STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525616	A. BUILDING _____ B. WING _____	**07/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROSSROADS CARE CENTER OF MAYVILLE	**305 S CLARK ST MAYVILLE, WI 53050**

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 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Based on observation and interview, the facility did not ensure prompt resolution of all grievances for 1 of 4 sampled residents (R1). R1 voiced concerns with care. The facility had no evidence that they attempted to resolve the concerns. Evidenced by: R1's Nurse Note, dated 5/30/20 includes, in part: Writer approached by Former Activity Director I (FAD) about R1 wanting filling (SIC) a grievance about writer. FAD I reports (R1 stated), I told CNA D I had chest pain and CNA D told me she told RN E and RN E said she (R1) always has chest pain and then walked away. Then I told CNA D again and that's when RN E and LPN F came down. Then I told (another named staff member) again that I was complaining about chest pain and nothing got done and I'm fed up with this place and I want to file a grievance about RN E and the situation that I'm not getting taken care of. Writer then went down with LPN G as a witness to talk about the concern, R1 stated (named staff member) told her that he heard CNA D tell LPN F that I (R1) chest pain (SIC). Writer told R1 that when I was told she had chest pain I asked, Is it the same she has had since last night? The next time I walked by R1 was sleeping. Further I had been in a bit earlier and gave her her meds and she said nothing. R1 was told she was welcome to file a grievance but that RN felt like she was thrown under the bus even though she called DON B two times and then the on call and got labs drawn for her pain. Writer told R1 she was welcomed to refuse further care from RN however if she continues to fire staff then people to help her will continue to become limited. R1 replied, I'm not even sure I am going to talk to former NHA H. Writer called DON B to update on situation and was told that we had done everything possible here and that if she still wanted to go out she was welcome to. FAD I returned to room to update R1 who stated, I would like to be sent out. R1 volunteered that she got very heated at the moment and threw a spoon at RN E. 911 was called and responded to R1 for chest pain. Report was called to .emergency room . Facility policy, entitled Grievance Guideline, revised 1/27/17, includes, in part: At the time the grievance is noted . The staff member will,,, attempt to resolve the issue or direct the resident to the appropriate department head or staff member for further action and/or notify the Grievance Officer. Upon notification of a resident grievance, information sufficient to identify the individual registering the concern, the name of resident, date of receipt, nature of concern, and location of the resident will be recorded. The Grievance Officer will route the grievance to the appropriate department head related to the grievance filed, and an investigation of the grievance will be conducted .Al grievances receive immediate priority and must be investigated with efforts made toward resolution within 7 days. The resident will be provided with a verbal follow up to their grievance including the following information: The name of the Department Head who conducted the follow up/investigation, steps taken to investigate and resolve the grievance, the final result of the grievance. Additionally the resident may obtain a written decision regarding his/her grievance upon request. On 7/27/20 at 11:20 AM during an interview, DON B indicated there was no grievance filed for R1 related to the 5/30/20 Nurses Note and there should have been. DON B stated she called the former NHA H and he indicated a grievance was not filled out regarding this incident. On 7/27/20 at 1:00 PM during an interview, LPN F indicated he did not fill out a grievance and had already left for the day when the Nurses Note was written. He would have filled one out with or for R1, if R1 told him she wanted to fill one out. On 7/27/20 at 1:05 PM during an interview, CNA D indicated she did not fill out a grievance for R1 and did not assist R1 in filling one out. CNA D indicated she had reported the concern to RN E and LPN F. On 7/27/20 at 1:30 PM NHA A indicated a grievance was not filled out, but should have been. (It is important to note facility did not provide evidence that a grievance was filled out, investigated, or resolved for R1's concern regarding the care she received.)

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