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N 000	Initial Comments On 05/09/2025 to 05/19/2025, Surveyor conducted a complaint investigation and an abbreviated survey at Eagle Court Memory Care. Two deficiencies were identified. The complaint was substantiated. Census: 29	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 2's legal representative, Person F, was immediately notified when Resident 2 was touched inappropriately by another resident. Findings include: On 01/03/2025, the Department received a complaint alleging undesired contact had occurred between 2 residents without any follow up from the provider.	N 169		

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

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N 169	Continued From page 1 On 05/09/2025, Surveyor conducted a complaint investigation and identified the following: On 05/09/2025 at 10:40 AM, Surveyor interviewed Caregiver C. Caregiver C reported s/he had worked at the facility since July 2023. Caregiver C reported around the beginning of the year, s/he had heard Resident 1 was caught with his/her hand down Resident 2's pants. On 05/09/2025 at 10:55 AM, Surveyor interviewed Caregiver D. Caregiver D reported s/he had heard of another incident where Resident 1 had their hand down Resident 2's pants, but s/he was unaware of the date. On 05/09/2025 at 11:16 AM, Surveyor interviewed Caregiver E. Caregiver E reported on 12/31/2024, s/he was told by another staff member earlier in the month, Resident 1 had stuck his/her hand down Resident 2's pants and gotten a hold of his/her [explicit]. Surveyor reviewed Resident 1's and Resident 2's record. Resident 1 was admitted to the facility on 02/13/2023 with diagnoses including dementia and alcohol abuse. Resident 1 had an activated healthcare power of attorney. Resident 2 was admitted to the facility on 10/22/2021 with a diagnosis of Alzheimer's disease. Resident 2's facesheet identified Person F as their activated healthcare power of attorney. Resident 2's most recent individual service plan (ISP) dated 02/17/2025 was signed by Person F. Resident 1's progress note dated 12/14/2024 documented: "12/14/2024: Resident was caught sexually touching room [Resident 2], when resident was asked to move. [S/he] began to get violence and	N 169		

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combative with staff stating that [s/he] could do whatever [s/he] wanted to. Staff directed to continue to redirect [Resident 1] and to keep other resident in their sight when both residents are out in common dining room. Message sent to PCP and [Director of Health Services (DHS) B] via Bluestone Bridge."

Resident 2's record had no evidence his/her activated healthcare POA was notified about the above incident.

On 05/09/2025 at 1:18 PM, Surveyor interviewed Director of Health Services (DHS) B. DHS B reported s/he was aware of the 12/14/2024 incident between Resident 1 and Resident 2 via their electronic health record (EHR). DHS B reported s/he overlooked the progress note/notification and did not complete any follow up, including notifying Resident 2's POA. Surveyor asked what is the provider's protocol for after an incident like above happens. DHS B stated staff wrote a note in their EHR, the on-call nurse notified the offending resident's physician and myself, and I (DHS B) was responsible for follow up. DHS B reported s/he would have created an adverse event note and investigated the incident. DHS acknowledged an understanding of the Surveyor's concern and confirmed Person F should have been notified immediately after the incident. Surveyor asked if police were notified. DHS B stated s/he did not complete any follow up, so police were not contacted.

On 05/19/2025 at 11:42 AM, Surveyor interviewed Person F. Person F confirmed s/he was Resident 2's activated healthcare power of attorney. Person F reported Resident 2 had discharged from the facility in April 2025. Surveyor asked

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N 169	Continued From page 3 Person F if s/he had any concerns with Resident 2 and another fe/male resident towards the end of Resident 2's admission. Person F stated s/he had a feeling something was going on at times because another fe/male resident would be near Resident 2 when visiting, but was not aware of any incidents. Surveyor asked Person F if s/he was aware of the incident on 12/14/2024 between Resident 1 and Resident 2. Person F stated s/he was never notified after the 12/14/2024 incident and wished s/he would have been contacted. Cross Reference: N0389 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 169		
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 interview, the provider did not update Resident 1's Individual Service Plan (ISP) when there was a change in	N 389		

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resident's needs, abilities or physical or mental condition.

Resident 1's ISP was not updated when s/he had a change in behaviors related to sexual touching or comments towards other residents.

Findings include:

On 01/03/2025, the Department received a complaint alleging undesired contact had occurred between 2 residents without any follow up from the provider.

