Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525486	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grancare Nursing Center	1555 Dousman St Green Bay, WI 54303

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. 47248 Based on staff and resident interview and record review, the facility did not report allegations of abuse to the State Agency (SA) for 2 residents (R) (R1 and R4) of 4 sampled residents. On 11/11/24, R1 reported an allegation of potential sexual abuse that occurred on 11/10/24. The facility did not report the allegation to the SA in a timely manner. On 9/20/24, R4's family reported that a staff pushed R4 down and told R4 to stop it when R4 attempted to stand. The facility did not report the allegation of abuse to the SA. Findings include: The facility's Neighbor Abuse, Neglect, Exploitation, Misappropriation, Injuries of Unknown Source, Reporting of Incident, Neighbor-to-Neighbor policy, revised 7/25/24, indicates: It is the policy of the facility to ensure that all neighbors be free of all forms of abuse and that all alleged violations of federal or state laws which involve .abuse, neighbor-to-neighbor altercations .are verbally reported immediately to the community mentor/designee and verbally or written to other officials in accordance with state law. Federal requirements under 42 CFR state that if the events that cause the allegation involve abuse or result in serious bodily injury, nursing homes must report the violation to the administrator of the facility and the Division of Quality Assurance (DQA) no later than 2 hours after the allegation is made. All other allegations that do not involve abuse and do not result in serious bodily injury must be reported no later than 24 hours after the allegation is made. In addition, nursing homes must report to DQA and law enforcement any reasonable suspicion of a crime against any individual who is a resident of or is receiving care from the facility .Administrator or designee will complete the online form through the State of Wisconsin Misconduct Incident Reporting (MIR) system .the facility must immediately report all incidents of alleged .neighbor-to-neighbor altercations, abuse . to DQA. 1. On 11/27/24, Surveyor reviewed R1's medical record. R1 had diagnoses including Alzheimer's disease and Parkinson's disease. R1's Minimum Data Set (MDS) assessment, dated 10/18/24, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderately impaired cognition. R1 had an activated decision maker. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/27/2024
NAME OF PROVIDER OR SUPPLIER Grancare Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1555 Dousman St Green Bay, WI 54303	

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	On 11/27/24, Surveyor reviewed a facility-reported incident that indicated R1 reported to staff on 11/11/24 that during personal cares on the evening of 11/10/24, Certified Nursing Assistant (CNA)-D asked R1 if it felt ok and indicated CNA-D wanted to make sure CNA-D was not hurting R1. CNA-D then stated, Women usually like it when I'm down there. R1 indicated CNA-D did not touch R1 inappropriately, however, R1 did not like the comments CNA-D made. The facility initiated an investigation and submitted an initial report to the SA on 11/13/24. The initial report was not submitted within the required timeframe. On 11/27/24 at 12:10 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the self-report regarding R1 was not submitted timely because NHA-A thought the incident was not reportable. NHA-A indicated R1 was not able to accurately recall events due to a diagnosis that caused confusion. NHA-A confirmed the allegation resulted in an investigation and CNA-D no longer worked at the facility. 2. On 11/27/24, Surveyor reviewed the facility's grievance file. A grievance submitted on 9/20/24 indicated R4's family reported to Social Worker (SW)-C that a staff pushed R4 down and told R4 to stop it when R4 attempted to stand without assistance. Surveyor reviewed the grievance and investigation and noted the allegation of abuse was not reported to the SA. On 11/27/24, Surveyor reviewed R4's medical record. R4 had diagnoses including chronic obstructive pulmonary disease (COPD) and multiple fractures. R4's MDS assessment, dated 9/6/24, had a BIMS score of 9 out of 15 which indicated R4 had moderately impaired cognition. R4 had an activated decision maker. On 11/27/24 at 9:45 AM, Surveyor interviewed R4 who indicated nursing staff ask R4 not to stand without assistance. R4 indicated R4 feels like R4 is being told what to do and feels a loss of independence. R4 indicated a staff grasped R4's arms to assist with a transfer and R4 felt that R4 was pushed. R4 indicated R4 now understood that the nurse attempted to assist R4 and did not have harmful intent. R4 reported the incident to R4's decision maker. Staff spoke to R4 and the staff about the incident. R4 confirmed R4 did not have abuse or neglect concerns and indicated R4 should request assistance from staff who were attempting to help prevent R4 from falling. On 11/27/24 at 10:15 AM, Surveyor interviewed SW-C who indicated R4's decision maker reported that R4 stated a staff grabbed R4's arms and prevented R4 from fully standing without assistance. SW-C interviewed R4 who indicated a staff grabbed R4's arms to steady R4 and that R4 cannot do anything on R4's own. SW-C indicated R4 did not like staff assistance with transfers and ambulation despite multiple falls prior to admission. SW-C confirmed an investigation was completed and there was no misconduct on the part of staff. SW-C indicated the grievance was not reported to the SA because the incident was not viewed as an allegation of abuse. SW-C indicated R4's decision maker did not indicate they believe abuse occurred, however, R4 had reported the incident to them. On 11/27/24 at 12:10 PM, Surveyor interviewed NHA-A who indicated the grievance regarding R4 was an allegation of abuse, however, due to discussions with SW-C, R4, and staff, it was determined the allegation was not reportable because the allegation was reported by R4's decision maker. During the investigation, NHA-A indicated R4 reported staff grabbed R4 to steady R4 when R4 attempted to stand and was told not to stand without assistance. NHA-A indicated customer service and resident approaches education was provided to nursing staff to prevent future incidents.