STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525351	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA PINES LIVING CENTER	**201 PARK ST, PO BOX 130 FRIENDSHIP, WI 53934**

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from sexual abuse for 2 of 48 residents (R2 and R3) as staff observed R1 inappropriately touching R3's private area and observed R1 with his hands moving under sheets by R2's private area. The facility failed to: 1. Implement a policy on one to one monitoring/supervision and educate all staff on one to one supervision/monitoring. 2. Staff did not provide adequate supervision to keep further abuse from occurring. 3. Staff did not ensure R1's sexual behaviors were captured in behavior tracking documentation. 4. Staff did not update R3's care plans with intervention to ensure his safety. Using the concept of a reasonable person, women and men don't want to be touched by strangers and would feel threatened, unsafe and vulnerable if unable to defend themselves from unwanted sexual advances. R2 and R3 are vulnerable and unable to protect themselves. The facility's failure to keep residents free from sexual abuse created a finding of Immediate Jeopardy (IJ), beginning on 3/31/20. On 7/29/20 at 12:30 PM, NHA A (Nursing Home Administrator) was informed of the IJ. The facility removed the jeopardy on 8/6/20; however, the deficient practice continues at a scope/severity of D as the facility continues to implement its action plan. Evidenced by: The facility's Abuse policy, revision date of 9/16/17, includes, in part: . sexual abuse is non-consensual sexual contact of any type with a resident. Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation .includes verbal abuse, sexual abuse, physical abuse, and mental abuse . The facility will make all efforts to protect all residents after alleged abuse, neglect, and/or exploitation .Temporary separation from other residents if resident's behavior poses a threat of abuse . Temporary or permanent room change . involve family members to sit with resident . Temporary one-on-one supervision . R1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R1 has an APOAHC (Activated Power of Attorney for Health Care) in place. R1's most recent MDS (Minimum Data Set), with ARD (Assessment Reference Date) of 5/20/20, indicates he ambulates and toilets independently. It also indicates R1 is cognitively intact with a BIMS (Brief Interview for Mental Status) score of 14 out of 15. R1's Comprehensive Care Plan, initiated on 1/9/20, includes, in part: . 1/9/20 targeted behaviors: difficulty sleeping, difficulty falling asleep, verbalizes sadness, crying, impulsive, restless, and exit seeking . R1's Nurse Note, dated 3/12/20, indicates at 10:10 PM R1 was found in an adjoining room, sitting on R3's bed. During an interview on 7/28/20 at 4:30 PM, RN C indicated CNA D reported the incident to her and when she went in to the room, R3 was asleep and R1 was back in his room. DON B was notified and spoke to RN C. DON B indicated during an interview she decided to not investigate further due to no contact being observed by staff. (It is important to note CNA D is no longer employed by the facility and the facility's contact information for her was not current.) Incident 1. R1's Nurse Notes, dated 3/31/20, indicate there is an ongoing investigation as R1 was witnessed in (R2)'s room that visually looked like he was touching (R2's) crotch . R1 placed on one-on-one as of 3:35 PM. R2 was admitted to the facility on [DATE]. His MDS, dated [DATE], indicated R2's cognition was severely impaired with a BIMS score of 00 out of 15. Investigation, dated 3/31/20, includes, in part: CNA E statement: I was walking in the hallway going pass R2's room and I seen (R1) in R2's room. R1 was bent over by R2 with his hands by his crotch and moving his hands around down there by crotch area. I said (resident name) and startled him. R1 was coming out of the room and he said he needs to be covered up. I told R1 he needs to go sit down. I checked on R2 and covered him up to make sure he was safe and went to my supervisor to let her know what happened. DON B statement: CNA E came to my office stating she found R1 in R2's room. R2 was in bed. She found R1 bent over R2 and R1's hands were near R2's crotch. I asked her