STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525452	A. BUILDING _____ B. WING _____	03/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELROY HEALTH SERVICES	307 ROYALL AVE ELROY, WI 53929

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 interview and record review the facility did not ensure residents are free from abuse, for 1 of 4 sampled Residents (R1). RN C (Registered Nurse) indicated he threatened to break R1's hands and swore at R1. This is evidenced by: Facility Policy entitled 'Abuse Prevention Program,' dated 3/2018 states, in part: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.7) Reporting/Responding: .The resident will be assessed for any needs every shift for 72 hours or until comfortable regarding incident. Nurse will chart each shift for 72 hours regarding resident's condition. Social Services will conduct safe surveys. The Administrator with the assistance of the DON, Social Services and regional support will determine the findings of the investigation based on a thorough review of the incident information . R1 was admitted on [DATE], with [DIAGNOSES REDACTED]. R1's Quarterly MDS (Minimum Data Set) dated 2/17/20 indicates R1 has a BIMS (Brief Interview of Mental Status) of a 4 out of 15, which indicates severe cognitive impairment. Section B indicates R1 is able to hear adequately, his speech is unclear, R1 is usually able to make himself understood, and is able to understand others. Section E indicates that R1 had wandering behaviors 4 to 6 days during the look back period. Section G indicates that R1 requires supervision while ambulating in his room and on the unit. Facility Grievance Log, indicates on 3/11/20 an alleged abuse grievance was filed by another Resident. NHA A (Nursing Home Administrator) and SW F (Social Worker) were assigned to the grievance on 3/12/20. The grievance log indicates a written warning was provided on 3/13/20. Please note that the facilities grievance log indicates that this situation is a potential abuse situation. The Facility's follow up for this grievance is as follows: NHA A's written summary states: 3/12/20 I received a phone call the evening of 3/11/20 saying that a resident had reported (RN C) had made a comment that she perceived as threatening. (R1) had apparently stolen (RN C's) wallet and he got to the (gas station) and couldn't find it and when he came back and found (R1) and retrieved it he made a statement while walking away. As it was the end of the shift and (RN C) was going home, I said I would complete interviews in the morning. I interviewed (R3) the resident who witnessed this and reported to the nurse. She said I think he said something like keep your hands off of my f***ing wallet, but I don't think (R1) heard him. I then followed up with (R1). I asked (R1) about what happened (R1 is difficult to interview) he told me he took (RN C's) wallet, I asked if (RN C) was mad and he laughed and shook his head yeah. I then asked if (RN C) said anything to him about it. He shook his head no. I asked if he felt scared or threatened, again he shook his head no. 3/13/20 I interviewed (RN C) today. He told the same story as above except he stated that he said Don't touch my f***ing wallet again. I explained to (RN C) that although (R1) did not hear this it is unacceptable to speak to a resident this way. I reviewed what constitutes abuse with him. He stated Don't we have any rights? Residents can do whatever they want to us any (sic) its ok. I again provided counseling and talked through the situation. I offered a locked office for (RN C) to keep his coat and wallet in. I issued a written warning and assigned an additional training on anger management. 3/16/20 (DON B) followed up with (R1) as she is back from vacation and has a close relationship with him. Facility follow up indicates staff interviewed 7 different residents and one family member related to interacting with RN C. On 3/16/20, DON B's (Director of Nursing) written statement, states, in part: Writer met with (R1) regarding an incident that occurred on 3/11/1965 (sic). Writer asked (R1) if he was good while writer was on vacation. (R1) stated that unless the F pissed me off. Writer asked about a particular incident. (R1) remembered the incident and stated that he made (RN C) furious when he took his wallet. (R1) went on to say that (RN C) had 6 dollars and a hundred in his wallet and he gave it back to (RN C). Writer asked (R1) if he felt threatened by (RN C) and (R1) stated no. Asked (R1) if (RN C) threatened him in any way and gave examples and (R1) stated no. Writer asked if (RN C) made a comment verbally of a threat and (R1) said no. Writer asked (R1) is he (sic) was afraid of (RN C) and (R1) stated no. Writer asked (R1) if he like (sic) (RN C) and he stated not particularly. Writer asked why and (R1) stated that he is always telling him to take his meds (medications). (R1) does have some cognitive impairment, but writer feels his statements to be accurate. (R1) spends a lot of time with this writer during the day. On 3/13/20, RN C's Disciplinary Record form, signed by NHA A and ADON G (Assistant Director of Nursing) indicates the incident was inconsiderate care. Education assigned on anger management and a written warning provided. Describe the incident A resident took (RN C's) wallet from his coat. When he went to retrieve the wallet from the resident he stated, Don't touch my fxxxing wallet again in a threatening tone. R1's Care Plan, has not been updated to reflect the incident on 3/11/20. R1's Medical Record has no record of the incident occurring on 3/11/20 or that the facility followed up with R1 for at least 72 hours after the incident per their policy. Facility staffing schedules received on 3/19/20 indicate that RN C continued to work as a PM (evening shift) charge nurse on 3/13, 3/14, 3/15, and 3/18/20. RN C was scheduled to work on 3/19/20, but was taken off the schedule by NHA A around 12:50 PM after Surveyor informed NHA A of RN C's statement. On 3/19/20 at 9:35 AM, Surveyor interviewed R3 regarding the incident she witnessed with R1. R3 indicated that RN C found out his wallet was missing and R1 has a history of taking stuff. R3 indicated R1 was on the couch in the Bird lounge and she was at the table. R3 indicated RN C said give me my wallet. R3 indicated R1 stood up and RN C said if you take anything of mine I'm going to break your hands or fingers. R3 indicated RN C dug through R1's personal items on the couch and obtained his wallet. R3 indicated RN C again said he would break his hands or fingers. R3 indicated the incident was also witnessed by R4. R3 indicated R1 kept looking in the room before coming into the Bird lounge after the incident. R3 indicated she told LPN E and RN D about the incident. R3 indicated she thinks RN C was mad and took his anger out. R3 indicated she does not want RN C to work with her because that type of incident should not happen. R3 indicated if RN C threatened one resident, he's going to keep doing it. On 3/19/20 at 9:50 AM, Surveyor interviewed R4 regarding the incident she witnessed with R1. R4 indicated she was out in the Bird room when RN C came in angry. R4 indicated R1 likes to pick up things and got RN C's wallet. R4 indicated RN C got after R1 and threatened to break his hand if he ever touched anything again. R4 indicated R1 gave RN C his wallet back. R4 indicated she told the nurse. R4 indicated RN C did not touch R1, but she did not want to say anything as she didn't want to escalate the situation. On 3/19/20 at 10:01 AM, Surveyor interviewed RN D regarding the incident on 3/11/20 with R1. RN D indicated R1 has dementia and took RN C's wallet. RN D indicated she was working when LPN E (Licensed Practical Nurse) pulled her into a room and indicated two residents told her RN C walked up to R1. RN D stated LPN E indicated RN C walked up to R1 and said give me my wallet, if you ever touch my stuff again I'll break your arm. RN D stated she spoke to R3 and R4, who witnessed the situation. RN D stated R3 and R4 both indicated RN C said he was going to break his arms. RN d stated she questioned if she should send him home, as they only had a half hour left in the shift. RN D stated the supervisor (ADON G) was notified. RN D stated she did not send him home due to being afraid it might escalate to a physical altercation. RN D indicated no one has followed up with her on the incident and she was told it was being

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) handled. On 3/19/20 at 10:16 AM, Surveyor interviewed ADON G regarding the incident on 3/11/20 with R1. ADON G indicated she received a call from LPN E, and was unsure if LPN E overheard it or was told about it. ADON G indicated RN C saw R1 going through his coat and when he went to (gas station), he didn't have his wallet. ADON G indicated RN C came back and confronted R1, saying don't ever touch my F'ing stuff again. ADON G indicated she then called SW F (Social Worker). ADON G indicated she was notified towards the end of the shift, so she did not pull him RN C was off duty immediately. ADON G indicated that NHA A and SW F talked to RN C on Friday before his shift. ADON G indicated she was unaware RN C threatening to break R1's hands or fingers. On 3/19/20 at 10:25 AM, Surveyor interviewed SW F regarding the incident on 3/11/20. SW F indicated she received a phone call from ADON G it was reported a wallet was stolen and RN C confronted the resident. SW F indicated RN C said Don't steal my f'ing