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	0014023	A. BUILDING: _____ B. WING _____	C 12/11/2024

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CENTURY RIDGE OF GREEN BAY I	2498 BLUESTONE PL GREEN BAY, WI 54311

(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 12/04/2024 with additional information gathered through 12/11/2024, Surveyor conducted a complaint investigation and standard survey. As a result eleven deficiencies were identified. The complaint was substantiated. Census: 17	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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

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N 239	Continued From page 1 This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Caregiver A obtained all department approved training as required. Caregiver A did not have training for fire safety or first aid and choking within 90 days after starting employment. This is a repeat deficiency and is being cited for the sixth time. See Statement of Deficiency (SOD) OBJ111 dated 01/27/2021, SOD OBJ112 dated 05/17/2021, SOD OBJ113 dated 09/16/2021, 54L111 dated 03/15/2023 and 54L112 dated 08/09/2023. Findings include: On 12/04/2024, Surveyor conducted a review of employee training records to verify compliance with department approved training requirements. Surveyor requested training records for Caregiver A. Caregiver A was hired on 04/29/2024. Caregiver A's record did not contain evidence of training or evidence of meeting an exemption for fire safety or first aid and choking. On 12/04/2024, Surveyor verified Caregiver A was not on the Community-Based Care and Treatment training registry for first aid and choking. On 12/04/2024 at 1:30 PM, Surveyor interviewed Caregiver A. Caregiver A stated s/he could not recall if s/he had the department approved training for fire safety and first aid and choking.	N 239		

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N 239	Continued From page 2 On 12/10/2024 at approximately 9:30 AM, Surveyor interviewed Administrator B. Administrator B confirmed Caregiver A had not received the department approved training for fire safety and first aid and choking.	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and	N 243		

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N 243	Continued From page 3	N 243		

responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.

This Rule is not met as evidenced by:
Based on interview and record review the provider did not ensure 2 of 2 employees reviewed, obtained all training as required within 90 days after starting employment.

Caregiver A and Caregiver C did not have training in recognizing, preventing, managing and responding to challenging behaviors or client groups within 90 days after starting employment.

Findings include:

The facility is licensed to provide care and services to residents within the client groups of terminally ill, advanced age and irreversible dementia and/or Alzheimer's.

On 12/04/2024, Surveyor conducted a review of 2 employee records to verify compliance with all employee training requirements. Surveyor requested training records from Administrator B for Caregiver A and Caregiver C.

On 12/04/2024, Surveyor reviewed the employee record for Caregiver A. The record for Caregiver

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N 243	Continued From page 4 A, hired 04/29/2024, did not contain evidence of training or evidence of meeting an exemption for client group or challenging behaviors training. On 12/04/2024, Surveyor reviewed the employee record for Caregiver C. The record for Caregiver C, hired 04/26/2022, did not contain evidence of training or evidence of meeting an exemption for client group or challenging behaviors training. On 12/10/2024, at approximately 9:30 AM, Surveyor interviewed Administrator B. Administrator B confirmed the provider did not have evidence Caregiver A or Caregiver C completed or met an exemption for challenging behaviors or client group training. Administrator B stated, "I will get both staff [Caregiver A and C] signed up through Clarity Care to complete the trainings."	N 243		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by:	N 277		

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N 277	Continued From page 5 Based on record review and interview, the provider did not ensure staff received at least 15 hours per calendar year of continuing education that included standard precautions, client group training, medications, resident rights, prevention and reporting of abuse/neglect/misappropriation, and fire safety procedures, including first aid. For 2023, Caregiver C did not receive at least 15 hours per calendar year of continuing education that included standard precautions, client group training, medications, resident rights, prevention and reporting of abuse/neglect/misappropriation, and fire safety procedures, including first aid. Caregiver C began employment in April 2022. This is a repeat deficiency. See Statement of Deficiency (SOD) OBJ111 dated 01/27/2021. Findings include: On 12/04/2024, Surveyor reviewed Caregiver C's employee record for continuing education requirements for completed calendar year 2023. Caregiver C began employment in April 2022 and the record had no evidence of 15 hours of continuing education completed for 2023. Additionally, the record showed no evidence of continuing education in 2023 in the following areas; standard precautions, client group training, medications, resident rights, prevention and reporting of abuse/neglect/misappropriation, and fire safety procedures, including first aid. On 12/04/2024 at approximately 3:15 PM, Surveyor requested Caregiver C's continuing education for 2023. Administrator B indicated s/he would look for the training documentation and send it to Surveyor by 12/09/2024.	N 277		

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N 277	Continued From page 6 Note: Administrator B was given the opportunity to submit evidence of Caregiver C's 2023 continuing education training by 12/09/2024. No additional information was received. On 12/10/2024 at 9:30 AM, Surveyor interviewed Administrator B about Caregiver C's missing continuing education for 2023. Administrator B stated s/he would continue to look for it and send it to Surveyor by the end of the day. On 12/10/2024 at 3:00 PM, Administrator B sent Surveyor the following email which indicated, "I spent a lot of time looking for [Caregiver C's] 2023 continuing education envelope. I know it is here, just not sure where. I cannot find it at this time."	N 277		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by:	N 386		

