STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013045	A. BUILDING: _____ B. WING _____	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY ESTATES V	1810 LINCOLN ST WISCONSIN RAPIDS, WI 54495

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	INITIAL COMMENTS On 08/23/2023 with additional information gathered through 8/30/2023, Surveyor conducted a complaint investigation at River City Estates V. As a result one deficiency was issued. The complaint was substantiated. Census: 4	M 000		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on interviews and record review the licensee permitted the existence or continuation of a condition in the home which placed the health, safety, and welfare of the residents at substantial risk of harm. On 08/04/2023, Resident 1 reported to staff s/he was yelled at and pinned against the bathroom wall during the morning shift by Staff A, which resulted in a bruise to her/his left shoulder area. After learning of the allegation, the licensee did not take immediate steps to protect all residents from subsequent incidents of misconduct or investigate and document a thorough investigation. Staff A continued to work alone, unsupervised, providing direct resident care during multiple night shifts. Findings include:	M 230		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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M 230	Continued From page 1 On 08/29/2023, Surveyor reviewed department records and noted the facility had not submitted any Misconduct Incident Reports (MIR) or self-reports documenting investigations into allegations of abuse, neglect, and/or mistreatment of a resident any time after 08/04/2023. On 08/29/2023, Surveyor reviewed the facility policy titled, "Abuse/Neglect/Misappropriation of Property" which was undated and indicated, "It is the policy of RCE (River City Estates) to require that all consumers served through RCE be treated with dignity and respect and be free of and protected from any form of physical or emotional abuse, neglect, or misappropriation of property. RCE maintains zero tolerance of any form of abuse, neglect, or misappropriation of property. This policy relates to all consumers served by RCE in any capacity...All employees must report to RCE management, any knowledge of or suspicion of abuse, neglect or misappropriation of property by any person whether or not employed by RCE...When notified, the management staff shall take immediate steps to secure and protect the individual from additional abuse, neglect or misappropriation of property...For employees involved in or suspected of being involved in an act of abuse, neglect or misappropriation of property: If an act of abuse, neglect or misappropriation of property is suspected, the alleged perpetrator may be immediately placed on unpaid suspension until an investigation determines the validity of the suspicion..." RESIDENT 1 On 08/29/2023, Surveyor reviewed the medical	M 230		

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record for Resident 1. The resident was admitted to the facility on 07/25/2023. Resident 1's ISP (Individual Service Plan) dated 08/22/2023 indicated, "[Resident 1] needs help with bathing, toileting, transfers on/off toilet, and changing clothing. [Resident 1] uses an incontinent brief, needs cueing to use the toilet, cries often and needs reassurance." The ISP also indicated, "[Resident 1] prefers to sleep in a recliner and yells for assistance during the night."

Resident 1's progress notes revealed the following:

*08/04/2023 7 AM- 3 PM- "[Resident 1] crying and screaming for help immediately after staff arrived. Claimed morning staff pushed [her/him] into the bathroom wall yesterday while toileting..."

*08/06/2023 3 PM- 11 PM- "Assisted resident with toileting at 6 PM followed with staff assisting with a shower...Staff member noticed some bruising on left shoulder and left leg of resident."

*08/08/2023 7 AM- 3 PM- "Ate all meals. Crying a lot and stated [s/he] is scared of some staff..."

APS (Adult Protective Services) REPORTS

On 08/29/2023, Surveyor reviewed APS Reports.

Review of an APS report dated 08/08/2023 indicated, "APS arrived at the home to investigate a complaint regarding potential caregiver misconduct. On 08/09/2023, APS called [Manager B] to inform [her/him] an investigation was being completed regarding potential caregiver misconduct."

Review of an APS report dated 8/16/2023

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indicated, "Law enforcement accompanied APS to the facility to file a police report...It was reported by multiple people [Resident 1] was physically abused on 8/3...Staff and other residents confirmed this did happen. Told law enforcement about [Resident 1] being pinned to the wall in the bathroom and having bruises as a result...[Resident 1] still had small, light bruising on [her/his] shoulder..."

Review of an APS report dated 8/17/2023 indicated, "APS called [Licensee D] about the investigation and [Licensee D] asked what happened with [Resident 1]. Told [Licensee D] APS was told about physical abuse which took place on 8/3/23...APS told [Licensee D] multiple residents and staff confirmed this incident happened..."