The provider is licensed to care up to 30 residents in the client groups of irreversible dementia/Alzheimer's and advanced age.

On 05/09/2025, Surveyor conducted a complaint investigation and identified the following:

On 05/09/2025 at 9:25 AM, Surveyor interviewed Administrator A. Administrator A reported Resident 1 pursued Resident 2 at times when s/he lived here. Administrator A reported Resident 1 wandered the unit and would approach Resident 2 if s/he was in the common area resting in his/her broda chair. Administrator A stated s/he was aware of 1 incident involving undesired contact between Resident 1 and Resident 2 around February 2025. Administrator A reported the provider completed an investigation. Administrator A noted Resident 2 had advanced dementia, was in a broda chair, could no longer communicate, so this made him/her our most vulnerable male/female resident. Administrator A stated after the February 2025 incident, the provider put interventions in place for staff to always have eyes on Resident 2 if s/he was out of their room. Administrator A

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reported Resident 2 discharged in April 2025 to another memory care.

On 05/09/2025 at 10:40 AM, Surveyor interviewed Caregiver C. Caregiver C reported s/he had worked at the facility since July 2023. Caregiver C reported Resident 1 had pursued [Resident 3] when s/he first started, but nothing again until most recent incidents with Resident 2. Caregiver C reported around the beginning of the year, s/he had heard Resident 1 was caught with his/her hand down Resident 2's pants. Caregiver C stated s/he did not think Resident 1's ISP was ever updated after the incident but staff would keep Resident 2's door locked when s/he was in there.

On 05/09/2025 at 10:55 AM, Surveyor interviewed Caregiver D. Caregiver D confirmed there was an incident between Resident 1 and Resident 2 on 02/09/2025. Caregiver D reported s/he observed Resident 1 made sexual comments while touching Resident 2's arm. Caregiver D stated s/he reported the incident to management and an investigation was completed. Caregiver D reported s/he had heard of another incident where Resident 1 had their hand down Resident 2's pants, but s/he was unsure of the date. Caregiver D reported s/he had observed Resident 1 pursue (manually wheel him/herself over to) Resident 2's broda chair while in the dining room and make sexual comments towards Resident 2. Caregiver D reported s/he was unsure if Resident 1's ISP was updated after the 2 above incidents.

On 05/09/2025 at 11:16 AM, Surveyor interviewed Caregiver E. Caregiver E reported on 12/31/2024 s/he was told by another staff member earlier in the month, Resident 1 had stuck his/her hand

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down Resident 2's pants and gotten a hold of his/her [explicit]. Caregiver E reported management was not notified timely. Caregiver E stated no reeducation was completed with staff and treated like this was how Resident 1 behaves and we just need to keep eyes on him/her when by Resident 2.

Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 02/13/2023 with diagnoses including dementia and alcohol abuse. Resident 1 had an activated healthcare power of attorney.

Resident 1's ISP dated 08/26/2024 documented: "Behavior observation: Staff to monitor for any behavior changes. Redirect verbally, talk about family, assist turning on TV, give cup of coffee w/milk, give newspaper, look for wildlife out window-if resident is displaying behaviors. Ensure that basic needs are met: hunger, thirst, bathroom, temperature, free from pain. Alert nurse to any new or increase behaviors. Follow responsive behavior plan. The community to provide assistance to monitor reactive behaviors in a supportive environment. Goal: Resident to be easily redirected if behavior occurs."

Resident 1's ISP dated 10/08/2024 documented: "Behavior observation: Behavioral health interventions to follow for [Resident 1]: Behavior health care manager will visit monthly to assist [Resident 1], the staff and update the care plan as necessary. 3/30/24-Sexual urges do not diminish with age or dementia. At times, they can actually be increased. It is important to remember that [Resident 1] no longer has control over [his/her] brain and that impulsive behavior will occur. When it does, staff will need to remain calm and approach with ease and be careful not

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to shame [Resident 1].
-Attempt to redirect [Resident 1] by remaining calm and let [him/her] know that the meal is ready or [s/he] is needed to take [his/her] medication, etc. If you can't redirect [Resident 1], attempt to redirect the other resident that [s/he] is making advancements to. Try to remove this person without making [Resident 1] feel like [s/he] did something wrong.
-Provide tactical stimulation for [Resident 1], such as fidgets, modeling clay, shaving cream, etc. A task that can redirect [his/her] thoughts but [s/he] still receives sensory input. If this need is not met, [s/he] could continue to seek it or obtain it.
-Sexual aids like movies or magazines can be provided for [Resident 1] to use in the privacy of [his/her] room. Most likely [s/he] is looking for comfort and intimacy, so heavier blankets or particular clothing may provide that."

