STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525375	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKWOOD LUTHERAN HOMES ASSOC	**6201 MINERAL POINT RD MADISON, WI 53705**

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 -** Few	**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 interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, to the appropriate agencies for 1 of 3 residents reviewed (R1). When certified nursing asistant (CNA) D observed CNA C place his hand over R1's mouth and told her to shut up, CNA-D did not report the incident until 48 hours later. This reporting was done by e-mail, which was not received by the Director of Nurses (who was off duty) until another 5 days had elapsed. This is evidenced by: The facility's Abuse, Neglect, Misappropriation, Mistreatment and Exploitation Preventing, Investigating and Mandatory Reporting Policy dated 2/21/17, states in part: . Any nursing home employee or volunteer who becomes aware of mistreatment, neglect, exploitation or misappropriation shall immediately report to the Nursing Home Administrator. The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements . Immediately: means as soon as possible, when the entity knew or should have known, but ought not to exceed 24 hours after discovery of the incident . 1 Employee Screening and Training . i. All new employees . will be oriented to the Abuse Policy and made aware of their responsibility to report any suspected maltreatment as defined and described in this policy . Training Components: It is the policy of (facility name) to train employee, through orientation and on-going sessions on issues related to abuse and prohibition practices . Findings: R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1's Significant Change MDS (Minimum Data Set) assessment on 5/6/20 notes R1 has severe cognitive impairment. Review of R1's record notes monitoring and tracking of targeted behaviors including agitation and yelling out. R1's Care Plan dated 4/7/20 includes non-pharmacologic interventions to deal with R1's behaviors including in part: toileting, pain monitoring, music on CD player, T. V., aroma therapy, offering R1 space and re-approach if showing signs of agitation (calling out). On 7/2/20 at 9:20 AM and 11:00 AM, Surveyor observed staff providng care to R1, including implementation of appropriate interventions for R1 calling out behaviors. On 7/2/20, Surveyor reviewed facility's Self-report investigation noting an accusation of abuse toward R1 which occurred on evening of 6/8/20. Review of facility investigation notes in part, on 6/8/20 when CNA D (Certified Nursing Assistant) and CNA C were repositioning R1, R1 was calling out and yelling, CNA D witnessed CNA C place his hand over R1's mouth and stated shut up lady. CNA D did not immediately report this event to the facility in accordance to the facility Abuse Neglect, Misappropriation, Mistreatment and Exploitation Preventing, Investigating and Mandatory Reporting Policy. On 6/10/20 at 10:05 PM (48 hours after the event occurred), CNA D sent an email to DON B (Director of Nursing) describing what occurred with R1 and CNA C on 6/8/20. This email was not received by DON B until 6/15/20, as DON B was off duty from 6/11/20-6/15/20. DON B immediately reported this to NHA A (Nursing Home Administrator) on 6/15/20,who reported this to the State Agency and started the abuse investigation. Surveyor reviewed witness statements, interviews and education related to the 6/8/20 incident involving R1. Review of CNA D's interview and statement dated 6/15/20, notes after CNA D's shift on 6/8/20, CNA D reported this event with R1 to CNA E. CNA E told CNA D to report the incident. CNA E's interview and statement noted she heard about the event with R1 on 6/8/20 or 6/9/20 from CNA D, CNA E stated she told CNA D to report it. CNA E said she was not present and would let CNA D report it. It is important to note neither CNA D or CNA E reported the abuse incident for R1 immediately to the facility. On 6/15/20, CNA C and CNA D were immediately suspended from work, investigation notes CNA C was terminated from employment, and CNA D received disciplinary action for not reporting abuse immediately. Investigation notes show CNA D and CNA E received education on 6/15/20 to immediately report resident abuse to NHA A. On 7/2/20 at 2:00 PM, Surveyor interviewed NHA A asking about her expectations for staff reporting abuse. NHA A stated that staff are to immediately report any abuse to their supervisor and then this is to be immediately reported to NHA A. Surveyor asked if abuse should be reported by email, NHA A stated no, it should be reported verbally face to face or directly by phone. Surveyor asked when the facility was aware that an abuse event had not been reported, what the facility did to ensure all staff were educated on reporting abuse immediately. Surveyor asked NHA A why all staff had not received Abuse reporting education immediately? NHA A stated that she thought this was an isolated event and the staff involved had been educated or terminated. NHA A stated on 6/17/20 (2 days after being aware of the event with R1), she sent an email to all staff about abuse reporting and provided a copy of this email to Surveyor. Surveyor asked if NHA A had evidence that all staff had read this email, NHA A stated no, but staff were expected to read email daily. NHA A reported she besides sending the email, all staff had a laminated cards they carried daily which states If abuse is suspected the first thing you do is ensure the resident is safe, and then report to supervisor immediately. NHA A stated all nursing home staff were receiving education and a quiz on abuse reporting and were told they had to complete the education by 7/10/20. Review of abuse education to staff from 6/15/20-7/2/20 noted 22 of 87 nursing staff (25 percent) working in the nursing home had received the facility education and quiz on abuse reporting, 75 percent had not. It was noted that other ancillary staff, outside of the nursing department had received the abuse education before 7/2/20. The facility did not ensure staff reported abuse to NHA A immediately on 6/8/20 for R1. When the facility was notified of the abuse, and aware 2 staff had not immediately reported abuse, the facility did not ensure all staff were immediately re-educated on the facility's Abuse Policy reporting requirements to prevent a delay in reporting resident abuse.

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.