| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525689 | A. BUILDING _____ B. WING _____ | 06/23/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| MAPLE LANE HEALTH SERVICES | N4231 STATE HWY 22 SHAWANO, WI 54166 |

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) |
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| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interview, the facility did not ensure all allegations of verbal and physical abuse were reported to the State Survey and Certification in a timely manner for 2 Residents (R) (R1 and R2) of 6 residents reviewed. Multiple staff and residents witnessed an instance of verbal abuse between CNA (Certified Nursing Assistant)-C and R1. The verbal abuse was not reported to NHA (Nursing Home Administrator)-A or the State Survey and Certification Agency in a timely manner. R6 entered R2's room and kicked R2 in the shin. Staff were alerted when they heard R2's screams. The allegation of physical abuse was not reported to the State Survey and Certification Agency. Findings include: The facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy states: It is the policy of the center to encourage and support all residents, team members, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property. Reporting and Response Components It is the policy of this center that abuse allegations .are reported per Federal and State Law. The center will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately .but not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the center and the DQA (Division of Quality Assurance) in accordance with State law through established procedures. Training Components It is the policy of this center to train team members, through orientation and on-going sessions on issues related to abuse and prohibition practices. Team members, contracted team members will receive education about resident mistreatment, neglect and abuse .including abuse policies and procedures. Internal Reporting a. Team members .will receive orientation and education on the center's Abuse Policy and reporting requirements. Team members must always report any abuse or suspicion of abuse immediately to the Administrator. 1. The Surveyor reviewed a facility self-report submitted to the State Agency on 5/31/20. The report stated on 5/31/20, R1 informed NHA-A that CNA-C swore at R1 on the evening of 5/29/20. R1 exited the facility to smoke and rang the doorbell six times when finished smoking. When CNA-D answered the door, R1 used vulgar language and asked why CNA-C didn't answer the door. CNA-D informed R1 that CNA-C was off-duty and in the facility visiting R7. R1 remained at the nurses' station until CNA-C exited R7's room. When CNA-C exited R7's room, R1 called CNA-C a derogatory name and the two exchanged words. The investigation stated R4 heard the altercation and confirmed R1 and CNA-C swore at each other. CNA-D witnessed the altercation and stated CNA-C used profanity and stated R1, was lazy and lived off the government and shouldn't be going outside to smoke. LPN (Licensed Practical Nurse)-E and CNA-F also witnessed the incident and verified CNA-C used profanity during the interaction with R1. On 6/23/20 at 2:05 PM, the Surveyor interviewed NHA-A regarding the incident. NHA-A verified NHA-A was notified of the abuse on 5/31/20 at approximately 5:30 PM after R1 reported the abuse to LPN-H. NHA-A stated NHA-A did not ask staff why the verbal abuse wasn't reported immediately. NHA-A stated NHA-A believed staff were hesitant about the incident because CNA-C was off the clock and wasn't working at the time of the incident. NHA-A stated CNA-C left the building following the incident and did not work on 5/30/20 or 5/31/20. NHA-A stated CNA-C was scheduled to return to work on 6/01/20, but was suspended on 5/31/20 pending the outcome of the investigation. NHA-A stated CNA-C was still suspended as of 6/23/20 pending the outcome of an investigation that included additional allegations of abuse. On 6/23/20 at 12:04 PM, the Surveyor interviewed SSD (Social Services Director)-G regarding staff education. SSD-G verified staff education conducted following the incident did not include information regarding timely reporting of observations and allegations of abuse. On 6/23/20 at 1:50 PM, the Surveyor interviewed CNA-F regarding the incident. CNA-F verified the allegation of verbal abuse as documented in the self-report. CNA-F was unsure if the abuse was reported to NHA-A immediately following the incident. CNA-F verified LPN-E, the charge nurse on the 5/29/20 PM shift, was present during the altercation. As of this writing, LPN-E and CNA-D, who work for local staffing agencies, did not respond to voice messages left on 6/23/20. 2. On 6/23/20, the Surveyor reviewed R2's medical record. A progress note, dated 6/19/20, stated an RN (Registered Nurse) heard R2 screaming and saw R6 (R2's spouse) leaving R2's room. R2 stated R6 kicked R2 in the shin. R2 stated R2 did not want R6 in R2's room. The note indicated the incident was reported to SSD-G. On 6/23/20 at 1:55 PM, the Surveyor interviewed SSD-G regarding the incident. SSD-G stated the physical abuse was not reported to the State Agency because R2 didn't want the police notified and didn't want anything done besides (R6) not being in (R2's) room. SSD-G stated R2 had a bullhorn in R2's room for protection as that was not the first physical altercation to occur between R2 and R6. On 6/23/20 at 2:10 PM and 3:20 PM, the Surveyor interviewed DON (Director of Nursing)-B regarding the incident. DON-B stated the physical abuse was not reported to the State Agency because R2 changed R2's mind about spending time with R6 and whether or not R6 was allowed in R2's room. DON-B also stated the abuse was not reported because R2 did not have a visible injury and did not suffer psychological harm. DON-B stated a grievance was initiated following the altercation because R2 did not want R6 in R2's room. DON-B stated R2 endured physical abuse in their marriage and stated, (R2) said (R2) puts up with (R6) because (R6) never really hurts (R2). I thought I won't get anywhere with it because it's so ingrained. DON-B verified R6 had a history of [REDACTED]. DON-B stated multiple interventions were instituted in the past, including a stop sign on R2's door and a motion sensor on R6's door; however, none were effective in keeping R6 out of R2's room. DON-B stated, It's hard because, yes, we have to protect (R2), but (R2 and R6) go back and forth about wanting to be together and will say they have a right to be together. |
