

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525688	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER WI Veterans Home-Boland Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 21425 E Spring St Union Grove, WI 53182	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025</p> <p>Based on interview and record review, the facility did not ensure 2 (R25 and R38) of 2 injuries of unknown origin investigations that were reviewed were reported to the state agency.</p> <p>* On 11/8/24, R25 was discovered with a 15 cm by 6 cm bruise to left posterior axilla. The facility assumed it was from transferring R25 without a gait belt. This injury was not reported to the state agency.</p> <p>* On 10/15/24, R38 was discovered with a 7.5 cm by 4.4 cm bruise to the right upper arm. The facility assumed it was from R38 ambulating about the unit and hitting a walls and doorways. This injury was not reported to the state agency.</p> <p>Findings include:</p> <p>The facility's Abuse Prohibition and Investigation policy dated last revision on June 2021 documents:</p> <p>Definition: Injury of unknown source-an injury should be classified as an injury of unknown source when both of the following conditions are met:</p> <ol style="list-style-type: none"> 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the member and 2. The injury is suspicious because of the extent and size of the injury or the location of the injury, e.g. the injury is located in an area not generally vulnerable to trauma (face or any area covered by a swimming suit) or the number of injuries observed at one particular point in time or the incidences of injuries over time. <p>Policy: .</p> <ol style="list-style-type: none"> 2. When abuse is observed or suspected . <p>c. Report the allegation to the State Survey Agency and local law enforcement and Adult Protective Services as required by State and Federal law and regulations.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8. Reporting and Response.</p> <p>a. The facility will ensure that all alleged violations involving abuse, neglect, involuntary seclusion, exploitation or mistreatment, including injuries of unknown source and misappropriation of Member property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. No later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury are reported to the Commandant and to other officials (including to the State Survey Agency) in accordance with State law through established procedures.</p> <p>1) R25 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, Parkinson's disease, dementia and history of DVT (deep vein thrombosis).</p> <p>The annual MDS (minimum data set) dated 9/24/24 documents that R25 has severe cognitive impairment.</p> <p>The CAA (care area assessment) dated 9/24/24 documents that R25 needs supervision to limited assist of 1 with ADLs (activity of daily living): bed mobility, transfers, ambulation, hygiene, toileting and dressing. The CAA states that R25 can be both incontinent and continent of both bladder and bowel, that R25 is able to eat independently after set up, that R25 is able to self ambulate and transfer with walker and that R25 uses a wheel chair for longer distances at times.</p> <p>R25's nurses note dated 11/8/24 documents: Aid notified writer (R25) has bruise to left posterior axilla. Upon skin assessment, 15 cm (centimeters) by 6 cm dark purple bruise noted to area. (R25) denies pain. It appears as result of staff assisting with transfer.</p> <p>On 1/7/25 at 3:00 p.m., during the daily exit meeting with DON (Director of Nursing)-B and NHA (Nursing Home Administrator)-A, Surveyor asked for the investigation into R25's left axilla bruise that was documented in R25's nursing note dated 11/8/24.</p> <p>Surveyor received an incident note indicating R25 is on blood thinners and has a history of falling. The note also indicates that R25 needs assistance with standing and staff would assist R25 by placing their arms under his left side. The note documents that staff was educated in real time to use gait belt when helping R25 with transfers.</p> <p>On 1/8/25 at 9:06 a.m., DON-B explained to Surveyor they followed the injury of unknown origin flowchart as to whether they should report this incident to the state agency. DON-B stated they facility did not report this incident to that state agency. DON-B stated it was concluded that staff were assisting with transfers with R25 without a gait belt. Surveyor explained was there any training provided to the staff regarding the use of gait belt. DON-B stated training was done on the unit. Surveyor asked for the documentation of training. Surveyor explained the extent of the bruise and the fact R25 was not able state what happened is the definition of an injury of unknown origin.</p> <p>As of exit on 1/9/25, Surveyor did not receive any additional documentation as to why the facility did not report this injury of unknown origin to the state agency.</p> <p>2) R38 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, anxiety, and a pacemaker.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The quarterly MDS (minimum data set) dated 9/24/24 indicates R38 has severe cognitive impairment. R38 is independent with transfers and ambulation.</p> <p>R38's nurses note dated 10/15/24 documents: During routine shower skin check and identified a bruise to the upper right arm. Bruise was 7.5 cm (centimeters) by 4.4 cm and was purple towards the center and yellow at the edges. (R38) denies pain or discomfort to area.