STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525232	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CCC OF WEST GREEN BAY	1760 SHAWANO AVE GREEN BAY, WI 54303

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** - Minimal harm or potential for actual harm **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 record review and staff interview, the facility did not ensure 1 Resident (R) (R2) of 3 residents was free from verbal abuse. Multiple staff overhead CNA (Certified Nursing Assistant)-C verbally abuse R2 through a closed door during PM cares. Staff did not open R2's door and intervene during the abuse to ensure R2's safety. Findings include: The facility's Abuse Prevention Program, dated 2/07/17, states: The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of [REDACTED].immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property. V. Protection of Residents Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately. On 6/16/20, the Surveyor reviewed a facility self-report filed with the State Survey and Certification Agency. The report stated CNA-C was verbally inappropriate toward R2 during PM cares on 5/30/20. The report indicated the incident was discovered by administrative staff on 5/31/20. The investigation stated LPN (Licensed Practical Nurse)-F and CNA-G overheard CNA-C speak inappropriately and raise CNA-C's voice toward R2. CNA-G stated CNA-C raised CNA-C's voice and gave R2 commands. CNA-G stated R2 told CNA-C to rot in hell and CNA-C stated R2 would be right along side (CNA-C). LPN-F stated CNA-C spoke loudly to R2 and explained R2 needed to stop (R2's behavior). CNA-C stated R2 did not follow CNA-C's instruction, became upset, scratched CNA-C and drew blood. CNA-C verified CNA-C spoke in a raised voice to R2 due to frustration with the situation. CNA-C also verified CNA-C stated CNA-C would rot in hell with R2. The Surveyor reviewed R2's medical record. R2 was admitted to the facility with [DIAGNOSES REDACTED]. R2's most recent Quarterly MDS (Minimum Data Set), dated 4/11/20, indicated R2 was severely cognitively impaired and displayed physical and verbal behavior and rejection of care. R2 required extensive to full assistance with bed mobility and ADLs (activities of daily living). R2's plan of care indicated R2 had a history of [REDACTED]. On 6/16/20 at 3:06 PM and 3:54 PM, the Surveyor interviewed LPN-F regarding the incident. LPN-F stated LPN-F wasn't the nurse on R2's unit that evening; however, CNA-G asked LPN-F to stand outside R2's closed door. LPN-F stated, I heard (CNA-C) yelling at (R2). LPN-F stated CNA-C and R2 were yelling stop it back and forth. LPN-F verified LPN-F did not open R2's door or intervene. LPN-F stated LPN-F initially, didn't think much of the situation and wasn't sure if yelling was considered abuse. The next day (5/31/20), LPN-F rethought LPN-F's reaction to the incident when LPN-F went online to see if yelling was considered abuse. LPN-F stated the incident occurred at approximately 9:00 PM. LPN-F stated LPN-F did not assess R2, did not notify R2's nurse and did not notify NHA (Nursing Home Administrator)-A following the incident. LPN-F verified CNA-C was not removed from the floor following the incident and worked the remainder of the shift until 10:00 PM. LPN-F was unsure if CNA-C provided care to any residents following the altercation with R2. On 6/16/20 at 3:28 PM and 3:50 PM, the Surveyor interviewed CNA-G regarding the incident. CNA-G stated, I remember (CNA-C) yelling commands at (R2) .telling (R2) what to do. (R2) told (CNA-C) (CNA-C) was going to burn in hell and (CNA-C) said (CNA-C) would be right along beside (R2). CNA-G verified CNA-G called LPN-F to R2's door and stated, I couldn't find my nurse so I called the closest nurse I could get. CNA-G verified CNA-G didn't open R2's door or intervene during the abuse and stated, We're to report to our nurse .I didn't say anything to (CNA-C). I left it in (LPN-F's) hands .I just gave it to the nurse like we're supposed to do. CNA-G stated after CNA-G alerted LPN-F and stood outside R2's door for a short time, CNA-G left the area and continued with cares. CNA-G also stated, I considered (CNA-C's) tone verbally abusive. On 6/16/20 at 2:45 PM and 4:10 PM, the Surveyor interviewed NHA-A regarding the incident. NHA-A stated NHA-A was not notified of the verbal abuse until 5:30 PM the following day (5/31/20). NHA-A stated after LPN-F called NHA-A's cell phone, NHA-A contacted the corporate office and notified CNA-C (who was scheduled to work at 6:00 PM) that CNA-C was suspended pending the investigation. CNA-C's personnel file contained a Corrective Action Notice, dated 11/22/19. The notice indicated CNA-C received a third and final written warning on 11/22/19 for swearing in resident areas and speaking inappropriately. The notice also stated multiple conversations took place regarding CNA-C's behavior. NHA-A stated LPN-F didn't know for sure what happened with the situation and didn't have a good reason for not notifying NHA-A immediately following the incident. LPN-F's personnel file contained a Corrective Action Notice, dated 6/01/20. The notice indicated LPN-F received a written warning on 6/01/20 for failure to report abuse allegations to (NHA-A) on 5/30/20. The notice also stated multiple verbals and educations completed on reporting abuse. The notice did not indicate LPN-F was educated on the need to intervene and provide protection for a resident during abusive treatment. NHA-A stated LPN-F did not receive abuse education following the incident because LPN-F was a long-term employee of the facility and took part in numerous abuse trainings, including the most recent training on 3/31/20. In addition, NHA-A verified abuse education for all staff, including CNA-G, was not completed following the incident. R2 was not interviewable during this investigation.
