STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525686	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MUSKEGO HEALTH CARE CENTER	S77 W18690 JANESVILLE RD MUSKEGO, WI 53150

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that 1 (R1) of 1 allegations involving potential abuse or misappropriation were thoroughly investigated. R1 made an allegation of abuse to RN (Registered Nurse)-C and called the police on 5/29/20. The facility did not have evidence that R1's allegations of abuse were thoroughly investigated. There were no statements taken from R1 that documented the details of her allegation, such as who was pushing her up against the wall, and when the incident(s) occurred. There were no statements taken from RN-C, whom was working at the time of the allegation, and whom R1 reported the alleged abuse to. The facility did not have evidence that they attempted to speak with or obtain additional information from PO (Police Officer)-G regarding R1's allegation of abuse. Findings include: The facility's policy dated as reviewed and revised in 2019 and titled, POLICY FOR CLIENT ABUSE & MISUSE OF CLIENTS PROPERTY documents, Muskego Nursing Home prohibits mistreatment, neglect and abuse and misappropriation of resident property. All alleged violations involving mistreatment, neglect and abuse, including injuries of unknown source, and misappropriation or resident property are to be reported immediately to the Charge Nurse, Director of Nursing and Administrator of Muskego Nursing Home and to other officials in accordance with Wisconsin state law. Muskego Nursing Home investigates all alleged violations thoroughly according to procedures established by the facility. Muskego Nursing Home assures that further potential abuse is prevented during the investigation procedure. Under the PROCEDURES FOR CLIENT ABUSE AND MISUSE OF CLIENTS PROPERTY section it documents, The facility begins its investigative process by: 1. Assessing the resident involved for any evidence of injury; 2. Talking to an employee alleged to have abused a client or misused a client's property. 3. Once an allegation has been made against an employee the employee will be suspended, and removed from the facility, pending the outcome of the investigation. 4. The Administrator, Director of Nursing, or Charge Nurse will stay with the alleged employee until they have exited the building. The following needs to be followed when investigating an alleged abuse or misuse of client's property: 5. Interview all persons who would have information regarding the alleged abuse examples: photos, tapes, and medical records. The facility's policy dated as reviewed on October 2019 and titled, ADDENDUM: ABUSE POLICY documents; 8. Documentation regarding the abuse situation is to be kept in a separate file. Include the following in the file: a. Residents face sheet; b. Incident report; c. All statements; d. All interviews; e. Staffing Schedules and assignment lists; f. Nursing documentation for 24 hours following incident; g. Verification that all appropriate State and Federal agencies has been notified. On 6/29/20, a complaint was filed with the Southeastern Regional Office that alleged that on 5/28/20, R1 called the police to report an allegation of abuse. The complaint also alleged that the facility did not report these allegations to the State Agency and or have documentation regarding R1's allegations. R1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. R1's Quarterly MDS (Minimum Data Set) dated 6/30/20 documents a BIMS (Brief Interview of Mental Status) score 15, indicating that R1 is cognitively intact. Section E0100 ([MEDICAL CONDITION]) documents that R1 did not have Hallucinations and or Delusions. R1's Behaviors Care Plan dated 6/1/20 documents under the Care Area section, Behaviors: Accusatory towards staff; can speak and understand English but will at times claim only understands Spanish. Under the Interventions section it documents, Has been known to call 911; Contact CC (Community Care) caseworker, family if noncompliant, accusatory; Report to Nursing staff and accusations. R1's nursing note written by RN (Registered Nurse)- C and dated 5/29/20 at 12:15 a.m. documents, Resident called 911 to complain of staff pushing her (R1) into the wall. At the time of her complaint, the aides (Certified Nursing Assistants) had not rounded off on her. Staff .and writer went in the room to check on her (R1) because from the call to 911, they thought someone was in the car parking (lot) (sic). R1 was on her phone speaking in Spanish. Resident was checked and changed. Will continue to monitor per plan of care. Surveyor was unable to locate any additional information regarding R1's allegation of abuse as documented on 5/29/20 in R1's medical