</p> <p>On 1/7/25 at 3:00 p.m., during the daily exit meeting with DON (Director of Nursing)-B and NHA (Nursing Home Administrator)-A, Surveyor asked for the investigation into R38 right arm bruise as documented in R38's 10/15/24 nursing note.</p> <p>Surveyor received a document indicating that due to R38 having poor safety awareness, a decline in cognitive abilities and ability to ambulate and transfer without assistance, R38 could have bumped her arm on a doorway or wall causing the bruise.</p> <p>On 1/8/25 at 9:06 a.m. DON-B explained to Surveyor they followed the injury of unknown origin flowchart as to whether they should report this incident to the state agency. DON-B stated they facility did not report this incident to that state agency. Surveyor explained the extent of the bruise and the fact R38 was not able state what happened is the definition of an injury of unknown origin.</p> <p>As of exit on 1/9/25 Surveyor did not receive any additional documentation as to why the facility did not report this injury of unknown origin to the state agency.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025</p> <p>Based on interview and record review, the facility did not ensure that 3 (R25, R38 and R43) of 7 facility investigations involving potential abuse thoroughly investigated.</p> <p>* R25 was discovered with a 15 cm by 6 cm bruise to left posterior axilla. The facility assumed it was from transferring R25 without a gait belt. A thorough investigation into the bruise and its origin was not completed.</p> <p>* R38 was discovered with a 7.5 cm by 4.4 cm bruise to the right upper arm. The facility assumed it was from R38 ambulating about the unit and hitting a walls and doorways. A thorough investigation into the bruise and its origin was not completed.</p> <p>* On 12-30-24 the facility investigated an allegation of potential neglect of R43 by Certified Nursing Assistant (CNA)-I. The facility failed to conduct a thorough investigation of the reported incident.</p> <p>Findings include:</p> <p>The facility's Abuse Prohibition and Investigation policy dated last revision on June 2021 documents:</p> <p>Definition:</p> <p>Injury of unknown source-an injury should be classified as an injury of unknown source when both of the following conditions are met:</p> <ol style="list-style-type: none"> 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the member and 2. The injury is suspicious because of the extent and size of the injury or the location of the injury, e.g. the injury is located in an area not generally vulnerable to trauma (face or any area covered by a swimming suit) or the number of injuries observed at one particular point in time or the incidences of injuries over time. <p>Policy:</p> <ol style="list-style-type: none"> 3. The facility staff shall investigate any allegations of abuse, mistreatment, verbal abuse, sexual abuse, physical abuse, mental abuse, neglect, exploitation, misappropriation of property, involuntary seclusion and injuries of unknown origin and shall report investigation results to appropriate agency in accordance with State and federal law. <p>1) R25 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, Parkinson's disease, dementia and history of DVT (deep vein thrombosis).</p> <p>The annual MDS (minimum data set) dated 9/24/24 documents that R25 has severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The CAA (care area assessment) dated 9/24/24 documents that R25 needs supervision to limited assist of 1 with ADLs (activity of daily living): bed mobility, transfers, ambulation, hygiene, toileting and dressing. The CAA documents that R25 can be both incontinent and continent of both bladder and bowel, that R25 is able to eat independently after set up, that R25 is able to self ambulate and transfer with walker and that R25 uses wheel chair for longer distances at times.</p> <p>R25's nursing note dated 11/8/24 documents Aid notified writer (R25) has bruise to left posterior axilla. Upon skin assessment, 15 cm (centimeters) by 6 cm dark purple bruise noted to area. (R25) denies pain. It appears as result of staff assisting with transfer.</p> <p>On 1/7/25 at 3:00 p.m., during the daily exit meeting with DON-B and NHA-A, Surveyor asked for the investigation into R25's left axilla bruise as documented in R25's nursing note dated 11/8/24.</p> <p>Surveyor received the incident note indicating R25 is on blood thinners and has a history of falling. It also indicates R25 needs assistance with standing and staff would assist R25 by placing their arms under his left side. Staff was educated in real time to use gait belt when helping R25 with transfers.</p> <p>On 1/8/25 at 9:06 a.m. Surveyor interviewed DON-B. Surveyor asked why was there no investigation into R25 significant bruise. DON-B stated it was concluded that staff were assisting with transfers with R25 without a gait belt. Surveyor explained was there any training provided to the staff regarding the use of gait belt. DON-B stated training was done on the unit. Surveyor asked for the documentation of training.</p> <p>Surveyor explained the extent of the bruise and the fact R25 was not able state what happened is the definition of an injury of unknown origin and there should have a thorough investigation completed on the source of the unknown injury. No staff or resident statements were provided to Surveyor.