STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525490	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VIRGINIA HEALTH AND REHAB CTR	1451 CLEVELAND AVE WAUKESHA, WI 53186

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

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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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not report an incident of sexual abuse immediately to the State Survey Agency with the results of the facility's investigation submitted within 5 working days for 1 of 2 resident to resident (R3) altercations reviewed. * Surveyor reviewed a facility's self-report investigation of an allegation of sexual abuse between R2 and R1. During this investigation, Surveyor learned of an additional incident of sexual abuse which occurred between R2 and R3 on 2/18/20, sometime after the first incident on 2/18/20 between R2 and R1. The facility did not immediately report this second incident involving R2 and R3 to the State Agency and did not submit the results of a facility investigation (as there was none) to the State Agency within 5 working days. Findings include: The facility's policy and procedure for Incident Reporting and Investigation dated 12/2016 indicates the following under E. Investigations of Incidents and Adverse Events: * obtain factual information regarding the incident. * determine what remedial and/or corrective action, if any, may be appropriate to protect residents, prevent reoccurrence and improve quality of care. * interviews are conducted with all parties and witnesses involved in the incident. Surveyor reviewed a facility self-report investigation that occurred on 2/18/2020 that indicated R1 and R2 were engaged in a sexual act. R1 and R2 both have dementia with activated Power of Attorney's. The facility investigation provided to the Surveyor did not include staff statements of potential information. The facility's self-report investigation does not include information that R2 was involved in another similar occurrence later on 2/18/20 involving R3 and in which Surveyor became aware of through medical record review and through staff interviews. The facility did not immediately submit a facility self-report to the State Agency and did not submit a completed facility investigation to the State agency regarding R2's sexual altercation with R3 that occurred on 2/18/20. On 8/4/20 at 10:30 AM Surveyor spoke with Administrator-A and requested any interviews or statements to go along with the facility self-report investigation involving R2 and R1. Administrator-A was able to locate 3 staff statements. This included, AD-G (Activity Director), LPN-D (Licensed Practical Nurse) and Agency CNA (Certified Nursing Assistant)-J. These staff statements just reference the event between R1 and R2. There are no staff statements that reference the time, and actions taken, for the sexual encounter between R2 and R3. There are no staff statements from other involved staff of R2 standing naked over R3 trying to pull R3's pajama bottoms off while R3 was in bed on 2/18/20. There was no separate investigation or separate facility self-report completed for the resident to resident sexual abuse incident between R2 and R3. R3's medical record was reviewed by Surveyor. R3 was admitted on [DATE] and has an activated POA since 1/6/18. R3's Progress Note dated 2/18/20 at 8:00 PM by LPN-D indicates R2 was naked in R3 room attempting to pull down their pajama bottoms in bed. R2 was difficult to redirect out of R3's room. The note indicates Administrator-A and RN (Registered Nurse)-C were notified for event and assistance, The Progress Note prior dated 2/18/20 at 6:34 PM by RN-C indicates that R2 was naked and trying to remove R3 clothes. R2 was difficult to direct and 911 was called and the police came in. R2's medical record was reviewed by Surveyor. R2 was admitted on [DATE] and their POA has been activated since 7/3/19. R2's Admission, and History with Physical, does not indicate any sexual behaviors. R2's Progress Note on 2/18/20 at 4:00 PM by LPN-D indicates R2 was having sex with R1 in R1 bed. LPN-D indicated they saw R2 naked standing by the bed refusing to leave R1 bedside. R1 was in their bed with their brief down past their knees. The Progress Note on 2/18/20 at 7:00 PM by LPN-D indicated R3 was heard making noises and upon entering R2 was naked attempting to remove R3's pajamas in bed. R2 was resistive and Administrator-A and RN-C were notified. The Progress Note on 2/18/20 at 8:00 PM by RN-C indicates that MD -I came in to evaluate after R2 had 2 physical altercations this evening. R2 was sent out to the hospital for further evaluation. On 8/4/20 at 11:09 AM Surveyor spoke with Administrator-A who did not conduct an investigation regarding the encounter with R2 and R3 because no act occurred. Administrator-A indicated they were notified of the 1st event however, RN-C was confused with the time and timeline of events. The police came in and did not have anything they could do. The MD did come in and then sent R2 out to the hospital for the changes in behavior. Administrator-A has no additional interviews or statements besides what was already provided. The investigation summary does not address or report the incident involving R2 and R3 on 2/18/20. On 8/4/20 at 2:51 PM Surveyor spoke with Administrator-A who indicated she was not upstairs (on 2/18/20). She talked to RN-C in her (Administrator's) office. Administrator-A could not recall the actual events that happened that evening. The DON-B (Director of Nurses) was not in work status when these events occurred on 2/18/20. Administrator-A had no additional information and expressed there is things to work on with this investigation. The facility did not immediately report this Resident to Resident sexual abuse altercation between R2 and R3 to the State agency and did not submit a completed investigation within 5 working days of the incident which occurred on 2/18/20.
