STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016004	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBI CARING HEARTS B LLC	1614 HENRY JOHNS BLVD BANGOR, WI 54614

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N 000	Initial Comments On 02/13/2025, Surveyor conducted 2 self-report investigations at RBI Caring Hearts B LLC. Data collection continued through 02/20/2025. One deficiency was identified. Census: 12	N 000		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not provide supervision adequate to meet the needs of all residents. Findings include: The provider is licensed to care for up to 12 residents in the client groups of: irreversible dementia/Alzheimer's disease, physically disabled and advanced age. The provider submitted 3 self-reports to the department between 05/14/2024 and 08/26/2024 related to resident elopements.	N 426		

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

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N 426	Continued From page 1 A self-report, dated 05/14/2024, identified Resident 1 eloped on 05/11/2024 at 7:30 PM. The report stated, in part, "At approx. (approximately) 7:30 pm [sic] staff went to get [Resident 1] for noc (overnight) meds (medications) and could not find [him/her]... The staff in house had stated when [s/he] was outside with the residents earlier that [Resident 1] had been talking about taking off, that [s/he] has actually been talking about it for a few days. OnCall [sic] was notified. Before [OM B] arrived to help search for [Resident 1,] [s/he] walked in the door with a young [person] named [Citizen C.] [Citizen C] stated that [Resident 1] was by the log cabin hitchhiking so [s/he] picked [him/her] up ...[Citizen C] stated [s/he] got to West Salem when [s/he] realized that [Resident 1's] behaviors were those of one with dementia so [s/he] pulled over and asked [Resident 1] if [s/he] had an ID (identification.) [Resident 1] handed [him/her] [his/her] wallet which didn't contain an ID but did have a bunch of numbers so [Citizen C] started calling them ..." A self-report, dated 08/08/2024, identified Resident 2 eloped on 08/07/2024 at 4:36 PM. The report stated, in part, "After assisting another resident in thei [sic] rbedroom [sic], writer went to check on [Resident 2] as [s/he] had been sitting outside but [s/he] was no where [sic] in sight ...Less than 10 mins (minutes) later [sic] another resident who had been out on an outing with [his/her] [family member] [sic] pulled in the driveway with [Resident 2] in the back seat. They stated that [s/he] was up by the library standing on the corner ..." A self-report, dated 08/26/2024, identified Resident 1 had eloped on 08/25/2024 at 1:15 PM. The report included supplemental information in	N 426		

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the form of staff observation notes, incident reports and Medication Administration Records (MARs) for Resident 1.

The following staff observation notes were included:
07/28/2024 at 1:00 PM: "[Resident 1] is sitting outside."
08/02/2024 at 8:30 AM: "sitting outside."
08/03/2024 at 8:45 AM: "sitting outside."
08/04/2024 at 1:15 PM: "sitting outside."
08/08/2024 at 12:45 PM: "sitting outside."
08/10/2024 at 10:30 AM: "Resident came out of [his/her] room very [sic] very agitated. Determined that [s/he] is going to the store to buy Band-Aids. Staff found some for the resident to try to redirect [him/her,] but [s/he] is getting more verbal [sic] aggressive. Resident took off out [sic] the door and down the road. Staff tried to run after [him/her], and [s/he] would not come back ..." Another staff was noted to grab the resident from down the road.
08/10/2024 at 1:30 PM: "Resident sitting outside."
08/11/2024 at 10:30 AM: " ...[s/he] is very persistent on leaving the building and walking to [his/her] [family member] [sic] ...Resident has threatened to to [sic] take off and walk to [his/her] [family member] [sic] house. Resident said [s/he] does not care, and [s/he] is leaving ...Resident is being kept a very close on eye [sic].
08/12/2024 at 9:30 PM: "I walked up to [Resident 1] who took off down the street and [s/he] was agitated ...[S/he] sat on the steps by [store] and took a break before going in. The cops and first responder met us before we went in to make sure everything was okay ..."
08/16/2024 at 11:15 AM: "sitting outside."
08/18/2024 at 11:30 AM: "sitting outside."
08/20/2024 at 1:00 PM: "sitting outside."
08/24/2024 at 12:00 PM: " ...refused to come

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inside, refused water and refused cares, [sic] advised [sic] I would be out every 10 mins to check on [him/her] and tell [him/her] to drink water and come inside, [s/he] said you'll just be wasting your time."
08/24/2024 at 3:30 PM: "Resident has been outside since 8AM ..."