</p> <p>As of exit on 1/9/25, Surveyor did not receive any documentation that a thorough investigation was completed for R25's left axilla bruise as documented in R25's nursing note dated 11/8/24.</p> <p>2) R38 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, anxiety, has a pacemaker.</p> <p>The quarterly MDS (minimum data set) dated 9/24/24 indicates R38 has severe cognitive impairment. R38 is independent with transfers and ambulation.</p> <p>R38's nurses note dated 10/15/24 documents during routine shower skin check and identified a bruise to the upper right arm. Bruise was 7.5 cm (centimeters) by 4.4 cm and was purple towards the center and yellow at the edges. (R38) denies pain or discomfort to area.</p> <p>On 1/7/25 at 3:00 p.m., during the daily exit meeting with DON-B and NHA-A, Surveyor asked for the investigation into R38's right arm bruise as documented in R38's nursing note dated 10/15/24.</p> <p>Surveyor received a document indicating due to R38 poor safety awareness, decline in cognitive abilities and able to ambulate and transfer without assistance, R38 could have bumped her arm on a doorway or wall. Surveyor was not provided with any staff or residents statements as part of R38's investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/8/25 at 9:06 a.m. Surveyor interviewed DON-B. Surveyor asked DON-B why was a thorough investigation into R38 significant bruise completed. DON-B explained they just concluded it was because R38 bumped into walls or a doorway because she is ambulatory.</p> <p>Surveyor explained the extent of the bruise and the fact R38 was not able state what happened is the definition of an injury of unknown origin and an investigation should have been completed.</p> <p>As of exit on 1/9/25, Surveyor did not receive any documentation that a thorough investigation was completed for R38's left axilla bruise as documented in R38's nursing note dated 10/15/24.</p> <p>51016</p> <p>3.) On 01/09/25, at 08:40 AM, Surveyor reviewed the facility investigation dated 12/30/2024 which documented:</p> <p>Member (R43) needed to go to the bathroom and it felt more urgent than normal especially after waiting for a long time for a nurse call to be answered. CNA-I answered call but according to member said it was too busy to toilet and was told R43 could go in his pants, and CNA-I would clean him up later. CNA-I stated member usually goes in bed pan but did not offer because R43 appeared sleepy and left room and intended to check back later.</p> <p>Member (R43) may or may not have misunderstood CNA-I. CNA-I may have just told R43 to go in his pants or, CNA-I may have meant in the event R43 went in his pants; CNA-I would clean R43 up later. Either way it should not have been an issue. Even if the member was sleepy, he still needed to go to the bathroom and CNA-I should have provided a bed pan or arranged with the other CNA to assist with Hoyer to toilet R43, CNA-I did not prioritize R43's needs.</p> <p>CNA-I placed on Administrative Leave on Friday, 12/27/24, pending investigation.</p> <p>On 01/07/25, at 07:42 AM, Surveyor requested from Nursing Home Administrator (NHA)-A, the facility's self reported investigation and all information related to the investigation dated 12/30/24.</p> <p>On 01/07/25, at 03:10 PM, during the daily exit meeting with Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A, Surveyor asked if there was more information on R43's facility reported incident investigation dated 12/30/24. Surveyor requested any statements or interviews of other residents that had been cared for by CNA-I. Surveyor requested any education provided to CNA-I and all other staff regarding neglect and abuse prevention. NHA-A informed Surveyor they would look for this information and get it to the Surveyor.</p> <p>On 01/08/25, at 03:01 PM, Surveyor during exit meeting with DON-B, Assistant Director of Nursing (ADON)-E, Assistant Director of Nursing (ADON)-F and Assistant Nursing Home Administrator (ANHA)-C. Surveyor requested any staff education documentation for CNA-I and all staff related to neglect and abuse prevention. Surveyor requested any interviews or statements from other residents who were in the care of CNA-I. DON-B told Surveyor they would look for this information and give it to the Surveyor.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/09/25, at 10:19 AM, Surveyor interviewed ANHA-C about the self-report investigation dated 12/30/24 provided to the state agency regarding an incident between R43 and CNA-I. Surveyor asked ANHA-C if there were any resident interviews or staff education done related to this self-reported incident between R43 and CNA-I, investigation dated 12/30/24. ANHA-C informed Surveyor that no statements or interviews with other residents potentially under CNA-I's care were done.</p> <p>ANHA-C informed Surveyor, that no education had been found so far, but they would continue to look for the staff education on neglect and abuse prevention. Surveyor requested that the names of staff who were educated with sign off sheets and content of the education be included along with the dates the education was provided to the staff. Surveyor asked ANHA-C to confirm if no other interviews with residents were conducted related to the incident between CNA-I and R43 investigation dated 12/30/24. ANHA-C confirmed for the Surveyor that no interviews were done with other residents related to the incident between CNA-I and R43 investigation dated 12/30/24.