STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018398	A. BUILDING: _____ B. WING _____	R-C 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWOOD SENIOR LIVING EAGLES NEST	115 BOWMAN ROAD WISCONSIN DELLS, WI 53965

(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 09/04/2024-09/05/2024, Surveyors conducted a verification visit and standard survey at Riverwood Senior Living Eagles Nest. Three deficiencies were identified. The violation from Statement of Deficiency (SOD) U1IM11, dated 06/28/2023 was substantially corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 48	{N 000}		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental	N 243		

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

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N 243	Continued From page 1 considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview the provider did not provide, obtain, or otherwise ensure 2 of 3 employees reviewed, obtained all training as required within 90 days after starting employment. Caregivers D's and E's records did not contain evidence of training in resident rights within 90 days after starting employment. Caregivers D's and E's records did not contain evidence of training in recognizing, preventing, managing, and responding to challenging behaviors within 90 days after starting employment.	N 243		

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N 243	Continued From page 2 Findings include: On 09/04/2024, Surveyors conducted a review of 3 employee records to verify compliance with all employee training requirements. Surveyor requested training records from Administrator A for Caregivers D, E, and F. Surveyor stated evidence of meeting the training requirements could include a CBRF training certificate obtained prior to 2009, in-service training documentation, or evidence of meeting an exemption for the training requirements. Resident Rights The records for Caregiver D, hired 05/01/2024 and Caregiver E, hired 03/18/2024, did not contain evidence of training or evidence of meeting an exemption for resident rights. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The records for Caregiver D, hired 05/01/2024, and Caregiver E, hired 03/18/2024, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. At 3:25 PM, Surveyor interviewed Administrator A. Administrator A confirmed the facility did not have evidence Caregivers D and E completed or met an exemption for resident rights and challenging behaviors training. Administrator A stated prior to giving documentation to the Surveyors, s/he recognized the provider was out of compliance for the above training. Administrator A stated the provider had already fixed the systems error and would ensure new employees received resident rights and challenging behaviors training going	N 243		

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N 243	Continued From page 3 forward.	N 243		
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 individual service plan (ISP) was not updated for 1 of 1 resident reviewed when there was a change in resident needs and abilities. Resident 2's ISP was not updated when s/he had a change in behaviors including disrobing and paranoia. Findings include: On 09/04/2024 at 10:15 AM, Surveyors toured the locked memory care unit with Community Relations Director (CRD) G. Surveyor observed Resident 2's bedroom door. There was a mesh stop sign across the door and a door alarm mounted. Surveyors asked CRD G why those	N 389		

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N 389	Continued From page 4	N 389		

items were being used. CRD G stated that Resident 2 becomes very paranoid about others entering his/her room, and the interventions had been used to provide Resident 2 peace of mind.

On 09/04/2024, Surveyor reviewed Resident 2's record and identified the following:

Resident 2 admitted to the provider on 10/18/2023 with diagnosis that included generalized anxiety disorder and unspecified dementia. Resident 2 had an activated power of attorney who assisted in making decisions on his/her behalf.

Resident 2's observations from May 2024 to September 2024, documented:

"06/04/2024 6:10 AM- [Resident 2] told writer that [s/he] had an accident but when writer went into [Resident 2's] bathroom to [him/her] [s/he] had all [his/her] clothes off and [s/he] didn't have an accident the brief that [s/he] had on or the one in the garbage. [Resident 2] just had to use the bathroom. Writer helped [Resident 2] get changed into warmer weather clothes.

07/04/2024 2:06 PM- [Resident 2] appeared to be upset with staff this morning. [Resident 2] was out of [his/her] milk and staff asked [Resident 2's] [husband/wife] to bring [Resident 2] more milk. [Resident 2] started being rude to staff stating that we won't feed [him/her]. Staff offered [Resident 2] other breakfast items to eat while [s/he] waits for [his/her] milk and [Resident 2] refused. [Resident 2] was redirected and explained that [his/her] [husband/wife] is bringing more, and [Resident 2] went to other residents in the dining room and was stating that staff won't feed [him/her] and that we stole [his/her] milk.

