

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2024
NAME OF PROVIDER OR SUPPLIER  Manawa Com Nur Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  400 East 4th St Manawa, WI 54949	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40342</p> <p>Based on staff interview and record review, the facility did not ensure allegations of abuse were reported to Nursing Home Administrator (NHA)-A, the State Agency (SA), and/or local law enforcement for 4 residents (R) (R1, R2, R3, and R6) of 6 sampled residents.</p> <p>On 5/29/24 and 6/9/24, R1 verbally abused R2. Staff did not report the allegations of abuse to NHA-A in a timely manner. In addition, the allegations of abuse were not reported to the SA.</p> <p>On 6/2/24, R1 verbally abused R3. Staff did not report the allegation of abuse to NHA-A in a timely manner. In addition, the allegation of abuse was not reported to the SA.</p> <p>On 6/7/24, R6 allegedly sexually abused R2. Staff did not report the allegation of abuse to NHA-A in a timely manner. In addition, the allegation of abuse was not reported to the SA or local law enforcement.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy, dated February 2023, indicates: It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion, or misappropriation of resident property .Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation, or misappropriation shall immediately report to the Nursing Home Administrator or designee. The Nursing Home Administrator or designee will report abuse to the State Agency per state and federal requirements .A resident-to-resident altercation should be reviewed as a potential situation of abuse .Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions .Staff should monitor for any behaviors that may provoke a reaction by residents or others which include, but are not limited to: Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating .Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing .All reports of suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated .</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/12/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including dysthymic disorder (a type of depression that occurs over a long period of time), alcohol-induced dementia, low back pain, and anxiety disorder. R1's Minimum Data Set (MDS) assessment, dated 5/23/24, stated R1's Brief Interview for Mental Status (BIMS) score was 00 out of 15 which indicated R1 had severe cognitive impairment. R1's medical record indicated R1's Power of Attorney for Healthcare (POAHC) was responsible for R1's healthcare decisions.</p> <p>On 6/12/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including Huntington's chorea (a neurodegenerative disease exhibited by problems with mood or mental abilities and a general lack of coordination). R2's MDS assessment, dated 4/18/24, stated R2's BIMS score was 10 out of 15 which indicated R2 had moderate cognitive impairment. R2's medical record indicated R2's POAHC was responsible for R2's healthcare decisions.</p> <p>On 6/12/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive nervous system disorder that affects movement). R3's MDS assessment, dated 4/25/24, stated R3's BIMS score was 8 out of 15 which indicated R3 had moderate cognitive impairment. R3's medical record indicated R3's POAHC was responsible for R3's healthcare decisions.</p> <p>On 6/12/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease. R6's MDS assessment, dated 5/11/24, stated R6's BIMS score was 15 out of 15 which indicated R6 had no cognitive impairment. R6's medical record indicated R6 was responsible for R6's healthcare decisions.</p> <p>On 6/12/24, Surveyor reviewed R1's nursing notes which included the following:</p> <p>~ A note, dated 5/19/24, indicated: R1 was aggressive with PM shift staff upon shift change. R1 yelled at and pushed R2 in R2's wheelchair. Staff attempted to intervene. R1 cursed and yelled, I'm going to kill you. I should just off you now. Staff attempted to re-direct R1 and move R1 away from R2 who was tearful and upset. The Activity Director provided 1:1 with R1 in a separate room until R1 settled.</p> <p>~ A note, dated 6/2/24, indicated: R1 got into an argument with R3 by the nurses' station. R1 stated to R3, Go to hell. You're in my house. You don't live here. Get the f*** out. A Certified Nursing Assistant (CNA) separated R1 and R3. R1 was reluctant to leave the area and cursed and pushed the CNA. All interventions and re-direction were ineffective.