</p> <p>At the time of exit on 01/09/2025 no further information was provided to Surveyor related to the incident between CNA-I and R43 investigation dated 12/30/24.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845</p> <p>Based on interview and record review, the facility did not refer all PASRR (Preadmission Screening and Resident Review) Level I residents with a possible serious mental disorder on admission or with a significant change in status assessment to the referring agency to complete the PASRR Level II for 1 (R17) of 1 residents reviewed for PASRR completion.</p> <p>* R17 had a change in condition level 1 PASRR screen, which indicated R17 has a major mental disorder, which would trigger a level 2 PASRR to be completed. A level 2 PASRR was not completed for R17.</p> <p>Findings include:</p> <p>1.) R17 was admitted to the facility on [DATE] with diagnoses of major depressive disorder, anxiety disorder, post-traumatic stress disorder (PTSD), and dementia.</p> <p>R17's Annual Minimum Data Set (MDS) dated [DATE], documents R17 has a Brief Interview for Mental Status (BIMS) score of 5, indicating R17 has severe cognitive impairment. R17's Annual MDS documents that R17 has anxiety disorder, depression, and PTSD and receives antidepressant medication and uses psychotropic drugs.</p> <p>Surveyor reviewed R17's Significant Change in Condition MDS, dated [DATE]. R17's MDS documents R17 exhibited physical behavioral symptoms directed towards others, verbal behaviors directed towards others.</p> <p>Surveyor reviewed the facility provided document, titled PREADMISSION SCREEN AND RESIDENT REVIEW (PASRR) LEVEL 1 SCREEN SUMMARY, with no date, that documents R17 has a major mental disorder, receives psychotropic medications to treat symptoms or behaviors of a major mental disorder and R17 is suspected of having a serious mental illness.</p> <p>On 01/08/2024, at 01:10 PM, Surveyor interviewed SW-D in the presence of ANHA (Assistant Nursing Home Administrator)-C. SW-D informed Surveyor that PASRR screens are done initially upon admission or change if a resident is put on psych medications. SW- indicated there was no level 2 screen for R17 previously. SW-D informed Surveyor that a level 2 PASRR is completed if a resident has any mental illness outlined in the DSM (The Diagnostic and Statistical Manual of Mental Disorders) 5. SW- informed Surveyor that it was a mistake, and that R17 should have had a level 2 PASRR completed.</p> <p>On 01/09/2024, during the exit conference with the facility, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above concern. No additional information was provided at that time.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011</p> <p>Based on observation, interview, and record review, the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 2 (R10 and R40) of 3 residents reviewed for pressure injuries.</p> <p>* R10 was found to have MASD (Moisture Associated Skin Damage) on 8/18/24 by an LPN (Licensed Practical Nurse) and there is no documentation that an RN (Registered Nurse) assessment was completed until 8/21/2024. No skin evaluation documentation was available for R10 between 8/18/24 and 8/21/24.</p> <p>* R40 had a care plan intervention in place to wear gripper socks due to a pressure injury to R40's heel. R40 was observed during the survey wearing shoes.</p> <p>Findings include:</p> <p>The Facility Policy titled Wound Prevention and Treatment Program last reviewed June 2021 documents (in part):</p> <p>Policy:</p> <p>-The wound prevention and treatment program shall include:</p> <p>Prompt assessment and treatment .</p> <p>-All Members shall have goals and approaches in their plan of care for prevention or treatment of skin breakdown initiated as soon as possible but within 2 hours of admission. It shall be reviewed and updated quarterly and at time of admission from hospital .</p> <p>-Whenever a non-blanching area or any skin change is identified:</p> <p>-It must be reported immediately to licensed staff.</p> <p>-RN Shall proceed with Root Cause Analysis, MD and family notification, and care planning to include active treatment plan as well as preventative measures to promote healing and prevent further skin breakdown .</p> <p>7. CNA (certified nursing assistant) staff provides care that reduces risk factors contributing to skin changes/pressure injuries as indicated on the MD (medical doctor) orders, plan of care and CNA Kardex.</p> <p>8. Prevention:</p> <p>a. Members at risk for skin impairment have skin care addressed in their care plan .</p> <p>Licensed staff: Initial Evaluation:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Initial evaluation of Member's wound shall be documented in EHR (electronic health record).</p> <p>a. Documentation includes complete description of findings including measurements, condition of peri-wound, condition of wound bed, percentage, and type of tissue (e.g., 40% yellow slough, 5% eschar, and 55% red wound bed), type/amount of drainage, presence, or absence of odor. Presence and level of pain, intervention effectiveness. Documentation also includes types of interventions and treatment to be started according to Skin Care Protocol .</p> <p>c. The following is initiated:</p> <p>i) Documentation of skin event by licensed nurse is completed in EHR.</p> <p>ii) Appropriate treatment is initiated per medical provider order.</p> <p>iii) Plan of care is started and/or updated, if indicated.