STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525396	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenway Manor	501 S Winsted St Spring Green, WI 53588

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26190 Based on interview, record review, and policy review, the facility failed to implement the facility's Abuse policy that prohibits staff to resident abuse for 1 of 1 resident (R46) reviewed for abuse in the sample of 14. Specifically, the facility did not protect R46 and other residents during the abuse investigation and failed to conduct a thorough investigation into the allegation of physical abuse as instructed in the facility's Abuse policy. This failure had the potential to negatively impact all 46 residents currently residing at the facility. Findings include: Review of the facility's policy titled, Policy and Procedures for grievances, Mistreatment Investigations, Mistreatment Prevention and Injuries of Unknown Source dated 04/25/24 provided by the Administrator as the facility's Abuse policy indicated, Purpose: To prevent and prohibit mistreatment, abuse .of all residents. To ensure that all residents and family complaints are investigated thoroughly, and appropriate corrective action is promptly taken. Policy: It is the policy of (Facility Name) that all residents will live in a safe, secure environment that is free of any type of mistreatment, abuse .Procedure .3. Ensure that all residents are kept safe during the investigation and the alleged abuser shall not work directly with residents until the outcome of the investigation is determined .5. If the complaint is directed toward a staff member, it is to be handled by Social Services and Administrator/Director of Nursing .8. Immediately begin a thorough investigation of any . mistreatment allegations. Thorough internal investigation may include .Interviewing alleged victim(s) and witness(es); interviewing accused individual(s) .interviewing other residents to determine if they have been abused .Interviewing staff who worked the same shift as the accused to determine if they ever witnessed any mistreatment by the accused .Document steps taken during the internal investigation .10. Document the investigation, outcome and any corrective action taken if any is needed. Documentation to be filed in the Grievances folder, which is located in the Social Services office. 11. Ensure that the resident filing a complaint is to remain safe during the investigation procedure . Review of R46's Face Sheet, found in the electronic medical record (EMR) revealed R46 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, hemiplegia of the left dominant side, heart failure, chronic obstructive pulmonary disease, dysphasia, and type II diabetes. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R46's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/19/24, located in the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R46 was cognitively intact. The MDS indicated that R46 was dependent on staff for mobility of rolling from side to side. The MDS indicated that R46 had no psychosis, no behavioral symptoms, and no behavior of resisting care or medications. Review of the facility's investigative file indicated an email from the Director of Nursing (DON) to the Social Service Director (SSD) dated 06/11/24 at 8:00 AM that indicated, Nurse Manager (NM)1 was informed of 'behaviors' when listening to night shift report .Writer (NM1) immediately went to assess resident at 7:35 AM. Upon entering the room writer asked R46 how her night was. R46 stated that Certified Nursing Assistant (CNA) 1 was rough with her last night. Writer asked R46 to explain how CNA1 was rough. R46 stated that CNA1 was checking her during cares/rounds and pulled the soaker pad to the side causing her to hit the side of her head on the assist bar that is closest to the bathroom side. Writer checked R46's head where she said she had hit it. There are no marks, redness, skin issues, or bruising noted. R46 said that after CNA1 had finished rolling her towards the bathroom and she then rolled her back to the window side by pushing on her hip area. Writer checked R46's legs which were equal in length with no hip rotation noted. Writer asked if R46 was in any pain or discomfort and R46 stated, No. Writer completed a full body skin assessment. There were no bruises, red marks, cuts, scrapes, or skin issues noted . During an interview on 09/30/24 at 1:24 PM, R46 was asked about the incident with CNA1 that occurred four months ago. R46 stated she felt it was abusive. R46 stated this was the first and only time something like this had happened. R46 stated that CNA1 had not been back in the room to provide care. During an interview on 10/02/24 at 11:10 AM with the DON and Human Resources Manager, CNA1's time sheet was reviewed, and it was confirmed that CNA1 worked at the facility on 06/11/24 from 10:00 PM through 06/12/24 at 7:35 AM. The DON and Human Resource Manager confirmed that CNA1 returned to work on R46's hallway the night of 06/11/24 after they were aware of the incident that occurred on 06/10/24 between CNA1 and R46. The DON stated the investigation was not completed prior to CNA1 returning to work on 06/11/24 and that they wanted to complete the abuse investigation prior to placing CNA1 on suspension. Interview on 10/02/24 at 12:00 PM, Nurse Manager (NM) 1 stated that on 06/11/24 in the morning, facility staff became aware of R46's statement that CNA1 treated her roughly based on the night shift nurse report. NM1 stated that she immediately completed R46's full body skin assessment which indicated no skin abnormalities. R46 denied any pain at this time. NM1 stated that she notified the DON of R46's statement. During an interview on 10/02/24 at 12:15 PM, Registered Nurse (RN) 1 stated that she heard from R46 that when CNA1 rolled her over in bed, without a verbal warning, it felt unsafe. R46 told RN1 that she bumped her head on the grab bars during the incident. RN1 stated she reported the incident to the DON and SSD.