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 interview, the facility did not ensure all allegations of abuse were reported timely to facility administration and the State Survey and Certification Agency for 2 Residents (R) (R1 and R2) of 3 residents. R1 reported an allegation of abuse regarding CNA (Certified Nursing Assistant)-C. The allegation of abuse was not reported to the State Survey and Certification Agency. Multiple staff overheard CNA-C verbally abuse R2 during PM cares on 5/30/20. The allegation of abuse was not reported to NHA (Nursing Home Administrator)-A until 5/31/20. Findings include: The facility's Grievance Guideline, dated 1/27/17, states: Procedure: The Grievance Officer will route the grievance to the appropriate department head related to the grievance filed .Based on the nature of the grievance, the Grievance Officer will initiate any additional interventions that are indicated at that time (i.e. notify the Abuse Coordinator if potential for abuse neglect, exploitation or misappropriation of resident property exists .) The facility's Abuse Prevention Program, dated 2/17/17, states: IV. Internal Reporting Requirements and Identification of Allegations Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately or to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. VII. External Reporting 1. Initial Reporting of Allegations - When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or designee, shall .notify DQA that an occurrence of potential abuse

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) .has been reported to the administrator and is being investigated. 1. On 5/13/20, the Surveyor reviewed a complaint and facility self-report filed with the State Survey and Certification Agency. The complaint stated R1 reported CNA-C hurt R1 on purpose by spreading R1's buttocks far apart during treatment. The self-report stated R1 reported CNA-C spreads my cheeks and rams (R1's) fist up my butt. The investigation stated R1 reported to a [MEDICAL TREATMENT] social worker on 4/30/20 that a male nurse pokes and pushes (R1). During an interview with NHA-A, R1 identified CNA-C as the employee in question and stated CNA-C spread (R1's) butt cheeks open far apart and scrubbed hard. During an interview with UM (Unit Manager)-E, R1 stated CNA-C spreads my cheeks and rams (CNA-C's) fist up my butt. The investigation also stated CNA-C wasn't in R1's room for approximately one month prior to the allegation due to previous statements R1 made regarding CNA-C. On 5/13/20 at 3:10 PM, the Surveyor interviewed NHA-A via telephone. NHA-A verified R1 previously reported CNA-C dug poop out of (R1's) butt. NHA-A stated a grievance was initiated regarding the allegation. The grievance, dated 4/01/20, stated R1 reported to RN (Registered Nurse)-D that CNA-C was the one who digs in (R1's) butt . The grievance stated R1, who had a history of [REDACTED]. The grievance indicated R1 stated to NHA-A, (CNA-C) digs the poop out of my butt. (CNA-C) was sent to jail for it, which is good because I don't like (CNA-C). NHA-A's interview with R1 stated R1 denied being abused and felt safe in the facility because CNA-C was in jail. During an interview with NHA-A, CNA-C denied touching R1 inappropriately or digging in R1's rectal area. The grievance did not state the allegation of abuse was reported to the State Survey and Certification Agency. On 6/16/20 at 10:30 AM, the Surveyor again interviewed NHA-A regarding the grievance. NHA-A stated the grievance was not reported to the State Surveyor and Certification Agency because R1's statements were not allegations of abuse. NHA-A stated, (R1) wasn't afraid of (CNA-C) and said (R1) felt safe (in the facility). When asked if R1 had a history of [REDACTED]. 2. On 6/16/20, the Surveyor reviewed a self-report submitted to the State Survey and Certification Agency. The report stated CNA-C was verbally inappropriate toward R2 during PM cares on 5/30/20. The report also stated the incident was discovered and reported on 5/31/20. The investigation stated LPN (Licensed Practical Nurse)-F and CNA-G overheard CNA-C speak inappropriately, give commands and raise CNA-C's voice toward R2. CNA-G stated R2 told CNA-C to rot in hell and CNA-C stated R2 would be right along side (CNA-C). LPN-F stated CNA-C spoke loudly to R2 and explained R2 needed to stop (R2's behavior). CNA-C stated R2 did not follow CNA-C's instruction, became upset, scratched CNA-C and drew blood. CNA-C verified CNA-C spoke in a raised voice to R2 due to frustration with the situation. CNA-C also verified CNA-C stated CNA-C would rot in hell with R2. On 6/16/20 at 2:45 PM, the Surveyor interviewed NHA-A regarding the self-report. NHA-A stated LPN-F called NHA-A's cell phone on 5/31/20 at approximately 5:30 PM to report verbal abuse that occurred the previous day. NHA-A stated NHA-A wasn't sure why LPN-F waited until the next day to report the abuse as LPN-F was a long-term employee of the facility and participated in many abuse trainings. NHA-A stated LPN-F was given a written discipline for not reporting the abuse timely. NHA-A stated staff reeducation was not completed regarding timely reporting because a staff-wide abuse training was conducted on 3/31/20. On 6/16/20 at 3:06 PM, the Surveyor interviewed LPN-F regarding the incident. LPN-F verified LPN-F did not report the altercation between CNA-C and R2 until 5/31/20 and stated, .I didn't give it much thought until the next day. The next day I thought about it and contacted (NHA-A) .I went online to check if yelling was considered abuse . LPN-F stated LPN-F was not the nurse on R2's unit that shift and stated, I probably should've told that nurse also, but I didn't. I knew I had twenty-four hours to report and that was within the window, but I should've done it immediately.