wallet again. SW F indicated she offered to come into the facility, as it was the end of the shift. SW F indicated she was ensured he was not doing cares and RN C was off the next day. SW F indicated there is a potential for verbal abuse and it should have been reported. SW F indicated they interviewed R3 but did not interview R4. SW F indicated RN C works as the evening shift charge nurse. On 3/19/20 at 10:37 AM, Surveyor interviewed NHA A regarding the 3/11/20 incident with R1. NHA A indicated SW F called her after receiving a phone call from LPN E, indicating RN C made a comment while walking away from R1 of Don't touch my f***ing wallet again. NHA A indicated she felt it was an off the cuff comment and thought she needed to find out about the comment and wanted to see if it rises to the abuse level. NHA A indicated R3 has a history of blowing things out of proportion. NHA A indicated she went to R1 and R1 laughed about it. NHA A indicated R1 was his normal self and indicated RN C was mad. NHA A indicated R3 did not believe R1 heard RN C. NHA A indicated RN C was not removed due to it being the end of the shift and was not providing care at this time as he was finishing up his work and would be leaving. NHA A indicated RN C did not work the next day as he was off. NHA A indicated she did not report it as R1 did not hear it and she did not feel it rose to abuse. NHA A indicated she interviewed RN C who indicated he went to (gas station name) and didn't have his wallet. NHA A indicated RN C did not know who took it and he had quite a bit of money in it. NHA A indicated RN C was frustrated with R1 and was asking Don't we have any rights. NHA A indicated she told RN C he can't make comments like that. NHA A indicated she did a written warning with RN C and assigned anger management. NHA A indicated the facility just provided abuse training to staff. NHA A indicated she asked DON B to follow up with R1 when she was back from vacation. NHA A indicated R4 was not interviewed as she did not know R4 was in the lounge. NHA A indicated the statement of breaking R1's arm first came up on Friday (3/13/20) and R3 is now changing her story. NHA A indicated swearing at residents can be potential abuse. NHA A indicated staff interviews were not completed as it was reported by LPN E, and LPN E did not witness it. NHA A indicated she did not think staff interviews were pertinent due to R1 did not hear it. NHA A indicated R1 indicated he did not hear it, by shaking his head no. NHA A indicated in hind sight, yes I should of interviewed staff and reported this. On 3/19/20 at 11:10 AM, Surveyor interviewed LPN E regarding the incident on 3/11/20 with R1. LPN E indicated she did not hear the incident first hand. LPN E indicated she was doing her evening medication pass and went into the bird room to give R4 her medication. LPN E indicated R3 and R4 indicated RN C was loud and it scared them. LPN E indicated R3 and R4 reported RN C stated Don't touch my f***ing stuff. LPN E indicated it was late in the shift and she reported it to ADON G. LPN E indicated the incident scared the ladies and must of scared R1, as he was in his room. LPN E indicated R1 was in his room which is not typical for him, as he likes to sleep on the cough in the bird room. LPN E indicated R1 came out of his room looked around and then went back into his room. LPN E indicated she is unaware if the incident is charted and is unaware if R1's family was updated on the incident. LPN E indicated they just had abuse training 2 days before this incident, which prompted her to call SW F. LPN E indicate she was not asked to provide a statement, she only reported verbally to ADON G. LPN E indicated she told management that R3 and R4 were also in the bird room at the time of the incident. On 3/19/20 at 11:15 AM, Surveyor interviewed ADON G. ADON G indicated she was aware R3 and R4 were in the room during the incident. On 3/19/20 at 11:25 AM, Surveyor interviewed R1 regarding the 3/11/20 incident. R1 indicated he remembers taking RN C's wallet vaguely. R1 indicated RN C is sarcastic and demeaning. R1 indicated he took money from RN C. R1 indicated he took the wallet out of his back pocket and nothing was in there. R1 indicated there was a there was a one hundred dollar bill and six dollar bills. R1 indicated he did not feel safe around RN C as he took the wallet out of RN C's pocket and RN C threatened he was going to hit me. R1 indicated he gave RN C the one hundred dollar bill that was in there (in the wallet). R1 stated He threatened me about three times. R1 indicated he tried to apologize to RN C, which did not make a difference as RN C was really mad. R1 indicated again RN C threatened him a few times. R1 indicated he does not feel safe at