</p> <p>R3's medical record did not contain a corresponding nursing note for the incident on 6/2/24.</p> <p>~ A note, dated 6/9/24, indicated: R1 talked to R2. It was unknown what R1 said but it upset R2. R1 was not easily redirected.</p> <p>R2's medical record contained the following corresponding nursing note for the incident on 6/9/24:</p> <p>~ A note, dated 6/9/24, indicated: R1 stood by R2 and said something unknown. R2 screamed at R1 and stated, Leave me alone, I don't like you. R2's face was beet red. R2 cried, kicked R2's legs, and threw R2's arms up. Staff took R2 to another part of the building.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/12/24 at 9:40 AM, Surveyor interviewed Hospitality Aide (HA)-C who stated R1 does not interact in a kind or friendly manner. HA-C stated R1 cusses and scowls at other residents and occasionally touches other residents.</p> <p>On 6/12/24 at 10:46 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D via phone. LPN-D stated LPN-D works PM shifts at the facility and often tells Director of Nursing (DON)-B and the Social Worker (SW) the next day to check LPN-D's nursing notes after an incident occurs between R1 and another resident. LPN-D stated resident-to-resident incidents happen pretty often with R1. LPN-D stated, I get the brunt of it on PM shift. When asked if the above incidents were reportable, LPN-D stated, Yes I would say so. I reported to (DON-B). LPN-D stated the incidents were not always reported at the time they occurred because it happens so often.</p> <p>On 6/12/24 at 11:13 AM, Surveyor interviewed DON-B who stated R1's behaviors had worsened with increased agitation and sun-downing. DON-B verified R1 was verbally aggressive with other residents. Following a review of the above incidents, DON-B verified the incidents were reportable resident-to-resident altercations. When asked when DON-B learned of the incidents, DON-B stated, A couple of them just now. DON-B stated staff should report incidents as soon as everyone is safe. When asked if waiting until the next day to report is acceptable, DON-B stated, I would prefer not.</p> <p>In addition, R2's medical record contained the following nursing note:</p> <p>~ A note, dated 6/7/24, indicated: R2 cried today after R6 grabbed R2's hand and asked R2 to touch R6. Staff moved R2 away from R6 and kept R2 close so staff could monitor R2.</p> <p>R6's medical record contained the following nursing notes:</p> <p>~ A note, dated 5/11/24, indicated: Two CNAs witnessed R6 outside R2's room while R2 was in R2's wheelchair watching TV. R6 asked R2 for a kiss. The CNAs told R6 that was not okay and asked R6 to leave R2's doorway. When R6 was asked if R6 asked R2 for a kiss, R6 stated R6 did but said R6 would never kiss (R2) but blows kisses. Staff told R6 that R6 cannot ask R2 or any other residents for kisses or blow kisses. R6 stated R6 would no longer do that and called the two CNAs stupid.</p> <p>~ A note, dated 5/13/24 and written by the SW, indicated: There has been an increase in R6's unwanted sexual interest in a younger resident and an increase in R6's inappropriate sexual comments toward some of the younger staff members. R6 admitted R6 asked R2 if R2 wants a kiss. R6 stated if R2 says yes, R6 blows R2 a kiss, and if R2 says no, R6 leaves R2 alone. The SW informed R6 the behavior was upsetting to R2 and staff. R6 stated R6 didn't expect to kiss R2 but asked R2 for a kiss as a way to interact with R2. The SW suggested R6 say hello if R6 wanted to interact with R2. R6 agreed.</p> <p>~ A note, dated 6/7/24, indicated: R6 held R2's hand and asked R2 to touch R6. Staff moved R2 away which upset R6 who asked multiple times why staff moved R2. R6 wanted staff to bring R2 back so R6 could talk to R2. R2 appeared upset and staff keep the residents separated.</p> <p>~ A note, dated 6/8/24, indicated: R6 again attempted to touch/be close to R2. R6 was reminded that R6's behavior was unwanted and inappropriate. R6 yelled and stated, You take the fun out of everything. Staff again explained the seriousness of the situation. Staff returned R6 to R6's room. Staff will update DON-B and the SW.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R6's care plan contained the following problem statement, initiated on 3/1/22: I have been verbally sexually inappropriate with (opposite gender) staff members. No additional updates were made to R6's care plan regarding inappropriate behavior with R2 or other residents.