STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 07/17/2023, Surveyors conducted a verification visit and complaint investigation at SV South Beloit North. Six deficiencies were identified. Four of the 6 deficiencies were repeat violations (see Statement of Deficiency (SOD) GU6113, SOD GU6114, SOD GU6115, SOD GU6116, and SOD ORJ411). Complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 14	{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	N 158		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

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N 158	Continued From page 1 maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct an investigation of possible caregiver misappropriation of Resident 10's personal property. Resident 10 passed away on 06/14/2023 and jewelry was left in his/her room. This is a repeat violation. See statement of deficiency (SOD) ORJ411, dated 06/06/2022. Findings include: On 07/05/2023, the Department received a complaint alleging resident belongings were being misappropriated. On 07/17/2023, Surveyors conducted a complaint investigation and verification visit. The following was found: Resident 10 was admitted on 02/23/2022 with diagnosis including dementia and anxiety disorder. Resident 10 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 10 passed away on 06/14/2023. On 07/17/2023, Surveyor requested documentation into Resident 10's missing jewelry from House Manager M. On 07/17/2023 at 12:00 PM, Surveyors interviewed House Manager M about Resident 10's missing items. House Manager M confirmed s/he was aware that Family Member N brought concerns to management's attention about Resident 10's missing jewelry when Family	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

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N 158	Continued From page 2 Member N cleaned out Resident 10's room following his/her death. House Manager M stated s/he was unaware Resident 10 wore jewelry because s/he did not see him/her wear any. Surveyor asked House Manager M if s/he conducted an investigation into Resident 10's missing jewelry. House Manager M stated, "No," and noted s/he did not know s/he had to do one. On 07/17/2023 at 2:40 PM, Surveyors conducted an exit conference and shared findings with Administrator L and House Manager M. Administrator L stated s/he is responsible for conducting investigations into misappropriation of resident's property. Administrator L confirmed s/he did not have evidence an investigation was completed into Resident 10's missing jewelry. On 07/17/2023 at 3:25 PM, Surveyor interviewed Family Member N. Family Member N stated that Resident 10 always wore his/her diamond wedding ring set, along with other rings, when s/he was visiting. Family Member N stated Resident 10 would place them in his/her jewelry box when preparing for bed. Family Member N stated the jewelry box was empty, along with other personal belongings, when s/he went to clean out Resident 10's room.	N 158		
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	N 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

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N 164	Continued From page 3	N 164		

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 record review and interview, the provider did not send a written report to the Department within 3 working days after law enforcement personnel were called to the facility as a result of an incident that jeopardizes the health, safety, or welfare of resident or employees. Resident 10 was allegedly sexually assaulted by Resident 11 resulting in law enforcement coming to the facility.

Findings include:

On 07/17/2023, Surveyor reviewed Resident 10's record and identified the following:

Resident 10 was admitted on 02/23/2022 with diagnosis including dementia and anxiety disorder. Resident 10 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 10 passed away on 06/14/2023.

Resident 10's individual service plan (ISP) with an unknown date documented:

"Supervision-24-hour supervision"

Resident 10's ISP did not document Resident 10's ability to consent to a relationship with input from his/her legal representative, the resident's ability to understand the nature of an intimate relationship, and current mental and physical abilities.

Resident 10's progress notes dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