record. On 7/1/20 at approximately 11:32 a.m., Surveyor asked DON (Director of Nursing)-B for any investigation and or documentation regarding R1's above allegation. On 7/1/20 at 11:54 a.m., DON-B provided Surveyor with a copy of R1's facility self-report dated 6/18/20 and faxed into the the State Agency on 6/18/20. The facility's self-report dated 6/18/20 included the facility's investigation regarding R1's allegation of abuse as documented on 5/29/20. R1's Facility Self-Report and Investigation dated 6/18/20 documents under the Summary of Incident section; The Resident called 911 on 5-28-2020 at 23:45 (11:45 pm) spoke to a dispatcher stated to dispatcher per report that she was getting hit and pushed and she did not want to be there anymore. She wanted to go live with her daughter. PO (Police Officer)-G responded at 5-29-20 0:07. His summary stated that his investigation revealed the last few nights (R1's name) refused to accept help with being changed and additional staff was used. PO-G stated he would make contact with family in morning. Resident has ongoing behavioral issues. Staff work in twos for cares. She did not identify any staff who she was accusing. She did make comments after the police left during cares in front RN (Registered Nurse)-C that staff were pushing her against the wall. RN-C reassured her that this was not happening. RN-C stated no bruising or marks on body. Muskego Police Department's Roll Call Summary dated 5/28/20 documents, WCC (Waukesha County Communication Center) transferred R1 who dialed 911 to report she was pushed by staff at Muskego Health Care Center and wanted to live with her daughter. Officer sent. Investigation revealed that the last few nights, R1 refused to accept help with being changed and additional staff had to assist. PO (Police Officer)-G will make contact with family members in the morning. The facility's self-report investigation included a statement written on 6/16/20 by DON-B that documents, Regarding: R1; I was asked today (6/16/20) at about noon to come into the conference room. There was a meeting being held with R1's case workers from community care. They were asking .about an incident that took place on 5/29/20. They explained that R1 placed a 911 call on 5/29/29. They went on to say that she (R1) made accusations towards staff. I explained to them I knew about her ongoing behaviors. Making comments like the staff are prejudiced because no one knows Spanish. Refusing to get out of bed. Refusing her meals. Refusing cares .Therefore, the staff always work in twos. I stated I really feel nothing took place that night otherwise it would have been reported to me (DON-B) or the Administrator. I explained to them about the ongoing issues with R1's behaviors. Then one of them (case worker from Community Care) stated they are just now piecing this together. They now are aware that she had a behavioral support team in the past in Milwaukee County. Waukesha County was not aware of this .They then went on to tell us they reported this as abuse to Quality Assurance (State Agency). We assured them no abuse took place. She (R1) had just been acting out more than usual with her comments. All staff here are continuing to work in pairs .I made Administrator aware of this after the meeting. I then went to speak with RN-C who was on that night. RN-C did speak with police when they came. RN-C stated the police stated they thought she (R1) was in the parking lot. RN-C explained she (R1) was in bed and is unable to get out of bed without assistance. RN-C stated police did go see her. They (police) then left without saying anything. RN-C was in the room when staff were cleaning her after police left. R1 kept on stating during the cares that the staff was pushing her against the wall. RN-C reassured her that his was not happening .RN-C knew these were fabricated comments therefore not necessary to contact Administrator. Also spoke with staff on duty that night, nothing unusual occurred. No abuse identified. Surveyor noted that DON-B's statement documented that RN-C had not reported to her (DON-B) R1's allegation of abuse on 5/29/20. Surveyor noted the facility's investigation did not include any written

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

