STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525232	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CCC OF WEST GREEN BAY	1760 SHAWANO AVE GREEN BAY, WI 54303

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** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility did not ensure all allegations of abuse and neglect were reported to the State Survey and Certification Agency for 4 Residents (R) (R1, R6, R5 and R7) of 6 residents reviewed A complaint filed with the State Agency indicated SW (Social Worker)-C was notified that R1 reported CNA (Certified Nursing Assistant)-D yelled at and hit R1. SW-C stated R1 reported to SW-C that R1 was left in a wet bed. The potential allegation of neglect was not reported to the State Agency. R6 reported a staff member stated R6 didn't need skilled care and should go home. The allegation of abuse was not reported to the State Agency. R5 reported R6 was mean to R5. Approximately two weeks later, R5 reported R5 felt bullied by R6 who swore at and called R5 names. The allegations of abuse were not reported to the State Agency. R7 reported RN (Registered Nurse)-F made a rude remark when R7 requested pain medication. The allegation of abuse was not reported to the State Agency. Findings include: The facility's Abuse Prevention Program policy, dated 2/07/17, states: The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of [REDACTED]. External Reporting 1. Initial Reporting of Allegations: When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or designee, shall complete and submit a DQA (Division of Quality Assurance) form (F-), notifying DQA that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated. This report shall be made immediately. The term immediately .shall be defined as, Following management of the immediate risk to the resident or residents, including the administration of necessary medical attention, and establishing the safety of the residents involved or not later than two hours after forming the suspicion, if the events that cause the suspicion result in seriously bodily injury, or not later than 24 hours if the events that cause suspicion do not result in serious bodily injury. 2. Five-day Final Investigation Report: Within five working days after the report of the occurrence, the Administrator or designee shall complete and submit a Misconduct Incident Report form (F-) notifying the regulatory agency of the conclusion of the investigation. 1. On 3/16/20, the Surveyor reviewed an anonymous complaint filed with the State Agency. The complaint stated, (R1) stated that (CNA-D) hit and yelled at (R1) about three weeks ago. Complainant informed (SW-C) of the incident .(SW-C) stated the Ombudsman has addressed the issue . On 3/16/20 at 9:15 AM, the Surveyor interviewed R1 regarding the allegation. R1 stated R1 reported the incident to staff. R1 stated a staff member struck R1 a couple of times with her forearm on R1's shoulder and upper chest. (R1) stated, She was mad at me. She was a jerk .It was painful. R1 stated the incident occurred a couple weeks ago. When asked if anyone followed up with R1, R1 stated, You're the one who followed up with me .It seems like they're letting it slide. R1 could not recall the name of the staff who hit R1 and could not recall whether R1 encountered the staff since the incident. R1 also could not recall to whom R1 reported the incident. The Surveyor reviewed R1's medical record. R1 was admitted to the facility with [DIAGNOSES REDACTED]. R1's most recent quarterly MDS (Minimum Data Set), dated 12/19/19, indicated R1 was cognitively intact and required extensive assistance of staff for ADLs (activities of daily living). R1's plan of care stated R1 had escalated behaviors with agitation and a history of yelling at staff. R1's plan of care also indicated R1 had a history of [REDACTED]. On 3/16/10 at 10:40 AM, the Surveyor interviewed SW-C regarding the allegation. SW-C stated SW-C vaguely recalled an incident, but didn't recall it involved an allegation of abuse. SW-C stated, (R1) says this all the time. I talked to (R1). (R1) said staff didn't do what (R1) wanted them to. SW-C couldn't recall the details of the conversation with R1 and couldn't recall when the conversation occurred. SW-C stated VO (Volunteer Ombudsman)-E met with R1 and reported R1 was, left in a wet bed over the weekend. SW-C stated SW-C didn't consider the report of being left in a wet bed an allegation of neglect due to R1's history. SW-C indicated R1 had behaviors, but hadn't ever accused staff of hurting R1. SW-C indicated SW-C didn't report the potential allegation of neglect and stated, Maybe I should have. SW-C also stated, I felt my conversations with (R1) and the staff were sufficient. When asked which staff SW-C interviewed, SW-C stated, I can't remember what staff I talked to. I'd have to check the schedule for that day. When asked what day SW-C interviewed staff, SW-C stated, I can't remember what day it was. SW-C stated SW-C believed the potential allegation of neglect was reported in January 2020, but couldn't recall any other details about SW-C's conversations with R1, VO-E or staff. On 3/17/10, the Surveyor received an email from CB (Counsel to the Board)-I from the Board of Aging and Long-Term Care. The email stated VO-E did not receive any recent direct complaints from a resident about abuse in the facility. 