STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525535	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUGUSTA HEALTH AND REHABILITATION	**901 BRIDGE CREEK LANE AUGUSTA, WI 54722**

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policy and procedure related to the prevention of abuse for 1 of 3 residents reviewed (R1). Facility staff witnessed potential abuse and the staff did not immediately intervene to protect the resident and report the incident immediately as the policy and procedure directs. The nurse who was told of the incident failed to notify administration of the allegation of abuse/mistreatment. The nurse also failed to put measures in place to protect the resident, failed to document the incident, and the assessment of the resident following the incident in the medical record, according to the facility policy and procedures. This is evidenced by: The facility's policy and procedure entitled Mistreatment, Neglect, Exploitation, Abuse and Misappropriation Prevention and Protection states in part: Staff will identify, correct, and intervene in situations in which mistreatment, abuse, neglect, exploitation and/or misappropriation of resident property is likely to occur. Facility staff will identify any events .that may constitute abuse. This will be reported to the facility designee immediately. The nurse will complete a narrative notation in the medical record describing the incident, the protective measures used for the resident(s) involved as well as follow-up action and notification of . the Director of Nursing and Administrator. R1 was admitted to the facility with [DIAGNOSES REDACTED]. R1's care plan indicates assist of 2 for repositioning, R1 requests to only be woken up 2 times on night shift for incontinence cares, please do not turn bright lights on is also indicated. If R1's response is aggressive, staff to walk calmly away (if safe to do so). According to the facility's self report investigation, on 08/12/20, Certified Nursing Assistant (CNA) C reported to the facility Social Worker (SW) F that she was calling to report abuse. CNA C indicated she had worked on the 6 P.M. to 6 A.M. shift on August 9th to 10th. CNA C indicated that while working with CNA E, they went in to help R1. CNA C stated as they entered the room CNA E went into R1's room turned the lights on and ripped off blanket. CNA E started rolling R1 and took off her incontinence product, R1 stated Ow, ow, ow as she did this. CNA C reported that CNA E said it doesn't hurt that bad. CNA C indicated they rolled her back and forth and that R1 was screaming and yelling. CNA C stated that CNA E was too rough and moving too fast. CNA C stated that CNA E grabbed her wrist and held her wrist down against the bar. CNA C stated she thought the resident was in pain and that CNA E was mocking her and stated relatives should take care of you if you behave this way. CNA indicated this happened around 2:15 AM. SW F indicated she asked CNA C how R1 seemed when they were done, CNA A indicated as soon as we finished, she calmed down. During a 1:00 P.M. interview on 08/26/20, CNA C reiterated the above information adding staff knows that R1 does not like to be disturbed much at night. CNA C stated R1 does not like the bright lights on, and that is what CNA E turned on. CNA C stated R1 likes a slow calm approach and does not like to be uncovered a lot. The approach CNA E used was not the right approach, she was too fast, pulled the blankets way down, right away. CNA C indicated CNA E grabbed R1's wrists and held them down to the grab bar. CNA C stated CNA E had not been that way at any other time with any other residents. CNA C stated she told the night nurse (LPN D) about what happened, and that CNA E had been taunting and had been way too rough, with R1. CNA C stated she was upset by the incident and after telling the nurse about it, she Had to go outside and have a smoke, to calm down. When asked why CNA C did not intervene in the situation, and report it immediately. CNA C indicated she was unsure why she had not intervened and why she waited a few days before reporting to anyone besides the nurse, but now knows she should have stopped it and reported it immediately. Interview with LPN D at 4:30 P.M. on 08/25/20. During the interview, LPN D stated CNA C reported CNA E had been mocking, demeaning, and rough with R1 during the night shift of 08/9-10/2020. LPN D stated she thought the incident occurred a little after 5 in the morning, and administrative staff would be in the facility at 6 something, so it would be reported soon. LPN D stated CNA C indicated she would like to report the incident to administration herself, so LPN D did not report the incident according to the facility's policy and procedures. LPN D stated she now realizes she should have reported it right away herself. When asked if LPN D had put anything into place immediately to keep R1 and other residents safe from further potential abuse from CNA E after the incident was reported to her. LPN D said no, she had not thought of that. Surveyor asked if LPN D had looked at or spoken with R1 following the incident. LPN D indicated she went in to check to see if the resident was awake, and she was. LPN D indicated she had asked R1 if she was feeling alright? LPN D indicated R1 stated Yes, everything was fine. LPN D indicated she asked R1 if her care and treatment seamed mean and rough and R1 had responded no. When asked if LPN D viewed R1's wrists and hands, LPN D responded she did look at them and they looked normal. No redness or bruising was seen. When asked if LPN D had documented her observations of the resident and what occurred, as the facility's policy and procedure directs, LPN D responded she was not sure if she had as it was a busy morning. Surveyor reported the medical record was reviewed and no information about the incident, or the LPN's observations were able to be located. LPN D relayed she forgot. When asked if LPN D had reported the incident to the Director of Nursing (DON) or the Nursing Home Administrator (NHA) as the facility policy and procedures directs, LPN D stated she encouraged CNA C to report it, but had not reported it herself. Interview with R1, R2, and R3 did not reveal any concerns related to abuse or neglect. Review of their medical records did not reveal any injuries of unknown source or concerns of mistreatment. Interviews with other staff reveal they have been recently trained on abuse and neglect. Staff interviewed reveal they are to intervene, protect and report any concerns with abuse or neglect to the DON or the NHA immediately. Review of the facility's policy and procedure for abuse/self report revealed concerns the facility failed to implement its policy and procedures in relation to the immediate reporting of allegations of abuse and neglect, and documenting the incident within the resident's medical record.

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.