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N 386	Continued From page 7 Based on record review and staff interview, the provider did not develop a comprehensive ISP (Individual Service Plan) for each resident within 30 days after admission for 1 of 2 sampled residents (Resident 2). Findings include: On 12/04/2024 at 1:35 PM, Surveyor reviewed Resident 2's medical record and noted s/he was admitted on 06/14/2021. Surveyor was unable to locate a comprehensive ISP in Resident 2's paper file. On 12/04/2024 at 2:15 PM, Surveyor questioned Caregiver C about where Resident 2's most current ISP was located. Caregiver C logged into ECP (a web-based software for assisted living) and verified no ISPs were found in ECP for Resident 2. On 12/04/2024 at 3:00 PM, Surveyor interviewed Administrator B. Administrator B stated, "All resident ISPs were located within ECP, however a former employee deleted all the residents' ISPs out of ECP sometime in May 2024...I'm going to work on getting all the residents' ISPs completed over the weekend and will send them to you Monday..." On 12/10/2024 at 9:30 AM, Surveyor interviewed Administrator B regarding Resident 2's comprehensive ISP. Administrator B confirmed Resident 2 had a temporary care plan when s/he was first admitted but s/he could not locate a comprehensive ISP. Administrator B indicated s/he was currently developing a new one for Resident 2 and stated, "I've been working on Resident 2's ISP over the weekend so staff have something to look at."	N 386		

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N 386	Continued From page 8 The provider did not develop a comprehensive ISP for Resident 2, which identified the resident needs and desired outcomes; the program services, frequency and approaches the facility would provide; with measurable goals and specific time limits for attainment; with specified methods for delivering needed care and who is responsible for delivering the care.	N 386		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure Resident 1's Individual Service Plan (ISP) was updated annually and signed by all required participants. Findings include: On 12/04/2024, Surveyor reviewed Resident 1's record and noted s/he was admitted to the facility	N 389		

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N 389	Continued From page 9 on 02/02/2021. The most current ISP was dated 07/13/2021, with signatures to include acknowledgment of Resident 1's plan of care. There was no updated ISP in 2022, 2023 or 2024. On 12/04/2024 at 2:15 PM, Surveyor questioned Caregiver C about where Resident 1's most current ISP was located. Caregiver C logged into ECP (a web-based software for assisted living) and verified no ISPs were found in ECP for Resident 1. At approximately 2:30 PM, Caregiver C and Manager F reviewed and inspected Resident 1's paper record. Caregiver C and Manager F located Resident 1's ISP dated 07/13/2021, but could not located any additional updated ISPs for Resident 1. On 12/04/2024 at 3:00 PM, Surveyor interviewed Administrator B who verified there were no annual ISP reviews for Resident 1. Administrator B stated, "All resident ISP's were located within ECP, however a former employee deleted all residents' ISPs out of ECP sometime in May 2024. I became aware of the deleted ISPs sometime in September 2024 when Lakeland (a managed care organization) and APS (Adult Protective Services) asked me for an ISP and the ISP had no information on it." Administrator B stated, "I'm going to work on getting all residents' ISPs completed over the weekend and will send them to you Monday..."	N 389		
N 391	83.35(3)(f) Staff access to assessment and ISP Availability. All employees who provide resident care and services shall have continual access to the resident ' s assessment and individual service plan.	N 391		

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N 391	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure all employees who provide resident services had access to each resident's Individual Service Plan (ISP) affecting 17 residents in the facility. Findings include: The provider is licensed to provide services for up to 20 residents with terminal illness, advanced age and/or irreversible dementia/Alzheimer's. At the time of survey this facility was home to 17 residents. On 12/04/2024 at 2:15 PM, Surveyor questioned Caregiver C about where residents current ISPs were located. Caregiver C indicated s/he was not sure. Caregiver C then logged into ECP (a web-based software for assisted living) and verified no current ISPs were found in ECP for the residents. Caregiver C stated, "Lakeland (a managed care organization) care teams always ask me for residents' ISPs when they come in. I can never locate the ISPs or give Lakeland a copy of an ISP because I don't have the ISPs." Caregiver C indicated s/he would call Manager F at the sister building for assistance. On 12/04/2024 at approximately 2:20 PM, Surveyor asked Manager F about accessing residents' current ISPs. Manager F stated, "We did have all residents' ISPs in ECP but a former employee deleted all of them before [s/he] left. I had to redo all the ISPs in the sister building, but haven't redone any ISPs for this building." Manager F stated, "I'm assuming residents' ISPs are handwritten in a binder located in [Administrator B's] office, but [Administrator B's] office is locked and we can't go in there."	N 391		

