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	0015841	A. BUILDING: _____ B. WING _____	R-C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 2	1901 LIBAL STREET GREEN BAY, WI 54301

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{N 000}	Initial Comments On 06/26/2023, with information gathered through 06/29/2023, Surveyor conducted a verification visit and 2 complaints at Allouez Parkside Village 2 in Green Bay. All previous citations were corrected. One (1) of 2 complaints were substantiated. As a result of the survey, 5 deficiencies were issued. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 47	{N 000}		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not give the resident or legal	N 326		

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

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representative a 30 day written advance notice prior to discharge and did not provide assistance in relocating the resident to ensure a living arrangement suitable to meet the needs of the resident was obtained for 1 of 1 (Resident 1) resident reviewed.

Resident 1 was transferred to the hospital on 06/16/2023 due to challenging behaviors. Resident 1 was medically cleared to return to the facility on 06/17/2023. The provider refused to accept Resident 1 back at the facility. Resident 1 was discharged from the facility on 06/17/2023. Resident 1 was discharged from the hospital to Resident 1's elderly family member's home due to not having other options. Resident 1 did not receive a 30 day written notice regarding the discharge from the facility. Additionally, the provider did not ensure a living arrangement suitable to meet Resident 1's needs was obtained prior to discharge from the facility.

Findings Include:

On 06/20/2023, the department received a complaint regarding transfer and discharge concerns.

On 06/26/2023 at 8:30 A.M., Surveyor entered the facility to conduct an onsite visit. Upon entering, Surveyor interviewed Administrative Assistant C. Administrative Assistant C indicated Resident 1 was no longer residing in the facility. Administrative Assistant C stated s/he was unsure where Resident 1 was moved to but LPN (Licensed Practical Nurse) B would know. Surveyor requested Resident 1's closed record information.

On 06/26/2023, Surveyor reviewed Resident 1's

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closed record. Resident 1 was admitted to the facility on 08/07/2017 with the following diagnoses: altered mental status, multiple sclerosis, alcohol dependence with unspecified alcohol-induced disorder, Wernicke's encephalopathy, anxiety disorder, and unspecified dementia without behavioral disturbance.

Observation notes for Resident 1 included the following:

On 06/17/2023, "Call placed to [hospital] ED [Emergency Department] inquiring on the status of [Resident 1]. [Hospital charge nurse] advised that [Resident 1] is cleared to return. Writer stated to [charge nurse] that it is not a safe discharge and the facility is not equipped to quarantine [Resident 1] from the rest of the residents..."

On 06/17/2023, "Reached out to [hospital staff] to let [them] know that we are unable to accept resident back at this time. [S/he] continuously came back with [Resident 1] is medically cleared to go back and the ED is not the place for [Resident 1]...I told [him/her] that per MD [Medical Doctor] orders and safety that [s/he] is not to be returned...I also reached out to the facility and informed them that [s/he] is not to be returned to facility. If [s/he] were to return to the facility not to accept the transfer per MD orders."

On 06/17/2023, "Received phone calls from [hospital staff]. Writer contacted the guardian to let [him/her] know that the ED needs to discharge and that we can't have [Resident 1] at the facility at this time. Guardian stated that [s/he] will get ahold of the [family member] to pick [Resident 1] up from ED. Guardian aware that resident can not

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come in the facility for safety reasons..."

On 06/17/2023, "Received phone call that resident's [family member] was at the facility. [Family member] indicated [s/he] was picking things up...[S/he] kept stating to writer and staff that no one was available to take care of [Resident 1] in the family and that whatever happened wasn't [Resident 1's] fault..."

On 06/19/2023, "Met with APS [Adult Protective Services] in regards to placement outside of this facility due to the "not safe discharge." Gave them details of the incident that happened. [Resident 1's family member] is taking [his/her] things out of [his/her] room..."

On 06/27/2023 at 12:55 P.M., Surveyor interviewed APS Worker D. APS Worker D indicated Resident 1 was discharged from hospital to 93 year old family member's home. APS Worker D stated the hospital insisted someone needed to pick up Resident 1 and the facility was refusing so family had to come and pick up Resident 1. APS Worker D stated as of today, Resident 1 was still residing with family member.

On 06/27/2023 at 8:45 A.M., Surveyor interviewed Administrator A. Administrator A verified the facility refused to take Resident 1 back due to the incident that occurred and unsafe behaviors towards staff and residents. Administrator A stated Resident 1's primary physician called the ED and requested a psychiatric evaluation and told the hospital the facility would not be taking Resident 1 back. The hospital did not follow through on the psychiatric evaluation and insisted Resident 1 needed to be transferred back to the facility. Administrator A

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N 326	Continued From page 4 stated Resident 1's physician stated, "absolutely not taking [him/her] back." Resident 1's physician felt Resident 1 needed a gero-psych unit to stabilize behaviors. Administrator A verified a 30 day written advanced notice was not issued to Resident 1 or the legal responsible party prior to the discharge from the facility.	N 326		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 (Resident 3) resident reviewed was free from sexual abuse. On 06/16/2023, Resident 1 was found in Resident 3's bed fondling Resident 3's genitalia and kissing Resident 3. Findings Include: On 06/20/2023, the department received a complaint regarding an allegation of sexual assault. On 06/20/2023, the department also received a facility self report regarding Resident 1 and	N 348		