F 0610 **Level of harm -** Actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not have evidence of a thorough investigation regarding an allegation of sexual abuse, involving R1 and R2 which occurred at 4:00 pm on 2/18/20 and did not have evidence that measures were put in place to prevent further potential abuse. The facility's completed investigation did not contain statements from all involved staff and staff statements that were obtained did not include specific details involving R2's behaviors and events of 2/18/20. After the first resident to resident sexual encounter between R1 and R2, the facility did not develop interventions to prevent R2 from abusing R3 or other female residents. The facility did not protect R3 while an investigation involving R1 was underway. The facility did not conduct an investigation into the observation of R2 observed being naked and trying to remove R3's clothes. This deficient practice affected 3 of 3 residents (R1, R2, and R3) involved in allegations of sexual abuse. Using a reasonable person concept, it is likely that a female resident (R3) would feel terrified when a naked man is standing in her room trying to take off her pajama bottoms. Findings include: The facility's policy and procedure for Incident Reporting and Investigation dated 12/2016 indicates the following under E. Investigations of Incidents and Adverse Events: * obtain factual information regarding the incident. * determine what remedial and/or corrective action, if any, may be appropriate to protect residents, prevent reoccurrence and improve quality of care. * interviews are conducted with all parties and witnesses involved in the incident. Surveyor reviewed a facility self-report investigation that occurred on 2/18/2020 that indicated R1 and R2 were engaged in a sexual act. R1 and R2 both have dementia with activated Health Care Power of Attorney's (HCPOA). The facility's investigation summary states in part; On February 18, 2020 at approximately 4:00 pm, it was reported to the Administrator .that R2 and R1 had been seen by agency Certified Nursing Assistant (CNA) J in a sexual position on the bed in R1's room. She (CNA) J called for help. The nurse on duty on the second floor, LPN-D and Activities Director (AD) G immediately responded and moved R2 from the side of R1's bed where he was standing when they entered the room. They redressed R2 and took R2 back to his room. The facility's investigation summary indicates that the facility's first order of business was that staff moved quickly to protect R1.

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

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F 0610 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) When CNA J first entered R1's room, she saw R2 who was naked .lying on top of R1 whose pants and brief were at her knees when CNA J called for help, R2 stood up next to R1's bed. In the meantime, AD G came to my office (Administrator's) to report this incident to me. I called our Medical Director (MD) I who came in less than 15 minutes, examined and assessed both R1 and R2 neither had any bruises or scratches. R1 appeared relaxed and in good spirits. R1 told MD I she had invited R2 into her room. This coincided with AD G's description .where R1 did not appear in any distress. Two officers from Waukesha Police Department arrived .They went upstairs to speak to R1 and R2. R1 told the officers she had not been assaulted and was fine. R2 was not-interviewable. When the officers came back down stairs they said they did not see any violent behavior from R2. R1's HCPOA did not want R1 to go to the hospital for an examination .R2's wife was not surprised but thought this type of behavior was in the past as she had gone through this with him as his dementia progressed .she thought R2 had more than likely mistaken the other resident for her. In fact R2 was told by the AD G that R1 was not his wife, and R2 argued that, in fact, she was his wife. . MD I was concerned that may be a change of condition/altered mental status and decided to sent R2 to the emergency department .Initial hospital notes indicate agitation as the principle problem likely related to [MEDICAL CONDITION] with dementia and urine retention as possibly contributing to his agitation .Following our thorough review of the circumstances of this resident- to- resident incident, we have not been able to show willful intent on R2's part, particularly when he and his wife both stated R2 more than likely thought R1 was R2's wife. R1 did not report pain, MD I could see no physical injury or emotional harm at the time of MD K's assessments and nothing of this nature was discovered while following R1 on our twenty-four hour report and beyond. This was signed by Administrator A on 2/25/20. The facility investigation provided did not include staff statements or complete information from all staff involved. The facility's investigation does not indicate that before the Medical Director had assessed R2 and before the police arrived, R2 