</p> <p>iv) CNA: Kardex is updated with preventative measures: e.g., re-positioning schedules, change of mattresses .</p> <p>1.) R10 was admitted to the facility on [DATE] with diagnoses that includes spondylosis with myelopathy, thoracic region, neurogenic bowel, neuromuscular dysfunction of bladder and paraplegia.</p> <p>R10's Quarterly Minimum Data Set (MDS) with an assessment reference date of 11/21/2024 indicated R10 had a Brief Interview for Mental Status score of 15 (cognitively intact). R10 is responsible for self. For the question: did resident reject evaluation or care the MDS was coded as behavior not exhibited. R10 was coded as frequently incontinent of bowel and bladder.</p> <p>R10 had multiple Braden Scale for Predicting Pressure Score Risk evaluations completed. On 6/20/24 and 8/18/24, R10 was assessed as a high risk of developing a pressure injury. On 8/31/24 and 9/14/24, R10's risk of developing a pressure injury dropped to a moderate risk. Assessments done on 9/21/24, 9/28/24, 10/6/24, 10/29/24, 11/5/24, 11/9/24 and 11/20/24, read that R10 is at risk of developing a pressure injury.</p> <p>R10's progress note written on 8/18/24 by LPN-M documents: CNA (certified nursing assistant) reported open areas to member's buttocks. Assessed area and noted 3 open areas to right buttocks and right gluteal. Area pink, with scant amount of serosanguinous drainage on brief, no odor. Measurements of open areas 1. 0.5 x 0.5cn is size 2. 1.0 x 1.0cm in size and 3. 0.4 x 0.4cm in size. O/A (open area) 1. on top and 2. middle and 3. bottom. Applied Zinc Oxide f/b (followed by) Mepilex dressing. Updated charge RN. Notified on call APNP (advanced practice nurse practitioner) and see new order for Zinc Oxide f/b Mepilex dressing and wound nurse to assess area.</p> <p>On 8/19/24, RN-L wrote a progress note that reads Open area documented in POC (plan of care), nurse review and follow-up needed. Order in place, wound team to assess 08/21/24.</p> <p>On 8/20/24, RN-L wrote a second progress note that reads Open area documented in POC, nurse review and follow-up needed. not new treatment in place.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/21/24, RN-L wrote a third progress note that reads: Open area documented in POC, nurse review and follow-up needed. Treatment in place, wound team to assess today.</p> <p>On 8/21/2024 a Weekly Wound Observation Tool evaluation was completed for R10 by the wound nurse. The date acquired was recorded as 8/18/2024. Surveyor notes this is the first completion of a comprehensive assessment of the wound by a RN.</p> <p>Surveyor noted the MASD discovered on 8/18/24 was upgraded to a stage 3 pressure injury on 10/23/2024.</p> <p>On 01/09/25, at 09:32 AM, Surveyor interviewed Nursing Instructor-K regarding the MASD found on 8/18/2024. Surveyor asked if there were any RN assessments completed before the wound nurse saw R10 on 8/21/2024. Nursing Instructor-K agreed that there were no RN assessments done after the MASD was found by LPN-M until the wound nurse saw R10 on 8/21/2024.</p> <p>On 01/09/25, at 09:45 AM, Surveyor interviewed Director of Nursing (DON)-B about the MASD found on 8/18/24 and no RN assessment completed until 8/21/24. DON-B acknowledged and was going to look into issue.</p> <p>No additional information was provided as to why no RN assessment was completed for R10's MASD when it was found on 8/18/24.</p> <p>49845</p> <p>2.) R40 was admitted to the facility on [DATE] with diagnoses that include long term use of insulin, pressure ulcer left heel stage 2, hemiplegia and hemiparesis affecting the left side.</p> <p>R40's Admission Minimum Data Set (MDS), dated [DATE], documents R40 has a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact), requires partial/moderate assistance putting on/taking off footwear, and is at risk for pressure ulcers.</p> <p>R40's most recent quarterly MDS, dated [DATE], documents R40 did not exhibit any behaviors or refusals of care and that R40 is at risk for the development of pressure ulcers. The Skin and ulcer treatments section documents that R40 uses pressure reducing devices and has the application of ointments/medications to R40's body.</p> <p>On 01/06/2025, at 10:57 AM, Surveyor interviewed R40. R40 indicated to Surveyor that R40 has a wound on his foot for about a month and is unsure how it developed. R40 pointed to R40's left foot, Surveyor noted R40 wearing black shoes and socks, unable to see R40's wound.</p> <p>Surveyor reviewed R40's wound assessments, and noted R40 was discovered to have a stage 2 pressure injury on 11/09/2024. The following are the documented wound assessments:</p> <p>11/10/2024- left medial heel, stage 2 pressure injury, 100% granulation, no drainage length- 1.2 cm (centimeters), width 1.3 cm, depth 0.1 cm.</p> <p>11/20/2024-left medial heel, stage 2 pressure injury, 100% slough, moderate serosanguinous exudate. Length 2.5 cm, width 2.8 cm, depth 0.2 cm.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11/27/2024- left medial heel, stage 2 pressure injury, 20% granulation 80% devitalized tissue, moderate seranguinous exudate. Length 2.3cm, width 2.8 cm, depth 0.2 cm. slight redness induration, slight warm-obtained order for culture swab when culture swabs obtained from diagnostics.</p> <p>12/04/2024- left medial heel, stage 2 pressure injury, 30% granulation, 70% eschar, light sersanguinous exudate. Length 2.5 cm, width 2 cm, and no documented depth. Doxycycline Monohydrate oral tablet 100mg BID LD 12/16</p> <p>12/11/2024- left medial heel, stage 2 pressure injury, 100% fibrous tissue. Length 2.5cm, width 2.3 cm, depth 0.3 cm.