STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525363	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAY AT SURING HEALTH AND REHAB CENTER (THE)	430 MANOR DR SURING, WI 54174

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 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.** Based on record review and staff interview, the facility did not ensure all allegations of abuse and misappropriation were reported to the State Survey and Certification Agency for 3 Residents (R) (R1, R4 and R3) of 11 residents reviewed for abuse allegations. R2 was observed with arm around R1's shoulder and grazing hand down R1's side (close to breast area) on 5/1/2020. Additionally, R2 was observed rubbing R1's back and neck areas, and was removed from R1's room. The allegation of potential abuse was not reported within 24 hours to the State Agency. An allegation of potential verbal and physical abuse regarding R4 was reported to the facility. The allegation of potential abuse was not reported within 24 hours to the State Agency. R3 reported on 3/23/2020 or 3/24/2020 that $180 was missing from R3's wallet. The allegation of potential misappropriation of money was not reported within 24 hours to the State Agency. Findings include: The facility policy entitled Abuse Investigation and Reporting with a revised date of July 2017, indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, and mistreatment shall be promptly reported to local, state and federal agencies (as defined by current regulations). Findings of these investigations will also be reported. An alleged violation of abuse, neglect, exploitation, and mistreatment including misappropriation of resident property will be reported immediately, but not later than two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury, or twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. The facility will provide the State Agency with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. 1. On 5/12/2020, a complaint was received by the State Agency indicating R2 had inappropriately touched R1's shoulder and breast area. The complaint indicated the potential allegation of abuse had not been reported to the State Agency. On 5/13/2020 at 2:36 PM, the Surveyor interviewed facility SW (Social Worker)-C via telephone regarding the potential allegation of abuse. SW-C stated R2 touched R1's side which was close to the breast area. On two occasions, R2 got handsy with R1 by placing R2's hand on R1's shoulder and sliding hand down the side of R1's arm. R2 was moved to another room in the facility and R1 was placed on a one to one. Care plans for R1 and R2 were both updated as maybe R1 touched R2 first because R1 has the mental capacity of an 18 month old. R2's cognition was intact. SW-C stated an allegation of abuse was made to the facility and the allegation was not reported to the State Agency. The information/investigation related to the abuse was placed in a soft file at the facility. This allegation of abuse should have been reported to the State Agency per SW-C. On 6/2/2020, the Surveyor reviewed the investigation completed by the facility regarding R2 touching R1. The investigation indicated on 5/1/2020, staff reported to NHA (Nursing Home Administrator)-A that R2 had arm around R1's shoulder and grazed hand down R1's side. R1 and R2 were split up immediately and NHA-A spoke with R2 about keeping (R2's) interactions appropriate. On 5/2/2020, NHA-A received a message from facility staff that staff needed to pull R1 and R2 apart five or six times and R2 was stopped from going in R1's room. NHA-A asked if anybody saw R2 inappropriately touching R1. Staff stated R2 would have touched R1 inappropriately if staff didn't stop R2 from going in R1's room and R2 would've copped a feel if staff didn't intervene. NHA-A advised staff to put R1 on a strict one to one and to have a conversation with R2 about appropriate behavior. R1's care plan was updated to reflect one on one and R2's room was moved down the other hallway to keep them further apart due to them being in neighboring rooms. R2's shower day was changed to Saturday early in the morning as a male CNA (Certified Nursing Assistant) works every Friday night shift and would be willing to complete R2's shower each week. This would eliminate female staff members from having to do R2's shower and will hopefully help alleviate any inappropriate behavior towards staff. R2 does at times make advances towards staff, but is easily redirected with reminders. The investigation included written statements from staff members. An unknown staff (requested name of staff twice with additional page of documentation) member documented on 5/2/2020 that R2 was informed prior to breakfast that R2 needed to be six feet apart from R1. R2 moved away and then moved back by R1 and started rubbing R1's back. After breakfast, R2 sought out R1 again and was rubbing R1's back. R2 was moved to another room and when interviewed stated R1 likes it when I touch her. The writer then informed R2 that staff observed (R2) touching (R1's) breast this morning and entering (R1's) room and was taken out of (R1's) room by another staff. The investigation revealed statements written by staff pertaining to the investigation of R2 touching R1. One statement was written by CNA (Certified Nursing Assistant)-F on 5/2/2020. CNA-F documented CNA-F saw R2 rubbing (R1's) neck. Another statement was written on 5/2/2020 by HA (Housekeeping Aide)-G which stated on 5/2/2020, at approximately 12:30 PM, HA-G observed R2 sitting by R1 in the lobby and saw R2 rubbing R1's back. R2 noticed HA-G watching and stopped rubbing R1's back, then left the lobby area. On 6/2/2020 at 3:30 PM, the Surveyor interviewed RN (Registered Nurse)-E regarding R2 touching R1. RN-E stated the allegation of R2 inappropriately touching R1 was reported to NHA-A on Friday 5/1/2020 or Saturday 5/2/2020. RN-E was made aware on 5/2/2020 that R1 was a one to one because R2 was seeking out R1. RN-E was told R2's room was moved because R2 was seeking out R1 and trying to touch R1. R2 has a history of touching female staff inappropriately and R2 has brushed an arm on RN-E's butt before. On 6/3/2020 at approximately 4:00 PM, the Surveyor interviewed NHA-A via telephone regarding R2 touching R1. NHA-A stated the facility decided the incident was not abuse as the facility did not feel touching R1 was malicious in action as R2 had not touched R1's breast area. The facility did not report the incident to the State Agency because the facility did not feel that R2 was going to R1 in a sexual way. Facility staff did not see R2 with anyone else. R2 will make dirty comments when showering. That is why showering assistance was switched to male staff. Staff that were working the day of the incident were interviewed regarding R2 touching R1. 