

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Clark County Rehabilitation & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE W4266 County Highway X Owen, WI 54460	

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 - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43352</p> <p>Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when an allegation of sexual abuse, was not reported immediately but not later than 2 hours after the allegation is made, to the administrator of the facility and to other officials (including to the State Survey Agency and law enforcement where state law provides for jurisdiction in long-term care facilities) in accordance with state law for 1 of 1 abuse allegations reviewed for resident (R) 1.</p> <p>Findings include:</p> <p>The facility policy, entitled Abuse, Neglect, Mistreatment & Misappropriation of Resident Property Policy & Procedure, reads in part, It is the policy of the facility that reports of abuse are promptly and thoroughly investigated.</p> <p>R1 was admitted to the facility on [DATE], and has diagnoses that include congestive heart failure, anxiety disorder, major depressive disorder, type 2 diabetes and heart failure.</p> <p>On 03/13/24, Family Member (FM) D requested to speak to Director of Nursing (DON) B and reported that on 03/08/24 FM D reported to Registered Nurse (RN) E that R1 told FM D that an Amish man was having his way with R1.</p> <p>On 03/13/24, FM D indicated to R1 that R1's hair was done nice today. FM D asked R1 who did it. R1 told FM D to guess. FM D went through a list of staff then asked another staff member who did R1's hair. The staff indicated that Certified Nursing Assistant (CNA) C did R1's hair today. When R1 heard CNA C's name, R1 indicated he's the one. FM D asked R1 who the one was; R1 referenced the one at night that has his way with me.</p> <p>On 04/02/24 at 2:38 PM, Surveyor interviewed Director of Nursing (DON) B and asked if RN E should have reported the allegations when FM D brought it to RN E. DON B indicated that FM D thought R1 was having a delusion. DON B indicated looking back maybe it should have been reported.</p> <p>The Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report was not submitted to the State Agency until 03/14/24 at 4:29 PM. Police were not notified until 03/14/24. The reporting was not completed within 2 hours when an allegation of abuse was reported by FM D.</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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