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(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** 26190 Based on interview, record review, and policy review, the facility failed to report an allegation of staff to resident physical abuse for 1 of 1 resident (R46) reviewed in the sample of 14 residents to the State Agency (SA) immediately, but no later than 2 hours after the allegation was made when the incident involved abuse. This failure had the possibility to negatively impact all 46 residents currently residing at the facility. Findings include: Review of the facility's policy titled, Policy and Procedures for grievances, Mistreatment Investigations, Mistreatment Prevention and Injuries of Unknown Source dated 04/25/24 provided by the Administrator as the facility's Abuse policy indicated, Purpose: To prevent and prohibit mistreatment, abuse .of all residents. Policy: It is the policy of (Facility Name) that all residents will live in a safe, secure environment that is free of any type of mistreatment, abuse . If the event that causes the allegation involves abuse .a report of the violation will be made to the NHA (Nursing Home Administrator) and DQA (Division of Quality Assurance) no later than two hours after the allegation is made. Reports are to be made .via the online reporting system . Review R46's Face Sheet, found in the electronic medical record (EMR) revealed R46 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, hemiplegia of the left dominant side, heart failure, chronic obstructive pulmonary disease, dysphasia, and type II diabetes. Review of R46's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/19/24, located in the EMR under the MDS tab with a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R46 was cognitively intact. The MDS indicated that R46 was dependent for mobility of rolling from side to side, no psychosis, no behavioral symptoms, and no behavior of resisting care or medications. Review of the facility's investigative file indicated an email dated 06/11/24 at 8:00 AM from the Director of Nursing (DON) to the Social Service Director (SSD) that stated, Nurse Manager (NM)1 was informed of 'behaviors' when listening to night shift report .Writer (NM1) immediately went to assess resident at 7:35 AM. Upon entering the room writer asked R46 how her night was. R46 stated that Certified Nursing Assistant (CNA) 1 was rough with her last night. Writer asked if R46 explain how CNA1 was being rough. R46 stated that CNA1 was checking her during cares/rounds and pulled the soaker pad to the side causing her to hit the side of her head on the assist bar that is closest to the bathroom side. Writer checked R46's head where she said she had hit it. There are no marks, redness, skin issues or bruising noted. R46 said that after CNA1 had finished rolling her towards the bathroom and she then rolled her back to the window side by pushing on her hip area. Writer checked R46's legs which were equal in length with no hip rotation noted. Writer asked if R46 was in any pain or discomfort and R46 stated, 'No.' Writer completed a full body skin assessment. There were no bruises, red marks, cuts, scrapes, or skin issues noted . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R46's EMR Progress note' in the Progress note tab dated 06/12/24 indicated, Late entry 6/11/24. Behavior: CNA1 reported resident demonstrated resistance to care behavior. CNA1 reported resident was pushing back when she was trying to lead her in another direction in an attempt to change her brief. Additionally, resident was calling her names. Review of the facility's investigative file indicated on 06/13/24 at 2:36 PM the SSD documented, .Concern resolved on: 06/13/24 Actions/Response to Concern: Investigation completed, and action concluded CNA1 no longer works in this facility. During an interview on 09/30/24 at 11:23 AM, the SSD was asked why the incident of alleged staff to resident abuse with CNA1 and R46 was not reported to the SA (State Agency). The SSD replied, We addressed it right then, so we did not send a report to the state. R46 said she did not want to file a grievance. SSD stated the incident was not considered abuse and was handled internally. CNA1 was 'let go' so we did not feel it needed to be reported to the SA. SSD stated that the time period to report abuse to the SA was eight hours. During an interview on 10/02/24 at 11:50 AM with the DON and the Human Resources Manager, they stated this incident did not meet our (the facility's) definition of abuse and that the incident was not intentional so that was why the SA was not notified of the abuse allegation.