times, he did not tell anyone he threatened him due to being embarrassed. R1 again indicated RN C stated how mad he was at him and threatened to clobber (hit) him two or three times. At 11:45 AM, Surveyor brought DON B into the room with R1. R1 proceeded to tell DON B at this time RN C threatened him. DON B asked R1 why he didn't say anything before and R1 indicated he was embarrassed. On 3/19/20 at 12:35 PM, Surveyor interviewed RN C regarding the incident on 3/11/20 with R1. RN C indicated he saw R1 messing around with his coat which was in the Doctor's office. RN C indicated he didn't think much of it and he told R1 he was not to be in there. RN C indicated when he left for lunch he could not find his wallet. RN C indicated he went back to the facility and told R1 to give me, my wallet. RN C indicated he reached into R1's pocket and removed it. RN C indicated he stated If you ever touch my stuff again, I'll break your hands. RN C indicated he is sure he swore at R1 as well at this time. RN C indicated he then left to the gas station around approximately 7:15 PM. RN C indicated he could not remember what he did the rest of the shift as he has many duties. RN C indicated NHA A talked to him and he told NHA A exactly what he just told Surveyor. RN C indicated his statement could be abuse. RN C indicated it's not grandma and grandpa coming in, its [AGE] year olds and [AGE] year olds coming in who have no boundaries and think they can do whatever they want and don't have to respect anything. RN C indicated R1 knows exactly what he's doing and it's not just random to go into a jacket and steal money. RN C indicated he knows he shouldn't have said those things to R1 he was just so angry. RN C indicated R3 and R4 witnessed the incident. RN C indicated he received an education for anger management. On 3/19/20 at 12:50 PM, Surveyor informed NHA A, DON B, ADON G, and SW F regarding RN C's statement saying he told R1 he would break his hands. DON B indicated at this time she is unaware of any psychosocial assessment or follow up being done for R1 as R1's behavior has not changed. On 3/19/20 at 1:45 PM, R1's Psychosocial Note, signed by DON B, states, in part: Writer meets with (R1) on a daily basis, tends to come in writers office during day to hang out and listen to music and snack. Writer often asks (R1) if he has been taking his HS (bedtime) medications which he often refuses his Parkinson medication. (R1) has had not (sic) change in his demeanor with this writer, has been actually joking around more than what he did prior. When writer returned from vacation on 3/16/2020 (R1) greeted writer at the front door with a big smile and stated writer was missed. Writer did ask (R1) if he was good while writer was gone and he stated he was unless they made him mad. Incident on 3/11/2020 does not appear to have an effect on (R1). See grievance.
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 interview and record review the facility did not ensure all alleged violations involving abuse, neglect, exploitation or mistreatment of [REDACTED]. RN C indicated he threatened and swore at R1, this was not reported to the state agency within the prescribed time frame. This is evidenced by: Facility Policy entitled 'Abuse Prevention Program,' dated 3/2018 states, in part: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.7) Reporting/Responding: Abuse Policy Requirement: It is the policy of the facility to report all abuse, neglect, misappropriation of property of residents, exploitation and mistreatment of [REDACTED]. within specified timeframes. It is also the policy of the facility to report all reportable incidents as identified by State and Federal guidelines.Results of the investigation will be reported to the state within 5 days of the initial allegation.Procedure: Staff are to report suspected violations to their supervisor immediately, who in turn will notify the Administrator. The Administrator of designee will report to the state alleged abuse resulting in bodily injury (this includes sexual assault) within 2 hrs. of the allegation. If the alleged abuse does not result in bodily injury, the Administrator of designee will report no later than 24 hours from the allegation to the state. Results of the investigation will be reported to the state within 5 days of the initial allegation.The resident will be assessed for any needs every shift for 72 hours or until comfortable regarding incident. Nurse will chart each shift for 72 hours regarding resident's condition. Social Services will conduct safe

