STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016367	A. BUILDING: _____ B. WING _____	C 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC HEIGHTS ASSISTED LIVING II	63 SOUTH WACKER DRIVE HARTFORD, WI 53027

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N 000	Initial Comments On 09/03/2024 with additional information obtained through 09/13/2024, Surveyors conducted a complaint investigation at Majestic Heights Assisted Living II. As a result, the complaint was substantiated and 1 deficiency was identified. Census: 16	N 000		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange services adequate to meet the needs of Resident 1's behavior management. Resident 1 was not provided adequate supervision and services to manage resident's behaviors that may be harmful to themselves or others. Resident 1 directed inappropriate sexual comments and sexual touching of caregivers and Resident 2. Resident 1 has a diagnosis of Neurocognitive Disorder. Resident 2 has a diagnoses of Lewy Body dementia. The provider did not consistently document or monitor the behaviors and did not implement interventions to	N 433		

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

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ensure the safety of Resident 2 and other residents.

Findings Include:

Facility is licensed to serve 26 non-ambulatory (CNA) residents who may be physically disabled, advanced aged, terminally ill and irreversible dementia and Alzheimer's.

On 08/20/2024, the department received a complaint regarding an allegation of inappropriate sexual behaviors.

On 09/03/2024, Surveyor reviewed Resident 1's record to include the Individual Service Plan (ISP), Care Plan, Behavior Notes and Behavior Chart and noted:

Resident 1 was admitted to the facility on 10/13/2023. Resident 1's ISP, dated 11/13/2023, indicates Resident 1 will maintain an appropriate attitude and socialize with staff and peers without conflict thru next review. Resident 1's Care Plan indicates a diagnosis of Neurocognitive Disorder and states "Allow for privacy time for personal sexual activity as needed in his room." "2 caregivers if needed for cares" and "move to PD if inappropriate during meals or back to room." Resident 1's records do not indicate an activated Power of Attorney (POA), however A-C stated Family Member E is the POA for Resident 2.

Resident 1's behavior notes read:

On 08/07/2024 "PM Shift - After dinner while doing nightime [sic] cares, resident grabbed caregiver in private area and started laughing. Redirected but resident continued to laugh. Staff walked out of the room.

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N 433	Continued From page 2 On 08/13/2024 "NOC Shift - was very crabby/rude at start of shift took [his/her] CPAP off & threw it, pressed care button 3x didn't need anything." On 08/17/2024 "AM Shift - Staff went to toilet before lunch ...resident wanted staff to come closer to help out of chair. When staff asked resident to grab the walker, resident reached for staff's hips. Resident was redirected to grab walker & to keep hands to self. Resident laughed & continued to try to grab staff. Staff left & tried again a few minutes later, resident was asked to grab walker. Resident looked at staff & said you have to lift me. Staff agreed to help him, but s/he needed to grab walker so he could use the restroom & get new pants on before eating lunch. Resident laughed & stared at staff & began to make slurping sounds & said "you can be my lunch". Staff walked away and had someone else try." On 08/19/2024 "AM Shift / on get ups [sic]this morning, was touching himself and pulled it out of [his/her] pants, then tried grabbing caregiver to touch it for [him/her], [s/he] got redirected, didn't work, so a new person went in by [him/her]. On 08/24/2024 "PM Shift / I went into [his/her] room, walked in to [him/her] with [his/her] hand on [his/her] back & continued to stare at [him/her] throughout dinner. Would not stand up with multiple staff members help - walked away with no problem (sat for over an hour until staff intervention)." On 08/30/2024 "PM shift: Staff member was giving [him/her] [his/her] shower, said [he/she] was going to 'spray up staff members blouse'. Staff member redirected [him/her] and told [him/her] we don't do that. [S/he] then began playing with [himself/herself], staff member walked out and had someone else takeover ... [s/he] then preceded to play with [himself/herself]..."	N 433		

