STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017857	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS CLINTONVILLE II	61 INDUSTRIAL AVE CLINTONVILLE, WI 54929

(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
N 000	Initial Comments On 01/17/2024, Surveyor conducted a standard survey and complaint investigation at Care Partners Clintonville II. Additional information was collected through 01/22/2024. The complaint was substantiated. As a result of the investigation, 1 deficient practice was identified. Census: 24	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were immediately protected from Caregiver C after Resident 1 reported an allegation of abuse on	N 158		

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

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N 158	Continued From page 1 12/03/2023. The reported allegation was not immediately investigated by the provider. Resident 1 reported abuse allegations against Caregiver C that occurred on 12/01/2023 and 12/02/2023 to Caregiver D on 12/03/2023. Caregiver D told Assistant Director E who delayed informing Director A about the allegations, causing no immediate protection of the residents or investigation of the allegations. Subsequently, Caregiver C came in to work the evening of 12/03/2023 which caused Resident 1 stress and fear. Findings include: On 01/17/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 01/04/2024 with diagnoses including type 2 diabetes, sleep apnea, COPD, and depression. Resident 1 is his/her own person. On 01/19/2024 at 11:45 AM, Surveyor interviewed Resident 1. Resident 1 gave the following timeline of events: Friday 12/01/2023 Resident 1 stated Caregiver C was asked to assist with his/her incontinence cares and s/he was rough, disrespectful, and left the bed still soaking wet with urine. Resident 1 had to call in another caregiver (Caregiver G) to assist and get dry bedding. Saturday 12/02/2023 Caregiver C worked the overnight shift and came in to assist Resident 1 with incontinence cares. Resident 1 stated Caregiver C was verbally and physically aggressive, intimidating, and disrespectful. Resident 1 stated s/he did not put the call light on for the rest of the night because	N 158		

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N 158	Continued From page 2 s/he was fearful it would be Caregiver C that answered. Resident 1 expressed a feeling of being caught during the weekend without any caregiver to report to that could protect him/her and resolve the issue. Resident 1 stated many of the caregivers are kind, but s/he perceived s/he could not rely upon all of them to report the incident or know how to handle it appropriately. Resident 1 stated s/he felt there was no one to go to over the weekend that was capable of helping him/her so s/he had to wait until Sunday morning when a capable caregiver would be present. Resident 1 reported feeling upset at being yelled at, frustrated, and vulnerable. Sunday 12/03/20203 Resident I stated at 7:00 AM s/he reported to Caregiver D that Caregiver C had been aggressive to him/her on 12/01/2023 and 12/02/2023 while changing his/her briefs and bedding at night. Resident 1 stated s/he after s/he reported to Caregiver D s/he expected "something to be done about it." In the investigation report dated 12/04/2023, a handwritten statement from Caregiver D noted Caregiver D immediately notified Assistant Director E, "[Resident 1] expressed that [Caregiver C] had been rough while changing [him/her] in bed ...yanking [him/her] around in bed ... raised [his/her] voice and yelled at [Resident 1] ... [Resident 1] was visibly upset ... I called [Assistant Director E] and explained the situation ... I had talked with [Assistant Director E] ... and that [s/he] would be in that night to talk to [Caregiver C] ..." Assistant Director E does not immediately ensure the resident's safety, does not begin an investigation, acknowledges the	N 158		

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N 158	Continued From page 3 accused caregiver is scheduled to come in for the night shift with no intention of placing him/her on suspension until an investigation is completed, and states his/her intent to instead speak with the accused caregiver which has the potential to cause further harm and safety risk to Resident 1 who will be left alone with the caregiver that evening without an investigation. Resident 1 stated later in the evening on 12/03/2023 s/he was surprised and scared to see Caregiver C was "still working" as s/he came in for his/her scheduled overnight shift. Resident 1 stated s/he was so stressed about knowing Caregiver C was in the building and could come into his/her room that s/he could not sleep. Resident 1 stated s/he was fearful and asked the other caregiver working (Caregiver F) to be the only one to assist with cares if s/he used his/her call light. Caregiver F did not question further or report the behavior as a possible indicator of abuse. Monday 12/04/2023 Per interview with Director A on 01/19/2024 at approximately 12:00 PM, Director A was notified by Assistant Director E about the reported allegations. Director A immediately took steps to ensure resident safety and began an investigation. On 01/18/2024 at approximately 1200 PM, Surveyor interviewed Director A with RN B present. Director A reviewed the record and verified Resident 1 informed the provider of the abuse allegations on 12/03/2023 via Caregiver D at 7:00 AM and alluded to the concerns with Caregiver F in the evening of 12/03/2023. Director A stated Caregiver D reported to Assistant Director E who "made the mistake" of	N 158		

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N 158	Continued From page 4 waiting to report the allegations to Director A until the morning of 12/04/2023. Director acknowledged the provider did not immediately protect the residents when they had been made aware of the allegations and allowed Caregiver C to continue to work on 12/03/2024. Director A acknowledged an investigation was not immediately started after the allegations were reported to the provider on 12/03/20203.	N 158		