STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525693	A. BUILDING _____ B. WING _____	**09/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWN CTY COMM TREATMENT CTR-BAYSHORE VILLAGE	**3150 GERSHWIN DRIVE GREEN BAY, WI 54311**

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	**Respond appropriately to all alleged violations.** Based on staff interviews and record review, the facility did not ensure an allegation of resident (R) to resident abuse was thoroughly investigated for 1 of 1 Facility Reported Incidents (FRI) reviewed involving 2 residents (R1 and R2) of 3 sampled residents. The facility did not obtain a statement from the first staff member to respond to a resident to resident incident; the FRI did not identify who discovered R2 on the floor. The facility investigation only contained interviews with Licensed Practical Nurse (LPN)-C, R1, and R2; no other staff or residents were interviewed. Findings include: On 9/14/2020, Surveyor reviewed FRI which documented a resident to resident altercation occurring on 4/18/2020 between R1 and R2. Per the FRI, R1 entered R2's room, hit R2's shoulder, pushed R2 to the ground, and took R2's glasses. Per FRI information, R2 was on the floor at the time LPN-C entered the room and the documented events above were R2's account of what happened. LPN-C's interviewed statement documented by Registered Nurse (RN)-E included detail that R1 was seen walking down the hallway away from (R2's) room, with (R2's) glasses in hand. On 4/18/2020, R1 and R2 were both interviewed. R1 could not recall which room R1 had been in, denied hitting anyone, and did not know where R2's glasses came from. R1 was provided one on one supervision following the incident. Surveyor noted the FRI only contained interview statements of LPN-C, R1 and R2. On 9/15/2020 at 2:50 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-D via telephone regarding the 4/18/2020 incident. CNA-D verified working in the facility at the time of the resident to resident altercation. CNA-D recalled hearing R2 yell. When CNA-D arrived in R2's room, R2 was on the floor and R2's wheelchair was on the other side of the room, which was unusual. CNA-D described R2 as shook up at the time CNA-D arrived. CR2 indicated the person who lived across the hall hurt R2. NA-D immediately paged LPN-C. CNA-D verified the facility provided R1 with one on one supervision following the incident and indicated that R1 was being checked on every 15 minutes from admission until the time of the incident as part of being a new resident. Surveyor noted FRI documents did not indicate CNA-D was the first to respond to the resident to resident altercation and the FRI did not contain an interview or statement from CNA-D. FRI documents did not mention 15 minute checks or the most recent time R1 was visualized by staff prior to the incident. On 9/15/2020 at 9:04 PM, Surveyor interviewed LPN-C via telephone regarding the 4/18/2020 incident between R1 and R2. LPN-C recalled being in the process of passing medications at the time he saw R2 on the floor. LPN-C verified CNA-D was the first staff to respond to R2's room. LPN-C indicated that at the time LPN-C responded, R1 was in the day room. LPN-C recalled R1 saying they and that guy were hoarding cigarettes and not giving them back. LPN-C indicated R1 was on 15 minute checks prior to the altercation as part of being a new admission. Surveyor noted LPN-C's interview was documented by RN-E and did not include information about R1's cigarette comments or that CNA-D was first to respond. Surveyor again noted 15 minute checks were not part of the FRI documentation. On 9/15/2020 at 12:38 PM, Surveyor interviewed RN-E via telephone regarding the 4/18/2020 incident. RN-E recalled being at the nurse station when LPN-C came to get RN-E. RN-E immediately placed R1 on one to one supervision. RN-E assessed R1 and R2, documented LPN-C's statement, and contacted the on-call supervisor. During a follow-up interview with RN-E on 9/16/2020 at 2:37 PM, RN-E indicated the usual practice is to interview anyone who RN-E knows to be involved in an incident and document the interviews in the Point Click Care (Electronic Health Record software) incident report via a drop down menu that allows names and interviews to be entered. RN-E could not recall which CNAs were on duty the night of the 4/18/2020 incident but if LPN-C mentioned another staff member, that person would be interviewed. RN-E also indicated that the on-call supervisor has a practice to ask questions and direct investigations at the time of the call to report an incident. RN-E recalled 4/18/2020 in particular had multiple incidents and estimated RN-E completed three to five incident forms for different events that occurred. On 9/15/2020 at 12:24 PM, Director of Nursing (DON)-B explained to Surveyor during telephone interview that the facility practice generally includes other resident interviews but it depends on if an event is witnessed or unwitnessed. DON-B verified not finding documentation of other resident interviews as part of this incident's investigation. At 1:18 PM, DON-B indicated to Surveyor via email that the facility InterDisciplinary Team met and decided not to pursue doing other interview due to (R1) being in the facility for less than 24 hours and it being a witnessed event. On 9/16/2020 at 12:12 PM, Nursing Home Administrator (NHA)-A communicated to Surveyor via email that neither LPN-C or CNA-D were true spectators to the altercation. NHA-A verified the facility did not have a statement by or interview with CNA-D documented for this FRI. On 9/16/2020 at 9:18 AM, NHA-A indicated to Surveyor that 15 minute checks are not a standard intervention for new admissions. NHA-A verified R1 was admitted to the facility as an Emergency Protective Placement following being found wandering into another person's home. NHA-A indicated the facility did not initiate 15 minute checks for R1 as evidenced by the baseline (admission) care plan. Surveyor asked how the facility planned to keep other residents safe from R1 who was admitted with a known history of wandering into other's homes. NHA-A indicated staffing levels were five star with three staff per ten residents. NHA-A also asserted that it is not the facility's practice to obtain staff statements from all staff responsible for a resident's care when a resident is involved in a resident to resident altercation.

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.