2. On 5/13/2020 at approximately 7:56 PM, the Surveyor interviewed SW-C via telephone. SW-C indicated on 4/14/2020 between approximately 5:30 PM and 6:00 PM, SW-C overheard CNA-H yelling and swearing at R4, and other residents. When SW-C went to assist, SW-C observed CNA-H pulling on R4's arm. This was reported to HR (Human Resources)-I the next day by SW-C as an allegation of abuse. On 6/2/2020 at 1:54 PM, the Surveyor interviewed HR-I via telephone on speaker phone with NHA-A present in NHA-A's office. HR-I verified SW-C reported to HR-I the following day (4/15/2020) that CNA-H was yelling, swearing and pulling on R4's arm the night before. HR-I stated SW-C stated it was an allegation of abuse. HR-I stated when CNA-H got to work, CNA-H was interviewed and CNA-H stated CNA-H did not pull R4's arm, but guided R4 down the hall. There were not any staff or resident witnesses. There were not any marks on R4's arms when observed the next day. NHA-A stated, If this truly was abuse, why didn't I get a phone call? NHA-A then stated, Yes, would report (to the State Agency) if found true abuse. Additionally, NHA-A indicated CNA-H admitted to being frustrated with R4. On review of CNA-H's personnel file, it was noted, CNA-H received an employee warning on 4/20/2020 for unsatisfactory behavior towards staff or elders. The date of violation varied. The warning indicated CNA-H's attitude while at work has been increasingly unprofessional towards both staff and residents. Raising your voice, speaking cruel/rude words in a negative tone of voice, and nonverbal gestures are all issues CNA-H needs to improve on. Take a break off the floor when becoming frustrated to alleviate

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) outbursts. Failure to improve will result in a consequence of suspension/dismissal. 3. On 5/12/2020, a complaint was received by the State Agency indicating R3 had $180 missing from R3's wallet and the missing money had not been reported to the State Agency. On 6/2/2020, the Surveyor reviewed the investigation completed by the facility regarding R3's missing money. The investigation indicated SW-C was notified by HS (Housekeeping Supervisor)-D on 3/24/2020 that R3 reported R3 was missing money. SW-C interviewed R3 and R3 stated, I think that one guy who walks around probably took it. R3 was missing $180. On 3/24/2020, a memo was put out to the staff which indicated R3 had missing money. The memo stated if anyone has seen the money or has any knowledge of this money to let NHA-A or SW-C know. On 3/27/2020, SW-C noted in R3's medical record that RN-E had created a late entry on 3/24/2020 at 5:56 PM with an effective date of 3/21/2020 at 6:01 PM. The late entry stated R3's family member brought money to the facility for R3. RN-E took the money to R3 and asked R3 if R3 would like RN-E to put the money in the narcotic lock box for safe keeping. R3 stated, No, it's just $180.00. I'll just keep it. RN-E performed risk vs benefit of keeping own money. On 4/3/2020, SW-C contacted the police department regarding R3's missing money. The police report indicated a staff member remained a suspect, but there was not enough information available to move forward with charges. The facility did not report the allegation of misappropriation of resident property to the State Agency until 5/6/2020. On 5/13/2020, HS-D wrote a statement which indicated R3 went to a dresser drawer in R3's room, took R3's wallet out of the drawer, opened the wallet, was swearing that someone took (R3's) money, and said I had $180.00 in it (wallet). HS-D indicated on the written statement that HS-D went to SW-C right away and advised SW-C of the allegation of misappropriation immediately. On 4/16/2020, the investigation regarding R3's missing money indicated NHA-A was informed of the investigation regarding R3's missing money. NHA-A indicated R3 did not report the money stolen, but rather missing. NHA-A held an all staff meeting on 4/15/2020 regarding the proper procedure on accepting money from residents and their friends/family. On 6/2/2020 at 11:40 AM, the Surveyor interviewed SW-C regarding the written investigation related to R3's missing $180.00. SW-C verified the information documented above in the investigation was accurate. SW-C then stated the allegation of missing money was not reported to the State Agency within 24 hours and/or five (5) days and should have been reported as R3 indicated someone took the money from R3's wallet. On 6/2/2020 at 2:08 PM, the Surveyor interviewed NHA-A regarding reporting R3's missing $180.00. NHA-A stated R3 did not tell NHA-A someone took the money. Initially, it was thought R3 had not received the money. If R3 had told NHA-A the money was stolen, NHA-C would have reported the allegation of missing money to the State Agency prior to sending in the 24 hour and five (5) day report together on 5/6/2020. The allegation of missing money was not submitted per OCQ (Office of Caregiver Quality) because the report stated DRAFT across the report. If DRAFT is printed on the report, the report was not submitted to OCQ.