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Resident 3. The reason for self report was "suspected non-consensual sexual contact" which happened on 06/16/2023. The report stated, "See attached incident reports." The attached incident reports stated, "A facility observation note dated 06/17/2023 at 12:23 A.M. stated, 'Late Entry: Received call from Executive Administrator at 1908 and asked to go to facility to investigate a possible non-consensual sexual incident involving resident. Upon my arrival to facility resident was standing with staff outside of [Resident 3's] room. [S/he] was refusing to go back to [his/her] room. Writer was able to get [him/her] back to [his/her] room. Writer didn't notice any obvious blood or fluids on [his/her] hands or clothing. Staff informed writer that at 1835 when entering [Resident 3's] room they found [Resident 1] sitting on [his/her] bed with [his/her] torso over [him/hers], [Resident 3's] brief was opened and [his/her] shirt pushed up. Staff asked [Resident 1] what [s/he] was doing and [s/he] got up and exited room. Staff noted small amount of blood on brief. During writer's time in the building, [Resident 1] continued to exit [his/her] room and come and sit by writer. [Resident 1] asked writer if [s/he] was going to go to jail, I responded that I didn't know and asked if [s/he] did something. [Resident 1] responded that I just [performed sexual act] and kissed [Resident 3]. [Resident 1] made several remarks to writer that [s/he] 'wanted to play with you... do you like being played with.' Writer advised that conversation was inappropriate and [s/he] needed to stop. [Resident 1] then asked writer if I was [homosexual]. Writer placed call to [Resident 1's primary physician] to inform of incident. [S/he] stated that we wanted resident sent to ER for evaluation due to hypersexual behaviors, have just started in past 3-4 days and [s/he] wanted to rule out any physiological causes. Also advised

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that [s/he] needed to be seen by [hospital] Psych as [s/he] is a patient of theirs. Writer called 911 and asked for ambulance transfer to [hospital] ER [emergency room] as [Resident 3] is at [hospital] ER. Ambulance arrived and taken to [hospital] ER. Awaiting update.'"

On 06/26/2023 at 8:30 A.M., Surveyor entered the facility to conduct an onsite visit. Upon entering, Surveyor interviewed Administrative Assistant C. Administrative Assistant C indicated Resident 1 and Resident 3 were no longer residing in the facility. Surveyor requested Resident 1's and Resident 3's closed record information.

RESIDENT 1
On 06/26/2023, Surveyor reviewed Resident 1's closed record. Resident 1 was admitted to the facility on 08/07/2017 with the following diagnoses: altered mental status, multiple sclerosis, alcohol dependence with unspecified alcohol-induced disorder, Wernicke's encephalopathy, anxiety disorder, and unspecified dementia without behavioral disturbance. Resident 1 had a POA (Power of Attorney) with an activated date of 07/18/2017. Resident 1's most recent ISP dated 08/26/2022 stated Resident 1 was independent with toileting, transferring, ambulating and dressing with some standby assistance for cueing. The ISP (Individualized Service Plan) indicated Resident 1 was a point of rescue due to severe cognitive impairment, and could be uncooperative with cares and redirection. The ISP also indicated Resident 1 was to receive complete supervision and constant monitoring and cuing to avoid/prevent self abusive behavior related to a messy unkept appearance at times. Additionally, the ISP indicated Resident 1 needed much

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encouragement to get out of bed, change clothes, shower, and go to meals and activities. Resident 1 was discharged from the facility on 06/17/2023.

RESIDENT 3
On 06/26/2023, Surveyor reviewed Resident 3's closed record. Resident 3 was admitted to the facility on 05/26/2020 with the following diagnoses: unspecified dementia with behavioral disturbance and hypothyroidism. Resident 3 had an activated POA. Resident 3's most recent ISP dated 05/02/2023 indicated Resident 3 required staff assistance for dressing, bathing, eating, toileting and transfers. Resident 3 required a hoyer lift for transfers and used a broda chair. Resident 3 was discharged from the facility on 06/21/2023.

A facility observation note for Resident 3 dated 06/17/2023 at 12:04 A.M., stated, "Late Entry: Received call from Executive Director at 1908 and asked to into facility to investigate a possible non-consensual sexual act involving resident. Arrived at facility at 1920, spoke with staff who were standing by residents door, with [Resident 1] who was close to [Resident 3's] door. Writer got [Resident 1] to go to [his/her] room, advised staff that we need to keep eyes on [him/her] at all times. Writer also advised staff to contact hospice immediately. Call was placed by care staff. Writer entered [Resident 3's] room and informed [him/her] who I was. Staff showed me the brief that [Resident 3] was wearing and writer noted small amount of blood in brief. Writer did gentle visual exam of genital area and noted pink irritated skin near [genital] area. No blood noted in area or on brief, no scratches or bruising noted to visible skin. [Resident 3] was calm at this time. Per staff report they found [Resident 1] at 1835 sitting next to [Resident 3] on [his/her] bed with

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[his/her] torso over [his/her] and [s/he] was kissing [him/her]. At 1929 writer called law enforcement to report incident. [Resident 1] did tell writer that [s/he] was just kissing and [sexual act] [him/her]. Hospice on site at 2029 and advised writer after their exam that they noted fresh bleeding size of silver dollar in brief...family to notify of incident...[Resident 3] to be sent out for SANE [Sexual Assault Nurse Examiner] exam, ambulance called per Officer on site..."