Resident 1's ISP dated 04/29/2025, was not updated after the 12/14/2024 and 02/09/2025 incidents. Additionally, the ISP was not updated to direct staff to utilize the behavioral health care plan to mitigate his/her behaviors.

Resident 1's record contained an investigation dated 05/25/2023, which summarized the provider's steps in interviewing Resident 1 regarding a relationship with Resident 3.

Resident 1's adverse event investigation dated 2/9/25 documented:
"Provide detailed description of event or allegation: [Resident 1] made sexual comments while touching [Resident 2's] arm ...Resident interview summary: in follow up interview, had no recollection of incident .... Provide summary and outcome of investigative findings: [Resident 1] touched arm of [Resident 2], stating [s/he] would

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be interested in sexual relations. Team intervened, when [Resident 1] was reminded to be appropriate w/ peer [s/he] verbalized to team they were yelled at by [Resident 1]. [Resident 1] did not remember interaction within minutes after. [Resident 2] displayed no reaction, no change in mood/behavior. Team kept both in view for 24 hrs to monitor. No further comments."

Resident 1's progress notes documented:
"11/10/2024: Resident was witnessed by caregivers pleasuring [him/herself] near the front entrance, this am.
12/14/2024: Resident was caught sexually touching room [Resident 2], when resident was asked to move. [S/he] began to get violence and combative with staff stating that [s/he] could do whatever [s/he] wanted to. Staff directed to continue to redirect [Resident 1] and to keep other resident in their sight when both residents are out in common dining room. Message sent to PCP and [Director of Health Services (DHS) B] via Bluestone Bridge.
12/16/2024: Communication from Bluestone behavioral health specialist: "I know that [Resident 1] has become combative before when redirected. Often [s/he] will be offended or upset when redirected because staff may be inferring to [him/her] that [s/he] is inappropriate. Which in "normal" situations that would be true, but it is best to redirect [Resident 1] without making it seem like [s/he] is doing something wrong. Redirecting [him/her] should include staff acknowledging [him/her], offering [him/her] something to eat or drink and attempting to physically have [him/her] leave the area. If [s/he] will not move to another area, then move the [gentlemen/women] that [s/he] is advancing upon. Telling [him/her] "no" or "[Resident 1] that is inappropriate" is only going to increase [his/her]

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frustration or agitation. I will update [his/her] behavioral health care plan to include redirections and appropriate approaches.
01/02/2025: 12/31/24 BHI update: Completed monthly visit with [Resident 1] and staff 12/30 .... [Resident 1] continues to exhibit inappropriate sexual behaviors with other residents and when redirected becomes verbally aggressive and combative. BHCM reviewed behavioral health care plan to aid [Resident 1] on daily basis with sexual behaviors. Please have staff review.
02/09/2025: Resident went upto (sic) another [fe/male] resident stating that [s/he] wanted inappropriate things with resident as [s/he] was touching the other [fe/male] resident. Staff had asked if [s/he] could step away from resident and to not touch [him/her], [s/he] lashed out and yelled at staff saying that staff was vulgar."

On 05/09/2025 at 1:18 PM, Surveyor interviewed DHS B. DHS B stated s/he was responsible for updating resident care plans and the provider's ISPs were what staff followed. DHS B stated s/he looked at Resident 1's record while gathering documents for the Surveyor and saw the progress note from 12/14/24 involving Resident 1 and Resident 2. DHS B reported s/he was aware of the incident but forgot to complete any follow up from the incident. DHS B explained Resident 1 sees a behavioral specialist monthly through Bluestone, and they create interventions on their behavioral health care plan. Surveyor asked how staff were made aware of the behavioral health care plan. DHS B stated there was a binder staff were supposed to read. Surveyor expressed concern Resident 1's most recent ISP did not direct staff to utilize or where to find the behavioral health care plan. DHS B acknowledged an understanding of the Surveyor's concern and stated s/he usually would

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N 389	Continued From page 10 have completed an adverse event note and investigated the incident. Cross Reference: N0169 83.12(5)(a) Notification: Incident, Injury, Changes	N 389		