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N 433	Continued From page 3 On 08/20/2024 at 10:45 AM, Surveyor interviewed Administrative C (A-C) and Register Nurse D (RN-D). A-C stated, "[Resident 1] is a very nice person, and behaviors only happened a few times, they are no big deal." A-C described Resident 1 being comfortable at the facility and behaviors started randomly. A-C indicated younger caregivers just needed to be educated on how to handle these situations. A-C stated caregivers are trained to redirect Resident 1 to his/her room for personal time. A-C further explained if these situations happen in the dining room, caregivers redirect Resident 1 to the smaller dining room for privacy. A-C stated they track Resident 1's behavior on a behavior chart kept in Resident 1's medication administration record (MAR). A-C stated they do not keep a detailed log of Resident 1's inappropriate behavior or other interventions for handling the inappropriate behaviors other than verbal redirection. On 09/03/2024 at approximately 4:15 PM, Surveyor interviewed Caregiver A. Caregiver A reported Resident 1 often engages in inappropriate behaviors with others. Caregiver A described an incident s/he and Caregiver B entered Resident 1's room and observed Resident 2 sitting in their wheelchair, located close to Resident 1 who was seated in a chair. Caregiver A further explained Resident 1 was fondling Resident 2's upper chest. Caregiver A stated Caregiver B immediately moved Resident 2 out of Resident 1's room. Caregiver A advised Resident 1 this is inappropriate behavior and s/he needs to keep his/her hands to themselves. Caregiver A described another incident when Resident 1 said to Caregiver A," You have a nice bush.". Caregiver A did not understand what this	N 433		

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meant and asked Resident 1, "What do you mean?" Resident 1 stated, "You have a nice [genitals]!" Caregiver A told Resident 1 this was inappropriate and left the room. Resident 1 proceeded to laugh about it. Caregiver A stated s/he reported these incidents to A-C s/he responded, "You do not need to document these incidents, just redirect [Resident 1]." Caregiver A stated after many concerning incidents of inappropriate behavior from Resident 1, Caregiver's began to documenting the incidents. Caregiver A stated A-C does not care about these incidents and does not want caregivers documenting the details, only check the box in the behavior tracker to indicate a behavior occurred.

On 09/05/2024 at 11:43 AM, Surveyor interviewed Caregiver B. Caregiver B reported Resident 1 expresses his/her desire to touch Caregiver B's genitalia and Resident 1 has grabbed his/her body many times. Caregiver B stated it makes him/her feel uncomfortable assisting with Resident 1's cares. Caregiver B expressed concern for the vulnerable residents who are near Resident 1. Caregiver B described an incident when Caregiver B and Caregiver A found Resident 2 in Resident 1's room. Caregiver B stated, "Resident 1 had [his/her] hands on Resident 2's upper body. I am glad we walked in and intervened, but I am concerned it will happen again." Caregiver B stated we started to document these behaviors on 08/07/2024, until A-C advised this is not necessary and started requiring caregivers to use the checklist behavior tracker. Caregiver B stated they received no training on these behaviors and was told by A-C to verbally redirect Resident 1 to his/her room.

On 09/10/2024, Surveyor reviewed Resident 2's

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N 433	Continued From page 5 record. Resident 2's Care Plan indicates Resident 2 was admitted to the facility on 11/20/2018 and has a diagnosis of Lewy body dementia without behavioral disturbance. The ISP indicates Resident 2 requires 24-hour supervision, has periods of agitation and combativeness several times a week, uses a bed and chair alarm due to exit seeking, ambulates in a wheelchair unsupervised throughout the facility, and seeks the attention of a male resident. Resident 2's record do not indicate an activated Power of Attorney (POA), however, A-C stated Family Member F is the POA for Resident 2. Resident 2's record contained a "Nurse's Note' dated 08/16/2024, read in part ..."discussed with [Family Member F] [Resident 2] attention seeking with specific [fe/male] resident. [Family Member F] states resident reminds [him/her] of boyfriend from her past, and [s/he] is aware [s/he] has the attraction. [Resident 2] is able to wander throughout the facility in her w/c. [Family Member F] and staff discussed [him/her] behavior and are in agreement to continue general supervision when up in chair and will offer distraction and redirection at those times. [Family Member F] verbalizes [s/he] has no concerns and is agreement with this plan at this time." On 09/13/2024 at approximately 10:00 AM, Surveyor interviewed A-C who reported s/he was unaware of inappropriate sexual behavior between Resident 1 and Resident 2. A-C stated she first became aware of caregiver's behavior notes on 09/03/2024. A-C stated s/he did not complete a sexuality assessment for Resident 1 and Resident 2 to identify resident's ability to consent to sexual activity. A-C stated resident and caregiver safety is important and they will find training and interventions to prevent future incidents.	N 433		

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N 433	Continued From page 6 In summary: Resident 1 had an increase in inappropriate sexual comments and behaviors directed towards caregivers starting on 08/07/2024. In addition, Caregiver A and Caregiver B observed Resident 1 fondling Resident 2's upper chest in Resident 1's room. The provider did not provide services to manage the increase in sexual comments and behaviors to prevent the inappropriate sexual behaviors and protect vulnerable residents and caregivers.	N 433		