On 06/29/2023, Surveyor obtained the Sheriff's office incident report. The incident continues to be under investigation with charges being referred to the District Attorney's office.

On 06/26/2023 at 9:00 A.M., Surveyor interviewed LPN (Licensed Practical Nurse) B. LPN B verified the incident on 06/16/2023 between Resident 1 and Resident 3. Resident 1 recently had an increase in sexual comments and behaviors towards staff. LPN B stated on 06/16/2023 s/he had reached out to Resident 1's POA (Power of Attorney) to discuss the increase in sexual behaviors and the potential for 1:1 supervision. Resident 1's POA had indicated s/he was going to step down. LPN B had indicated s/he had told staff they needed to keep an eye on Resident 1 at all times, but verified there was no 1:1 staff assigned to Resident 1 after the phone call with Resident 1's POA.

On 06/26/2023 at 11:15 A.M., Surveyor interviewed Caregiver E. Caregiver E indicated s/he was working the evening of 06/16/2023 when the incident between Resident 1 and Resident 3 occurred. Caregiver E stated s/he was going into Resident 3's room to give Resident 3 medications. When Caregiver E entered room, s/he observed Resident 1 sitting on Resident 3's

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bed leaning over Resident 3. Caregiver E asked Resident 1 what s/he was doing in the room. Resident 1 got up and came charging at Caregiver E and as Caregiver E backed up out of room, Resident 1 also came out of room. Caregiver E stated another staff member came to help and escort Resident 1 to his/her bedroom. Caregiver E stated s/he then entered Resident 3's room to give medications and noticed Resident 3 had brief off, shirt pulled off and was in the fetal position. Caregiver E stated s/he observed a small amount of blood in Resident 3's brief. Caregiver E stated s/he started to cry when s/he realized what had happened. Caregiver E stated s/he was aware of Resident 1's recent increase in sexual comments and behaviors. Caregiver E stated s/he was told by previous shift "to keep eyes on Resident 1 at all times" and to keep all doors locked. Caregiver E stated Resident 1 did not have a 1:1 caregiver that evening, the facility was short staffed and Caregiver E had already worked a double shift that day. Caregiver E stated Resident 1 should have had a 1:1 and this wouldn't have happened. Caregiver E stated Resident 3's door was not locked because a staff member had just left Resident 3's room due to providing incontinence cares.

On 06/27/2023 at 8:45 A.M., Surveyor interviewed Administrator A. Administrator A acknowledged s/he was aware of the incident between Resident 1 and Resident 3. Administrator A stated s/he was aware Resident 1 was making inappropriate sexual comments towards staff, however, didn't realize how bad it was. Administrator A stated s/he was called the night of the incident between Resident 1 and Resident 3 and while on the phone with staff, s/he could hear Resident 1 talking and constantly making inappropriate sexual comments towards

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staff. Administrator A stated this was not normal for Resident 1. Administrator A stated staff never reported Resident 1 going after any other residents, other then Resident 2 but that relationship was consensual. Administrator A stated prior to incident with Resident 3, staff were told to know Resident 1's whereabouts at all times. Administrator A stated after the incident, staff were instructed to be 1:1 with Resident 1, lock all doors and keep everyone else in their rooms. Administrator A stated s/he called Director of Training H to go to the facility to investigate what happened.

On 06/27/2023 at 12:30 P.M., Surveyor interviewed Director of Training H. Director of Training H verified s/he received a call from Administrator A to go to facility to investigate allegation of sexual assault. Director of Training H stated s/he is usually behind the scenes but has heard of concerns about Resident 1 having an increase in sexual behaviors recently. Director of Training H indicated when s/he arrived at the facility, two staff were outside of Resident 3's room and Resident 1 was standing with them. Director of Training H instructed Resident 1 to go to his/her room and after a few minutes, Resident 1 did. Director of Training H stated s/he then entered Resident 3's room and did a very brief, gentle exam on Resident 3 and noticed a small silver dollar size spot of blood on sheet. Director of Training H then called hospice and 911 and provided 1:1 supervision on Resident 1 the rest of the night. Director of Training H stated while providing 1:1 with Resident 1, Resident stated, "I was just [sexual act] [Resident 3] and kissing [Resident 3]." Director of Training H stated that prior to incident, Resident 1 was to be closely supervised but not specifically a 1:1. "If [Resident 1] was on a true 1:1, [s/he] absolutely shouldn't