| F 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Respond appropriately to all alleged violations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interview, the facility did not ensure all allegations of physical and verbal abuse were thoroughly investigated for 2 Residents (R) (R2 and R1) of 6 residents reviewed. On 6/19/20, staff heard screams from R2's room. R6 was observed exiting the room. R2 reported R6 kicked R2 in the shin. The allegation of abuse was not thoroughly investigated. On 5/29/20, three agency staff observed an instance of verbal abuse between CNA (Certified Nursing Assistant)-C and R1. The staff who witnessed the incident did not receive education on the facility's abuse policy and procedure. Findings include: The facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy states: Training Components Team members, contracted team members .will receive education about resident mistreatment, neglect and abuse .upon first employment and annually after that including: Training on abuse policies and procedures. Investigation Components It is the policy of this center that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. The center will immediately begin a thorough investigation of any reported incident, collect information that corroborates or disproves the incident and document the findings for the incident. 1. On 6/23/20, the Surveyor reviewed R2's medical record. A progress note, dated 6/19/20, stated an RN (Registered Nurse) heard R2 scream and saw R6 (R2's spouse) leave R2's |

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 0610<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>room. R2 stated R6 kicked R2 in the shin and R2 did not want R6 in R2's room. On 6/23/20 at 2:10 PM and 3:20 PM, the Surveyor interviewed DON (Director of Nursing)-B regarding the incident. DON-B stated a grievance was initiated following the altercation because R2 did not want R6 in R2's room. DON-B verified R6 had a history of [REDACTED]. DON-B stated multiple interventions were instituted in the past, including a stop sign on R2's door and a motion sensor on R6's door; however, none were effective in keeping R6 out of R2's room. DON-B said R2 was given an air horn to use if R6 entered the room and R2 felt unsafe and stated, It's hard because we have to protect (R2), but they go back and forth about wanting to be together and will say they have a right to be together. DON-B stated, (R6) is outside with (R2) at this point pushing (R2's) wheelchair .They're sitting outside together. DON-B stated staff approached R2 multiple times when R2 and R6 were together, but R2 indicated it was okay that the two were together. The grievance, dated 6/19/20, stated, Spouse (R6) came into (R2's) room and asked about .(R2's) pension check. (R2) told (R6) not to worry about it and then (R6) kicked (R2) in the shin. (R2) stated it (sic) not a big deal. (R2) just doesn't want (R6) near (R2). The grievance did not contain interviews with other residents to see if they had similar concerns or experienced similar behavior. The grievance also did not contain interviews from staff working that shift or other shifts to determine if other concerns were expressed or observed regarding R6. The grievance did not contain statements from R2 or R6 or the nurse who responded to the incident. During an interview with the Surveyor on 6/23/20 at 2:30 PM, UM (Unit Manager)-I, who initiated the grievance, verified R6 had a history of [REDACTED]. I went out to intervene and (R2) said it was fine. UM-I verified the investigation did not contain interviews with residents to determine if they had concerns or experienced similar behavior. UM-I also verified the investigation did not contain interviews with staff and did not contain statements from R2, R6 and the nurse who responded to the incident. UM-I provided the Surveyor with a copy of a physical assessment, dated 6/19/20, that indicated R2 had no injuries. The assessment stated to continue weekly observations. A follow-up assessment was not completed to determine if bruising developed later on R2's shin. 2. The Surveyor reviewed a facility self-report submitted to the State Agency on 5/31/20. The report stated on 5/31/20, R1 informed NHA (Nursing Home Administrator)-A that CNA-C swore at R1 on the evening of 5/29/20. R1 exited the facility to smoke and rang the doorbell six times when finished. When CNA-D answered the door, R1 used vulgar language and asked why CNA-C didn't answer the door. CNA-D informed R1 that CNA-C was off-duty and in the facility visiting R7. R1 remained at the nurses' station until CNA-C exited R7's room. When CNA-C exited R7's room, R1 called CNA-C a derogatory name and the two exchanged words. CNA-D witnessed the incident and stated CNA-C used profanity and stated R1 was lazy and lived off the government and shouldn't be going outside to smoke. LPN (Licensed Practical Nurse)-E and CNA-F also witnessed the incident and verified CNA-C used profanity during the interaction with R1. The report also stated staff were reeducated on the facility's abuse policy and guidelines. On 6/23/20 at 12:04 PM, the Surveyor interviewed SSD (Social Services Director)-G regarding staff education. SSD-G provided the Surveyor with a copy of the staff education and sign-in sheets. SSD-G verified the education focused on what constituted abuse. The Surveyor noted LPN-E, CNA-D and CNA-F were not listed on the sign-in sheets. SSD-G stated SSD-G attempted to educate all staff verbally on a 1:1 basis; however, LPN-E, CNA-D and CNA-F did not receive abuse reeducation following the incident. |