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N 391	Continued From page 11 Caregiver C then stated, "I have the code to [Administrator B's] office." Surveyor then asked Caregiver C if s/he could go look for the binder with the residents' handwritten ISPs. Caregiver C went into Administrator B's office to look for the binder and stated, "I can't find the binder with the handwritten ISPs." On 12/04/2024 at approximately 2:30 PM, Surveyor, Caregiver C and Manager F reviewed and inspected resident paper records. The ISPs in the records were either missing or outdated. Surveyor asked Caregiver C and Manager F if residents ISP's were located anywhere else. Caregiver C and Manager F confirmed they were unaware of any other location. On 12/04/2024 at 3:00 PM, Surveyor asked Administrator B where residents current ISPs were located. Administrator B indicated resident ISPs were located and accessible within ECP, however a former employee deleted all the residents ISPs out of ECP sometime in May 2024. Administrator B stated, "I became aware of the deleted ISPs sometime in September 2024 when Lakeland and APS (Adult Protective Services) asked me for an ISP, and the ISP had no information on it." Administrator B confirmed there were no current up to date ISPs for the current residents in the facility and the ISPs within the residents' paper records were either outdated or missing. Administrator B then verified staff did not have access to any current handwritten ISPs or ISPs within ECP. Administrator B stated, "I'm going to work on getting all the residents' ISPs completed over the weekend and will send them to you Monday (12/09/2024)...Honestly staff don't even look at the ISPs." On 12/09/2024 at 10:09 AM, Administrator B sent	N 391		

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N 391	Continued From page 12 the following email, "I have nearly all the temporary care plans and resident ADL (Activities of Daily Living) sheets complete." Cross Reference: N0386 DHS 83.35(3)(a) Comprehensive Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 391		
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 interviews, the provider did not provide supervision appropriate to the resident needs to prevent elopement for 1 of 1 resident. Resident 2 was cognitively impaired, would wander/exit seek often and had a history of elopement. Sometime in May 2024 Resident 2 left the facility unnoticed. On 11/21/2024, Resident 2 left the facility unnoticed and was returned by the LPD (Local Police Department) at 2:31 AM. The provider did not ensure Resident 2	N 426		

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N 426	Continued From page 13	N 426		

received adequate supervision, which resulted in Resident 2 being able to leave the facility on 11/21/2024 unsupervised for an undetermined amount of time. As a result, Resident 2 was found wearing no pants or shoes and appeared to be cold. Additionally, the provider did not develop an effective plan for supervision or make changes after Resident 2 wandered out of the building unattended.

Findings Include:

The facility has been licensed since 05/10/2012 as a Class CNA (non-ambulatory) facility which serves residents who are ambulatory, non-ambulatory, or semi-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting. The facility is licensed to care for 20 residents with programming for residents including terminally ill, irreversible dementia, Alzheimer's disease, and advanced age.

On 11/22/2024, the Department received a complaint regarding concerns with supervision of residents.

On 12/09/2024, the provider emailed Surveyor a facility self-report. The report was dated 11/22/2024 and indicated, "On 11/21/2024 with an unknown time [Resident 2] eloped from the building. Sheriff's Department notified [Administrator B] at approximately (blank) AM, via phone to come to the building. Sheriff's officers reported [Resident 2] was found knocking on a neighbor's door and they called 911. Sheriff reported [s/he] heard an alarm going off as [s/he] entered the building. [Caregiver A] reported [s/he] did not hear an alarm going off at any time.

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N 426	Continued From page 14 [Caregiver A] reported [her/his] last contact with [Resident 2] was at approximately 1:30-1:45 AM, when [s/he] gave [Resident 2] a anti-anxiety as needed medication. When administration asked to see the documentation in the eMAR (electronic Medication Administration Record), [Caregiver A] could not find any documentation in it and stated, "It's not there but I gave it to [Resident 2]." [Resident 2] was brought back into the facility by EMT's who reported [Resident 2's] MD did not feel [s/he] needed any further examination. [Resident 2's] vitals were good and no injuries...Self-report filled out and faxed to DQA 11/(blank)/2024...(Note: Surveyor requested documentation regarding this incident during the onsite visit on 12/04/2024. Administrator B indicated s/he faxed the Department a self-report of the incident but did not have the self-report available for surveyor during the onsite visit or confirmation of the fax. Prior to initiating the survey on 12/04/2024 and again on 12/05/2024, Surveyor reviewed Department records and noted the facility had not submitted any self-reports in 2024.) On 12/11/2024, Surveyor reviewed the LPD report. The report indicated, "On 11/21/2024 at 2:31 AM a welfare call came into the LPD for a [Fe/male] partially naked with no pants, only wearing a sweatshirt and shorts and no shoes. The [Fe/male] arrived at a neighbor's door, appearing lost, out of it, and fell". The report indicated the following: *2:36 AM- Attempting Century Ridge, no answer *2:40 AM- Century Ridge, No missing people *2:44 AM- Out with Manager that manages both buildings *2:46 AM- Assisted Living [Administrator B] *2:49 AM- [Resident 2] *2:50 AM- Got a hold of Administrator will be here	N 426		