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N 348	Continued From page 11 have been in [Resident 3's] room." In summary, Resident 1 had increased sexual comments and behaviors starting on 06/14/2023. On 06/16/2023, Resident 1 was found in Resident 3's room performing a sexual act. The provider did not provide services to manage the increase in sexual comments and behaviors. Resident 3 was sexually assaulted by Resident 1. Cross Reference N0433 DHS 83.38(1)(i) Behavior Management	N 348		
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	N 383		

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N 383	Continued From page 12 make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 (Residents 1 and 2) residents reviewed were assessed for interpersonal relationships between each other. Resident 1 was admitted to the facility on 08/07/2017. Resident 1 was discharged from the facility on 06/17/2023. Resident 1's closed record did not contain documentation of an assessment to consent to a consensual sexual relationship with another resident. Resident 2 was admitted to the facility on 03/23/2021. Resident 2's record did not contain documentation of an assessment to consent to a consensual sexual relationship with another resident. Findings Include: On 06/20/2023, the department received a complaint regarding an allegation of sexual assault. On 06/26/2023 at 8:30 A.M., Surveyor conducted an onsite visit to the facility. Upon entrance, Administrative Assistant C stated Resident 1 was no longer residing at the facility. Surveyor requested Resident 1's closed record.	N 383		

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N 383	Continued From page 13 On 06/26/2023 at 9:00 A.M., Surveyor interviewed LPN B. LPN B verified the incident involving the allegation of sexual assault. LPN B stated Resident 1 was having an increase in sexual behaviors towards staff but nothing towards residents. LPN B stated Resident 1 was residing at the facility for several years and in the past has had a "consensual" relationship with Resident 2. LPN B stated that over the last few months, the relationship with Resident 1 and 2 had diminished. Surveyor requested Residents 1 and 2's assessments for consent to this consensual sexual relationship. LPN B stated the relationship between Resident 1 and 2 was prior to LPN B starting at the facility. LPN B stated Administrator A or Director of Training H might know more information about that because they were here when Resident 1 and 2 were admitted to the facility. Surveyor requested Resident 2's resident record. On 06/26/2023, Surveyor reviewed Resident 1's closed record. Resident 1 was admitted to the facility on 08/07/2017 with the following diagnoses: altered mental status, multiple sclerosis, alcohol dependence with unspecified alcohol-induced disorder, Wernicke's encephalopathy, anxiety disorder, and unspecified dementia without behavioral disturbance. Resident 1 had a POA (Power of Attorney) with an activated date of 07/18/2017. Resident 1 was discharged from the facility on 06/17/2023. Resident 1's closed record did not contain an assessment to consent to a sexual relationship with another resident. On 06/26/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 03/23/2021 with the following diagnoses: Von Willebrand's disease (bleeding disorder), anxiety	N 383		

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disorder, panic disorder and dementia. Resident 2 had a POA with an activated date of 07/24/2020. Resident 2's record did not contain an assessment to consent to a sexual relationship with another resident.

On 06/26/2023 at 10:00 A.M., Surveyor interviewed Caregiver F. Caregiver F stated s/he mostly works 1st shift and has been employed at the facility for over a year. Caregiver F stated s/he was familiar with Resident 1. Caregiver F indicated Resident 1 "didn't give us too much trouble." Caregiver F stated that most of the time Resident 1 would sit on the couch in common areas during his/her shift. Caregiver F stated a week or so ago, Resident 1 started to get more "touchy" with staff, using inappropriate language with staff and telling staff what s/he wanted to do to them sexually. Caregiver F stated that Resident 1 "poked" Caregiver F's butt and Caregiver F told Resident 1 not to do that again. Caregiver F then described an event that took place on 06/14/2023 between Resident 1 and Resident 2. Caregiver F stated that staff found Resident 2 in Resident 1's bed, Resident 2's pants were off and shirt remained. Resident 1 took off out of the room when staff arrived. Caregiver F stated when s/he arrived to room Resident 2 was holding genital area. Caregiver F stated s/he helped Resident 2 back to his/her room and cleaned up. Caregiver F stated that Resident 2 can not take any of their clothes off by self. Caregiver F stated Resident 1 and Resident 2 "used to be a couple." Caregiver F indicated Resident 2 is not able to comprehend directions, Resident 2 will just mumble when you attempt to ask questions.

On 06/26/2023 at 10:30 A.M., Surveyor interviewed Caregiver G. Caregiver G stated s/he