if R1 touched R2's skin and she stated she did not see that R1 touched his skin. One-on-one began immediately . R1's statement: Just trying to cover him up. R1 indicated he saw R2 trying to play with himself and he went to cover R2 with a sheet so his private area could not be seen from the door. R1 denied touching R2 inappropriately. Conclusion: On 3/31/20 CNA E was walking down the hall . and noted R1 was in room of R2. Both residents reside on the (same) wing. She observed that R2 was in bed and R1 was leaning over and his hand was near R2's crotch area. CNA E did not actually see R1's hand on R2 but saw the movement of the sheet. R2 is unable to articulate and his BIMS of 0 . We were unable to substantiate or not substantiate that there was any inappropriate action. For safety of all residents R1 will continue to be on one-on-one observation. On 7/29/20 at 2:30 PM during an interview with Surveyor, CNA E indicated on 3/31/20 around 3:30 PM she was walking pass R2's room and observed R1 was in R2's room. CNA E indicated she observed R1 was standing bent over R2 who was lying in his bed. CNA E stated, R1 was fondling down there. No skin on skin, but I could see sheets moving down there. CNA E indicated R2's brief was on, but opened and he also had on a gown. CNA E indicated R1's hand was in sheets and they were moving up and down by R2's private area. CNA E removed R1 and reported this immediately. R1's Nurses Notes, dated 4/1/20, include, in part: R1 found lying in bed on his left side with no shirt on and with his pants and underwear pulled down to his knees masturbating. Resident was allowed privacy and instructed to inform staff when it is ok to return to room. R1's Nurses Notes, dated 4/18/20, include, in part: R1 was walking in hall with supervision. Reported R1 kept putting his hand down his pants .Writer stopped R1 from touching R2. Again writer reminded R1 of social distance and no touching other residents. R1 then went to his room and proceeded to cat call [MEDICATION NAME] at staff for about 30 minutes. R1's Fall Report, dated 5/4/20, indicates R1 had an unwitnessed fall on 5/3/20 at 7:00 PM. Review of post fall findings, in this report, include, in part: . Describe new fall prevention interventions to be implemented as a result of the assessment: closer observation with one-on-one staff . List suggestions of referrals to be made as a result of the fall: closer observation of staff, also if resident felt dizzy he should sit back down and use call light for assistance. Always have call light close by. On 7/28/20 at 4:10 PM during an interview with Surveyor, CNA F stated, I left to break in the breakroom. I told CNA G to watch him. He fell while I was on break. On 7/28/20 at 4:20 PM, Surveyor interviewed CNA G stated, I remember the fall. I was in a resident's room and heard a noise. I came out and found R1 on the floor by the kiosk machine, in hall. CNA F, the unit helper was one-on-one with R1. She was warming up her food in the break room. I was watching him to the best of my ability. CNA G indicated she was not one-on-one with R1, because she had other residents to care for on that hall. Progress Notes, dated 5/6/20, indicate the Interdisciplinary Team met and discussed R1's fall. They suggest to continue one-on-one supervision. (It is important to note there was no one-on-one with R1 at the time of his fall. R1 was care planned to have one to one supervision related to his sexual behavior toward others.) Incident 2. Progress Notes, dated 5/11/20, include, in part: Call placed to R1's power of attorney and medical doctor to update incident of inappropriate touching of R3. Notified medical doctor of psych consult and new orders. This resident will be moved to room [ROOM NUMBER] with a private bathroom today. Of note R1 had a shared bathroom with R3. R3 was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. R3's MDS, with ARD of 3/10/20, indicates R3 is moderately cognitively impaired with a score of 12 out of 15. R3's MDS also indicates he requires limited assistance by one staff member for toileting and transferring. R1's Incident Report, dated 5/11/20, includes, in part: Housekeeper H's statement: Around

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

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.