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N 164	Continued From page 4 04/02/2023-06/12/2023 documented: 05/29/2023 at 7:45 PM: "Resident stated that another resident came into [his/her] room and fondled [his/her] [expletive] and private area. Staff asked why resident did not report it when it happened and resident stated that "[s/he] was too scared." Staff tried to contact house manager to see what next steps needed to be taken with no response at that time. Hospice was than notified." 05/29/2023 at 8:30 PM: "Writer went to pass 8pm meds around 7:30pm and resident's room door was locked. As [s/he] unlocked the door [s/he] stated "it was only locked because of that creep." Writer asked resident what [s/he] was meaning by that and resident stated [Resident 11] had come into [his/her] room and fondled [his/her] [expletive]. When asked why [s/he] did not report this [s/he] stated that [s/he] "is scared." Writer attempted to call the house manager to ask whay steps to take next but no answer, so staff proceeded to contact Hospice. Hospice told writer not to contact family until the nurse gets a chance to speak with resident." 05/30/2023: "Resident was shaken up and upset after officer had left. Staff was able to calm [him/her] down." A review of Beloit Police Department incident # BE2323410 documented: I [Police officer O] made contact with [Resident 10] at the facility address. [Resident 10] stated on 05/29/2023, early in the morning , [Resident 11] open [his/her] bedroom door and approached [him/her] while [s/he] was laying in [his/her] bed resting. [Resident 10] advised [Resident 11] took [his/her] hand and grabbed [his/her] [expletive] and [expletive] over [his/her] clothing. [Resident 10] advised while [Resident 11] was grabbing [him/her], [s/he] stated "I know you like it." [Resident 10] advised [s/he] stated, "No, I don't	N 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 164	Continued From page 5	N 164		

like it, just leave me alone." [Resident 10] advised [Resident 11] turned away from [him/her] and left the room. [Resident 10] stated [s/he] has not talked to [Resident 10] since the incident. [Resident 10] advised [s/he] did not give [Resident 11] consent to touch [him/her], stating it made [him/her] feel uncomfortable .... I [Police Officer O] asked [Resident 10] what [his/her] and [Resident 11's] relationship was and [s/he] advised [s/he] did not know [him/her]. I [Police Officer O] asked [Resident 10] again what the relationship was and [s/he] advised they were friends. A staff member at the nursing home had to remind [Resident 10] that [s/he] and [Resident 11] hung out regularly and recently went out together. When [Resident 10] was reminded of this [s/he[appeared to be confused ...

I [Police Officer O] made contact with [Resident 11] in the common area of the nursing home. [Resident 11] advised on 05/29/2023 in the early morning, [s/he] went into [Resident 10's] room to check on [him/her]. [Resident 11] advised s[/he] went up to [his/her] as [s/he] laid in [his/her] bed resting and grabbed [his/her] [expletive] and [expletive]. [Resident 11] advised "we like each other." ... [Resident 11] advised [s/he] often grabs [Resident 10] in that manner because they are [boyfriend/girlfriend] ... [Resident 11] stated they have had a "boyfriend/girlfriend" relationship for several months.

Disposition: Based on the circumstances of both individuals having ... and [Resident 10's] inconsistencies it was determined an arrest would not be made at this time."

On 07/17/2023 at 2:40 PM, Surveyors interviewed Administrator L and House Manager M. Administrator L stated after looking over his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 164	Continued From page 6 records, it did not look like a self-report was submitted to the Department. Administrator L stated it was his/her responsibility to submit self-reports and s/he must have forgotten regarding Resident 10's incident. On 07/17/2023, Surveyor reviewed Department records. There were no self-reports in the Department files regarding the above incident.	N 164		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 383	Continued From page 7 activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Based on interview and record review, the CBRF did not complete an assessment related to Resident 10's capacity for self-direction, including the ability to consent to a relationship and to make wants or needs known in the area of sexual intimacy including physical and emotional health. This is a repeat violation. See statement of deficiency (SOD) GU6115, dated 08/25/2022. Findings include: On 07/17/2023, Surveyor reviewed Resident 10's and Resident 11's record and identified the following: Resident 11 was admitted on 02/04/2021. Resident 11 is their own legal decision maker. Resident 11's individual service plan (ISP) dated 07/06/2023 documented: Attention Seeking Behavioral Patterns: "Resident currently displays behaviors where [s/he] will make inappropriate sexual comments towards [fe/male] staff members. Resident often tries to hug staff rubbing [his/her] head on their chest. Resident is normally easily redirected. Staff should make clear that sexual comments towards staff are inappropriate and will not be tolerated. Staff will chart on behaviors in daily tasks." Resident 10 was admitted on 02/23/2022 with	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 383	Continued From page 8	N 383		

diagnosis including dementia and anxiety disorder. Resident 10 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 10 passed away on 06/14/2023.

