Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019251	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARETTA SENIOR LIVING BELLUVUE CBRF	1780 SERVANT WAY BELLEVUE, 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 07/14/2025 with additional information obtained through 07/23/2025, Surveyors conducted (2) complaint investigations at Caretta Senior Living Bellevue CBRF in Green Bay. As a result, (1) complaint was substantiated, and 2 deficiencies were identified. Census: 26	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 maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the safety of all residents and investigate and report an allegation of abuse.	N 158		

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

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N 158	Continued From page 1 On 06/30/2025, the provider was notified of an allegation that caregivers had taken photographs with a deceased resident and shared the photographs with others. The provider did not investigate the allegations or report the allegations to the department. Findings include: The provider is licensed to provide services for up to 26 residents who may be of advanced age and/or have Alzheimer's/dementia. On 04/04/2025, the department received a complaint alleging resident abuse and neglect. On 07/14/2025, Surveyor conducted a complaint investigation. On 07/14/2025, at approximately 9:30 AM, Surveyor interviewed Executive Director D (ED-D), ED-D stated s/he was made aware of the allegation of mistreatment of residents by Office of Caregiver Quality (OCQ). ED-D stated his/her understanding was no investigation was conducted, and the allegation was not reported to the department. ED-D explained s/he began working at the facility after the incident occurred, once s/he was made aware of the allegation s/he did investigate and substantiate the allegation. Surveyor asked for a copy of ED-D's investigation, but ED-D did not provide a copy and did not report the allegation to the department. ED-D provided the facility's policy on Cell Phone and Personal Electronics usage, Resident Rights, and Caregiver Misconduct. ED-D confirmed educating caregivers that any future allegations of misconduct would be investigated, could result in	N 158		

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N 158	Continued From page 2 termination of employment and could be reported to the department. On 07/18/2025, at approximately 11:29 AM, Surveyor interviewed Resident Assistant A (RA-A). RA-A stated s/he was one of the people photographed with Resident 1 after s/he passed away. RA-A stated Resident Assistant B (RA-B) took the photograph with his/her cellphone and shared the photograph with other staff in a group text. RA-A acknowledged the incident did not respect Resident 1's right to privacy, dignity, and respect. On 07/24/2025, Surveyor reviewed the Entity Caregiver Misconduct Checklist (ECMC) completed by OCQ on 07/23/2025. The ECMC indicated the facility did not provide proof they conducted an internal investigation into the caregiver misconduct allegations. Additionally, the facility did not report the caregiver misconduct allegations.	N 158		
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	N 433		

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N 433	Continued From page 3 provider did not provide services to fully manage Resident 2's behaviors that were or had the potential to be harmful to themselves or others. Findings Include: On 04/04/2025, the department received a complaint the provider did not manage resident's behaviors. On 07/14/2025 at approximately 9:55 AM, Surveyor interviewed Executive Director D (ED-D). ED-D discussed Resident 2 being very intelligent and has snuck over to the connected Residential Care Apartment Complex (RCAC) where Family Member I (FM-I) lives. ED-D described Resident 2, waiting near the entrance door to the RCAC where FM-I resides, once someone opens the door, s/he will wait for them to enter and sneak through behind them entering the RCAC and to FM-I's room. ED-D stated this happens at least a few times weekly, sometimes more, sometimes less. ED-D stated Resident 2 does make many attempts to sneak beer in his/her pants from FM-I's refrigerator once s/he leaves to return to his/her own room at the Memory Care Facility (MCF). On 07/14/2025 at approximately 10:15 AM, Surveyor interviewed Licensed Practical Nurse F (LPN-F). LPN-F explained Resident 2 does sneak out the door to the RCAC where FM-I lives multiple times a week but staff usually find him/her within 5-15 minutes, if not see him/her as s/he walks through the door. LPN-F stated staff at both facilities, RCAC and MCF know to watch for Resident 2 and escort him/her back to his/her facility or call staff from the MCF to come visit with Resident 2 at FM-I's room. LPN-F stated Resident 2 has taken beer from FM-I and does	N 433		

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stick the cans in his/her pants between his/her legs near his/her crotch area. LPN-F stated staff are advised to encourage Resident 2 not to drink the beer for his/her own heath and safety. LPN-F stated there are written protocols or guidance for when Resident 2 is exit-seeking or taking beer or other items from other residents' rooms.

On 07/14/2025, at 10:45 AM, Surveyor reviewed Resident 2's record. The Individualized Service Plan (ISP) dated 05/13/2025 specified Resident 2 has a diagnosis of depression, anxiety disorder, alcoholism and drug addiction .... also noted Resident 2 can experience mild confusion at times and staff need to provide redirection and reorientation. Resident 2's ISP did not identify Resident 2's behavioral history or interventions related to wandering, exit-seeking, elopement, agitation, anxiety, verbal aggression, threatening others, and physical aggression.