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in a couple minutes
Additionally, the LPD report revealed, "[Resident 2] was found a few houses away from the Assisted Living facility and seemed to be fine physically and appeared to be just cold. [Resident 2] was found with no pants and no shoes and only wearing a sweatshirt. Called the Administrator of the Assisted Living [Administrator B] and informed [her/him] of what happened. [Administrator B] came to the property and spoke with deputies. [Administrator B] was informed that an alarm could be heard from the outside of the building when deputies arrived. We went inside and spoke with [Caregiver A] who was working tonight. [Caregiver A] stated [s/he] did not hear the alarm going off and the last time [s/he] checked in on [Resident 2] was when [s/he] gave [Resident 2] [his/her] medication around 2 AM. [Caregiver A] was unable to provide the time [s/he] gave the medication and could only provide the estimated time of 2 AM. [Resident 2] was checked on by rescue and the situation was turned over to [Administrator B]..."

According to www.wunderground.com the outside temperature in Green Bay, Wisconsin on 11/21/2024 at 1:53 AM was 34 degrees Fahrenheit and at 2:09 AM and 2:53 AM it was 34 degrees Fahrenheit with light snow.

On 12/04/2024, Surveyor toured the facility and reviewed the floor map. Surveyor noted the facility had a total of four exits (a front door, a back door, a west door, and a north door) that lead directly outside. Surveyor observed three of the four exit doors (the back, west and north doors) were delayed egress doors. (Delayed egress doors are used to alert staff with an audible alarm if a resident is attempting to leave and designed to delay the resident from exiting

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for 15 seconds.) The front door was not a delayed egress door but was equipped with a Wander Guard system (a bracelet placed on a resident to active an audible alarm when the resident wearing the bracelet approaches the front door). On 12/04/2024 at approximately 10 AM, Surveyor was accompanied by Caregiver C and Maintenance E. Surveyor physically tested and observed all 3 delayed egress doors. The back exit delayed egress door did not open after 30 seconds and did not alarm. Caregiver C attempted to open the door. The alarm did not sound, and the door did not open. Surveyor then asked Caregiver C how often staff check to ensure the delayed egress doors work properly. Caregiver C stated, "I don't know. I've never seen any one test the doors." Surveyor questioned Maintenance E if s/he tested and checked the delayed egress doors to ensure they work properly. Maintenance E stated, "I've worked here since 09/2024 and I've never been told to check the doors...I don't even have it on my list of things to look at...How do you check the doors?" Owner D then approached Surveyor. Surveyor asked Owner D if the delayed egress doors were checked and evaluated by staff to ensure the doors work properly. Owner D stated, "No. We've never had an issue with the doors they always work." At Approximately 10:40 AM, Surveyor interviewed both Owner D and Administrator B about the delayed egress doors and Wander Guard system. Administrator B indicated the front door was the only door equipped with a Wander Guard system and was not a delayed egress door. Administrator A stated, "We just got the Wander Guard system this summer for the front door." Surveyor asked how often staff check to ensure the Wander Guard bracelet(s) and the Wander Guard front door alarm work. Administrator B confirmed staff

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do not check and/or document if the Wander Guard bracelet/alarm is functioning properly because "We just got the Wander Guard System this past summer."

On 12/04/2024, Surveyor made observations of Resident 2's bedroom. Resident 2's bedroom was located at the end of the West Hall, next to the West exit door. Additionally, Surveyor observed a motion sensor alarm located on the outside of Resident 2's bedroom door frame.

On 12/04/2024, Surveyor reviewed the medical record for Resident 2. Resident 2 was admitted to the facility on 06/14/2021 with diagnoses to include dementia, anxiety, and senile degeneration of the brain. The record indicated Resident 2 had a guardian and was receiving hospice services. Resident 2's face sheet indicated, "Key Indicators- Fall risk and Wander Risk."

A "Resident Incident Report" for Resident 2 indicated, "Date of Incident: 11/21/2024, Time: 3:00 AM. [Resident 2] went out unwitnessed." Surveyor noted the report indicated Resident 2's family/guardian and Hospice were notified, and no injuries were discovered. The report also indicated documentation was required on every shift for the next 24 hours, but shift monitoring documentation was left blank.

On 12/11/2024, Surveyor reviewed Resident 2's Observations Notes from 09/01/2024 through 12/10/2024 which revealed the following:

*09/06/2024- "Resident was wandering around a lot and even went into the kitchen..."