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) surveys. The Administrator with the assistance of the DON, Social Services and regional support will determine the findings of the investigation based on a thorough review of the incident information . R1 was admitted on [DATE], with [DIAGNOSES REDACTED]. Facility Grievance Log, indicates on 3/11/20 an alleged abuse grievance was filed by another Resident. NHA A (Nursing Home Administrator) and SW F (Social Worker) were assigned to the grievance on 3/12/20. The grievance log indicates a written warning was provided on 3/13/20. Please note that the facilities grievance log indicates that this situation is a potential abuse situation. The Facility's follow up for this grievance is as follows: NHA A's written summary states: 3-12-20 I received a phone call the evening of 3/11/20 saying that a resident had reported that (RN C) had made a comment that she perceived as threatening. (R1) had apparently stolen (RN C's) wallet and he got to (gas station) and couldn't find it and when he came back and found (R1) and retrieved it he made a statement while walking away. As it was the end of the shift and (RN C) was going home, I said I would complete interviews in the morning. I interviewed (R3) the resident who witnessed this and reported to the nurse. She said I think he said something like keep your hands off of my f***ing wallet, but I don't think (R1) heard him. I then followed up with (R1). I asked (R1) about what happened (R1 is difficult to interview) he told me he took (RN C's) wallet, I asked if (RN C) was mad and he laughed and shook his head yeah. I then asked if (RN C) said anything to him about it. He shook his head no. I asked if he felt scared or threatened, again he shook his head no. 3/13/20 I interviewed (RN C) today. He told the same story as above except he stated that he said Don't touch my f***ing wallet again. I explained to (RN C) that although (R1) did not hear this it is unacceptable to speak to a resident this way. I reviewed what constitutes abuse with him. He stated Don't we have any rights? Residents can do whatever they want to us any (sic) its ok. I again provided counseling and talked through the situation. I offered a locked office for (RN C) to keep his coat and wallet in. I issued a written warning and assigned an additional training on anger management. 3/16/20 (DON B) followed up with (R1) as she is back from vacation and has a close relationship with him. Facility follow up indicates staff interviewed 7 different residents and one family member related to interacting with RN C. On 3/19/20 at 10:25 AM, Surveyor interviewed SW F regarding the incident on 3/11/20. SW F indicated she received a phone call from ADON G. SW F stated ADON G indicated it was reported a wallet was stolen and RN C confronted the resident. SW F indicated RN C said Don't steal my f'ing wallet again. SW F indicated there is a potential for verbal abuse and it should have been reported. On 3/19/20 at 10:37 AM, Surveyor interviewed NHA A regarding the 3/11/20 incident with R1. NHA A indicated SW F called her after receiving a phone call from LPN E, indicating RN C made a comment while walking away from R1 of Don't touch my f***ing wallet again. NHA A indicated she felt it was an off the cuff comment and thought she needed to find out about the comment and wanted to see if it rises to the abuse level. NHA A indicated R1 was his normal self and indicated RN C was mad. NHA A indicated R3 did not believe R1 heard RN C. NHA A indicated she did not report it as R1 did not hear it and she did not feel it rises to abuse. NHA A indicated RN C was frustrated with R1 and was asking Don't we have any rights. NHA A indicated the facility just provided abuse training to staff. NHA A indicated the statement of breaking R1's arm first came up on Friday (3/13/20). NHA A indicated swearing at residents can be potential abuse. NHA A indicated in hind sight, yes I should of interviewed staff and reported this. On 3/19/20 at 12:35 PM, Surveyor interviewed RN C regarding the incident on 3/11/20 with R1. RN C indicated he stated If you ever touch my stuff again, I'll break your hands. RN C indicated he is sure he swore at R1 as well at this time. RN C indicated he then left to the gas station around approximately 7:15 PM. RN C indicated NHA A talked to him and he told NHA A exactly what he just told Surveyor. RN C indicated his statement could be abuse. It's important to note the facility did not report this incident to the state until 3/19/20 after Surveyors were investigating this situation. The facility had an opportunity to report this sitaution on 3/11/20. NHA A indicated they were aware on 3/13/20 a resident indicated RN C threatened to break R1's arm, yet the facility still failed to report the incident to the state. The full investigation was not reported to the state agency within 5 days of being alerted to the incident. Please reference F600.