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N 383	Continued From page 15 primarily works 1st shift and has been at the facility for 4 or 5 months. Caregiver G indicated s/he was familiar with Resident 1 and Resident 2. Caregiver G stated s/he had heard from other staff that Resident 1 and Resident 2 had a relationship in the past. Caregiver G stated the other day Resident 2 was found in Resident 1's bed. Resident 2's pants were off but shirt was on. Caregiver G indicated Resident 1 turned around and walked out of room. Caregiver G stated Resident 2 is not capable of undressing self, needs assistance with dressing and toileting. Caregiver G stated when assisting Resident 2, Resident 2 will say "no" and be resistive to cares. Caregiver G stated staff got Resident 2 back to his/her room, cleaned Resident 2 up and Resident 2 was back to self. Caregiver G stated Resident 1 is on 15 minute checks. On 06/27/2023 at 8:45 A.M., Surveyor interviewed Administrator A. Administrator A stated s/he did Resident 1's admission assessment and verified Resident 1 and Resident 2 did have a consensual relationship. Administrator A stated at first it was just sitting together and holding hands but then progressed to more sexual acts. Administrator A stated Resident 2 started to initiate more encounters with Resident 1. Administrator A stated both Resident 1 and Resident 2 were in agreement with relationship, both families were also ok with it. Administrator A stated Resident 2's family would say, "that's [Resident 2], that's the way [s/he] has been all [his/her] life." Administrator A stated Resident 2 doesn't answer questions correctly, Resident 2 is worse now, s/he can't carry a conversation. Administrator A stated s/he did not have a formal assessment for Resident 1 or Resident 2 to consent to a sexual relationship, "it was more just talking with family."	N 383		

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N 383	Continued From page 16 Administrator A stated it looked like the relationship stopped for awhile because s/he was not hearing about it. Administrator A stated s/he didn't know how to mark the relationship in the ISP (individual service plan) thus staff were not instructed on how to handle the situation when Resident 1 and Resident 2 were together. Administrator A stated if Resident 2 was initiating contact with Resident 1, then we "failed because didn't chart it and let it go." Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually, or On Changes	N 383		
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 ensure the ISP (individual service plan) was revised annually or upon a change in a resident's needs, abilities, or physical or mental condition for 2 of 2 (Residents 1 and 2) residents	N 389		

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reviewed.

Resident 1 and Resident 2 were having a sexual relationship. Neither Resident 1's nor Resident 2's ISP contained documentation of the sexual relationship with each other.

Findings Include:

On 06/20/2023, the department received a complaint regarding an allegation of sexual assault.

On 06/26/2023 at 8:30 A.M., Surveyor conducted an onsite visit to the facility. Surveyor requested Resident 1's closed record and Resident 2's record.

On 06/26/2023 at 9:00 A.M., Surveyor interviewed LPN B. LPN B stated Resident 1 was residing at the facility for several years and in the past has had a "consensual" relationship with Resident 2. LPN B stated that over the last few months, the relationship with Resident 1 and 2 had diminished. Surveyor requested Resident 1 and 2's assessment for consent to this consensual sexual relationship along with their ISP's. LPN B stated the relationship between Resident 1 and 2 was prior to LPN B starting at the facility. LPN B stated Administrator A or Director of Training H might know more information about that because they were here when Resident 1 and 2 were admitted to the facility.

Surveyor reviewed Resident 1's closed record. Resident 1 was admitted to the facility on 08/07/2017 with the following diagnoses: altered mental status, multiple sclerosis, alcohol dependence with unspecified alcohol-induced

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N 389	Continued From page 18 disorder, Wernicke's encephalopathy, anxiety disorder, and unspecified dementia without behavioral disturbance. Resident 1 had a POA (Power of Attorney) with an activated date of 07/18/2017. Resident 1's most recent ISP dated 08/26/2022 stated Resident 1 was independent with toileting, transferring, ambulating and dressing with some standby assistance for cueing. The ISP indicates Resident 1 is a point of rescue due to severe cognitive impairment, can be uncooperative with cares and redirection. The ISP also indicates Resident 1 is to receive complete supervision and constant monitoring and cuing to avoid/prevent self abusive behavior related to a messy unkept appearance at times. Additionally, the ISP indicates Resident 1 needs much encouragement to get out of bed, change clothes, shower, go to meals and activities. Resident 1's ISP did not contain documentation of sexual relationship with Resident 2. Resident 1 was discharged from the facility on 06/17/2023. Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 03/23/2021 with the following diagnoses: Von Willebrand's disease (bleeding disorder), anxiety disorder, panic disorder and dementia. Resident 2 had a POA with an activated date of 07/24/2020. Resident 2's most recent ISP dated 05/27/2023 stated Resident 2 was independent with ambulation and transfers, however requires one assist for dressing, bathing, and toileting. The ISP indicates Resident 2 is a point of rescue due to confusion and requiring staff's verbal guidance to safely evacuate the facility. The ISP also indicates Resident 2 can be verbally aggressive with other residents at times. Resident 2's ISP did not contain documentation of sexual relationship with Resident 1.	N 389		

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N 389	Continued From page 19 On 06/27/2023 at 8:45 A.M., Surveyor interviewed Administrator A. Administrator A stated s/he did Resident 1's admission assessment and verified Resident 1 and Resident 2 did have a consensual relationship. Administrator A stated at first it was just sitting together and holding hands but then progressed to more sexual acts. Administrator A stated Resident 2 started to initiate more encounters with Resident 1. Administrator A stated both Resident 1 and Resident 2 were in agreement with relationship, both families were also ok with it. Administrator A stated Resident 2's family would say, "that's [Resident 2], that's the way [s/he] has been all [his/her] life." Administrator A stated s/he didn't know how to mark the relationship in the ISP (individual service plan) thus staff were not instructed on how to handle the situation when Resident 1 and Resident 2 were together. Administrator A stated if Resident 2 was initiating contact with Resident 1, then we "failed because didn't chart it and let it go." Cross Reference N0383 DHS 83.35(1)(c) Listed Areas For Assessment	N 389		
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.	N 433		