*09/10/2024- "Wander alarm bracelet was placed

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N 426	Continued From page 18 on [his/her] left wrist." *Surveyor noted there were no observation notes for Resident 2 from 10/06/2024 to 12/08/2024. A Physician Visit note dated 06/19/2024 for Resident 2 indicated, "Caregivers report [Resident 2] continues with periods of confusion and restlessness. Staff reports that [s/he] will at times attempt to exit seek. [S/he] is difficult to redirect... Continues to progress with an increase in agitation and anxiety and new behaviors of exit seeking. Behaviors are new for resident as [s/he] has always been calm and easygoing..." A Physician Visit note dated 07/05/2024 for Resident 2 indicated, "[Resident 2] continues experiencing aggression and agitation, with attempts to exit seek. Staff reports difficulty in redirecting [him/her]...[Resident 2] has been noted to often self transfer and ambulate..." On 12/04/2024, Surveyor was unable to locate an ISP in Resident 2's paper file. On 12/04/2024 at 2:15 PM, Surveyor questioned Caregiver C about where Resident 2's most current ISP was located. Caregiver C logged into ECP (a web-based software for assisted living) and verified no ISP was found in ECP for Resident 2. At 3:00 PM, Surveyor interviewed Administrator B. Administrator B stated, "All resident ISPs were located within ECP, however a former employee deleted all residents' ISPs out of ECP sometime in May 2024...I'm going to work on getting residents' ISPs completed over the weekend and will send them to you Monday..." On 12/10/2024 at 3:00 PM, Administrator B sent Surveyor an ISP for Resident 2 dated 12/07/2024.	N 426		

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N 426	Continued From page 19 The ISP indicated, Resident 2 required 24-hour supervision, needed continual assistance for bathing and toileting and intermittent assistance with ambulation and transfers. Additionally, the ISP stated, "Behavior Patterns: Wanders, Easily agitated, Confused...[Resident 2] when awake is always on the go seeking meals and snacks often. Requires redirection and 1 on 1. [S/he] can be unsafe while ambulating, [s/he] may be exit seeking. [S/he] requires 2-hour checks at minimum. [S/he] wears a Wander Guard for added safety and has an alarm on his doorway to alert staff of [his/her] whereabouts." On 12/10/2024, Surveyor interviewed Administrator B regarding Resident 2's ISP. Administrator B confirmed s/he could not locate any comprehensive ISPs for Resident 2 and indicated s/he developed the above ISP for Resident 2 over the weekend "So staff had something to look at." On 12/04/2024 at 9:30 AM, Surveyor interviewed Caregiver C regarding Resident 2. Caregiver C indicated Resident 2 was confused and would often wander and exit seek. Caregiver C stated, "Some days [Resident 2] can walk on [his/her] own and other days [s/he] needs a wheelchair and a walker. [Resident 2] stays up all night and sleeps all day. [Resident 2] tries to get out of the building every day, but mostly at night. [Resident 2] will usually try to go out the front door. [Resident 2] is known to be an elopement risk. [Resident 2] eloped from the building while I was working sometime in May 2024. I was working with another staff member, and we didn't know [Resident 2] left, until a staff from the sister building seen [Resident 2] outside walking. We brought [Resident 2] back in and didn't notice any injuries. I believe [Resident 2] left out the front	N 426		

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door in May 2024 because we didn't have the Wander Guard system yet. I'm pretty sure the Wander Guard system was added after the May 2024 incident." Surveyor then asked about the motion sensor alarm above Resident 2's doorframe. Caregiver C stated, "The motion sensor alarm was added about three or four months ago."

On 12/04/2024 at 12:50 AM, Surveyor interviewed Caregiver A regarding Resident 2. Caregiver A indicated, "[Resident 2] can be aggressive and tries to get out any of the four exit doors. Especially after 6 PM, [Resident 2] wanders around and does not stay in [his/her] room and will try to open all the exit doors. I know [Resident 2] got out of the building sometime in May 2024 because I was working next door and seen [Resident 2] walking outside. I called over to the building and told [Caregiver C]. Staff ran after [him/her] and brought [Resident 2] back." Surveyor then asked about the incident with Resident 2 on 11/21/2024. Caregiver A verified s/he was working alone in the building during the night shift on 11/21/2024 and stated, "I saw [Resident 2] sometime around 2 AM and then went to assist another resident. When I came back to check on [Resident 2] [s/he] was not in [his/her] room. I went looking all around and couldn't find [him/her] and that's when I saw the police next door...I didn't see [Resident 2] leave or hear [Resident 2] leave because I didn't hear any alarms go off." Surveyor then ask if the provider re-educated or retrained [her/him] on resident safety/supervision following this incident. Caregiver C stated, "No."

On 12/04/2024 at approximately 10:30 AM, Surveyor interviewed Administrator B and Owner D regarding the above incident with Resident 2.