</p> <p>On 6/12/24 at 11:35 AM, Surveyor interviewed DON-B who, following a review of the incident between R6 and R2 on 6/7/24, stated, I didn't know about that either. DON-B verified the incident should have been reported to the SA and verified the documentation sounded sexual in nature.</p> <p>During an exit conference on 6/12/24 at 1:35 PM, DON-B verified the incident between R6 and R2 on 6/7/24 should have been reported to local law enforcement.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40342</p> <p>Based on staff interview and record review, the facility did not ensure allegations of abuse were thoroughly investigated for 4 residents (R) (R1, R2, R3, and R6) of 6 sampled residents.</p> <p>On 5/29/24 and 6/9/24, R1 verbally abused R2. The facility did not thoroughly investigate the allegations of abuse.</p> <p>On 6/2/24, R1 verbally abused R3. The facility did not thoroughly investigate the allegation of abuse.</p> <p>On 6/7/24, R6 allegedly sexually abused R2. The facility did not thoroughly investigate the allegation of abuse.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy, dated February 2023, indicates: It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion, or misappropriation of resident property .The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation process immediately. A root cause investigation and analysis will be completed .</p> <p>On 6/12/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including dysthymic disorder (a type of depression that occurs over a long period of time), alcohol-induced dementia, low back pain, and anxiety disorder. R1's Minimum Data Set (MDS) assessment, dated 5/23/24, stated R1's Brief Interview for Mental Status (BIMS) score was 00 out of 15 which indicated R1 had severe cognitive impairment. R1's medical record indicated R1's Power of Attorney for Healthcare (POAHC) was responsible for R1's healthcare decisions.</p> <p>On 6/12/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including Huntington's chorea (a neurodegenerative disease exhibited by problems with mood or mental abilities and a general lack of coordination). R2's MDS assessment, dated 4/18/24, stated R2's BIMS score was 10 out of 15 which indicated R2 had moderate cognitive impairment. R2's medical record indicated R2's POAHC was responsible for R2's healthcare decisions.</p> <p>On 6/12/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive nervous system disorder that affects movement). R3's MDS assessment, dated 4/25/24, stated R3's BIMS score was 8 out of 15 which indicated R3 had moderate cognitive impairment. R3's medical record indicated R3's POAHC was responsible for R3's healthcare decisions.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>~ A note, dated 5/13/24, indicated: There has been an increase in R6's unwanted sexual interest in a younger resident and an increase in R6's inappropriate sexually charged comments toward some of the younger staff members. R6 admitted that R6 asked R2 if R2 'wants a kiss'. R6 stated if R2 says yes, R6 blows R2 a kiss, but if R2 says no, R6 leaves R2 alone. R6 was informed R6's behavior was upsetting to R2 and staff. R6 stated R6 didn't expect to kiss R2, but just asks R2 for a kiss as a way of interacting with R2. Staff suggested R6 say hello if R6 wants to interact with R2. R6 agreed.</p> <p>~ A note, dated 6/7/24, indicated: R6 held R2's hand and asked R2 to touch R6. Staff moved R2 away which upset R6. R6 asked multiple times why staff moved R2 and wanted staff to bring R2 back so R6 could talk to R2. R2 appeared upset and staff kept the residents separated.</p> <p>~ A note, dated 6/8/24, indicated: R6 again attempted to touch/be close to R2. R6 was reminded that R6's behavior was unwanted and inappropriate. R6 yelled at writer, You take the fun out of everything. Staff again explained the seriousness of the situation and returned R6 to R6's room. Staff will update DON-B and the SW.</p> <p>R6's care plan contained the following problem statement, dated 3/1/22: I have been verbally sexually inappropriate with (opposite gender) staff members. No additional updates were made to R6's care plan regarding inappropriate behavior with R2 or other residents.</p> <p>On 6/12/24 at 11:35 AM, Surveyor interviewed DON-B who, following a review of the above incident between R6 and R2 on 6/7/24, stated, I didn't know about that either.</p> <p>On 6/12/24 at 1:20 PM, Surveyor interviewed DON-B who verified the facility did not have documentation that any of the above incidents were investigated.</p>