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N 389	Continued From page 5 [Resident 2] then went to [his/her] room and waited for [husband/wife] to bring [him/her] milk. 08/11/2024 8:10 PM- [Resident 2] pressed [his/her] pendant for assistance after suppertime, and writer went to [his/her] room, [Resident 2] was in the toilet trying to remove [his/her] clothes ... 8/17/2024 8:35 AM- Writer noticed [Resident 2] had come out their room with different pants on writer had just toileted [Resident 2] 14 mins prior to and was dry. Writer brought [Resident 2] back into their room to see if [Resident 2] had a brief on cause [Resident 2] is known to take off briefs and not have one on. Writer did notice that the brief [Resident 2] was wearing 15 mins prior was in the trash and was dry along with the pants [Resident 2] was wearing and pants were dry as well. Writer put new brief on and put pants that were on back on [Resident 2]. Had to reassure [Resident 2] that their pants were dry and that they didn't need to change. 08/18/2024 2:45 PM- Writer was toileting residents and writer came to toilet [Resident 2], writer walked into [Resident 2's] room and noticed that [Resident 2] had their shirt off and was putting bra on backward as well. Writer asked what we were doing, and [Resident 2] said I don't know. Writer directed [Resident 2] into the bathroom to get a brief on as well as their shirt back on and [Resident 2's] pants were on backwards with no brief, the dry brief that was just on [Resident 2] 30 mins ago was dry and thrown in the trash can. Writer then got resident a new brief on and put [Resident 2's] pants on the (sic) right away. 08/21/2024 8:10 AM- Writer noticed that	N 389		

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N 389	Continued From page 6 [Resident 2] was wearing two pairs of pants so writer brought [Resident 2] to [Resident 2's] room writer then noticed that there was a dry brief in the trash can. Writer then got the first pair of pants off and then noticed that the second pair were on inside out and [Resident 2] also didn't have a brief on. 08/29/2024 11:17 PM- Writer and coworker went into [Resident 2's] room to put [him/her] back to bed. [Resident 2] had gotten out of bed at least 4 times in the past 30 minutes. Coworker heard a noise and writer walked to [Resident 2's] phone and found that [Resident 2] had called 911. Writer and coworker talked to the operator and the operator hung up because there was no issue. 08/30/2024 9:31 PM- [Resident 2] has been walking in and out of [his/her] room all evening, and at times [s/he] would go to another resident's room door, thinking that it was [his/hers]. 08/31/2024 4:01 AM- [Resident 2] has been restless throughout most of the night. [Resident 2] kept coming out of [his/her] room naked, stating that [s/he] does not want to wear what [s/he] had on, the writer changed [Resident 2] about five times throughout the night, and offered food. After the fifth time, [Resident 2] laid down only for about 15 mins, then [s/he] opened [his/her] door and was naked again. 08/31/2024 1:40 PM- Writer had come out of the laundry room to find [Resident 2] walking the halls without a shirt on. When writer brought [Resident 2] to their room writer then noticed that [Resident 2] did not have a brief on with [Resident 2's] pants on backwards. Writer noticed that there was also a pair of wet pants sitting on the floor in [Resident 2's] bathroom.	N 389		

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N 389	Continued From page 7 08/31/2024 10:58 PM- [Resident 2] continues to leave [his/her] room with only pants and shoes on. Writer brought [him/her] to [his/her] room and put [his/her] nightgown on [him/her] several times. [Resident 2] refuses to stay in [his/her] room. 09/01/2024 2:03 AM- [Resident 2] has been coming out of [his/her] room without a shirt on and when trying to redirect [him/her] to [his/her] room [s/he] it was hard to do that. Staff offered [him/her] snacks and water and calm down for a bit then [s/he] came out again [s/he] ripped off [his/her] depend other staff [s/he] cleaned [him/her] up put [him/her] up put [him/her] to bed [s/he] also had PrN(sic) were given due to the leg pain. 09/01/2024 5:22 AM- [Resident 2] continued with [his/her] behavior until morning [s/he] is confused and agitated staff tried turning on the tv for [him/her], [s/he] did not like it, offered [him/her] snack [s/he] refused we changed [his/her] clothes almost 5 to 6 times. [Resident 2] was not easy to redirect most of the times. 09/01/2024 7:46 AM- Writer had noticed that [Resident 2] had come out of [Resident 2's] room to come down for breakfast, writer then also noticed that [Resident 2] didn't have a brief on. Writer then took [Resident 2] back to [Resident 2's] room to find that [Resident 2] had thrown away a clean and dry brief that the [Resident 2] had been wearing. Writer then put a new one on and got into clean pants because the ones [Resident 2] was wearing were soiled. Then shortly after [Resident 2] sat down at the dining table at 8:00 am [Resident 2] went back into [Resident 2's] room and writer went to [Resident 2's] room and [Resident 2] was taking off the	N 389		