Resident 10's ISP with an unknown date documented:

"Supervision-24-hour supervision"

Resident 10's ISP did not document Resident 10's ability to consent to a relationship with input from his/her legal representative, the resident's ability to understand the nature of an intimate relationship, and current mental and physical abilities.

A review of Beloit Police Department incident # BE2323410 documented:
I [Police officer O] made contact with [Resident 10] at the facility address. [Resident 10] stated on 05/29/2023, early in the morning , [Resident 11] open [his/her] bedroom door and approached [him/her] while [s/he] was laying in [his/her] bed resting. [Resident 10] advised [Resident 11] took [his/her] hand and grabbed [his/her] [expletive] and [expletive] over [his/her] clothing. [Resident 10] advised while [Resident 11] was grabbing [him/her], [s/he] stated "I know you like it." [Resident 10] advised [s/he] stated, "No, I don't like it, just leave me alone." [Resident 10] advised [Resident 11] turned away from [him/her] and left the room. [Resident 10] stated [s/he] has not talked to [Resident 11] since the incident. [Resident 10] advised [s/he] did not give [Resident 11] consent to touch [him/her], stating it made [him/her] feel uncomfortable ..... I [Police Officer O] asked [Resident 10] what [his/her] and [Resident 11's] relationship was and [s/he] advised [s/he] did not know [him/her]. I [Police

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 383	Continued From page 9 Officer O] asked [Resident 10] again what the relationship was and [s/he] advised they were friends. A staff member at the nursing home had to remind [Resident 10] that [s/he] and [Resident 11] hung out regularly and recently went out together. When [Resident 10] was reminded of this [s/he] appeared to be confused ..... I [Police Officer O] made contact with [Resident 11] in the common area of the nursing home. [Resident 11] advised on 05/29/2023 in the early morning, [s/he] went into [Resident 10's] room to check on [him/her]. [Resident 11] advised s[/he] went up to [his/her] as [s/he] laid in [his/her] bed resting and grabbed [his/her] [expletive] and [expletive]. [Resident 11] advised "we like each other." .....[Resident 11] advised [s/he] often grabs [Resident 10] in that manner because they are [boyfriend/girlfriend] .....[Resident 11] stated they have had a "boyfriend/girlfriend" relationship for several months. I [Police Officer O] made contact with [Caregiver P] ...[Caregiver P] advised [Resident 10] and [Resident 11] have a very close relationship. [Caregiver P] stated [s/he] has seen [Resident 10] sitting on [Resident 11's] lap, hugging each other, and "flirting with one another." [Caregiver P] advised a couple days ago [Resident 10] and [Resident 11] went on "joyride" together. [Caregiver P] stated [Resident 10] was riding on [Resident 11's] lap when [his/her] wheelchair tipped over and they fell off and got hurt. Disposition: Based on the circumstances of both individuals having ....and [Resident 10's] inconsistencies it was determined an arrest would not be made at this time." Resident 10's record did not contain an	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 383	Continued From page 10 assessment assessing Resident 10's ability to consent to a relationship with input from his/her legal representative, the resident's ability to understand the nature of an intimate relationship, and current mental and physical abilities. On 07/17/2023 at 12:00 PM, Surveyors interviewed House Manager M. House Manager M stated s/he had been working at the facility for a little over 2 months and Resident 10 and Resident 11 were known to have a relationship. Surveyor asked House Manager M if the provider completed an assessment after Resident 10 accused Resident 11 of inappropriate sexual behaviors. House Manager M stated "no." On 07/17/2023 at 2:40 PM, Surveyors interviewed Administrator L and House Manager M. Surveyor questioned why Resident 10's and Resident 11's "relationship" was not assessed after police were involved on 05/31/2023. Administrator L stated the provider would never interfere with resident choices to whom they want to be friends with or more. Surveyor expressed concern that Resident 10's cognitive status vs Resident 11's was not questioned after allegations of inappropriate sexual behaviors. Administrator L stated that Resident 10's cognitive decline did not start until right before s/he passed away. Administrator L confirmed an assessment was not completed to assess Resident 10's ability to consent to a relationship. for self-direction, including the ability to consent to a relationship and to make wants or needs known in the area of sexual intimacy including physical and emotional health.	N 383		
N 388	83.35(3)(c) Implement, follow the individual service plan	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

