STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017755	A. BUILDING: _____ B. WING _____	C 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH MARINETTE NORTH	875 UNIVERSITY DR MARINETTE, WI 54143

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N 000	Initial Comments An abbreviated survey and complaint investigation were conducted at SV North Marinette North on 10/03/2023 with information gathered through 10/10/2023. As a result of this survey there were 2 deficiencies identified and the complaint was substantiated. Census: 12	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on staff and family interviews and a police interview the provider did not notify the State Agency of 3 incidents requiring law enforcement intervention for elopement or aggression for 1 (Resident 1) out of 13 residents between 08/05/2023 and 08/21/2023. Findings include: On 10/03/2023, Surveyor conducted a survey at the facility and investigated a complaint related to law enforcement involvement. A review of Resident 1's closed medical record by	N 164		

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

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N 164	Continued From page 1 Surveyor on 10/03/2023, showed Resident 1 had an admission date to the facility of 04/04/2023 and diagnoses of Parkinson's Disease, amnesia, hallucinations, and dementia. FMBR (Family Member) - C was Resident 1's DPOA - HC - activated. Resident 1's record contained multiple notations of elopement requiring police intervention to assist with return to the facility when facility staff were not able to safely bring Resident 1 back. Resident 1 expired at the facility on 09/14/2023 under Hospice care. On 10/03/2023 ADM (Administrator) - A provided Surveyor with Resident 1's closed record with progress notes and incident reports showing the following elopements or incidents of aggression with staff requesting and receiving police intervention: 08/05/2023 - Resident 1 took off around 12:50 pm headed toward the country club. Had to call the police to get (Resident 1) back. 08/11/2023 - Resident 1 walked out and would not return. Staff did call police for them to get Resident 1. 08/21/2023 - Resident 1 left the facility after becoming aggressive with staff. Police were called around 11:30 pm. There was no further evidence of submitted self-reports to the State Agency for the incidents of police intervention on 08/05/2023, 08/11/2023, and 08/21/2023. In and interview with Surveyor on 10/05/2023 at 1:30 pm ADM - A confirmed that notification to family had been inconsistent and confirmed not all police intervention incidents had been reported to the State Agency.	N 164		

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N 164	Continued From page 2 During an interview with Surveyor on 10/09/2023 LIC (Licensee) - E verified these incidents of police involvement should have been reported to the State Agency. LIC - E indicated the provider was aware Resident 1 was an elopement risk and always staffed with 2 on 1st and 2nd shifts and 1 on night shift. LIC - E indicated the staff were to call other staff on the emergency call list if more help was needed and confirmed police contact should not take the place of staff to manage resident behaviors. On 10/10/2023 in an email to Surveyor, RD (Regional Director) - G verified that the self-reports had not consistently been reported as they should have been.	N 164		
N 205	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on record review, staff, family, and police interviews the licensee permitted the continuation of a condition of risk having the potential to create substantial risk to 1 (Resident 1) out of 13 residents in the facility. Resident 1 had 8 elopements or incidents of aggression between 05/25/2023 and 08/21/2023 requiring police intervention to return Resident 1 to the facility or calm down. The 08/21/2023 incident included aggression towards CG (Caregiver) - B working alone with no other staff being able to be reached	N 205		

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to come for assistance resulting in police intervention.

Findings include:

On 10/03/2023, ADM (Administrator) - A provided Surveyor with Resident 1's closed record showing Resident 1 was admitted to the facility on 04/04/2023 with diagnoses of Parksinson's disease, dementia, amnesia, and hallucinations. Resident 1's hospital discharge summary dated 04/04/2023 indicated Resident 1 had severe cognitive impairment and was hospitalized on 03/18/2023 due to leaving his/her home and going outside in underwear and no shoes resulting in frostbite on both feet. The discharge summary indicated Resident 1 had a history of elopement at home.

Resident 1's record showed the following elopements or incidents of aggression towards staff who requested and received police intervention since admission to this facility on 04/04/2023:

05/25/2023 - Could not get resident back into the building and called Marinette Police Department for Assistance.
06/05/2023 - Could not get resident (1) back into building and called Marinette Police Department for Assistance.
07/01/2023 - Resident 1 left facility while staff busy with other residents. Already to far to get. Marinette Police Department called.
07/04/2023 - Resident 1 agitated and aggressive with staff and left the facility. Marinette Police Department called.
07/05/2023 - Resident 1 agitated and aggressive with staff and left the facility. Marinette Police Department had to be called to bring (Resident 1)

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back.
08/05/2023 - Resident 1 took off around 12:50 pm headed toward the country club. Had to call the police to get (Resident 1) back.
08/11/2023 - Resident 1 walked out and would not return. Staff did call police for them to get Resident 1.
08/21/2023 - Resident 1 left the facility after becoming aggressive with staff. Police were called around 11:30 pm.