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N 433	Continued From page 20 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure services were provided to 1 of 1 (Resident 1) residents reviewed to manage the resident's behaviors that may be harmful to themselves or others. Resident 1 was noted to have an increase in sexual comments and actions on 06/14/2023. On 06/16/2023, Resident 1 was found in Resident 3's room. Resident 1 had indicated to staff s/he had fondled Resident 3's genitalia. Resident 1's closed record did not contain any documentation of interventions that were put in place to protect residents when behaviors initiated on 06/14/2023. Findings Include: On 06/20/2023, the department received a complaint regarding an allegation of sexual assault. On 06/26/2023 at 8:30 A.M., Surveyor entered the facility to conduct an onsite visit. Upon entering, Surveyor interviewed Administrative Assistant C. Administrative Assistant C indicated Resident 1 was no longer residing in the facility. Surveyor requested Resident 1's closed record information. On 06/26/2023, Surveyor reviewed Resident 1's closed record. Resident 1 was admitted to the facility on 08/07/2017 with the following diagnoses: altered mental status, multiple sclerosis, alcohol dependence with unspecified alcohol-induced disorder, Wernicke's encephalopathy, anxiety disorder, and unspecified dementia without behavioral disturbance. Resident 1 had a POA (Power of	N 433		

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Attorney) with an activated date of 07/18/2017. Resident 1's most recent ISP dated 08/26/2022 stated Resident 1 was independent with toileting, transferring, ambulating and dressing with some standby assistance for cueing. The ISP indicates Resident 1 is a point of rescue due to severe cognitive impairment, can be uncooperative with cares and redirection. The ISP also indicates Resident 1 is to receive complete supervision and constant monitoring and cuing to avoid/prevent self abusive behavior related to a messy unkept appearance at times. Additionally, the ISP indicates Resident 1 needs much encouragement to get out of bed, change clothes, shower, go to meals and activities. Resident 1's ISP did not contain documentation of sexual behaviors, including comments or actions, and interventions for staff to utilize when Resident 1 expressed the sexual behaviors.

Facility observation notes for Resident 1 stated the following:

On 06/14/2023, "As writer was passing out meds to another resident the resident walked pass me an poked at my butt I then swiped [his/her] hand away then said out loud "don't do that." So resident then turns around an say 'or WHAT' so writer then say back 'I will tell my boss on you.' The resident continued to proceed towards me saying, 'So what so what.' Then finally turned around an walked to [his/her] room."

On 06/14/2023 at 9:48 P.M., "We were trying to locate [Resident 2] and when we did find [him/her] [s/he] was inside of [Resident 1's] room in [his/her] bed. [Resident 1] initiated inappropriate behaviors."

On 06/14/2023 at 9:55 P.M., "Resident lead

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N 433	Continued From page 22 [Resident 2] into [his/her] room and performed oral on [Resident 2] and proceeded to do other inappropriate things." On 06/15/2023 at 6:53 P.M., "Resident walked up to writer and grabbed writer's private area. [S/he] stated [s/he] hate writer." On 06/15/2023 at 7:15 P.M., "Resident was found in [Resident 2's] bathroom. [Resident 2] was found with no pants or brief on. When writer asked [Resident 1] to leave [Resident 2's] room, [s/he] seemed to get angry and tried to push writer, writer then called for help, as another caregiver approached [Resident 1] grabbed [his/her] groin and walked away. On call nurse was notified, and all Iris doors are locked. 15 minute checks to be continued." On 06/15/2023 at 9:41 P.M., "When writer went in to do cares resident was using the toilet, resident turned around and started to reach and boxed writer in the bathroom. [Resident 1] being very sexual towards the employees." On 06/15/2023 at 9:50 P.M., "Resident was very aggressive and sexual towards another resident and other caregivers. [Resident 1] asked me to pull my pants down when I went into [his/her] room to do [his/her] cares." On 06/16/2023 at 5:42 A.M., "Resident very aggressive and sexual toward any resident and staff [s/he] came into contact with. When writer was walking back to wing [s/he] approached and said, 'you're very pretty can I have a kiss' and got very close. When writer stepped back and said no resident stated, 'what if I attack you' and then laughed and walked away. Resident had to be redirected back to [his/her] room almost the entire	N 433		

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night."

On 06/16/2023 at 2:31 P.M., "Spoke with [nurse at physician's office] regarding the increase in sexual behavior towards staff and other residents. 1:1 and constant supervision to be done by staff. Awaiting response from [physician]. POA updated on behaviors."

On 06/16/2023 at 9:16 P.M., "POA updated regarding a sexual incident with another resident..."

On 06/16/2023 at 10:13 P.M., "I writer witnessed [Resident 1] grope [another resident] breast, I told [him/her] [s/he] need to stop and move away from [him/her], [s/he] was visibly upset, when I asked [Resident 2] to move, [s/he] asked can [s/he] touch me, I said no and [s/he] grabbed my butt..."