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N 426	Continued From page 21 Administrator B stated, "The police called me and said they found a resident wandering around in the neighborhood knocking on doors. When I arrived [Resident 2] was in the rescue squad. [Resident 2] didn't have any injuries and the MD declined [Resident 2] needing to go to the hospital...I believe [Caregiver A] was sleeping because when I came in [s/he] looked like [s/he] just woke up. [Caregiver A] denied [s/he] was sleeping and told me [s/he] gave [Resident 2] an as needed anti-anxiety medication between 1:30 AM- 2:00 AM. I asked [Caregiver A] to show me the documentation and the med card and nothing was given...[Caregiver A] said no alarms went off but the LPD said the alarms were going off when they arrived. When the door alarms go off staff need to check and see what's going on...This incident occurred due to staff failure." Surveyor then asked Administrator B how often s/he expects staff to check on Resident 2. Administrator indicated [Resident 2] was on a 2-hour rounding. Surveyor then asked if staff documented the 2-hour rounds. Administrator B stated, "No...I'm not sure if or when [Resident 2] was last checked on and I have no idea how long [Resident 2] was outside...[Resident 2] didn't have hypothermia." Surveyor questioned if all staff were re-educated or in-serviced following this event and if the re-education was documented. Administrator B stated, "No, but I did suspend [Caregiver A] for a day pending notification of the incident." Surveyor then asked what measures were put in place after Resident 2 wandered out of the facility on 11/21/2024. Administrator B verified no changes were made and stated, "We already have everything in place for [Resident 2]. [Resident 2] has a motion senor alarm on [his/her] bedroom door, the Wander Guard bracelet, and the delayed egress doors ...We have everything in place to keep [him/her]	N 426		

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N 426	Continued From page 22 safe." On 12/04/2024 and again on 12/10/2024, Surveyor requested documentation regarding the May 2024 incident when Resident 2 wandered out of the facility. On 12/10/2024 at 3:00 PM, Administrator B sent the following email, "I was not able to find an incident report from the elopement incident in May. Though, I do recall that day. I have had others "help" me file things and when needed this is what happens. I will only use ECP from this day forward for most if not all of our documentation needs. That way everything is in one place when needed." In conclusion, the provider did not ensure Resident 2 received adequate supervision, which resulted in Resident 2 being able to leave the facility on 11/21/2024 unsupervised for an undetermined amount of time. As a result, Resident 2 was found cold and inappropriately dressed for the weather condition. Additionally, the provider did not have an effective plan for supervision or make changes to Resident 2's plan of care after the resident wandered out of the building unnoticed on 11/21/2024. Cross Reference: N0386 DHS 83.35(3)(a) Comprehensive Individual Service Plan N0653 DHS 83.59(4)(e) Delayed Egress: Irreversible Process Release	N 426		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time.	N 525		

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N 525	Continued From page 23 Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure quarterly fire drills were conducted with both employees and residents including the time of the drill and the CBRF's (Community-Based Residential Facility) total evacuation time in calendar years 2023 and 2024. The facility is licensed as a Class CNA (non-ambulatory) CBRF to provide services for up to 20 residents who may be advanced aged, terminally ill and/or have irreversible dementia and/or Alzheimer's. Findings include: On 12/04/2024, Surveyor requested the fire evacuation drills for the years 2023 and 2024. Surveyor was provided a binder with fire drills and the following was noted: *Fire evacuation drills were conducted on 01/25/2023 and 05/24/2023. The fire drill	N 525		

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N 525	Continued From page 24 documentation did not include the time the drill took place or the total evacuation time. Additionally, there was no record of quarterly fire evacuation drills completed for the 3rd and 4th quarter. *Fire evacuation drills were conducted on 02/21/2024, 04/12/2024 and 05/24/2024. The fire drill documentation did not include the time the drill took place or the total evacuation time. Additionally, there was no record of a quarterly fire evacuation drill completed for the 3rd quarter. On 12/10/2024 at approximately 9:30 AM, Surveyor interviewed Administrator B regarding the above fire drills. Administrator B verified the above fire drills was what s/he had for documentation. Surveyor noted there were missing drills for 2023 and 2024 and the documented fire drills had no record of the time of the drill or the total evacuation time. Administrator B indicated a survey was conducted earlier in the year at her/his sister facility with similar findings, and as a result a different fire drill form was going to be use to include the time of the drills and total evacuation time.	N 525		
N 653	83.59(4)(e) Delayed egress: irreversible process release Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: An irreversible process will occur which will release the latch in not more than 15 seconds when a force of not more than 15 pounds is	N 653		

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N 653	Continued From page 25 applied for 3 seconds to the release device. Initiation of the irreversible process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, re-locking shall be by manual means only. This Rule is not met as evidenced by: Based on observation and interviews the provider did not ensure 1 of 3 delayed egress doors unlatched in not more than 15 seconds when force was applied to the release handle. The "Back Exit" within the common lounge room did not release or activate an audible signal in the vicinity of the door when a force of not more than 15 pounds was applied for 30 seconds, having the potential to affect all 17 residents in the facility. Findings include: The provider is licensed to care for 20 individuals who may be advanced aged, terminally ill, or have irreversible dementia/Alzheimer's disease. On 12/04/2024 at approximately 10 AM, Surveyor was accompanied by Caregiver C for a tour of the facility. During the tour, Surveyor noted the facility had 3 delayed egress doors which were all identified on the facility floor plan as emergency exits. On 12/04/2024, Surveyor physically tested and observed all 3 delayed egress doors. The delayed egress door also known as the "Back Exit" within the common lounge area had a sign posted on the door indicating, "EMERGENCY EXIT PUSH UNTIL ALARM SOUNDS DOOR	N 653		