2. On 3/16/20, the Surveyor reviewed the facility's grievance file. The Surveyor noted a grievance filed by R6 and R6's mother on 2/21/20. The grievance stated, Resident stated staff member told (resident) to,'Go home. You don't need to be here. You can do everything for yourself'. The grievance stated the facility provided diversity and [MEDICATION NAME] training for staff. On 3/16/20 at 2:15 PM, the Surveyor interviewed NHA (Nursing Home Administrator)-A regarding the allegation of abuse. NHA-A stated FNHA (Former Nursing Home Administrator)-G handled the grievance. NHA-A verified MR (Medical Records)-H made the statement to R6. NHA-A stated MR-H was told, not to go near (R6) and associate with (R6). NHA-A verified the allegation of abuse was not reported to the State Agency. 3. On 3/16/20, the Surveyor reviewed the facility's grievance file. The Surveyor noted two grievances filed by R5. The first grievance, dated 2/11/20, stated, (R5) stated (R6) was mean to (R5). (R5) does not feel harmed or worried about (R5's) safety, but would like (R6) to be spoken to. The second grievance, dated 2/23/20, stated, (R5) says (R5) feels bullied by (R6). (R6) keeps swearing at (R5) and calling (R5) names .says it's been happening for about a month. On 3/16/20 at 2:15 PM, the Surveyor interviewed NHA-A regarding the allegations of abuse. NHA-A stated FNHA-G handled both grievances. NHA-A stated the grievances involved issues related to smoking rules. NHA-A verified the allegations of potential abuse were not reported to the State Agency. 4. On 3/16/20, the Surveyor reviewed the facility's grievance file. The Surveyor noted a grievance, dated 3/08/20, that stated, (R7) .Very upset with (RN-F), thinks (RN-F) is rude and doesn't want (RN-F) in (R7's) room anymore. (R7) wanted something for headache and (RN-F) (replied) with rude remark. On 3/16/20 at 2:15 PM, the Surveyor interviewed NHA-A regarding the potential allegation of abuse. NHA-A indicated NHA-A did not report the allegation to the State Agency and stated, I didn't take it further because when I interviewed (R7), (R7) couldn't remember why (R7) said that.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and resident interview, the facility did not ensure all allegations of abuse and neglect were thoroughly investigated for 4 Residents (R) (R1, R6, R5 and R7) of 6 residents reviewed. A complaint filed with the State Agency indicated SW (Social Worker)-C was notified R1 reported CNA (Certified Nursing Assistant)-D yelled at and hit R1. SW-C stated R1 reported R1 was left in a wet bed. The potential allegation of neglect was not thoroughly investigated.

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 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) R6 reported a staff member stated R6 didn't need skilled care and should go home. The allegation of abuse was not thoroughly investigated. R5 reported R6 was mean to R5. Approximately two weeks later, R5 reported R5 felt bullied by R6 who swore at and called R5 names. The allegations of abuse were not thoroughly investigated. R7 reported RN (Registered Nurse)-F made a rude remark when R7 requested pain medication. The potential allegation of abuse was not thoroughly investigated. Findings include: The Facility's Abuse Prevention Program, dated 2/017/17, states: The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of [REDACTED]. V. Protection of Residents The facility will take steps to prevent potential abuse while the investigation is underway. 1. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all necessary steps to ensure the safety of residents including, but not limited to, the separation of residents. 2. Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property is unsubstantiated. Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an incident investigation. VI. Internal Investigation 1. All incidents will be documented whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. 4. Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. 1. On 3/16/20, the Surveyor reviewed an anonymous complaint filed with the State Agency. The complaint stated, (R1) stated that (CNA-D) hit and yelled at (R1) about three weeks ago. Complainant informed (SW-C) of the incident .