F 0610 **Level of harm** - Minimal harm or potential for 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 interview, the facility did not ensure all allegations of abuse were thoroughly investigated for 1 Resident (R) (R1) of 3 residents. R1 reported to staff that CNA (Certified Nursing Assistant)-C dug in his butt. The allegation of abuse was not thoroughly investigated. Findings include: The facility's Abuse Prevention Program policy, dated 2/07/17, states: The facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of [REDACTED].Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment and making the necessary changes to prevent future occurrences. V. Protection of Residents The facility will take steps to prevent potential abuse while the investigation is underway Accused individuals not employed by the facility will be denied unsupervised access to residents during the course of the investigation. Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegations of abuse, neglect, exploitation, mistreatment or misappropriation of resident property is unsubstantiated. 4. Investigation Procedures .Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. 1. On 5/13/20, the Surveyor reviewed a facility self-report filed with the State Survey and Certification Agency. The report stated R1 reported CNA-C spreads my cheeks and rams (R1's) fist up my butt. The investigation stated R1 reported to a [MEDICAL TREATMENT] social worker on 4/30/20 that a male nurse pokes and pushes (R1). During an interview with NHA (Nursing Home Administrator)-A, R1 identified CNA-C as the employee in question. R1 stated CNA-C spread (R1's) butt cheeks open far apart and scrubbed hard. The investigation also stated CNA-C wasn't in R1's room for approximately one month prior to the allegation due to previous statements R1 made regarding CNA-C. On 5/13/20 at 3:10 PM, the Surveyor interviewed NHA-A regarding the incident and the previous statements R1 made toward CNA-C. NHA-A stated R1 previously reported to staff that CNA-C dug poop out of (R1's) butt. NHA-A stated a grievance was initiated regarding the allegation. The grievance, dated 4/01/20, stated R1 reported to RN (Registered Nurse)-D that CNA-C was the one who digs in (R1's) butt . The grievance stated R1, who had a history of [REDACTED]. The grievance indicated R1 stated to NHA-A, (CNA-C) digs the poop out of my butt. (CNA-C) was sent to jail for it, which is good because I don't like (CNA-C). NHA-A's interview with R1 stated R1 denied being abused and felt safe in the facility because CNA-C was in jail. During an interview with NHA-A, CNA-C denied touching R1 inappropriately or digging in R1's rectal area. NHA-A stated CNA-C was moved to a different unit following the grievance and interventions for female caregivers and assist of two at all times were added to R1's care plan following the self report The Surveyor noted the grievance did not contain interviews with other residents to determine if they experienced or had the same concerns as R1. The grievance also did not contain interviews with additional staff to determine if similar concerns were voiced or observed. In addition, the grievance did not contain a statement from RN-D. On 6/16/20 at 11:40 AM, the Surveyor interviewed RN-D regarding R1's allegation. RN-D stated, I was doing med pass. (R1) blurted out that (CNA-C) was digging in (R1's) bottom. RN-D stated R1 reported the allegation occurred that morning. On 6/16/20 at 10:30 AM, the Surveyor again interviewed NHA-A regarding the grievance. NHA-A stated additional staff interviews were not completed regarding R1's grievance. NHA-A stated NHA-A didn't have RN-D write a statement because because NHA-A wrote on the grievance form what NHA-A was told by RN-D. NHA-A verified CNA-C was moved to a different unit following R1's grievance; however, CNA-C was not removed from or supervised during resident care pending the outcome of the investigation.