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 interview and record review the facility did ensure it thoroughly investigated the alleged violations of abuse, neglect, exploitation or mistreatment, prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation is in progress for 1 of 4 sampled Residents (R1). The facility did not thoroughly investigate a verbal abuse incident involving R1 and RN C (Registered Nurse). This is evidenced by: Facility Policy entitled 'Abuse Prevention Program,' dated 3/2018 states, in part: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.5. Investigation: Abuse Policy requirement: The facility's immediate response is to protect the alleged victim. To protect the alleged victim, the facility has clear delineated roles of those responsible for investigating and will respond to ensure protection of the alleged victim, identify any other alleged victims, ensure the safety of all other residents and the integrity of the investigation. Procedures: The components of an internal investigation will be initiated immediately and may include: (see Investigation protocols follow the abuse policy components for specific investigation procedures) 1) an initial evaluation and interview. 2) a clinical history (if needed). 3) a physical examination (if needed). 4) a psychosocial evaluation (if needed), and interviews with potential witnesses. 5) Search of premises. 6) Collecting of evidence. 7) Documentation. Collection of evidence and documentation will be ongoing until determination is made. All involved persons will be identified including the victim, alleged perpetrator, witness(es) and others with any information about the incident.Protection: .Procedures: .The alleged perpetrator will immediately be removed from the facility and denied access to the alleged victim and all other residents.MD (Medical Doctor) and family will be notified.The alleged victim's care plan will be updated. The alleged victim will receive increased supervision and assessment through the investigation and as long as deemed necessary.Results of the investigation will be reported to the state within 5 days of the initial allegation. R1 was admitted on [DATE], with [DIAGNOSES REDACTED]. R1's Quarterly MDS (Minimum Data Set) dated 2/17/20 indicates R1 has a BIMS (Brief Interview of Mental Status) of a 4 out of 15, which indicates severe cognitive impairment. Section B indicates R1 is able to hear adequately, his speech is unclear, R1 is usually able to make himself understood, and is able to understand others. Section E indicates that R1 had wandering behaviors 4 to 6 days during the look back period. Section G indicates that R1 requires supervision while ambulating in his room and on the unit. Facility Grievance Log, indicates on 3/11/20 an alleged abuse grievance was filed by another Resident. NHA A (Nursing Home Administrator) and SW F (Social Worker) were assigned to the grievance on 3/12/20. The grievance log indicates a written warning was provided on 3/13/20. Please note that the facilities grievance log indicates that this situation is a potential abuse situation. The Facility's follow up for this grievance is as follows: NHA A's written summary states: 3/12/20 I received a phone call the evening of 3/11/20 saying that a resident had reported (RN C) had made a comment that she perceived as threatening. (R1) had apparently stolen (RN C's) wallet and he got to the (gas station) and couldn't find it and when he came back and found (R1) and retrieved it he made a statement while walking away. As it was the end of the shift and (RN C) was going home, I said I would complete interviews in the morning. I interviewed (R3) the resident who witnessed this and reported to the nurse. She said I think he said something like keep your hands off of my f***ing wallet, but I don't think (R1) heard him. I then followed up with (R1). I asked (R1) about what happened (R1 is difficult to interview) he told me he took (RN C's) wallet, I asked if (RN C) was mad and he laughed and shook his head yeah. I then asked if (RN C) said anything to him about it. He shook his head no. I asked if he felt scared or threatened, again he shook his head no. 3/13/20 I interviewed (RN C) today. He told the same story as above except he stated that he said Don't touch my f***ing wallet again. I explained to (RN C) that although (R1) did not hear this it is unacceptable to speak to a resident this way. I reviewed what constitutes abuse with him. He stated Don't we have any rights? Residents can do whatever they want to us any (sic) its ok. I again provided counseling and talked through the situation. I offered a locked office for (RN C) to keep his coat and wallet in. I issued a written warning and assigned an additional training on anger management. 3/16/20 (DON B) followed up with (R1) as she is back from vacation and has a close relationship with him. Facility follow up indicates staff interviewed 7 different residents and one family member related to interacting with RN C. On 3/16/20, DON B's (Director of Nursing) written statement, states, in part: Writer met with (R1) regarding an incident that occurred on 3/11/1965 (sic). Writer asked (R1) if he was good while writer was on vacation. (R1) stated unless the F pissed me off. Writer asked about a particular incident. (R1) remembered the incident and stated he made (RN C) furious when he took his wallet. (R1) went on to say that (RN C) had 6 dollars and a hundred in his wallet and he gave it back to (RN C). Writer asked (R1) if he felt threatened by (RN C) and (R1) stated no. Asked (R1) if (RN C) threatened him in any way and gave examples and (R1) stated no. Writer asked if (RN C) made a comment verbally of a threat and (R1) said no.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525452	A. BUILDING _____ B. WING _____	03/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELROY HEALTH SERVICES	307 ROYALL AVE ELROY, WI 53929