(SW-C) stated the Ombudsman has addressed the issue . On 3/16/20 at 9:15 AM, the Surveyor interviewed R1 regarding the allegation. R1 stated a staff member struck R1 a couple of times with her forearm on R1's shoulder and upper chest. (R1) stated, She was mad at me. She was a jerk .It was painful. R1 stated the incident occurred a couple weeks ago. R1 stated R1 tried to report the incident; however, R1 felt the facility was, letting it slide. R1 could not recall the name of the staff who hit R1 and could not recall whether R1 encountered the staff since the incident. R1 also could not recall to whom R1 reported the incident. The Surveyor reviewed R1's medical record. R1 was admitted to the facility with [DIAGNOSES REDACTED]. safety and the safety of others). R1's most recent quarterly MDS (Minimum Data Set), dated 12/19/19, indicated R1 was cognitively intact and required extensive assistance of staff for ADLs (activities of daily living). R1's plan of care stated R1 had escalated behaviors with agitation and a history of yelling at staff. R1's plan of care also indicated R1 had a history of [REDACTED]. On 3/16/10 at 10:40 AM, the Surveyor interviewed SW-C regarding the allegation in the complaint. SW-C stated SW-C vaguely recalled an incident, but couldn't recall any allegations of abuse. SW-C stated, (R1) says this all the time. I talked to (R1). (R1) said staff didn't do what (R1) wanted them to. SW-C couldn't recall the details of the conversation with R1 and couldn't recall when the conversation occurred. SW-C stated VO (Volunteer Ombudsman)-E met with R1 and reported R1 alleged R1 was, left in a wet bed over the weekend. When asked if SW-C investigated the potential allegation of neglect related to being left in a wet bed, SW-C stated, I felt my conversations with (R1) and the staff were sufficient. SW-C stated SW-C couldn't remember what staff members SW-C spoke with and stated, I'd have to check the schedule for that day. When asked what day SW-C interviewed staff, SW-C stated, I can't remember what day it was. SW-C stated SW-C believed the allegation was reported in January 2020, but couldn't recall any other details about SW-C's conversations with R1, staff or VO-E. SW-C verified R1's potential allegation of neglect was not documented and was not reported to FNHA (Former Nursing Home Administrator)-G. SW-C also verified R1's statement as well as VO-E's statement and additional staff and resident interviews were not documented. On 3/17/10, the Surveyor received an email from CB (Counsel to the Board)-I from the Board of Aging and Long-Term Care. The email stated VO-E did not receive any recent direct complaints from R1 regarding abuse in the facility. 2. On 3/16/20, the Surveyor reviewed the facility's grievance file. The Surveyor noted a grievance filed by R6 and R6's mother on 2/21/20. The grievance stated, Resident stated staff member told (resident) to,'Go home. You don't need to be here. You can do everything for yourself. The grievance stated the facility provided diversity and [MEDICATION NAME] training for staff. On 3/16/20 at 2:15 PM, the Surveyor interviewed NHA (Nursing Home Administrator)-A regarding the allegation of abuse. NHA-A stated FNHA-G handled the grievance. NHA-A verified the grievance did not include the accused staff's name, but verified MR (Medical Records)-H was the accused staff. NHA-A verified the grievance did not include statements from R6 and MR-H as well as additional staff and resident interviews. The grievance indicated MR-H was told not to go near (R6) and associate with (R6). NHA-A verified MR-H was not removed from resident contact pending the outcome of the investigation and verified the allegation of abuse was not thoroughly investigated. 3. On 3/16/20, the Surveyor reviewed the facility's grievance file. The Surveyor noted two grievances filed by R5. The first grievance, dated 2/11/20, stated, (R5) stated (R6) was mean to (R5). (R5) does not feel harmed or worried about (R5's) safety, but would like (R6) to be spoken to. The second grievance, dated 2/23/20, stated, (R5) says (R5) feels bullied by (R6). (R6) keeps swearing at (R5) and calling (R5) names .says it's been happening for about a month. On 3/16/20 at 2:15 PM, the Surveyor interviewed NHA-A regarding the allegations of abuse. NHA-A stated FNHA-G handled both grievances. NHA-A stated the grievances involved issues related to smoking rules, but verified the issues were not documented. NHA-A verified the grievances did not include statements from R5 and R6 as well as additional staff and resident interviews. In addition, the grievances did not include interventions put in place by the facility to protect R5 from further abuse. NHA-A verified the allegations of abuse were not thoroughly investigated 4. On 3/16/20, the Surveyor reviewed the facility's grievance file. The Surveyor noted a grievance, dated 3/08/20, that stated, (R7) .Very upset with (RN-F), thinks (RN-F) is rude and doesn't want (RN-F) in (R7's) room anymore. (R7) wanted something for headache and (RN-F) (replied) with rude remark. On 3/16/20 at 2:15 PM, the Surveyor interviewed NHA-A regarding the potential allegation of abuse. NHA-A verified the grievance did not indicate what R7 alleged RN-F said when R7 reported RN-F was rude. NHA-A also verified the grievance did not include a statement from RN-F or additional staff and resident interviews. The grievance indicated ADON (Assistant Director of Nursing)-J interviewed R7 on 3/09/20 and stated R7 was not upset and didn't recall that RN-F was rude. The grievance did not contain a statement from ADON-J. The grievance also did not indicate if RN-F was removed from resident care pending the outcome of the investigation. NHA-A verified the potential allegation of abuse was not thoroughly investigated and stated, I didn't take it further because when I interviewed (R7), (R7) couldn't remember why (R7) said that.