was found naked in another female resident's room (R3) trying to take off her pajama bottoms. There was no documented interventions to prevent R2 from entering another Resident's room and to prevent potential further abuse, after R2 was observed in R1's room. There was no information on the timeframe's surrounding the event. On 8/4/20 at 10:30 AM, Surveyor spoke with Administrator-A. Surveyor requested any interviews or statements pertaining to the investigation involving R2. Administrator-A was able to locate 3 staff statements. This included, AD-G, LPN-D (Licensed Practical Nurse) and Agency CNA-J. These statements just reference the event between R1 and R2. There are no additional statements from other involved staff nor any information pertaining to the subsequent resident-to-resident incident involving R2 and R3. Surveyor review confirmed three residents were involved in the events of 2/18/20. They are: R2. R2's medical record was reviewed by Surveyor. R2 was admitted on [DATE] and his HCPOA has been activated since 7/3/19. R2's Admission, and History with Physical does not indicate any sexual behaviors. R2's admission MDS with a target date of 1/30/20 reflects a BIMs score of 00 which indicates R2 is severely cognitively impaired for daily decision making skills. The MDS has documented R2 has clear speech, is understood, understands with clear comprehensions, has adequate vision with corrective lenses. R2 was noted to have trouble concentrating on things. The MDS is checked for wandering and had this type of behavior 1 to 3 days. The MDS indicates yes to the question asking if Resident's wandering places Resident at significant risk of getting into potentially dangerous places (outside, stairs, etc.) The MDS also responds yes to the question if Resident's wandering significantly intrudes on the privacy of activities of other residents. The MDS also indicates that it is very important for R2 to see family/friends. The MDS also indicates R2 requires supervision with 1 physical assist with bed mobility, transfers, and ambulation in the corridor. He requires limited assistance of 1 for personal hygiene and toilet use. R1. R1's medical record was reviewed by Surveyor. R1 was admitted on [DATE] and has an activated HCPOA since 3/15/16. R1 does not have a documented history for sexual interactions. A quarterly Minimum Data Set (MDS) with a target date of 12/26/19 indicates a Brief Interview for Mental Status (BIMs) score of 15 indicating R1 is cognitively intact for daily decision making skills. The MDS also indicates R1 is independent with ambulation, requires supervision with 1 for bed mobility, and transfers independently with set up. For personal hygiene, toileting and dressing R1's requires extensive assist with 1. According to the MDS, R1 has adequate hearing, clear speech, is understood, understands and has adequate vision. R3. R3's medical record was reviewed by Surveyor. R3 was admitted on [DATE] and has an activated HCPOA since 1/6/18. R3's quarterly MDS with a target date of 11/22/19 documents R3's BIMs score of 2 indicating R3 is severely cognitively impaired for daily decision making skills. R3 requires extensive assistance with 1 for bed mobility, dressing, and personal hygiene. R3 requires extensive assistance of 2 staff for toileting and transfers. According to the MDS, R3 has adequate hearing, clear speech is usually understood and understands and has adequate vision. Incident 1. R2's Progress Note on 2/18/20 at 4:00 PM by LPN-D indicates R2 was having sex with R1 in R1's bed. LPN-D indicates they saw R2 naked standing by the bed refusing to leave R1's bedside. R1 was in her bed with her brief down past her knees. The Progress Note on 2/18/20 at 5:00 PM by LPN-D indicates R2 was naked laying with his head on R1 lower torso area. This was discovered by staff who then intervened. R2 was difficult to redirect and R1 did not express any concerns. The Progress Note prior dated 2/18/20 at 6:34 PM by RN-C indicates that R2 was naked and trying to remove R3 clothes. R2 was difficult to direct and 911 was called and the police came in. The Progress Note dated 2/18/20 at 7:54 PM by Registered Nurse (RN)-C indicates they were notified by LPN-D that R2 had his pants down R1 and its unsure if they had intercourse or not. And MD-I came in to the facility to evaluate. R1's plan of care was updated on 2/23/20 to include no male caregivers. R1 did not have any documented changes from this event. There is nothing in R2's care plan to indicate that staff implemented any changes to protect other residents from further potential abuse immediately following this incident. Incident 2. R3's Progress Note on 2/18/20 at 7:00 PM by LPN-D indicates R3 was heard making noises and upon entering R2 was naked attempting to remove R3 pajamas in bed. R2 was resistive and Administrator-A and RN-C were notified. Progress Note dated 2/18/20 at 8:00 PM by LPN-D indicates R2 was naked in R3 room attempting to pull down her pajama bottoms in bed. R2 was difficult to