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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** 26190 Based on interview, record review, and policy review, the facility failed to thoroughly investigate an allegation of physical abuse for 1 of 1 resident (R46) reviewed for abuse in the sample of 14 residents. This failure had the potential to negatively impact all 46 residents currently residing at the facility. Findings include: Review of the facility's policy titled, Policy and Procedures for grievances, Mistreatment Investigations, Mistreatment Prevention and Injuries of Unknown Source dated 04/25/24 provided by the Administrator as the facility's Abuse policy indicated, Purpose: To prevent and prohibit mistreatment, abuse .of all residents. To ensure that all residents and family complaints are investigate thoroughly and appropriate corrective action is promptly taken . 5. If the complaint is directed toward a staff member, it is to be handled by Social Services and Administrator/Director of Nursing .8. Immediately begin a thorough investigation of any . mistreatment allegations. Thorough internal investigation may include .Interviewing alleged victim(s) and witness(es); interviewing accused individual(s) .interviewing other residents to determine if they have been abused .Interviewing staff who worked the same shift as the accused to determine if they ever witnessed any mistreatment by the accused .Document steps taken during the internal investigation .9. Assess validity of complaint based on information gathered and gather additional information if needed. Identify whether or not alleged misconduct occurred .10. Document the investigation, outcome and any corrective action taken if any is needed. Documentation to be filed in the Grievances folder, which is located in the Social Services office . Review of R46's Face Sheet, found in the electronic medical record (EMR) tab, revealed R46 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, hemiplegia of the left dominant side, heart failure, chronic obstructive pulmonary disease, dysphasia, and type II diabetes. Review of R46's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/19/24, with a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R46 was cognitively intact. The MDS indicated that R46 was dependent for mobility of rolling from side to side, no psychosis, no behavioral symptoms, and no behavior of resisting care or medications. Review of the facility's investigative file indicated a document titled, Date of Concern dated 06/10/24 that revealed, R46 reported Certified Nursing Assistant (CNA) 1 is rough when performing cares. R46 reported Monday 06/10/24 CNA1 rolled R46 to her side and R46 bumped her head on the top rail. R46 stated CNA1 is arrogant offering no apology.Director of Nursing (DON) updated and investigation in progress. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigative file indicated an email from the DON to the Social Service Director (SSD) dated 06/11/24 at 8:00 AM that indicated, Nurse Manager (NM)1 was informed of 'behaviors' when listening to night shift report .Writer (NM1) immediately went to assess resident at 7:35 AM. Upon entering the room writer asked R46 how her night was. R46 stated that CNA1 was rough with her last night. Writer asked R46 to explain how CNA1 was rough. R46 stated that CNA1 was checking her during cares/rounds and pulled the soaker pad to the side causing her to hit the side of her head on the assist bar that is closest to the bathroom side. Writer checked R46's head where she said she had hit it. There are no marks, redness, skin issues or bruising noted. R46 said that after CNA1 had finished rolling her towards the bathroom and she then rolled her back to the window side by pushing on her hip area. Writer checked R46's legs which were equal in length with no hip rotation noted. Writer asked if R46 was in any pain or discomfort and R46 stated, 'No.' Writer completed a full body skin assessment. There were no bruises, red marks, cuts, scrapes, or skin issues noted . Review of the facility's investigative file indicated a document from the SSD dated 06/13/24 at 2:36 PM which indicated, .Concern resolved on: 06/13/24 Actions/Response to Concern: Investigation completed, and action concluded CNA1 no longer works in this facility. During an interview on 09/30/24 at 11:43 AM, the DON stated she went to R46 to obtain her description of rough and R46 stated rough was moving faster than usual. The DON stated she talked to R46 and that she did not feel the incident was abuse, just that CNA1 was just too fast with her care. During an interview on 09/30/24 at 1:24 PM, R46 was asked about the incident that happened with CNA1 four months ago, R46 stated she felt it was abusive. R46 stated this was the first and only time something like this had happened. R46 stated that CNA1 had not been back to provide her care since the incident. During an interview on 10/03/24 at 11:50 AM, the DON stated as part of the investigative process she interviewed various residents and asked how their night was the night of the incident. The DON stated the residents indicated that CNA1 was too fast and did not explain what she was doing, but the residents did not state that CNA1 had abused them. However, she had no documentation of the residents' interviews. The DON provided no documentation of R46's interview and said that CNA1 would not cooperate with the investigation so she did not have CNA1's statement.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 26190 Based on interview and document review, the facility failed to ensure that 2 of 6 (Certified Nursing Assistants (CNA5 and CNA8) completed the minimum of 12 hours of inservice training per year. The lack of inservice trainings could have a negative impact for all 46 residents currently residing at the facility. Findings include: Review of CNA5's personnel file indicated CNA5's Date of Hire (DOH) was 08/22/23 and that CNA5 had completed 10.25 hours of training during the past year (August 2023 through August 2024). Review of CNA8's personnel file indicated CNA8's DOH was 07/25/1995 and that CNA8 had completed 8.75 hours of training during the past year. (July 2023 through July 2024). During an interview on 10/03/24 at 3:45 PM, the Director of Nursing (DON) confirmed that the two CNAs' personnel files did not include documentation of 12 hours of inservice training for the past year. The DON stated that the facility did not have a policy regarding CNAs having 12 hours of inservice training per year.