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 alleged violations involving potential abuse were thoroughly investigated involving 2 Residents (R) (R1 and R4) of 11 sampled residents. Staff reported R2 touched R1 inappropriately. The facility did not conduct a thorough investigation of the incident to rule out abuse. Staff reported a CNA (Certified Nursing Assistant) was yelling, swearing and pulling on R4's arm. The facility did not conduct a thorough investigation of the incident to rule out abuse. Findings include: The facility policy entitled Abuse Investigation and Reporting with a revised July 2017, indicated any reports of resident abuse will be thoroughly investigated by facility management. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The individual conducting the investigation will, as a minimum interview the person(s) reporting the incident; interview any witnesses to the incident; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, and interview other residents to whom the accused employee provides care or services. 1. On 6/2/2020, the Surveyor reviewed the investigation completed by the facility regarding R2 touching R1. The investigation indicated on 5/1/2020, staff reported to NHA (Nursing Home Administrator)-A that R2 had arm around R1's shoulder and grazed hand down R1's side. R1 and R2 were split up immediately and NHA-A spoke with R2 about keeping (R2's) interactions appropriate. NHA-A advised staff to put R1 on a strict one to one and to have a conversation with R2 about appropriate behavior. R1's care plan was updated to reflect one on one and R2's room was moved down the other hallway to keep them further apart due to them being in neighboring rooms. R2's shower day was changed to Saturday early in the morning as a male CNA works every Friday night shift and would be willing to complete R2's shower each week. This would eliminate female staff members from having to do R2's shower and will hopefully help alleviate any inappropriate behavior towards staff. R2 does at times make advances towards staff, but is easily redirected with reminders. An unknown staff member documented on 5/2/2020 that R2 was informed prior to breakfast that R2 needed to be six feet apart from R1. R2 moved away and then moved back by R1 and started rubbing R1's back. After breakfast, R2 sought out R1 again and was rubbing R1's back. R2 was moved to another room and, when interviewed stated, R1 likes it when I touch her. The writer then informed R2 that staff observed (R2) touching (R1's) breast and this morning entering (R1's) room and was taken out of (R1's) room by another staff. On 6/3/2020 at approximately 4:00 PM, the Surveyor interviewed NHA-A via telephone regarding R2 touching R1. NHA-A stated the facility decided the incident was not abuse as the facility did not feel touching R1 was malicious in action as R2 had not touched R1's breast area. The facility did not feel that R2 was going to R1 in a sexual way. The investigation did not include documentation that the incident had been thoroughly investigated, as additional residents were not interviewed regarding the allegation of abuse. 2. On 5/13/2020 at approximately 7:56 PM, the Surveyor interviewed SW (Social Worker)-C via telephone. SW-C indicated on 4/14/2020 between approximately 5:30 PM and 6:00 PM, SW-C overheard CNA-H yelling and swearing at R4, and other residents. When SW-C went to assist, SW-C observed CNA-H pulling on R4's arm. This was reported to HR (Human Resources)-I the next day by SW-C as an allegation of abuse. On 6/2/2020 at 1:54 PM, the Surveyor interviewed HR (Human Resources)-I via telephone on speaker phone with NHA-A present in NHA-A's office. HR-I verified SW-C reported to HR-I the following day (4/15/2020) that CNA-H was yelling, swearing and pulling on R4's arm the night before. HR-I stated when CNA-H got to work, CNA-H was interviewed and CNA-H stated CNA-H did not pull R4's arm, but guided R4 down the hall. There were not any staff or resident witnesses. R4 was not interviewed as R4 had a [DIAGNOSES REDACTED]. The facility did not have a documented investigation of the allegation of abuse. Additionally, the facility did not have documentation that indicated the incident had been thoroughly investigated, as additional staff and residents were not interviewed regarding the allegation of abuse.