On 06/17/2023 at 12:23 A.M., "Late Entry: Received call from Executive Administrator at 1908 and asked to go to facility to investigate a possible non-consensual sexual incident involving resident. Upon my arrival to facility resident was standing with staff outside of [Resident 3's] room. [s/he] was refusing to go back to [his/her] room. Writer was able to get [him/her] back to [his/her] room. Writer didn't notice any obvious blood or fluids on [his/her] hands or clothing. Staff informed writer that at 1835 when entering [Resident 3's] room they found [Resident 1] sitting on [his/her] bed with [his/her] torso over [him/hers], [Resident 3's] brief was opened and [his/her] shirt pushed up. Staff asked [Resident 1] what [s/he] was doing and [s/he] got up and exited room. Staff noted small amount of blood on brief. During writers time in the building, [Resident 1] continued to exit [his/her] room and come and sit by writer. [Resident 1] asked writer if

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[s/he] was going to go to jail, I responded that I didn't know and asked if [s/he] did something. [Resident 1] responded that I just [performed sexual act] and kissed [Resident 3]. [Resident 1] made several remarks to writer that [s/he] "wanted to play with you" "do you like being played with." Writer advised that conversation was inappropriate and [s/he] needed to stop. [Resident 1] then asked writer if I was [homosexual]. Writer placed call to [Resident 1's primary physician] to inform of incident. [S/he] stated that we wanted resident sent to ER for evaluation due to hypersexual behaviors have just started in past 3-4 days and [s/he] wanted to rule out any physiological causes. Also advised that [s/he] needed to be seen by [hospital] Psych as [s/he] is a patient of theirs. Writer called 911 and asked for ambulance transfer to [hospital] ER [emergency room] as [Resident 3] is at [hospital] ER. Ambulance arrived and taken to [hospital] ER. Awaiting update."

Resident 1 was discharged from the facility on 06/17/2023.

On 06/26/2023 at 9:00 A.M., Surveyor interviewed LPN (Licensed Practical Nurse) B. LPN B verified the incident on 06/16/2023 between Resident 1 and Resident 3. LPN B stated there was a history of a relationship with Resident 1 and Resident 2, but it was consensual. The relationship with them had been diminishing recently. Resident 1 recently had an increase in sexual comments and behaviors towards staff. LPN B stated on 06/16/2023 s/he had reached out to Resident 1's POA (Power of Attorney) to discuss the increase in sexual behaviors and the potential for 1:1 supervision. Resident 1's POA had indicated s/he was going to step down. LPN B had indicated s/he had told

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	0015841	A. BUILDING: _____ B. WING _____	R-C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 2	1901 LIBAL STREET GREEN BAY, WI 54301

(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
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staff they needed to keep an eye on Resident 1 at all times, but verified there was no 1:1 staff assigned to Resident 1 after the phone call with Resident 1's POA. LPN B stated after the incident with Resident 1 and Resident 3, Resident 4 came to LPN B and told him/her about Resident 1 entering Resident 4's room and Resident 4 had to push Resident 1 out. LPN B stated Resident 4 was not able to give a date or time, but did indicate it was Resident 1 who entered the room.

On 06/26/2023 at 10:50 A.M., Surveyor interviewed Resident 4. Resident 4 stated last week a resident wandered into his/her room. Resident 4 stated "[S/he] wanted to kiss me." Resident 4 pushed the resident out of his/her room and locked his/her door. Resident 4 stated s/he wasn't sure the name of the resident but the resident isn't at the facility anymore. Resident 4 stated s/he told facility staff about the incident and they know who the resident was. "They got on it right away...I was happy they got on it so fast."

On 06/26/2023 at 10:00 A.M., Surveyor interviewed Caregiver F. Caregiver F stated s/he mostly works 1st shift and has been employed at the facility for over a year. Caregiver F stated s/he was familiar with Resident 1. Caregiver F indicated Resident 1 "didn't give us too much trouble." Caregiver F stated that most of the time Resident 1 would sit on the couch in common areas during his/her shift. Caregiver F indicated Resident 1 was able to ambulate and transfer independently without the assistance of staff. Caregiver F stated a week or so ago, Resident 1 started to get more "touchy" with staff, using inappropriate language with staff and telling staff what s/he wanted to do to them sexually. Caregiver F stated that Resident 1 "poked" Caregiver F's butt and Caregiver F told Resident

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1 not to do that again. Caregiver F then described an event that took place on 06/14/2023 between Resident 1 and Resident 2. Caregiver F stated that staff found Resident 2 in Resident 1's bed, Resident 2's pants were off and shirt remained. Resident 1 took off out of the room when staff arrived. Caregiver F stated when s/he arrived to room Resident 2 was holding genital area. Caregiver F stated s/he helped Resident 2 back to his/her room and cleaned up. Caregiver F stated that Resident 2 can not take any of their clothes off by self. Caregiver F stated Resident 1 and Resident 2 "used to be a couple." Caregiver F indicated Resident 2 is not able to comprehend directions, Resident 2 will just mumble.