</p> <p>12/18/2024-left medial heel, stage 2 pressure injury, 100% fibrous tissue. Length 2.2 cm, width 2.4 cm, depth 0.3 cm.wound debrided today. Tolerated procedure.</p> <p>12/25/2024- left medial heel, stage 2 pressure injury, 100% fibrous tissue. Length 2.2 cm, width 2.4 cm, depth 0.3 cm.</p> <p>01/03/2024- left medial heel, stage 2 pressure injury, 100% fibrous tissue. Length 2 cm, width 2.4 cm, depth 0.4 cm. wound MD debrided & silver nitrated wound today.</p> <p>Surveyor noted the current wound size on 01/08/2024 when assessed by Wound MD-P for R40's pressure injury was length 2.5 cm, width 2.2 cm, depth 0.8 cm.</p> <p>Surveyor noted an increase in length and depth since previous wound assessment.</p> <p>Surveyor reviewed R40's care plan and noted R40 is care planned for potential impairment to skin integrity with an intervention in place of 11/10/24: Gripper sock on at all times except for appointments.</p> <p>Surveyor observed R40 wearing socks and shoes on 2 separate days, 01/06/2024 and 01/08/2024, when resident was not leaving for an appointment.</p> <p>On 01/08/2024, at 10:09 AM, Surveyor observed the facility's wound team preform wound care of R40's left medial heel pressure injury. Surveyor noted the dressing currently on R40 did not have initials or date to indicate the last time wound treatment was done.</p> <p>Surveyor reviewed R40's Treatment Administration Record (TAR) for January 2025.</p> <p>R40's physician order dated 11/20/24 documents: Cleanse wound to left lateral heel with wound cleaner, dry, skin prep to surrounding tissue apply small amount of Medi-Honey to wound bed f/b calcium alginate f/b ABD pad, secure with Hypofix tape daily and PRN at bedtime for Wound care.</p> <p>Surveyor noted that from 01/01/2024 through 01/06/2024, R40 had wound treatment administered only 1 time, due to refusals and or R40 being out of the Facility.</p> <p>On 01/08/2024, at 10:36 AM, Surveyor interviewed R40. Surveyor asked R40 if R40 prefers not to wear gripper socks while in the facility. R40 indicated to Surveyor that staff just puts R40's shoes on in the morning while R40 is in bed and R40 denied refusing to wear gripper socks.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed R40's medical record and care plan, Surveyor noted there is 1 progress note addressing R40's refusal to wear gripper socks and no care plan for R40 regarding refusal of wearing gripper socks or that a risk versus benefits assessment was provided to R40.</p> <p>On 01/08/2024, at 02:24 PM, Surveyor interviewed CNA-O. CNA-O informed Surveyor that R40 wears socks and shoes everyday that CNA-O is working. CNA-O indicated to Surveyor that CNA-O has been working at the facility since September 2024. CNA-O indicated care plans and Kardex are used to look at resident information. CNA-O was not aware R40 is care planned to wear gripper socks instead of shoes when not going out for appointments. Surveyor encouraged CNA-O to review R40's careplan.</p> <p>On 01/08/2024, ay 02:26 PM, Surveyor interviewed LPN-Q. LPN-Q indicated R40 is supposed to wear gripper socks unless going out for an appointment, but refuses gripper socks and boots sometimes.</p> <p>On 01/08/2024, at 03:11 PM, Surveyor informed DON-B, ANHA-C, ADON-E and ADON-F of above findings.</p> <p>On 01/09/2024, at the exit conference Surveyor informed NHA-A (via phone), DON-B, ANHA-C, ADON-E and ADON-F, of the above findings. No additional information was provided.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845</p> <p>Based on interview and record review, the facility did not ensure 1 (R7) of 9 residents reviewed received adequate supervision, interventions to prevent accident hazards.</p> <p>* R7 did not have a Registered Nurse assessment status post a fall that caused a fracture of R7's left arm.</p> <p>Findings Include:</p> <p>The Facility's policy titled, [name of facility] Member Falls, with a last review date of 06/2021, documents in part, . After a Fall: 1) The Member is examined head to toe by an RN (Registered Nurse) before being moved, unless the Member is uncooperative, or needs to be moved because of danger in the environment.</p> <p>1.) R7 was admitted to the facility on [DATE] and has diagnoses that includes dementia.</p> <p>R7's Significant change Minimum Date Set (MDS), dated [DATE], documents a BIMS (Brief Interview for Mental Status) score of 09, indicating R7 has moderate cognitive impairment. The MDS also documents R7 has impairment on one side of lower extremity and uses cane/crutch and wheelchair for mobility purposes.</p> <p>R7's progress note written by LPN (Licensed Practical Nurse)-R, dated 08/26/2024, at 7:50 PM, documents: Member stumbled when writer approached member on his right side heading towards the nurse's station and member fell and landed on his left side. Member said he got startled when writer approached on his right side. Called charge nurse and assessed for injury. Member c/o (complains of) pain to left elbow and no swelling noted, but slight redness noted at time of fall. Member ROM (range of motion) WNL (within normal limit) at time of fall. Member gotten up from floor without difficulty. Continues to c/o pain to left elbow and left wrist tender with touch. Noted swelling to left elbow and pain with ROM. Obtained order for x-ray of left elbow and left wrist. Scheduled acetaminophen 975mg (milligrams) was given.VITALS: BP (blood pressure) 154/69 - 8/27/2024 00:39 (12:39 AM)Position: Sitting r/arm P (pulse) 63 - 8/27/2024 00:40 (12:40 AM) Pulse Type: Not Applicable T 98.2 - 8/27/2024 00:40 (12:40 AM) Route: Forehead (non-contact) R (respirations) 20 - 8/27/2024 00:40 912:40 AM) O2 (oxygen saturation) 96 % - 8/27/2024 00:40 (12:40 AM) Method: Room Air; FOLLOW-UP: New intervention implemented and added to TPOC. Staff make them self known when approaching member</p> <p>R7's progress note dated 08/27/2024, at 01:50 AM, documents R7 complained of increased left elbow pain with slight swelling and minimal redness. Received order for stat xray of left elbow and left wrist from on call Nurse Practioner (NP).