INTERVIEWS

On 08/23/2023 at 9:30 AM, Surveyor interviewed Resident 1 regarding the care and treatment s/he received in the home. Resident 1 stated, "Staff are nice except for one." Resident 1 went on to say, "Several weeks ago, one of the staff got frustrated and mad at me. [S/he] grabbed and pinned me to the bathroom wall and almost broke my glasses...I have bruises from it on my shoulder." ***Surveyor observed a faint yellow bruise on Resident 1's left shoulder and left bicep region and noted Resident 1 was in tears while explaining the above incident. Surveyor then asked Resident 1 if s/he could tell the surveyor what staff member was involved in the incident s/he described. Resident 1 stated, "It was [Staff A], [s/he] worked last night. I had to use the bathroom last night when [s/he] was here. It went better because [s/he] didn't push me this time... [Staff A] also apologized to me last night and said

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[s/he] was sorry for pinning me against the wall in the bathroom."

On 08/23/2023 at 10 AM, Surveyor interviewed Resident 2 regarding the care and treatment s/he received in the home. Resident 2 stated, "Some staff are nice, and some are crabby with a bad attitude." Surveyor asked Resident 2 to explain. Resident 2 stated, "There are two staff that work here with the same first name [Staff A] and [Staff E]. [Staff E] is nice and has never hurt anyone. [Staff A] fills in at the home when they need [her/him]. [Staff A] is not nice and no one likes [her/him] working here." Resident 2 went on to say, "On 8/3/23, I was on the phone and heard all types of yelling and screaming. I heard [Staff A] yelling and picking on [Resident 1]. [Staff A] was mocking [Resident 1] by saying "Waah-Waah" and then I heard a "thump" in the bathroom." Resident 2 went on to say. "I talked to [Resident 1] right after [s/he] came out of the bathroom and [Resident 1] told me [Staff A] pinned [her/him] against the wall...[Staff A] worked last night (8/22/23). As soon as I seen [Staff A] this morning I went back to bed because I didn't want to deal with [her/him]."

On 08/23/2023 at 1 PM, Surveyor interviewed Resident 3 regarding the care and treatment s/he received in the home. Resident 3 stated, "There's one staff I don't like...[Staff A] s/he was here this morning when I woke up. [Staff A] yells at residents and took [Resident 1] to the bathroom and hurt [her/him]. [Staff A] has called me names like [expletive] and [expletive]. I've told [Manager B] about it and [s/he] told me not to worry about it...I like [Staff E] better than [Staff A]."

On 08/23/2023 at 1:30 PM, Surveyor interviewed

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Resident 4 regarding the care and treatment s/he received from staff in the home. Resident 4 stated, "Staff are fine, but [Staff A] treats us like little kids ...[Staff A] was here last night."

On 08/23/2023 at 4:20 PM, Surveyor interviewed Staff F. Staff F indicated the home is staffed with one caregiver and stated, "Over the last few months all the residents have been complaining about [Staff A]. Residents tell me [Staff A] is mean and they don't know why [s/he] works there. About a week or so after [Resident 1] was admitted, [Resident 1] told me [Staff A] pushed [her/him] in the bathroom making [her/him] fall into the wall, which caused bruising to [her/his] shoulder. [Resident 1] showed me the bruise on [her/his] left shoulder. The bruise was big, the size of a plum. I know the bruise was not there prior to [Resident 1] coming because I gave [Resident 1] a shower within the first few days after [her/his] admission and there were no bruises. [Resident 1] has been talking about this incident and how [s/he] got the bruise for the past three weeks." Surveyor asked Staff F if s/he reported this information to anyone. Staff F stated, "I reported this to [Manager B] right away in person and [Manager B] told me it was probably just an accident and did nothing else... [Resident 1] tried to show [Manager B] the bruise when [s/he] came to the home, and [Manager B] was not interested and told [Resident 1] it was an accident...When you report things to [Manager B] nothing is ever done."

On 08/23/2023 at 5:20 PM, Surveyor interviewed Staff E regarding Resident 1. Staff E stated, "[Resident 1] reported to me sometime during the end of July 2023 or first week of August 2023 that [s/he] was scared of [Staff A] and didn't want [Staff A] to care for [her/him]. [Resident 1] told

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me [Staff A] pushed [her/him] in the bathroom against the wall and caused bruising. I did see a circular bruise on [Resident 1's] left shoulder blade." Surveyor asked Staff E is s/he reported this information to anyone. Staff E stated, "I've reported this to [Manager B] many weeks ago, but nothing ever gets done."