In an interview with Surveyor by phone on 10/04/2023 at 5:30 pm, CG (Caregiver) - B stated s/he was working with a second CG - F on 08/21/2023 and around 6:30 pm, Resident 1 became aggressive pushing and hitting at staff. CG - B stated Resident 1 had not been aggressive like that in the past and did calm down. CG - B was scheduled to work until 9 pm and CG - F's shift was done at 7 pm so CG - B was left working alone until the night shift staff came on duty at 9 pm. The night staff texted CG - B saying s/he would be late in coming to work. CG - B called ADM - A to advise him/her of that and CG - B agreed to stay on duty till the relief staff arrived.

On 10/04/2023 at 5:40 pm, CG - B told Surveyor that Resident 1 became agitated again around 10:30 pm and would not calm down. The relief staff had not arrived yet. CG - B said Resident 1 hit him/her in the rib area and s/he was concerned because s/he [had a medical condition]. CG - B indicated trying to call ADM - A but this time had no answer. CG - B said s/he called down the list of lead staff to send extra help but could not get anyone to answer including the staff who was to relieve him/her at 9 pm. Police were called to assist and arrived around 11:30 pm and attempted to call all the staff on the

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emergency phone list with no answer from anyone. CG - B said police were able to calm Resident 1 down.

On 10/08/2023, Surveyor received the police report from OFF (Officer Marinette Police Department) - D which showed police arrived at the facility at 11:35 pm on 08/21/2023 for a medical emergency. The report indicated Resident 1 had hit CG - B several times. EMS checked out CG - B whose vitals were stable but suggested s/he had to be seen in the emergency room to have an ultrasound due to the [medical condition]. The report indicated officers attempted to call everyone on the administrative list that they had hanging in the employee area several times. Officers were unable to get a hold of anyone on the list as their phones were either off or went to voicemail immediately. CG- B said s/he needed to stay with the 13 residents until other staff arrived and that ADM - A had been made aware of Resident 1's earlier aggression and told CG - B to call the police if it continued. Officers requested the Menominee Police Department go to ADM - A's home to see if s/he would come in and relieve CG - B.

On 10/04/2023 at 5:45 pm, CG - B indicated ADM - A arrived around 1:30 am and relieved him/her of his/her shift. ADM - A indicated to CG - B and police s/he was asleep and did not hear the phone. CG - B indicated s/he did not go to the emergency room and had no further problems due to being hit. CG - B said the facility was staffed with 2 caregivers on days, 2 on pm shift, and 1 on the night shift.

In an interview with Surveyor on 10/05/2023 at 1:30 pm, ADM - A confirmed police had come to his/her home and wake him/her up around 12:30

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am on 08/22/2023 to advise of the concerns at the facility and need for staff relief. ADM - A confirmed the staff who was to relieve CG - B never showed up. ADM - A confirmed the policy for getting relief staff is to go down the staff list calling everyone until someone can come in for relief. ADM - A indicated no missed calls were noted on his/her phone and did not hear any phone ringing. ADM - A indicated there were no changes made to the policy for calling in for extra help "because it works."

On 10/08/2023, Surveyor received a response from OFF - D of the Marinette Police Department who said in an email the main concern was for the safety of staff and residents when no one could be reached in a staff emergency and that police were frequently called to this facility for interventions with residents.

On 10/09/2023 at 10:00 am, Surveyor spoke with LIC (Licensee) - E about the concern of using police to manage Resident 1's behavior for elopements and aggression and the inability of staff to secure extra staff support if needed. LIC - E confirmed sometimes staff do not pick up the phone but they are paid extra for coming in on extra shifts and that typically management is very good at being able to get staff replacements. LIC - E confirmed they were aware of Resident 1's elopement history and calling the police is to be the last resort. Staff should use the other interventions on the care plan first and confirmed the police should not be used in place of staff to deal with resident behaviors. LIC - E had not indicated any changes made to current policies to prevent further need of police intervention and keep residents safe from elopement.

In an email to Surveyor from RD (Regional

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N 205	Continued From page 7 Director) - G on 10/10/2023, s/he indicated the facility's call-in process when an employee needed additional help was to call the "on call" employee, then the house manager, and then the director. Last resort was to call 911. The licensee was aware of Resident 1's elopement risk as noted in the admission paperwork prior to admission. Although the facility had approaches in place to try and re-direct Resident 1 from elopement or aggression, they were not effective as evidenced by the numerous calls to police for intervention. The licensee had a policy to call for additional help which was not effective as noted on the 08/21/2022 incident of not being able to reach additional staff in an emergency.	N 205		