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) 9:45-10:00 AM I was cleaning in R3's room when R3 went into his bathroom. R1 went into his room (they share a bathroom), then R1 closed his door. I heard the door handle on R1's side. I checked on R3 and caught R1 with his hand moving towards R3's privates. R1 was seen leaning on the toilet riser bar with one hand and the other hand on R3's lower abdomen, reaching, for the unknown. R1 was eye level with R3. R1's clothing was intact. I watched for maybe just a couple of seconds, then I yelled, (Resident Name) what are you doing, you don't touch him there. R1 said he was helping him. R3 was already on the toilet so I don't know what he would have been helping him with. I told R1 to get out of the bathroom. R1 left right away and went back to his room. I told UH I (Unit Helper) to keep an eye on him and I ran to get or tell DON B. UH I's statement: .an incident happened with patient, R1, around 10:20 AM. R1 went to his room around 10:19 AM after visiting with this writer. R1 shut his door as usual. As I was sitting at my post when the housekeeper, Housekeeper H, went in R3's room. About thirty seconds later I heard yelling coming from R3's room, I walked in. All I seen was the housekeeper standing there and R3 sitting on the toilet. That is when the housekeeper told me she heard something in the bathroom when opening the door. She seen R1 playing with himself in front of R3. But I did not hear a thing such as yelling or screaming, not even an alarm, until then. I did not witness R1 in there. (It is important to note UH I is assigned to be one-on-one with R1 at the time of this incident.) Police report, dated 5/11/20, includes, in part: . Housekeeper H stated she witnessed R3 go into the bathroom in his room. She stated R1 and R3 share a bathroom . but have their respective rooms. She stated after R3 went into the bathroom, she noticed R1 go into his room and close the door. Housekeeper I stated she was concerned with R1's behavior at that point and decided to stay in the area and continue to clean. She stated just a few moments later she heard another door click, the sound of latching, in R1's room. She stated she found this to be suspicious and went to check on R3. She stated as she entered R3's room, the bathroom door was cracked approximately one to two inches. She stated she asked R3 if he was okay and received no response. She stated she then entered the room and observed R3 seated on the toilet with his pants and diaper down to the ground and R1 standing above him with his hand in the groin area of R3. Housekeeper H stated she immediately asked R1 what was going on. She stated he replied with he was helping him use the restroom. Housekeeper H stated she never observed any staff members assisting R3 using the restroom and believed R1 was not being truthful about why he was in the bathroom with R3. I asked Housekeeper H to explain to me more about R1's hand positioning while he was in the restroom with R3. She explained R1's hand was touching the private parts of R3 while he was seated on the toilet. She states R1 was moving his hands up and down . She stated R1 usually liked his door closed and she believed this was the reason why he always wants the door closed . I asked Housekeeper H if R1 was saying anything to R3 when he was touching him. Housekeeper H stated she believed R1 was saying something to him, however, she could not determine what he was saying . A short time later . A following is a list of questions followed by R3's response to each question: . Were you in the bathroom this morning? Yes. Do you need help going to the bathroom? Yes, need help changing the diaper. Were you touched on your private parts? No. One man tries to touch. Who? One of the nurses touched himself. I have to slap his hands away. R3 commented that he has noticed a lot of gay men in this town . Do you trust that man? No. R3 stated that he will have to live in a home for the rest of his life because he can't take care of himself. Is there anyone you trust here? Not really. R3 commented the lady nurses touch him as well, but implied for cleaning purposes. Why does the man touch your privates? Homosexual Does he leave? Sometimes. Can the man walk on his own? Yeah. Would you recognize the man again? R3 responded that he doesn't want to get the man in trouble but he doesn't want him around his family. Does he talk to you when he is touching you? Tries to. How many times has he touched you? I don't know. Has he done anything else besides touching? No, look at me. I'm not a kid. Sometimes I have to say no more than once. Then my voice changes and I tell him to knock it off, then he stops. On 7/28/20 at 1:30 PM during an interview with Surveyor, Housekeeper H indicated she was mopping R3's floor when he walked into his bathroom. Housekeeper H indicated she walked out of the room to give R3 privacy to go to the bathroom and on her way out of room, Housekeeper H shut door, leaving it open a crack. Housekeeper H indicated she stood in the hallway, outside of R3's room and UH I was sitting in a chair in hallway. Housekeeper H stated, R1 was in hallway walking and he saw R3 going into his bathroom. R1 then B lined into his own room and shut the door. Housekeeper H