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	0014023	A. BUILDING: _____ B. WING _____	C 12/11/2024

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N 653	Continued From page 26 WILL OPEN IN 15 SECONDS." Surveyor attempted to open the door. Surveyor pushed on the handle and the door did not open after 30 seconds and did not alarm. Caregiver C attempted to open the door and was unable. Surveyor then asked Caregiver C how often staff check to ensure the delayed egress doors work properly. Caregiver C stated, "I don't know. I've never seen any one test the doors." On 12/04/2024 at approximately 10:10 AM, Maintenance E was questioned by Surveyor if s/he tested and checked the delayed egress doors to ensure they work properly. Maintenance E stated, "I've worked here since 09/2024 and I've never been told to check the doors...I don't even have it on my list of things to look at...How do you check the doors?" On 12/04/2024 at approximately 10:15 AM, Owner D verified all 3 delayed egress doors were used as emergency exits. Owner D attempted to open the "Back Exit" by pushing down on the levered handle and applying force. The "Back Exit" within the lounge area did not release or alarm when force was applied to the handle and door by Owner D. Owner D indicated s/he would reach out to the company and have the delayed egress door inspected. When Surveyor asked Owner D if the delayed egress doors were checked and evaluated by staff to ensure the doors work properly. Owner D stated, "No. We've never had an issue with the doors, they always work."	N 653		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE	Z 010		

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Z 010	Continued From page 27 If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction, after information obtained during Caregiver C's background check revealed charges of Disorderly Conduct (state	Z 010		

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statute 947.01), Misdemeanor Battery (state statute 940.19), Battery to unborn child (state statue 940.195), Reckless endangerment (state statute 941.30), and Substantial Battery-Intend Bodily Harm (state statute 940.19(2) during the previous 5 years.

Findings include:

On 12/04/2024, Surveyor reviewed the staff record for Caregiver C. The record indicated Caregiver C was hired on 04/26/2022. Surveyor reviewed the background check information contained in Caregiver C's record, including the background information disclosure form and the Department of Justice criminal background check. Surveyor noted the following:

-04/12/2022 Caregiver C completed and signed a pre-employment, background information disclosure form. Caregiver C disclosed s/he either had criminal charges pending and/or was convicted of a crime.

-04/22/2022 the DOJ (Department of Justice) criminal background check indicated Caregiver C was charged on 02/06/2020 with Disorderly Conduct (state statute 947.01), Misdemeanor Battery (state statute 940.19) and Battery to unborn child (state statue 940.195), all within the previous 5 years. Additionally, the DOJ report indicated Caregiver C was charged on 02/09/2022 with Reckless endangerment (state statute 941.30), Disorderly conduct (state statute 947.01) and Substantial Battery-Intend Bodily Harm (state statute 940.19(2), all within the previous five years.

On 12/04/2024, Surveyor reviewed CCAP (Circuit Court Automation Program) web site and

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determined on 01/21/2021 in Wood County Circuit Court, Caregiver C was charged with the following offenses, Disorderly Conduct (state statute 947.01) and Misdemeanor Battery (state statute 940.19) related to the above charges on 02/06/2020. Additionally, CCAP revealed Caregiver C was charged on 03/09/2023 in Brown County Circuit Court with the following offences, Reckless endangerment (state statute 941.30) and Substantial Battery-Intend Bodily Harm (state statute 940.19(2)).

Surveyor did not locate copies of the criminal complaints or judgments of convictions associated with the aforementioned charges in Caregiver C's staff file.

On 12/04/2024, at approximately 3 PM, Surveyor asked Administrator B if the facility obtained the criminal complaint and judgment from the clerk of courts office for Caregiver C for the above charges. Administrator B indicated s/he was not aware of the requirement and confirmed the criminal complaint and judgement of convictions from the Clerk of Courts office was not in Caregiver C's record. Administrator B confirmed s/he was aware of Caregiver C's criminal charges, but did not obtain any copies of the criminal complaint or judgement of convictions as it was the responsibility of Owner D.

On 12/10/2024 at 9:00 AM, Surveyor interviewed Owner D regarding Caregiver C's background check. Owner D verified s/he completes employee background checks, reviews the documentation and determines staff employment. Surveyor then ask if s/he obtained the criminal complaint and judgement of conviction from the clerk of courts office related to the above charges for Caregiver C. Owner D stated, "No, I did not.