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N 388	Continued From page 11	N 388		

Implementation. The CBRF shall implement and follow the individual service plan as written.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not follow the resident's Individual Service Plan (ISP) for 1 of 1 residents reviewed. Resident 10's weight loss was not reported as outlined in his/her ISP.

This is a repeat deficiency. See Statement of Deficiency (SOD) GU6113 dated 08/16/2021.

Findings include:

On 07/05/2023, the Department received a concern alleging resident weight losses were not monitored.

On 07/17/2023, Surveyors reviewed Resident 10's record.

Resident 10 was admitted, 02/23/2022, with diagnosis including dementia and anxiety disorder. Resident 10 passed away on 06/14/2023.

Resident 10's ISP, undated and unsigned, documented:
"Eating - Independently/Verbal Cues: Resident will go days without eating if not encouraged to. Encourage resident by eating a meal or snack with [her/him]. 06/09/2022."
"Weekly Weights - Incident report completed if weight is under or over 3 lbs (pounds) in 1 week. Incident report completed if weight is under or over 5 lbs in 1 month. MD (medical doctor) faxed with concerns."

Resident 10's documented weights were:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 388	Continued From page 12 04/12/2023 - 94 lbs 04/19/2023 - 95 lbs 04/26/2023 - 95 lbs 05/03/2023 - 87 lbs - 8 pound weight loss 05/10/2023 - 91 lbs - 4 pound weight gain 05/17/2023 - 90 lbs 05/24/2023 - 95 lbs - 5 pound weight gain Resident 10's facility progress notes, dated 04/26/2023 to 05/24/2023, documented no issues. On 07/17/2023 at 2:40 PM, Surveyors interviewed Administrator L and House Manager M. Surveyors asked Administrator L and House Manager M for the incident reports regarding Resident 10's weight losses and gains. House Manager M stated s/he was unable to locate any incident reports regarding weights. Administrator L stated weight concerns would have been reported to the hospice nurse. Surveyor asked if there was documentation showing that hospice had been informed of the weight concerns. Administrator L stated s/he was unable to locate that kind of documentation and that future ISPs would not reference that incident reports are to be completed on weight concerns, as that is not protocol.	N 388		
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	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

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N 389	Continued From page 13	N 389		

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 observation, record review and interview, the provider did not ensure 1 of 1 Individual Service Plans (ISP) reviewed were updated annually or when there was a change in condition.

Resident 12's ISP was not updated to include his/her dietary, verbal, and physical behaviors.

Findings include:

On 07/17/2023, at approximately 11:40 AM, Surveyor observed Resident 12 eating lunch. Surveyor sat down at Resident 12's table and discussed the meal. Resident 12 stated, "I can't swallow the food." Surveyor observed her/him place food into his/her mouth, make a chewing motion, and then it would slip out of his/her mouth. Resident 12 placed the food back onto his/her plate. Surveyor asked Resident 12 if s/he could request a food item that would be easier for him/her to swallow. Resident 12 repeated, "It won't help, I can't swallow the food."

