not receive Polymyxin B-Trimethoprim Ophthalmic Solution 10000-0.1 Unit/ML-% after 9/8/25 at 1600 (4:00 p.m.).MD-L consultation note dated 9/16/25 under HPI (history present illness) for Interval History documents Per the daughter nursing home didn't give the pt (patient) polymyxin-trimethoprim drop. She stated they gave him the erythromycin and Valacyclovir. Tearing and some pain. Under Impression/Plan documents 2. Blepharoconjunctivitis OS angular (H10.522) Status: Resolved. Plan: F/U (follow up) for Next Visit. The patient should be scheduled for the following in prn (as needed): Plan: Treatment Regimen Comprehensive: Continue erythromycin ointment for 1 week then stop. Apply twice daily to LEFT EYE. Discontinue polymyxin-trimethoprim one drop four times a day to LEFT EYE.R1's incident note created on 9/16/25 with an effective date 9/8/25 at 1600 (4:00 p.m.) and written by RN-K documents DETAILS: Medication incident. Given/Ordered 09/08/2025 4:00 PM Initial shift after incident 09/08/2025 4:00 PM polymyxin-trimethoprim

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 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 interview and record review the facility did not ensure each resident received adequate supervision to ensure each resident's environment remains free of accidents and hazards for 1 (R10) of 3 residents.On 10/18/25 during a body check R1 was identified with a skin tear over purple senile purpura to the right side of R1's clavicle. There is no evidence staff were interviewed to inquire how R1 may have received this skin tear and did any staff observe R1 picking his clavicle. On 10/21/25 R1 sustained a skin tear due to the arm of a shower chair having a sharp area. The facility removed the chair but there is no preventative measures documented to prevent this from occurring in the future. On 12/2/25 & 12/3/25 there are multiple observations of R1's plan of care not being followed for non-slip material (Dycem) on the wheelchair and padding of the lower portion of the front bars on R1's wheelchair.Findings include: The facility's policy titled, Member Incidents and with an effective date of November 1, 2025, under Policy includes documentation of Interventions shall be implemented for any incident that causes or potentially causes injury; the intervention shall be appropriate and applicable to the cause of the incident to prevent recurrence.R1's diagnoses include Alzheimer's Disease (progressive brain disorder that causes gradual cognitive decline), dementia (loss of cognitive function that interferes with a person's daily life and activities), hypertension (high blood pressure), anxiety disorder (group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life), and hemiplegia (paralysis on one side of body) & hemiparesis (weakness on one side) following cerebral infarction (type of stroke) affecting right dominate side.R1 is not interview able and is dependent on staff for his ADL's (activities daily living).R1's at risk for falls care plan initiated 6/29/23 and revised on 10/19/23 includes an intervention of *Non-slip material to wheelchair to prevent member from sliding. Initiated 3/22/25 & revised 10/19/25.R1's potential for impairment to skin integrity care plan initiated 8/9/25 & revised 11/7/25 includes an intervention of *Padded side of w/c (wheelchair) seat and both front bars on lower part of w/c with black pool noodle for protection. Initiated 8/30/25 & revised 10/19/25.R1's Certified Nursing Assistant (CNA) care plan as of 12/2/25 under safety section includes *Non-slip material to wheelchair to prevent member from sliding. *Padded sides of w/c seat and both front bars on lower part of w/c with black pool noodle for protection.R1's nurses note dated 10/18/25, at 22:10 (10:10 p.m.), and written by Registered Nurse (RN)-M documents During members body check for shower, skin tear noted over purple senile purpura to right side of clavicle. Skin tear measuring 1. 3cm (centimeters) x (times) 0.3cm x 0.1 cm. No drainage or s/s (signs/symptoms) of infection. No indication of pain or discomfort noted. Area cleansed and mepilex applied per NP (Nurse Practitioner) order [Name]. Charge nurse & POA (Power of Attorney) made aware.R1's nurses note dated 10/20/25, at 05:15 (5:15 a.m.) and written by RN-M documents Member rested well during the night. Dressing to right clavicle clean, dry and intact. No drainage noted to dressing. Surrounding skin intact. No pain indicated to the area. Jacket in place for skin protection.R1's IDT (interdisciplinary team) note dated 10/20/25, 16:18 (4:18 p.m.) written by RN-I documents Reason for discussion: Met to discuss root cause and intervention for wound. Summary of discussion: Proper people notified. RCA (root cause analysis): Member has a history of picking at skin. Likely self-inflicted. Intervention: Treatment as directed by provider.On 12/3/25 Surveyor reviewed the facility's investigation for R1's skin tear. Surveyor was provided with impaired skin integrity/wound checklist dated 10/18/25, incident audit report with dates of 10/18/25, 10/20/25 & 10/24/25, incident note dated 10/18/25, nurses note dated 10/18/25 at 22:10 & IDT note dated 10/20/25 at 16:18, incident report dated 10/18/25 at 21:30 (9:30 p.m.) and R1's potential for pain & potential for impairment to skin integrity. Surveyor noted this information did not include any staff statements or indications that staff was spoken to regarding if this area was observed by any staff prior to skin check, how R1 may have sustained this injury, whether any staff observed R1 picking his clavicle area etc.On 12/3/25, at 12:10 p.m., Surveyor met with Interim Director of Nursing (IDON)-B to discuss R1. Surveyor informed DON-B R1 sustained a skin tear with purple purpura which was noted during a skin check on 10/18/25. Surveyor inquired if there are any staff statements or had any staff been interviewed regarding this area. DON-B informed Surveyor RN-I is no longer employed at the facility but will investigate this and get back to Surveyor.On 12/3/25, at approximately 1:30 p.m., IDON-B informed Surveyor R1's has a history of scratching himself and has no further information to provide Surveyor.*R1's nurses note dated 10/21/25 at 21:02 (9:02 p.m.) and written by RN-N documents Member had just got done receiving a shower, transferred to bath scale to weigh member, member raised his L (left)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility did not ensure pharmacy procedures were followed to identify an unaccounted for narcotic medication. This was observed with 1 (R2) of 4 resident medication reviews. R2 was missing a narcotic medication on 8/16/25 that was not discovered until 9/5/25.Findings include:The facility's policy and procedure titled Controlled Substances dated 7/1/2004. This documents under Procedures: 4.) At time of administration, the licensed nurse compares the last recorded remaining medication count in the Electronic Health Record (HER) with the bubble pack/ medication package and enters the new remaining count value after the ordered dose(s) is prepared for administration/application. The number being administered is also recorded in the appropriate column of the Controlled Substance Perpetual Inventory sheet.Surveyor reviewed a Facility Reported Incident (FRI) involving R2's medication. The FRI document on 9/5/25, during an audit, 1 tablet of Hydrocodone 5/325 milligrams was missing. The FRI investigation determined the 1 tablet was missing from 8/16/25. The root cause was not able to be determined. The facility's policy and procedures were not consistently followed to identify this missing medication with shift-to-shift narcotic counts. The FRI resolution was to follow through the Quality Assurance Program Improvement (QAPI) to monitor this process through audits. The Administration that conducted the FRI investigation is unavailable for interview. This pharmacy process was not included in QAPI for monitoring. On 12/2/25, at 10:34 AM, Surveyor interviewed Interim Director of Nurses (IDON) -B. The IDON-B is in the process of developing an audit for narcotic counts. The IDON-B did not have any additional information related to this FRI investigation.On 12/2/2025, at 3:09 PM, at the facility exit meeting with the Nursing Home Administrator (NHA)-A, Assistant Nursing Home Administrator(ANHA) -C and IDON-B. Surveyor shared the concern with the narcotic count process, No further information was provided.