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) statements from RN-C or R1 regarding R1's allegation of abuse as documented by RN-C on 5/29/20. Surveyor could not locate any documentation or evidence that RN-C reported the above incident to DON-B or Administrator-A on 5/29/20. Surveyor noted that the investigation provided did not include any evidence that the facility thoroughly investigated R1's allegation of abuse as reported on 5/28/20 to the 911 dispatcher and on 5/29/20 to RN-C and PO-G. Surveyor noted the facility's investigation did not include any follow up or a written statement from PO-G. The facility's investigation also did not include any evidence that RN-C or DON-B interviewed R1 and attempted to locate whom, if any, staff members R1 was alleging abuse from as documented above. On 7/1/20 at 12:32 p.m., Surveyor attempted to interview, via telephone, PO-G regarding R1's allegation of abuse as documented on 5/29/20. A voicemail was left for PO-G and as of the time of the investigation, no return phone call by PO-G had been received by Surveyor. On 7/1/20 at 12:50 p.m., Surveyor interviewed R1, in Spanish, regarding her allegations of abuse as documented on 5/29/20. Surveyor asked R1 if anyone had abused her as she alleged on 5/28/20 to the 911 dispatcher and on 5/29/20 to the police. R1 informed Surveyor that on 5/29/20 she (R1) tried to report to RN-C and the police that CNA-E and CNA-F were pushing her into the wall and that CNA-E was hurting her by pressing down on her left side of her rib cage. R1 informed Surveyor that RN-C did not take her statement and told her she (R1) was lying. R1 informed Surveyor that the police officer (PO-G) told her that he would call R1's daughter in the morning. R1 informed Surveyor that the morning of 5/29/20, she again attempted to report her abuse allegations to SWA (Social Worker Assistant)-D whom knew some Spanish. R1 informed Surveyor that SWA-D did not believe her and told her that he (SWA-D) would look into it, but that she (R1) never heard back from SWA-D. R1 then stated that SWA-D came into her room and took her personal cell phone and charger away from her. R1 informed Surveyor that SWA-D told her that because she (R1) kept calling 911, she could not have her personal cell phone. After interviewing R1, Surveyor immediately reported the above findings to DON-B whom initiated an investigation into the above allegations. Surveyor was unable to locate any documentation in R1's medical record that SWA-D documented, investigated, interviewed and or reported R1's allegation of abuse on 5/29/20 as described by R1. Surveyor was unable to interview SWA-D because at the time of the investigation, SWA-D was no longer employed by the facility. On 7/1/20 at 1:13 p.m., Surveyor interviewed RN-C regarding R1's allegations of abuse as documented on 5/29/20. Surveyor asked RN-C to describe what occurred in the early morning of 5/29/20. RN-C informed Surveyor that in the early morning of 5/29/20 she was notified that R1 had called 911 and that she (RN-C) went into R1's room prior to police arriving and asked R1 what was going on. RN-C informed Surveyor that R1 stated to her (RN-C) that facility staff were pushing her into the wall but that R1 did not name any specific staff names and simply stated they. RN-C informed Surveyor that police then arrived and that she left R1's room. RN-C told Surveyor that PO-G then left without speaking to her and that she and the other two CNA's went into R1's room when R1 received cares. RN-C informed Surveyor that she saw no abuse occur in the part of the staff working the night of 5/28/20 into the early morning of 5/29/20. Surveyor asked RN-C if she investigated R1's allegation of abuse and or took a statement from R1 regarding her allegations of abuse as reported to her (RN-C) on 5/29/20. RN-C informed Surveyor that she did not investigate or take any statement from R1 when R1 reported alleged abuse to her on 5/29/20. Surveyor asked RN-C if she notified DON-B or Administrator-A of R1's allegation of abuse on 5/29/20. RN-C informed Surveyor that because R1 was always making statements she did not report to DON-B or Administrator-A R1's allegation of abuse as reported to her by R1 on 5/29/20. On 7/1/20 at 4:10 p.m., Surveyor informed DON-B of the above findings. Surveyor asked DON-B if she (DON-B) had interviewed or taken a statement from R1 at any time regarding her allegation of abuse as documented on 5/29/20. DON-B informed Surveyor that she had not interviewed or taken a statement from R1 at any time regarding her allegation of abuse on 5/29/20, because she believed other facility staff had obtained one from R1 already. Surveyor asked DON-B if RN-C should have reported to her R1's allegation of abuse on 5/29/20. DON-B informed Surveyor that RN-C should have reported to her R1's allegation of abuse on 5/29/20 and that if RN-C had, she (DON-B) would have investigated R1's allegations of abuse (prior to 6/16/20). DON-B provided all staff inservice training conducted on 6/24/20 regarding the need to immediately report all allegations of abuse to the Administrator and DON however, no additional information was provided as to why the facility did not ensure that R1's allegation involving potential abuse was thoroughly investigated.