indicated this is when she suspected something was not right. Housekeeper H told UH I to go check on the two men, but UH I did not move. Housekeeper H then heard a sound of a latching bathroom door from R1's room. Housekeeper H stated, UH I didn't go. He stayed on his post so I did it myself. Housekeeper H indicated she entered R3's room and called through the bathroom door, Is everything ok? She did not receive a response so she opened the door. Housekeeper H indicated R3 was seated on the toilet with his pants and brief on the floor and R1 was bent over at eye level facing R3. Housekeeper H stated, His hand was down under and going. Housekeeper H stated she watched for a couple seconds and then yelled at R3 to stop what he was doing. On 7/28/20 at 1:50 PM during an interview with Surveyor, UH I indicated he does not have physical contact with residents in his position. UH I indicated he was assigned to one-on-one supervision of R1 and this means UH I sits outside of R1's room and waits for him to come out. Then UH I walks with R1 and makes sure he doesn't get too close with others. UH I stated on 5/11/20 he saw R3 go into his bathroom while Housekeeper H was mopping in his room. UH I stated when the doors were open, he could see into both rooms (R1 and R3's) from his post/chair in hallway. UH I indicated R1 went into his room to take a nap and he didn't worry about him. Then he heard Housekeeper H yelling. When UH I entered the shared bathroom, R1 was in his own room, R3 was on the toilet, and Housekeeper H said to him R1 was touching himself. UH I indicated Housekeeper told him to stay there and R3 and she was going to report it. The facility did not have a policy on what one-to-one supervision entailed, and staff had different understanding of what it meant. On 7/28/20 at 2:00 PM during an interview, DON B indicated the facility did not have a policy of what one-on-one supervision meant. DON B indicated one-on-one supervision means in line of sight when outside of room. Surveyor asked about R1 in his room. DON B indicated the facility staff respect R1's privacy. DON B indicated R3's door was to remain open at all times. Surveyor asked if this was care planned. DON B and Surveyor reviewed care plan and DON B stated, It isn't but it should have been. On 7/28/20 at 2:10PM during an interview NHA A indicated the facility does not have a policy on one-on-one supervision and to her it meant eyes on at all times. NHA A indicated UH I should have made sure R1 was not behind closed doors with another resident, in this case, R3. On 7/28/20 at 11:22 AM during an interview Business Officer Manager K (BOM K) indicated one-on-one supervision is to watch R1 while he is in the hallway and it is ok for him to have the door shut while he is in his room. On 7/28/20 at 4:10 PM CNA F indicated one-on-one supervision means to watch R1 and make sure he is safe and not misbehaving, because he is inappropriate with female staff and other residents. On 7/28/20 at 4:20 PM CNA G indicated one-on-one supervision means to watch resident at all times and know where he is, but she was not able to do this at all times due to other resident's on hallway needing assistance too. R1's Psych Initial Visit Note, dated 5/11/20, includes, in part: . R1 is requiring one-on-one supervision due to his impulsivity and sexual inappropriateness. He had been reported to have touched two other residents inappropriately .R1 exhibits the following moderate symptoms: Sexually inappropriate behavior has occurred. Poor judgement is creating safety issues when left alone. The facility's failure to protect R2 and R3 from sexual abuse by R1 created a situation of IJ. The jeopardy was removed on 8/6/20 by which time the facility had implemented the following action plan: Plan of Removal: The facility immediately moved R1 to a different hallway to a private room with a private bathroom on 5/11/20. Care plan was updated to show resident moved to a private room with a private bathroom. Immediate education will be provided to all staff before their next working shift on what one-on-one observation entails. Meaning, I will have eyes on R1 at all times. R1 will be allowed privacy with door shut, with one-on-one staff member outside the door at all times when in room. When R1 is out of room, R1 will have one-on-one with eyes on him at all times. The facility reviewed the care plan for appropriate interventions. The facility will provide all staff education on abuse/neglect/exploitation, audits will be completed to ensure this will not happen again. The facility did educate all staff on the types of abuse, what to do if suspect abuse, who to report abuse to and procedures on 5/12/20. The facility will ensure behavior charting is complete and accurate for R1 and if R1 would have been behaviors what interventions would be in place. The facility will review and update all resident care plans for potential sexual tendency [DIAGNOSES REDACTED]. The facility will do spot-check audits on one-on-one observation three times a week for two months or until substantial compliance is met. The facility will develop a one-on-one policy and all staff will be educated on the policy. The results of the audit will be reviewed at Quality Assurance Performance Improvement meetings.