Resident 2's Assessment dated 05/07/2025 indicates Resident 2 experienced a cognitive impairment caused by a Cerebrovascular Accident (CVA). Resident 2 has a history of alcohol use; term used: alcoholic and should not have any alcohol. Indicates a diagnosis of Dementia, cognitive impairment most likely alcohol induced.
Resident 2's assessment did not identify Resident 2's behavioral history or interventions related to wandering, exit-seeking, elopement, agitation, anxiety, verbal aggression, threatening others, and physical aggression.

Review of observation notes showed a pattern of wandering, exit-seeking, verbal, physical and threatening type behaviors.

Resident 2's observation notes:

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N 433	Continued From page 5 11/12/2024 11:29 AM "Resident 2 was found in another resident's room getting an oatmeal pie. [MP-K] reminded [Resident 2] that it was not okay to go into other residents (sic) rooms to take their snacks. [Resident 2] was very upset and stated "[s/he] invites me and tells me to take what I want." 11/14/2024 9:04 PM "Resident got out of the [MCF] unit (sic) ran up to [Family Member I (FM-I)] room and went straight to the fridge. [Resident 2] shoved beer in [his/her] pants. [Resident 2] walked back to memory care and all care staff noticed [Resident 2] has something in [his/her] pants, when asked about what was in [his/her] pants, [Resident 2] stated it was nothing. When taking [Resident 2] back to [his/her] room, [Resident Assistant J] pulled a beer out of [Resident 2's] pants." 01/02/2025 8:06 PM "Before dinner activity director took [Resident 2] up to [his/her] [FM-I's] room to visit, when [Resident 2] came back activity director informed staff that [Resident 2] was smuggling a bud light can in [his/her] pants. [Resident Assistant H (RA-H] stopped [Resident 2] before entering [his/her] room and told [Resident 2] RA-H could not let [Resident 2] go in [his/her] room with the alcohol. [Resident 2] was extremely upset that [RA-H] was trying to take the alcohol. [RA-H] told resident [s/he] wasn't able to drink because of the medications [s/he] was on [s/he] could get sick. RA-H called [Registered Nurse E (RN-E)] and another care staff to assist with removing the alcohol from [Resident 2's] pants. [RA-H] and RN-E help (sic) [Resident 2's] arms while another care staff grabbed the beer can from [Resident 2's] pants. [Resident 2] bit RA-H on the hand and was kicking the staff.	N 433		

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N 433	Continued From page 6 RA-H removed (sic) beer can and brought it back up to [FM-I's] room." 01/21/2025 12:50 PM Resident 2 brought out a party horn and startled staff by blowing it in their ear. Staff asked Resident 2 not to do blow the horn in people's ears. Resident 2 stuck his/her tongue out at staff. Resident 2 attempted to blow the party horn into the ear of another resident and staff intervened. Resident 2 then attempted to blow it in another resident's face, the resident put his/her hand up to block Resident 2 from blowing the horn. Resident 2 then attempted to slap the same resident's hand as the s/he was picking up a cup at lunch. Staff reminded Resident 2 this behavior was not appropriate and will cause the other residents to be upset. Resident 2 stated "you're a pain in my ass" and stuck his/her tongue out at staff. 03/21/2025 1:20 PM "Resident 2 was seen coming out of another resident's apartment with a full box of girl scout cookies and 4 pieces of chocolate. [Med Passer K (MP-K)] asked [Resident 2] to give the items to [MP-K] so [MP-K] could return the cookies and candy to the [other] resident's room. [Resident 2] then stated "I asked [him/her] if I could have some and [s/he] said yes" "[MP-K] did ask the other resident's [spouse] if this was ok, and it was not ok for [Resident 2] to take the cookies/chocolates. [Resident 2] gave the snacks back to [MP-K] and told [MP-K] to go to hell and stuck [his/her] tongue out at [MP-K] ...." 03/22/2025 12:54 PM "[Resident 2] went into another resident's room seeking food. [Resident 2] was redirected to [his/her] own apartment while [MP-K] looked for a snack in the cabinet that is in the dining room. [Resident 2] then ran back into	N 433		

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the other resident's room and attempted to take girl scout cookies again. [MP-K] then walked [Resident 2] back to [his/her] own room and brought back a cookie."

06/20/2025 5:12 PM "[Resident 2] notified [Resident Assistant L (RA-L)] that another resident was in someone's room that wasn't their own. Upon entering, [Resident 2] hit the resident who was laying on the bed and told [him/her] to get out. [RA-L] directed "[Resident 2] to get out of the room and that it is only statrs (sic) jobs (sic) to deal with other residents. "[Resident 2] continuously got in the other resident's face and told [him/her] that all [s/he] does is cause problems. [RA-L] directed "[Resident 2] to [his/her] room if [s/he] cannot leave this other resident alone."

07/17/2025 11:58 AM "[ED-D] Educated staff on resident rights if "[Resident 2] does get a hold of [FM-I's] beer they are not to forcefully remove from "[Resident 2]'s person."

Conclusion:
Resident 2 was identified by provider staff and Resident 2's observation notes to have exit seeking, wandering behaviors, verbal and physical aggression towards others, visiting Family Member I without staff noticing, and alcohol seeking behaviors. Resident 2 was not assessed, and his/her ISP did not reflect his/her behaviors or have interventions to support Resident 2's behaviors.