STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525418	A. BUILDING _____ B. WING _____	03/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVANSVILLE MANOR NURSING AND REHAB, LLC	470 GARFIELD AVE EVANSVILLE, WI 53536

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 all alleged violations involving misappropriation, neglect or abuse were reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures for 2 of 5 residents reviewed for abuse (R3 and R1). Staff did not report potential abuse to the NHA (Nursing Home Administrator) immediately for R3. A resident to resident incident occurred between R1 and R2 on 2/18/20 and was reported to NHA A (Nursing Home Administrator) on 2/18/20. The facility did not report this incident to the state agency or evaluate if it should have been reported to the state agency. This is evidenced by: The facility's policy Vulnerable Adult Abuse and Neglect Prevention dated with a revision on 7/2/19 includes: -4. Resident to Resident Abuse: a. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, exploitation, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants, or volunteers, staff of other agencies service the resident, family members or legal guardians, friends or other individuals. -5. Protection of Residents During Investigation: b. Call the DON (Director of Nursing) and Administrator immediately. -6. Reporting of Incidents: a. All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's designee. b. The facility must report to the State agency immediately, but no later than 2 hours after the allegation is made. Example 1 R3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R3's most recent Minimum Data Set (MDS) measures her BIMS (Brief Interview for Mental Status) at 8, which is moderately cognitively impaired. R4 was admitted to the facility 8/23/19 with [DIAGNOSES REDACTED]. R4's most recent MDS measures his BIMs at 14, which is cognitively aware. On 10/23/19 at 4:21 PM, R3's progress notes document: Resident was talked to in sexually inappropriate manner witnessed by staff and touched on her leg by another resident R4 in the hallway on [LOC]. The resident was separated from other resident and denied harm or talking to inappropriately; skin check revealed no harm. Director of Nursing (DON) aware notified by a fell ow nurse. Plan to have staff nurse notify POA (Power of Attorney) in am of incident. On 10/23/19 at 11:45 PM, R4's progress notes document: Writer updated wife that resident had been observed pursing a female resident from another wing. Both residents were noted to be holding hands, residents were separated immediately. Both residents have short term memory loss and have activated POA's. NP (Nurse Practioner) updated who ordered 15 minutes checks to be completed for 48 hours. DON updated and Administrator will be made aware. No further incidences noted will continue to monitor. On 3/19/2020 at 7:50 AM, Surveyor spoke with R3. R3 said she remembered R4 getting after her during the Thanksgiving and Christmas season. R3 said he wanted to kiss her at first, then kept after her for sex acts. R3 said I kept telling him a flat NO! I didn't want anything to do with that! R3 did not remember R4 saying anything to her on a specific day. R3 said she feels safe. R3 said she told her brother and sister in law and they told her to watch herself around R4. R3 said she told somebody in the front office. R3 said the person in the front office told her R4 would be disciplined. R3 said she stills sees R4, but he doesn't bother her anymore. Surveyor attempted to interview nursing staff who documented the incident nursing staff dod not return Surveyor's call. Although the DON was notified there is no indication the NHA was notified immediately of the incident. There is no investigation to determine if this incident should have been reported to the State Agency. During an interview with the current Nursing Home Administrator (NHA) A, NHA A stated this incident should have been reported to the State Agency. It is important to note the DON and NHA who were employed by the facility during the time period of the incident no longer work at the facility. On 3/19/2020 at 2:00 PM, Surveyor spoke with NHA. NHA said the incident should have been reported to the NHA immediately and then reported to the State Agency. Example 2 On 3/19/20 at 8:45 AM Surveyor interviewed PT C (Physical Therapist) who reported that she had witnessed R2 yelling at R1 and aggressively pulling on R1's left arm about 3-4 weeks ago. PT C stated that she immediately reported this to NHA A. On 3/19/20 at 10:58 AM Surveyor interviewed NHA A about the incident between R1 and R2. NHA A stated that she thought this incident occurred on 2/18/20. NHA A stated that she was made aware of the incident on 2/18/20, NHA A stated staff separated R1 and R2, there was no documentation of this incident. NHA A stated she did not complete an investigation and did not report this to R1's POA (Power of Attorney for Health Care), or to the state agency and should have, but would do this today (on 3/19/20). Cross reference F610