</p> <p>R7's progress note dated 08/27/2024, at 08:20 AM, documents R7's family member would like R7 to be sent to the emergency room for xrays due to the long wait time for the mobile xray to come to the Facility. Surveyor noted R7 was sent to the emergency room at 10:00 AM for xrays.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R7's progress note, dated 08/27/2024, at 04:00 PM, documents, Health Status Note Text: Member returned from [name of hospital] at 1505 (3:05 PM) with a splint to his left arm and a sling in place, member denies pain. See Imaging report of X-rays that were obtained- XR (x-ray) left forearm 2 views, XR left elbow 1 view, XR left humerus 2 views, XR left hand 3 views- left elbow showed single limited view, with possible nondisplaced fracture of the radial head. Discharge instructions: Member to have follow-up scheduled with Orthopedics, and a referral was made. Tylenol/Ibuprofen for pain. Rest, ice, elevate. Wear sling. Do not get splint wet. Return to the ER (emergency room) with any new or worsening symptoms. NP made aware. Members daughter HC-POA (healthcare power of attorney) was notified. POC (plan of care) updated.</p> <p>Surveyor reviewed R7's document, titled AFTER VISIT SUMMARY, dated 08/27/2024, and documents, R7 was seen in the emergency room and diagnosed with Fall, Left arm pain, and closed nondisplaced fracture of head of left radius. Instructions document, Follow up with orthopedics, Tylenol/Ibuprofen, rest, ice, elevate, wear sling, do not get splint wet and return to the emergency room with any new or worsening symptoms. A fiberglass cast was put on R7.</p> <p>Surveyor reviewed the document, titled MEDICAL PROVIDER CONSULTATION, dated 08/30/2024, which documents R7 was evaluated by an Orthopedic doctor. Findings include, fracture of the left radial head (elbow), recommendations include: sling at all times, remove 5-6 times a day for active range of motion of elbow, encourage range of motion in wrist and fingers and avoid weight bearing to left hand for 4-6 weeks. Follow up in 3-4 weeks for recheck.</p> <p>Surveyor reviewed the document, titled MEDICAL PROVIDER CONSULTATION, dated 10/29/2024, and documents R7's left radial head fracture is healed, may use left arm as tolerated, and follow up as needed.</p> <p>Surveyor noted no RN assessment after R7's fall could be located in R7's medical record.</p> <p>Surveyor reviewed the Facility provided document, titled FALL CHECKLIST, and noted LPN-R completed the check list on 08/26/2024.</p> <p>On 01/08/2025, at 03:11 PM, Surveyor informed DON-B, ADON-E, ADON-F and ANHA-C of above findings. Surveyor requested the timeline and RN assessment for R7's fall. DON-B indicated DON-B would gather that information for Surveyor.</p> <p>On 01/09/2025, at 10:44 AM, Surveyor inquired to DON-B regarding R7's RN assessment for R7's fall.</p> <p>On 01/09/2025, at 10:56 AM, Surveyor interviewed Nursing Educator-S. Nursing Educator- provided Surveyor a document titled, Witnessed Fall prepared by LPN-R, and highlighted called charge nurse and assessed for injury. Nursing Educator-S informed Surveyor the post fall head to toe RN assessment cannot be located.</p> <p>On 01/09/2025, at 11:06 AM, DON-B informed Surveyor that Nursing Educator-S gave Surveyor what the Facility has for R7's fall assessment. DON-B indicated LPN-R was the one on the floor. DON-B indicated the expectation is the LPN will call charge Nurse or RN, RN will come and assess resident before getting the resident up after a fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/09/2025, at 11:22 AM, Surveyor interviewed LPN-R. LPN-R indicated that R7 lost balance and fell . LPN-R then called charge nurse over, got R7 up, and assessed him over. LPN-R indicated that if someone falls, get the RN to help assess the resident, if resident cannot get up, suppose to get a lift to help and monitor after fall for 9 shifts. The LPN can chart the fall and the RN must put in an entry too as it is the RN the one LPN's report falls to. LPN-R indicated no education was provided to staff after the fall. LPN-R indicated LPN-R could not remember exactly, but they will usually assess resident while on the floor post fall.</p> <p>On 01/09/2025, at 11:31 AM, Surveyor called RN via phone, and left message for RN to call Surveyor back.</p> <p>On 01/09/2025, during the exit conference, Surveyor informed the Facility of above findings.</p> <p>No additional information was provided as to why R7 did not have an RN assessment completed after R7's fall on 8/27/2024.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845</p> <p>Based on interview and record review the Facility did not ensure residents maintained acceptable parameters of nutritional status for 1 (R17) of 1 residents reviewed for weight loss.