redirect out of R3 room. The note indicates Administrator-A and RN-C were notified for event and assistance, The Progress Note on 2/18/20 at 8:00 PM by RN-C indicates that MD-I came in to evaluate after R2 had 2 physical altercations this evening. R2 was sent out to the hospital for further evaluation. The facility investigation indicates R2 was sent out to the hospital and does not include the encounter with R3. The investigation does not include what R2 was doing between the encounter with R1 and the encounter with R3. On 8/4/20 at 10:28 AM Surveyor spoke with LPN-D. LPN-D indicated Agency CNA-J alerted them. LPN-D then went to R1's room. R2 was naked standing next to R1's bed. R1 was not expressing any concerns. R2 was difficult to redirect. LPN-D indicated they notified RN-C. They indicated Admissions Director-F was doing 1 to 1 at some point. LPN-D indicated MD-I came in to assess. The police came in and they were not asked any questions by them. LPN-D indicated RN-C took over and they did not have any involvement with R2. On 8/4/20 at 10:39 AM, Surveyor spoke with AD-G who indicated they assisted R2 with redirection and took R2 back to his room. AD-G then gave R2 a snack and they left to go downstairs to tell Administration. AD-G did not recall who they told. AD-G indicated her shift ends at 4:00 PM and it would have been before then. On 8/4/20 at 11:09 AM Surveyor spoke with Administrator-A. Administrator-A did not conduct an investigation into the encounter between R2 and R3 because no act occurred. Administrator-A indicated she was notified of the 1st event however, RN-C was confused with the time and timeline of events. The police came in and did not have anything they could do. The MD did come in and then sent R2 out to the hospital for the changes in behavior. Administrator-A has no additional interviews or statements besides what was already provided. The investigation summary contains no definitive timelines and facts involving R1, R2 or R3. STAFF STATEMENTS NOT INCLUDED IN INVESTIGATION On 8/4/20 at 12:29 PM. Surveyor spoke with Admissions Director -F who stated they were helping Administrator-A out and called the police. Then she went to spend 1:1 time with R2 by wheeling R2 around after the 2nd event with R3. R2 was calm and was in his room after the event. Admission Director- F indicated she left by 8:00 PM and told RN-C they were leaving. The police had just left when Admission Director -F went upstairs. Admission Director-F is unsure of any exact times besides when they left for the evening. On 8/4/20 at 1:23 PM Surveyor spoke with MD-I. MD-I indicated they came in after the suppertime with the 2nd event. MD-I assessed R1 and R3 and found no trauma. MD-I assessed R2 and felt he was having a medical change in behavior and sent R2 to the hospital. MD-I thought R2 had mistaken R1 for his spouse and felt R3 was a change in behavior. On 8/4/20 at 1:35 PM Surveyor spoke with CNA-E who was working the floor on 2/18/20 and who had R2 on her assignment. CNA-E recalls R2 eating dinner in the dining room. CNA-E recalled hearing about the encounter between R2 and R1. CNA-E remembers after dinner seeing R2 lying in bed. CNA-E indicated it was quick for R2 to be in R3's room. CNA-E indicated they saw Admissions Director-F wheeling R2 around earlier then they took over. CNA-E doesn't remember exactly where R2 was between R1 and R3 encounters. R2 was eating in the dining room, lying in bed and being wheeled on the unit. On 8/4/20 at approximately 2:00 PM Surveyor observed R1 laying in their bed. R1 appeared to be sleeping and had a roommate that also appeared to be sleeping. R1 was not awake to be interviewed by Surveyor. On 8/4/20 at approximately 2:15 PM Surveyor observed R3 laying in bed. R3 appeared to be sleeping. R3 was not awake to be interviewed by Surveyor. On 8/4/20 at 2:40 PM, Surveyor spoke with RN-C. RN-C could not

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F 0610 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) recall times or actual events. RN-C remembered the police and the MD being in the facility. The police were not able to do anything. RN-C indicated Administrator-A was on the floor the 1st event and they took care of everything. RN-C indicated Administrator-A told them to call the police. The MD came in and sent out R2 for being a safety risk to others. RN-C indicated the Administrator took over and they were working downstairs. RN-C did not recall what happened after the 1st encounter between R1 and R 2 or the actual time line of events that evening. On 8/4/20 at 2:51 PM, Surveyor spoke with Administrator-A who indicated she was not upstairs. Administrator-A talked to RN-C in her office. Administrator-A could not recall the actual events that happened that evening. DON-B (Director of Nurses) was not in work status when these events occurred. Administrator-A had no additional information and expressed there are things to work on with this investigation. Administrator-A agreed this is not a thorough investigation.