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 interview and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation or mistreatment, that alleged violations are thoroughly investigated for 2 of 5 (R3 and R1) reviewed for abuse. Review of R3's progress notes documented alleged abuse allegations and there is no investigation documentation. R2 was observed yelling at R1 and pulling on R1's arm, this incident was not fully investigated and there is no documentation of the incident or what protective measures were put in place. This is evidenced by: The facility's policy Vulnerable Adult Abuse and Neglect Prevention dated with a revision on 7/2/19 includes: 4. a. Resident to Resident Abuse: The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, exploitation, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants, or volunteers, staff of other agencies service the resident, family members or legal guardians, friends or other individuals. 6. d. 11. All reports will be documented by the supervisor professional staff of the reporting preson using the incident report form. Investigation -4. a. Upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately and they, the Director of Nursing, or assigned designee will coordinate an investigation, which will include completion of witness statements. Example 1 R3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R3's most recent Minimum Data Set (MDS) measures her BIMS (Brief Interview for Mental Status) at 8, which is moderately cognitively impaired. R4 was admitted to the facility 8/23/19 with [DIAGNOSES REDACTED]. R4's most recent MDS measures his BIMs at 14, which is cognitively aware. On 10/23/19 at 4:21 PM, R3's progress notes document: Resident was talked to in sexually inappropriate manner witnessed by staff and touched on her leg by another resident R4 in the hallway on [LOC]. The resident was separated from other resident and denied harm or talking to inappropriately; skin check revealed no harm. DON aware notified by fell ow nurse plan to have staff nurse notify POA (Power of Attorney) in am of incident. On 10/23/19 at 11:45 PM, R4's progress notes document: Writer updated wife that resident had been observed pursing a female resident from another wing. Both residents were noted to holding hands, residents were separated immediately. Both residents have short term memory loss and have activated POA's. NP (Nurse Practioner) updated who ordered 15 minutes checks to be completed for 48 hours. DON (Director of Nursing) updated and NHA (Nursing Home Administrator) will

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) be made aware. No further incidences noted will continue to monitor. On 3/19/2020 at 7:50 AM, Surveyor spoke with R3. R3 said she remembered R4 getting after her during the Thanksgiving and Christmas season. R3 said he wanted to kiss her at first, then kept after her for sex acts. R3 said I kept telling him a flat NO! I didn't want anything to do with that! R3 did not remember R4 saying anything to her on a specific day. R3 said she feels safe. R3 said she told her brother and sister in law and they told her to watch herself around R4. R3 said she told somebody in the front office. R3 said the person in the front office told her R4 would be disciplined. R3 said she stills sees R4, but he doesn't bother her anymore. It is important to note the current DON and NHA were not working in the facility at the time of the incident. On 3/19/2020 at 8:15 AM, Surveyor spoke with CNA D (Certified Nurse Assistant). CNA D said she has worked here for eight years. CNA D said she knew that R4 had inappropriate behaviors, but did not remember the November 2019 incident. O 3/19/2020 at 9:30 AM, Surveyor spoke with SW E (Social Worker). SW E said she had no memory of an incident with R3 and R4. SW E said she was aware that R4 did have inappropriate behaviors at times. On 3/19/2020 at 10:00 AM, Surveyor spoke to the NHA. The NHA had no documentation of an investigation of the incident that happened with R3 and R4. The NHA was not aware of any incidents to do with R3 and R4. The NHA said the incident should have been investigated. Example 2 R1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. R2 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. R2's Annual MDS on [DATE] notes that R2 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R2 is cognitively intact. On 3/19/20 at 7:55 AM Surveyor interviewed R2 about any concerns or contact he had with R1, R2 stated R1 used to come into his room and stated, I'd tell her to get out. On 3/19/20 at 8:45 AM, Surveyor interviewed PT C (Physical Therapist) about any concerns or observations she had with R1 and R2. PT C stated about 3-4 weeks ago R1 was roaming the halls in her wheelchair. PT C stated that she was in R2's room. R2 had told PT C that he had been sleeping in his chair in his room and R2 came into his room and tapped him on the shoulder and R2 freaked out. PT C stated shortly after that, while still in R1's room, PT C witnessed R1 in her wheelchair in the hall and was attempting to enter a room across the hall from R2's room. R2 saw this, walked into the hall and was yelling at R1 to get out of there, PT C witnessed R2 was pulling R1 back by her left arm aggressively. Surveyor asked PT C what she did in response to this event. PT C stated she told R2 to stop, calm down and go back into his room, which he did. PT C stated a CNA (Certified Nursing Assistant) took R1 to her room but did not recall who the CNA was. PT C stated that she immediately reported this to NHA A (Nursing Home Administrator) who stated thank you, this needs to be reported, and that they would look into it. PT C stated that she was not asked to put anything into writing about this incident and has no documentation of this incident. Reviewed of R1's Nursing notes on 2/18/20 at 9:17 AM notes in part: Routine Physician visit. Confused. Says she's nervous when out of room . Surveyor attempted to reach the nurse who wrote this entry on the phone, left voice messages, with no response received. On 3/19/20 at 10:58 AM Surveyor interviewed NHA A about concerns she had received regarding R1 and R2. NHA A stated that PT C came to her and reported a concern between R1 and R2 but that her recollection was that it was a verbal situation, nothing physical. NHA A stated that she recalls that R2 got loud at her (R1) and they were separated and made everyone safe. NHA A stated if PT C is saying it happened a month ago, she thought this incident occurred on 2/18/20 as the State Agency was in the building on that date. NHA A stated that she had no documentation of this incident and that she should have conducted an investigation and completed the Resident to Resident Flow Sheet for this event and did not and would do so now. Cross Reference F609