</p> <p>R17 sustained a 4.8% weight loss over a period of 7 days. The Physician was not consulted with, no assessment or evaluations were conducted.</p> <p>Findings include:</p> <p>R17 was admitted to the facility on [DATE] and has diagnoses which include major depressive disorder, anxiety, hypothyroidism, and dysphagia.</p> <p>On R17's Quarterly Minimum Data Set (MDS) assessment, dated 12/05/2024, documents R17 was assessed as having moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 10. R17's MDS indicates R17 has a weight loss of 5% or more in the last month or loss of 10% or more in 6 months. R17's MDS indicated R17 is on a mechanically altered diet and therapeutic diet.</p> <p>R17's care plan documents, R17 has a nutritional problem or a potential nutritional problem related to a past history of colon cancer, colectomy, hyperlipidemia, dentures, multiple stents, gastroesophageal reflux disease (GERD), atrial fibrillation, recurrent urinary tract infections (UTIs), vitamin B deficiency, increased confusion, and history of open area to right gluteal fold. R17's care plan also documents, trigger weight loss over 1 month on COC (Change of Condition) MDS Sept (September) 2024. Wt (weight) loss over 6 months Nov (November) 2024, Dec (December) 2024 MDS. Surveyor noted interventions include, Monitor/record/report to MD (Medical Doctor) PRN (as needed) s/sx (signs/symptoms) of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight change > (greater than) 5% in 1 month, >7.5% in 3 months, >10% in 6 months. Date Initiated: 06/14/2018</p> <p>Surveyor reviewed R17's documented weights and noted R17's most current weight, dated 01/04/2024 documents 152.4 lb. (pounds) Surveyor noted on 12/21/2024 R17's weight was documented as 160.0 lbs and on 12/28/2024 152.2lb. Surveyor noted this is a 4.8% weight loss in 7 days.</p> <p>Writer noted the facility did not consult with R17's physician to identify appropriate interventions on 12/28/24 when R17 was documented to have a 4.8% weight loss in 7 days.</p> <p>On 01/09/2024, at 08:49 AM, Surveyor interviewed Dietician-N in the presence of Assistant Nursing Home Administrator (ANHA)-C. Dietician-N indicated to Surveyor R17 had a weight loss of 8 lbs in 1 week. Dietician-N indicated that amount of weight loss in 1 week would require notifying the MD and R17's Power of Attorney. Dietician-N indicated no notifications have been made yet. Dietician-N informed Surveyor Dietician-N was out of the office until 01/02/2024. Surveyor asked Dietician-N who would be responsible for noticing a weight change when Dietician-N is not at the Facility. ANHA-C indicated nursing staff would be responsible for making notifications to MD in absence of Dietician to get process/interventions started.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/09/2024, at 11:09 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B indicated to Surveyor the nurse or charge nurse assigned to the floor can see grafts when entering weights to recognize changes in weights and are expected to report to DON-B and notify MD of changes.</p> <p>On 01/09/2024, during the exit meeting with the Facility, Surveyor informed Nursing Home Administrator (NHA)-A (via phone), DON-B, ANHA-C, ADON-E, ADON-F know about the above concerns. No further information provided at that time.</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0868</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>49845</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on record review and interview, the facility did not ensure there was a QAPI (Quality Assurance Performance Improvement) meeting held at least quarterly with the required committee members in order to identify issues through the committee. This deficient practice had the potential to affect all 64 residents currently in the facility.</p> <p>Findings include:</p> <p>On 01/09/2025, at 08:16 AM, Surveyor reviewed the facility's QAPI attendance sign in sheets provided by the Facility.</p> <p>On 01/09/2025, at 11:36 AM, Surveyor interviewed Director of Nursing (DON)-B and Assistant Nursing Home Administrator (ANHA)-C regarding the QAPI Committee and documents provided. During interview Surveyor asked which months the Facility holds their Quarterly QAPI meetings. DON-B and ANHA-C were unable to tell Surveyor which months Quarterly QAPI meetings are held, based on provided QAPI documents. Surveyor noted Quarterly QAPI meeting minutes dated January 2024 for months October, November, December 2023.</p> <p>Surveyor was provided a document, titled Quarterly QI (Quality Improvement) Meeting Minutes April 2024. On the document, written in pen documents Combined didn't have consistent upper management did Data for Jan (January) Feb (February) Mar (March) together.</p> <p>The Facility was unable to provide attendance logs for 2 of 4 Quarterly QAPI meetings.</p> <p>On 01/09/2025, at 12:38 PM, ANHA-C informed Surveyor that ANHA-C called the staff person who was here during the other two quarters that are missing QAPI meetings, and there are no attendance logs for those quarters.</p> <p>On 01/09/2025, during the exit conference, Surveyor informed the Facility of the above concerns. NHA-A was present by phone. NHA-A informed Surveyor that NHA-A would get the QAPI information from another person who files that information.</p> <p>No other information has been provided.</p>		