The incident report, dated 08/25/2024, indicated Resident 1 was observed leaving the home at approximately 1:15 PM. The report stated, in part, "Writer watched resident walking down towards the road and as [s/he] went to go out to attempt redirection, [s/he] sat down by the dumpster facing the road ...When staff made it out to [him/her] [sic] resident started walking away and continued telling [him/her] that [s/he] wasn't coming back ...It was reported that [s/he] was found after searching for 2 hours [sic]"

A letter without a date was signed by Licensee E and Assistant F. The letter indicated Resident 1 received a 30-day notice from the provider. It read, in part, "We are concerned that [his/her] dementia has gotten worse, and this has started since May of this year more actively ..."

On 02/13/2025, at approximately 2:30 PM, Surveyor interviewed Registered Nurse (RN) A and Office Manager (OM) B. When asked about Resident 2's elopement on 08/07/2024, OM B stated staff would do 3-minute checks to make sure Resident 2 was still sitting outside. OM B stated Resident 2 had dementia and likely had a urinary tract infection (UTI) at the time of the elopement. OM B stated Resident 2 had gotten more confused because of the UTI and had walked away from the facility. OM B stated Resident 2 required 24/7 supervision and had not eloped before. OM B stated the staff working at

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the home next door, also licensed by the department, would assist with monitoring the residents that were sitting outside. OM B stated staff would assist with monitoring by looking out of the window or through the side door. OM B stated there was 1 staff working per shift in both facilities.

When asked about Resident 1's elopement in May 2024, OM B stated Resident 1 took off quick but luckily got picked up. OM B stated staff and the police looked for Resident 1. OM B stated that after the incident, they had a meeting with staff and staff were instructed to encourage Resident 1 to let staff know if s/he was going outside. OM B stated staff were encouraged to keep an eye on Resident 1 and would watch him/her through the window when Resident 1 was outside. OM B stated staff would go check on other residents and come back to look outside to ensure Resident 1 was still there. OM B stated the provider already had door alarms. OM B stated that when Resident 1 was indoors, staff would check on him/her approximately every 15-30 minutes to ensure s/he did not leave.

When asked about Resident 1's elopement on 08/25/2024, OM B stated Resident 1 was taken away by the police and was placed under an emergency chapter with the county. Resident 1's discharge date was 09/05/2024. OM B stated when staff realized Resident 1 eloped, they called the on-call staff and later the police. OM B stated the police found Resident 1 under a bridge and later assisted Resident 1 to the hospital. Resident 1 did not return to the provider.

At approximately 3:00 PM, Surveyor requested records for Resident 1 and Resident 2.

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Resident 1 was admitted on 09/20/2022 with multiple diagnoses, including vascular dementia and cognitive communication deficit. Resident 1 had a healthcare power of attorney (HCPOA). Resident 1's face sheet indicated s/he was a fall risk and wander risk. It stated, "Staff to monitor when [s/he] goes outside so [s/he] does not wander off." An Individual Service Plan (ISP), with an unknown date, included a section titled "Wandering." It read, "[Resident 1] has displayed wandering behavior, having walked away from the facility. If [s/he] chooses to sit outside, staff should check on [him/her] every 10 minutes while [s/he] is outside. Document when [s/he] goes out and comes back in."

Resident 2 was admitted on 07/17/2020 with multiple diagnoses, including unspecified dementia. Resident 2 had a HCPOA. Resident 2's face sheet indicated s/he was a fall risk and wander risk. A document titled, "Service Plan Task," included a section titled, "Wanderer." Under the "Wanderer" section, it read, "Staff should monitor resident whereabouts at all times. Has demonstrated [s/he] will leave the building unescorted and is confused as to [his/her] surroundings. Staff will redirect [him/her] back to a safe area if this happens." The scheduled dates for that section read, "07/24/2020-No end date."

At approximately 3:15 PM, Surveyor interviewed RN A and OM B. RN A stated Resident 1's "Wandering" section on his/her ISP was updated on 05/13/2024. The supervision section of the ISP was blank. OM B stated Resident 1 required 24/7 supervision. RN A stated s/he did not see any updates to Resident 1's ISP after 05/13/2024. When asked about the ISP's instruction for staff to check on Resident 1 every 10 minutes while

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N 426	Continued From page 6 Resident 1 was outside, OM B stated that probably was not appropriate. OM B stated staff did their best to help other residents and monitor the residents outside. RN A stated it was best to give Resident 1 space under some circumstances. At approximately 4:15 PM, Surveyor observed an outdoor patio area located between the 2 facilities. The patio area was unsecured and did not include a gated or fenced in area. OM B stated the patio area was where residents would spend time in the warmer months and may have been prior to their elopements. The provider did not provide supervision adequate to meet the needs of all residents when Resident 1 eloped on multiple occasions and Resident 2 eloped from an unsecured outdoor patio area.	N 426		