On 07/17/2023, at approximately 12:35 PM, Surveyor interviewed House Manager (HM) M. Surveyor commented to HM M that based on observation, Resident 12 displayed difficulty swallowing his/her meal which resulted in him/her spitting out the food. HM M stated s/he did not

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	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

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N 389	Continued From page 14	N 389		

know that Resident 12 was having difficulty swallowing his/her food but stated Resident 12 can become fixated on a particular action which could be viewed as attention seeking. Surveyor requested Resident 12's record.

Resident 12's "Observations," dated 03/01/2023 to 07/17/2023, documented:
"03/03/2023 - Resident is stealing paper work off the desk and out of the holder outside [administrator's] office. Resident just came out and said [s/he] is going to retain an attorney to sue everyone for fraud. [S/he] is mad because [s/he] cannot just take documents off the desk outside of [administrator's] office."
"03/04/2023 - Resident has been given [his/her] food to other resident, throwing [his/her] clothes away then digging them out of trash and putting them back on staff tried to ask why [s/he] got annoyed and upset with staff"
03/05/2023 - earlier at dinner time resident sat with resident #1 and was giving [him/her] food off of [his/her] plate which resident #1 was putting in [his/her] pocket for later [s/he] said. Writer explained to [Resident 12] that [s/he] cannot give this resident no food off [his/her] plate ... Resident has been rude and disrespectful to writer and coworker. Cussing at both saying [explicative] you. I will do whatever I want to and no one here will stop me from doing it ...then stating [s/he] is filing complaints against us."
03/06/2023 - "[Resident 12] went over the counter & stole my food I brought from home, informed me [s/he] can do what the hell [s/he] wants & [s/he] thinks I'm working for FBI ... resident came out complaint [s/he] did not get a root beer float and that [s/he] needs batteries for [his/her] remote. Resident came out of [his/her] room to get [his/her] remote and complained that staff stole [his/her] battery out of [his/her] remote, that

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	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 389	Continued From page 15	N 389		

is why [s/he] needs one."
03/07/2023 - Resident was pretty upset most of the day, but [s/he] calmed down when staff talked to [him/her] ..."
03/11/2023 - Resident is going into other residents room and taking things. Than getting very upset and cursing when staff questions [him/her] about why [s/he] is going in to others room and taking things. Staff explained to [him/her] that [s/he] cannot do these things and once again [s/he] replies that [s/he] does not care. Resident went into another residents room and put 2 pears under [his/her] pillow staff removed the pears and then resident grab staff and staff told [him/her] to keep [his/her] hands off staff and if [s/he] did it again there would be consequences for [his/her] actions. Resident stated that [s/he] didn't care."
03/15/2023 - "Resident gets very upset at [his/her] food being kept behind the counter."
03/17/2023 - "Resident was caught sneaking food into another residents room"
03/19/2023 - "Resident is up trying to go into another resident's room ..."
03/20/2023 - "Resident keeps taking food from other residents plates & placing them on #1's plate. #1 has no acknowledgement of this."
03/22/2023 - "Resident is still sneaking in and out of other residents rooms."
04/17/2023 - "POA (power of attorney) said resident cannot have any of the stuff brought in (reeses, fruit cups, etc) until [s/he] takes a shower and staff see that [s/he] has done so."
04/19/2023 - "Screaming [explicative] you 8 times to me blowing [his/her] breath in my face constantly saying obscene things to me constantly."
05/11/2023 - "Resident got up shortly after writer arrived asking me if I will dig some cheese out of the garbage for [her/him] I told [him/her] no [s/he]

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	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 389	Continued From page 16	N 389		

can't eat out of the garbage [s/he] then yelled at me and said well its mine so I can do whatever I want!"
05/17/2023 - "Resident has got up at least 10 times to weigh [him/herself]. [Resident 12] has violently attacked me grabbed my arm tried squeezing my arms flipped me off called me a [explicative name] ripped [his/her] paper up n threw at me ..."
06/10/2023 - "Resident is yet again grabbing [a residents] plate and taking food off it putting it on to [his/her] plate. Staff asked resident numerous times not to do this. She is also giving [resident] food [s/he] is not supposed to have due to a dye issue ..."
07/08/2023 - "Resident attempted to follow [another resident] into the public bathroom staff had asked what [s/he] was doing [s/he] said nothing talking to my friend ... staff remind [him/her] that [s/he] can't follow [residents] into the restroom."