On 06/26/2023 at 10:30 A.M., Surveyor interviewed Caregiver G. Caregiver G stated s/he primarily works 1st shift and has been at the facility for 4 or 5 months. Caregiver G indicated s/he was familiar with Resident 1 and Resident 2. Caregiver G stated s/he had heard from other staff that Resident 1 and Resident 2 had a relationship in the past. Caregiver G stated the other day Resident 2 was found in Resident 1's bed. Resident 2's pants were off but shirt was on. Caregiver G indicated Resident 1 turned around and walked out of room. Caregiver G stated Resident 2 is not capable of undressing self, needs assistance with dressing and toileting. Caregiver G stated when assisting Resident 2, Resident 2 will say "no" and be resistive to cares. Caregiver G stated staff got Resident 2 back to his/her room, cleaned Resident 2 up and Resident 2 was back to self. Caregiver G stated Resident 1 is on 15 minute checks. Caregiver G stated they communicate resident needs at shift change.

On 06/26/2023 at 11:15 A.M., Surveyor

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N 433	Continued From page 27 interviewed Caregiver E. Caregiver E indicated s/he was working the evening of 06/16/2023 when the incident between Resident 1 and Resident 3 occurred. Caregiver E stated s/he was going into Resident 3's room to give Resident 3 medications. When Caregiver E entered room, s/he observed Resident 1 sitting on Resident 3's bed leaning over Resident 3. Caregiver E asked Resident 1 what s/he was doing in the room. Resident 1 got up and came charging at Caregiver E and as Caregiver E backed up out of room, Resident 1 also came out of room. Caregiver E stated another staff member came to help and escort Resident 1 to his/her bedroom. Caregiver E stated s/he then entered Resident 3's room to give medications and noticed Resident 3 had brief off, shirt pulled off and was in the fetal position. Caregiver E stated s/he observed a small amount of blood in Resident 3's brief. Caregiver E stated s/he started to cry when s/he realized what had happened. Caregiver E stated s/he was aware of the relationship between Resident 1 and Resident 2 and Resident 1's recent increase in sexual comments and behaviors. Caregiver E stated s/he was told by previous shift "to keep eyes on Resident 1 at all times" and to keep all doors locked. Caregiver E stated Resident 1 did not have a 1:1 caregiver that evening, the facility was short staffed and Caregiver E had already worked a double shift that day. Caregiver E stated Resident 1 should have had a 1:1 and this wouldn't have happened. Caregiver E stated Resident 3's door was not locked because a staff member had just left Resident 3's room. On 06/27/2023 at 8:45 A.M., Surveyor interviewed Administrator A. Administrator A acknowledged s/he was aware of the incident between Resident 1 and Resident 3.	N 433		

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N 433	Continued From page 28 Administrator A stated s/he was aware Resident 1 was making inappropriate sexual comments towards staff, however, didn't realize how bad it was. Administrator A stated s/he was called the night of the incident between Resident 1 and Resident 3 and while on the phone with staff, s/he could hear Resident 1 talking and constantly making inappropriate sexual comments towards staff. Administrator A stated this was not normal for Resident 1. Administrator A stated never reported Resident 1 going after any other residents, other then Resident 2 but that relationship was consensual. Administrator A stated prior to incident with Resident 3, staff were told to know Resident 1's whereabouts at all times. Administrator A stated after the incident, staff were instructed to be 1:1 with Resident 1, lock all doors and keep everyone else in their rooms. Administrator A stated s/he called Director of Training H to go to the facility to investigate what happened. On 06/27/2023 at 12:30 P.M., Surveyor interviewed Director of Training H. Director of Training H verified s/he received a call from Administrator A to go to facility to investigate allegation of sexual assault. Director of Training H stated s/he is usually behind the scenes but has heard of concerns about Resident 1 having an increase in sexual behaviors recently. Director of Training H indicated s/he had heard of relationship with Resident 1 and Resident 2 second hand and was told it was a consensual relationship. Director of Training H indicated when s/he arrived at the facility, two staff were outside of Resident 3's room and Resident 1 was standing with them. Director of Training H instructed Resident 1 to go to his/her room and after a few minutes, Resident 1 did. Director of Training H stated s/he then entered Resident 3's	N 433		

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N 433	Continued From page 29 room and did a very brief, gentle exam on Resident 3 and noticed a small silver dollar size spot of blood on sheet. Director of Training H then called hospice and 911 and provided 1:1 supervision on Resident 1 the rest of the night. Director of Training H stated while providing 1:1 with Resident 1, Resident stated, "I was just [sexual act] [Resident 3] and kissing [Resident 3]." Director of Training H stated that prior to incident, Resident 1 was to be closely supervised but not specifically a 1:1. "If [Resident 1] was on a true 1:1, [s/he] absolutely shouldn't have been in [Resident 3's] room." In Summary, Resident 1 had increased sexual comments and behaviors starting on 06/14/2023. On 06/16/2023, Resident 1 was found in Resident 3's room performing a sexual act. The provider did not provide services to manage the increase in sexual comments and behaviors to prevent the sexual assault from occurring. Cross Reference N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment	N 433		