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) Writer asked (R1) is he (sic) was afraid of (RN C) and (R1) stated no. Writer asked (R1) if he like (sic) (RN C) and he stated not particularly. Writer asked why and (R1) stated that he is always telling him to take his meds (medications). (R1) does have some cognitive impairment, but writer feels his statements to be accurate. (R1) spends a lot of time with this writer during the day. On 3/13/20, RN C's Disciplinary Record form, signed by NHA A and ADON G (Assistant Director of Nursing) indicates the incident was inconsiderate care. Education assigned on anger management and a written warning provided. Describe the incident A resident took (RN C's) wallet from his coat. When he went to retrieve the wallet from the resident he stated, Don't touch my f***ng wallet again in a threatening tone. On 3/19/20 at 9:35 AM, Surveyor interviewed R3 regarding the incident she witnessed with R1. R3 indicated that RN C said he would break his hands or fingers. R3 indicated the incident was also witnessed by R4. R3 indicated that she told LPN E (Licensed Practical Nurse) and RN D about the incident. On 3/19/20 at 9:50 AM, Surveyor interviewed R4 regarding the incident she witnessed with R1. R4 indicated RN C got after R1 and threatened to break his hand, if he ever touched anything again. R4 indicated she told the nurse. On 3/19/20 at 10:01 AM, Surveyor interviewed RN D regarding the incident on 3/11/20 with R1. RN D indicated she spoke to R3 and R4, who witnessed the situation. RN D indicated R3 and R4 both indicated RN C said he was going to break his arms. RN D indicated she questioned if she should send him home, as they only had a half hour left in the shift. RN D indicated the supervisor (ADON G) was notified. RN D indicated she did not send him home due to afraid it might escalate to a physical altercation. RN D indicated no one has followed up with her on the incident and was told it was being handled. On 3/19/20 at 10:16 AM, Surveyor interviewed ADON G regarding the incident on 3/11/20 with R1. ADON G indicated she received a call from LPN E, and was unsure if LPN E overheard it or was told about it. ADON G indicated she then called SW F (Social Worker). ADON G indicated she was notified towards the end of the shift, so she did not pull him and RN C was off the next day. On 3/19/20 at 10:25 AM, Surveyor interviewed SW F regarding the incident on 3/11/20. SW F indicated she received a phone call from ADON G. SW F indicated ADON G indicated it was reported a wallet was stolen and RN C confronted the resident. SW F indicated RN C said Don't steal my f'ing wallet again. SW F indicated she offered to come into the facility, as it was the end of the shift. SW F indicated she was ensured he was not doing RN C was off the next day. SW F indicated they interviewed R3 but did not interview R4. SW F indicated RN C works as the evening shift charge nurse. On 3/19/20 at 10:37 AM, Surveyor interviewed NHA A regarding the 3/11/20 incident with R1. NHA A indicated SW F called her after receiving a phone call from LPN E, indicating RN C made a comment while walking away from R1 of Don't touch my f***ing wallet again. NHA A indicated she felt it was an off the cuff comment and thought she needed to find out about the comment and wanted to see if it rises to the abuse level. NHA A indicated RN C was not removed due to it being the end of the shift and was not providing care at this time as he was finishing up his work and would be leaving. NHA A indicated that RN C did not work the next day as he was off. NHA A indicated she did not feel it rises to abuse. NHA A indicated the facility just provided abuse training to staff. NHA A indicated R4 was not interviewed as she did not know R4 was in the lounge. NHA A indicated the statement of breaking R1's arm first came up on Friday (3/13/20) and R3 is now changing her story. NHA A indicated swearing at residents can be potential abuse. NHA A indicated staff interviews were not completed as it was reported by LPN E, and LPN E did not witness it. NHA A indicated she did not think staff interviews were pertinent due to R1 did not hear it. NHA A indicated in hind sight, yes I should of interviewed staff and reported this. On 3/19/20 at 12:35 PM, Surveyor interviewed RN C regarding the incident on 3/11/20 with R1. RN C indicated he stated If you ever touch my stuff again, I'll break your hands. RN C indicated that he is sure he swore at R1 as well at this time. RN C indicated he then left to the gas station around approximately 7:15 PM. RN C indicated NHA A talked to him and he told NHA A exactly what he just told Surveyor. RN C indicated that his statement could be abuse. RN C indicated that R3 and R4 witnessed the incident. There is no evidence that a thorough investigation was completed due to not taking witness statements from R4, LPN E, RN D, SW F, or ADON G, all of whom had knowledge of the situation. There is no evidence that an actual statement was taken from RN C at the time of the incident, other than what NHA A indicated in her statement. Please reference F600.