Resident 12's ISP, undated and signed by HM M, documented:
"Eating - Independently"
"Abusive Behaviors - Resident requires monitoring for out-lashing behaviors toward others"
"Attention Seeking Behavioral Pattern - Resident currently displays attention seeking behavior daily which requires staff intervention."
"Bathing - Resident requires minimal assistance from Team Member with bathing/showering needs including (hands-on assistance with washing, shampooing, and getting in and out of tub/shower.)

Resident 12's "Resident Vitals History" documented an 8 pound weight loss from 05/24/2023 (134.5 pounds) to 07/12/2023 (126

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 389	Continued From page 17 pounds). On 07/17/2023 at 2:40 PM, Surveyors interviewed Administrator L and HM M. Surveyor explained that Resident 12's ISP only documented that s/he would hide items in his/her room or other resident rooms. The ISP did not document his/her verbal, physical and dietary behaviors, and guidelines for staff on how to address/care for these behaviors. Administrator L and HM M stated s/he would review the resident ISPs and ensure individualization. Surveyor asked if Administrator L and HM M realized that Resident 12 had sustained an 8-pound weight loss in approximately five weeks. Administrator L and HM M did not respond.	N 389		
{N 499}	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were stored in a secured area. Surveyor observed the unlocked laundry room door and upon entrance observed cleaning compounds. This requirement is being cited for a fifth time. See Statements of Deficiency (SOD) GU6113 dated 08/16/2021, SOD GU6114 dated 03/15/2022, SOD GU6115 dated 08/25/2022, and SOD GU6116 dated 03/01/2023.	{N 499}		

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	0017756	A. BUILDING: _____ B. WING _____	R-C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

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{N 499}	Continued From page 18 Findings include: The provider is licensed for client groups advanced aged, irreversible dementia/Alzheimer's, terminally ill and physically disabled. On 07/17/2023, at approximately 11:10 AM, Surveyor conducted a tour of the facility and observed the laundry room door with a sign on it stating, "Employees Only - Keep Door Closed and Locked At All Times." The door had a locking device that required a code to be punched in to unlock the door. Surveyor attempted to enter the laundry room to determine if the door was locked; it was not, and Surveyor entered the room and observed the following cleaning compounds: -Housekeeping cart with a bottle of furniture polish, 1 spray bottle (quart) of cleaner with bleach and 100 fluid ounce bottle of muli-surface leaner (lemon fresh). -Gallon jug multi-purpose cleaner -1 spray can of insect repellant -(3)Gallon jugs of bleach -Gallon jug of germicidal bleach solution -(2) Gallon jugs of window cleaner -(3) 32 ounce spray bottles of all purpose cleaner -A 32 ounce bottle of floor polish -24 ounce spray bottle of pet urine remover -32 ounce bottle of floor cleaner inserted into mop -32 ounce spray bottle of mold remover -(2) Gallon jugs of liquid drain clog destroyer -(2) spray cans of heavy starch -(2) gallon jugs of alcohol antiseptic -160 count germicidal alcohol wipes -(5) 1 pound containers of disinfecting wipes This area was accessible to all residents. Residents were observed ambulating freely	{N 499}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT NORTH	2027 COLONY COURT BELOIT, WI 53511

(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 499}	Continued From page 19 throughout the facility. The laundry room is located at the start of a hall with resident rooms. On 07/17/2023, at approximately 1:00 PM, Surveyor interviewed Administrator L. Administrator L stated, "Our resident's dementia isn't so bad they would eat laundry pods." Administrator L stated a new lock would be ordered for the laundry room door.	{N 499}		