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Z 010	Continued From page 30 [Caregiver C] told [Administrator B] and I that [s/he] was in a fight and got arrested. The arrest had nothing to do with residents or the elderly." In conclusion, Caregiver C's DOJ report did not provide a conclusive disposition on the above criminal charges and no information was obtained by the provider to obtain the disposition information, including the criminal complaint, and conviction records from the appropriate jurisdiction. Cross Reference: Z0023 DHS 50.065(4m)(b) Caregiver Hiring and Contracting Process	Z 010		
Z 023	50.065(4m) (b) intro CAREGIVER HIRING AND CONTRACTING PROCESS Notwithstanding s.111.335, and except as provided in sub. (5), an entity may not hire or contract with a caregiver or permit to reside at the entity a nonclient resident if the entity knows or should have known any of the following: 1. That the person was convicted of a serious crime. 3. That a unit of government or a state agency, as defined in s. 16.61 (2) (d), has made a finding that the person has abused or neglected any client or misappropriated the property of any client. 4. That a determination has been made under s. 48.981 (3) (c) 4. that the person has abused or neglected a child.	Z 023		

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Z 023	Continued From page 31 5. That, in the case of a position for which the person must be credentialed by the Department of Safety and Professional Services, the person's credential is not current, or is limited so as to restrict the person from providing adequate care to the client. This Rule is not met as evidenced by: Based on record review and interviews, the provider continued to employ a caregiver the provider knows or should have known was convicted of a serious crime. Under the Caregiver Law, Chapter 50.065 Wis. Stats. some crimes and offenses require rehabilitation review approval for employment as a caregiver in a regulated entity. Caregiver C had a conviction for an offense which prohibited employment as a caregiver until rehabilitation approval was received. Caregiver C and/or the provider did not provide evidence of rehabilitation approval. Findings include: On 12/04/2024, Surveyor reviewed the staff record for Caregiver C. The record indicated Caregiver C was hired on 04/26/2022. Surveyor reviewed the background check information contained in Caregiver C's record, including the background information disclosure form, the Department of Justice criminal background check and the Department of Safety and Professional Services report. Surveyor noted the following: -04/12/2022 Caregiver C completed and signed a	Z 023		

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pre-employment, background information disclosure form. Caregiver C disclosed s/he either had criminal charges pending and/or was convicted of a crime.

-04/22/2022 the DOJ (Department of Justice) criminal background check indicated Caregiver C was charged on 02/09/2022 with Substantial Battery-Intend Bodily Harm (state statute 940.19(2).

-04/22/2022 the Department of Safety and Professional Services report did not contain a Rehabilitation Review Finding.

On 12/04/2024, Surveyor reviewed CCAP (Circuit Court Automation Program) web site and determined on 03/09/2023 in Brown County Circuit Court, Caregiver C was charged with Substantial Battery-Intend Bodily Harm (state statute 940.19(2).

Surveyor did not locate copies of the criminal complaint or judgment of conviction associated with the aforementioned conviction in Caregiver C's staff file. Additionally, there was no evidence in Caregiver C's record of a written approval for employment from the Rehabilitation Review Panel.

On 12/04/2024 at 2:00 PM, Surveyor interviewed Caregiver C regarding her/his background check. Caregiver C verified s/he was charged and convicted with Substantial Battery-Intend Bodily Harm (state statute 940.19(2), and Administrator B was aware of the charge/conviction. Caregiver C stated, "[Administrator B] knows all about this charge because [s/he] was at my court hearing." When Surveyor asked Caregiver C if s/he went through a rehabilitation review process for the

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above offense, Caregiver C was unaware of the rehabilitation review process.

On 12/10/2024, at approximately 9:30 AM, Surveyor asked Administrator B if the facility obtained the criminal complaint and judgment of conviction for the above charge for Caregiver C. Administrator B indicated s/he was not aware of the requirement and confirmed the criminal complaint and judgement of conviction from the Clerk of Courts office was not in Caregiver C's record. Administrator B did verify s/he was aware of Caregiver C's criminal charge and conviction of Substantial Battery-Intend Bodily Harm (state statute 940.19(2) and stated, "I went to [Caregiver C's] court appearance in 2023 for the charge and sentencing of Substantial Battery-Intend Bodily Harm (state statute 940.19(2)...I just wasn't aware more needed to be done with the caregiver background check..."

On 12/10/2024 at 9:00 AM, Surveyor interviewed Owner D regarding Caregiver C's background check. Owner D verified s/he completes employee background checks, reviews the documentation and determines staff employment. Surveyor then asked if s/he obtained the criminal complaint and judgement of conviction related to the above charge for Caregiver C. Owner D stated, "No, I did not. [Caregiver C] told [Administrator B] and I that [s/he] was in a fight and got arrested. The arrest had nothing to do with residents or the elderly...I know [Administrator B] went to the court appearance and did speak on behalf of [Caregiver C]." Owner D confirmed Caregiver C did not have a written approval from the Rehabilitation Review Panel and stated, "I found the form online and the process [Caregiver C] has to go through. I gave [Caregiver C] the rehab review information and

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Z 023	Continued From page 34 application to fill out." Cross Reference: Z0010 DHS 50.065(2)(bb) Determine Final Disposition of Charge	Z 023		