On 08/29/2023 at 2 PM, Surveyor interviewed Staff C regarding Resident 1. Staff C stated, "When I came into work on 08/04/2023, Resident 1 was very upset, and I tried to calm [her/him] down. [Resident 1] told me that when [Staff A] was taking [her/him] to the bathroom, [Staff A] pinned [her/him] up against the wall and yelled at [her/him] to stop crying. During my shift on 8/4/23, I observed redness on the front of [Resident 1's] left shoulder and collar bone, which did develop into a bruise over the next few days." Surveyor asked Staff C what s/he did with this information. Staff C indicated s/he told Manager B on 08/04/2023 about the reported incident by Resident 1 and documented it in Resident 1's record. Staff C went on to say, "Multiple staff have told [Manager B] about this incident, but [Manager B] doesn't listen to what we say."

On 08/23/2023 at 11:30 AM, Surveyor interviewed Manager B regarding Resident 1. Manager B stated, "APS called me around 08/08/2023 and told me they were investigating some concerns. APS was "very cryptic" and did not tell me who or what the concerns were about. I left for vacation on 08/15/2023 and returned on 08/21/2023. On 08/16/2023, [Assistant Manager G] called me to report APS and the police were at the home with a concern about [Staff E] pushing [Resident 1] in the bathroom and given [Resident 1] bruises. [Licensee D] directed me to take [Staff E] off the schedule, so I did." Surveyor then ask Manager

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B if s/he began an investigation into the allegation of potential abuse/mistreatment on 08/16/2023. Manager B confirmed s/he did not. Surveyor then asked if s/he directed anyone else and/or [Assistant Manager G] to start an investigation. Manager B verified Assistant Manager G did not investigate and s/he did not direct anyone else too. Manager B stated, "When I came back from vacation on 08/21/2023, [Assistant Manager G] gave me an APS business card and police contact information. I then began my investigation on 08/22/2023 and talked to all the residents. I found out there was a conflict when interviewing the residents. Some resident interviews indicated [Staff A] was the alleged perpetrator during the incident with [Resident 1] and not [Staff E]. [Staff A] and [Staff E] have the same first name and worked the same day, but I only gave APS [Staff E's] information not [Staff A's]." Surveyor asked if s/he documented/collected any additional information into this allegation involving Resident 1. Manager B confirmed s/he only interviewed residents starting on 08/22/2023. Surveyor then asked if Staff A was allowed to work in the home after s/he found out [Staff A] could be the alleged perpetrator. Manager B stated, "I let [Staff A] work last night (08/22/2023) because I needed someone to cover the shift."

The provider's investigation undated and written by Manager B included statements from the four residents living in the home. Three of the 4 resident's statements indicated they had no concerns with Staff E, but were displeased with Staff A. Surveyor noted the documented investigation did not include:
---the steps that were taken to ensure the health, safety, and well-being of the residents
---interviews with other staff to determine their

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knowledge of the incident or any inappropriate behavior they witnessed
---documentation a body assessment was completed for Resident 1
---documentation Resident 1 was assessed for psychosocial changes and any effects the incident may have had on the resident.
---information an interview was attempted or completed with the alleged perpetrator(s)
---the conclusion of the investigation or a determination if a Misconduct Incident Report should be reported to the department

Surveyor reviewed Staff A's time sheets for August 2023. The time sheets revealed Staff A worked the following dates and times:
*08/03/2023: 7 AM- 2 PM
*08/15/2023: 11 PM- 7 PM
*08/16/2023: 11 PM- 7 PM
*08/22/2023: 11 PM- 7 PM

***Surveyor noted Staff A worked alone in the home during all the above shifts. On 08/23/2023 at 12:30 PM during an interview with Surveyor, Manager B confirmed Staff A worked alone, and without supervision on the above dates.

On 08/23/2023 at 4:40 PM, Surveyor interview Licensee G. Licensee G stated, "I received a phone call from APS on 08/17/2023 explaining there was an allegation with a bruise in the bathroom that involved [Staff E] and [Resident 1]. So, I took [Staff E] off the schedule and did not have [her/him] work again. When [Manager B] came back from vacation, I didn't direct [her/him] to do anything because I assume [s/he] knows what [s/he's] doing...I should've told [Manager B] to do an investigation immediately, but I didn't...I take full responsibility for that." Surveyor then ask Licensee G if s/he conducted and/or

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M 230	Continued From page 9 documented an investigation into the incident involving Resident 1. Licensee G confirmed s/he did not complete or document an investigation into the allegation involving Resident 1. On 08/04/2023, facility management became aware of an allegation involving potential abuse/neglect/mistreatment of Resident 1. The provider did not take immediate steps to protect all residents from subsequent incidents of misconduct or conduct and document a thorough investigation after receiving the allegation. Additionally, the alleged perpetrator [Staff A] continued to work alone, unsupervised, providing direct resident care.	M 230		