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clean brief that was put on [Resident 2] a few minutes prior while that brief was dry.

09/02/2024 1:00 PM- Writer noticed that [Resident 2] was coming out of [Resident 2's] room with different pants on. Writer brought [Resident 2] back to room and noticed that [Resident 2's] pants were on backwards also [Resident 2] did not have a brief on either. Writer got a new brief on and then noticed that [Resident 2] had thrown away [Resident 2's] pants that were soiled with bm in the trash. Writer then also noticed that [Resident 2] to of happen to sit and get [Resident 2's] chair full of bm."

Resident 2's Care Plan, last updated 09/04/2024, documented:

"Toileting Schedule- When [Resident 2] is incontinent [Resident 2] may try to take off brief themselves and forget to put a new one on. Sleep Assistance- Care staff to make sure that [Resident 2's] door is locked every 2 hours on round or if alarm goes off."

Resident 2's ISP, last updated 08/22/2024, documented:

"Key to Room- ...has key due to increased anxiety of people going in room.

Toileting Schedule- ...[Resident 2] has had several episodes of incontinence. When [Resident 2] is incontinent [Resident 2] may try to take off brief themselves and forget to put a new one on.

Sleep Assistance- ...Care staff to make sure that [Resident 2's] door is locked every 2 hours on round or if alarm goes off.

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N 389	Continued From page 9 Behavior Monitoring- Staff monitors [Resident 2's] trigger behaviors when needed and have ability to participate in activities in daily living. Staff to provide behavior intervention for [Resident 2] based on their unique needs. Standard interventions: 1. Allow [Resident 2] to validate concerns. 2. Encourage [Resident 2] to use bathroom to relieve bowel and bladder. (Ask or check when last BM occurred, if possible) 3. Offer food and fluids. 4. Assess [Resident 2] for pain/discomfort. 5. Involve [Resident 2] in activity appropriate for cognition level. 5. Let [Resident 2] continue if there are no adverse consequences to self or others." On 09/04/2024 at 3:25 PM, Surveyors interviewed Administrator A who confirmed the updates to include disrobing and paranoia should have been in Resident 2's ISP. Surveyor asked Administrator A if s/he could show Surveyor where in the ISP it was located. Administrator A referenced the areas from the ISP that are noted above. Surveyor and Administrator A discussed the increased frequency of Resident 2's behaviors and Administrator A stated s/he would keep looking for the updates as s/he was certain they were added. Administrator A referenced a 6-month evaluation that s/he felt was more detailed. Surveyor asked if the caregivers reviewed the 6-month evaluation when they need information on Resident 2. Administrator A stated the caregivers should have had access to the evaluation but agreed that they would reference the care plan or ISP for Resident 2's personalized care needs.	N 389		

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N 539	Continued From page 10	N 539		
N 539	83.48(3)(b) Sensitivity testing performed Sensitivity testing shall be performed at intervals in accordance with NFPA 72. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the smoke and heat detector system had a sensitivity test performed at intervals in accordance with National Fire Protection Association (NFPA) 72 requirements. Findings include: On 09/04/2024, Surveyors reviewed the provider's safety documentation. The provider did not have evidence of sensitivity testing for inspections completed in 2023 and 2024. On 09/04/2024 at 3:27 PM, Surveyors conducted an exit conference and shared findings with Administrator A, Regional Nurse B, and VP Clinical C. Administrator A stated s/he would need additional time to follow up with the company who completed their fire alarm inspections to see if sensitivity testing was performed. On 09/05/2024 at 5:44 PM, Administrator A sent the Surveyor the following email: "Good evening, it looks like we do not have a sensitivity test completed."	N 539		