STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018641	A. BUILDING: _____ B. WING _____	C 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATURES POINTE	910 WINTER ST EAGLE RIVER, WI 54521

(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 06/24/2025, Surveyor conducted a complaint investigation at Nature's Pointe. Data collection continued through 06/25/2025. The complaint was substantiated. Two deficiencies were identified. One of 2 deficiencies was a repeat deficiency, see statement of deficiency (SOD) HG4011, dated 01/03/2023 Census: 29	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after Resident 1 went to the emergency room on 05/25/2025 after falling and sustaining a head injury. This is a repeat deficiency, cited for the 2nd time. See Statement of Deficiency (SOD) HG4011, dated 01/03/2023. Findings include: The facility is licensed to serve up to 36 residents	N 165		

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

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N 165	Continued From page 1 in the following client groups: emotionally disturbed/mental illness, advanced aged, traumatic brain injury, physically disabled, terminally ill, and irreversible dementia/Alzheimer's. On 03/21/2025, the department received a complaint alleging staffing concerns and care concerns. On 06/24/2025, Surveyor reviewed Resident 1's file. Resident 1 was admitted on 05/30/2024. According to observation notes, dated 05/25/2025 at 4:45 AM, Caregiver B noted, "At approximately 0145 hrs [sic] RA (resident assistant) radioed for assistance in the residents [sic] suite. Upon arrival writer observed the resident laying [sic] on the restroom floor near the shower, [sic] writer observed a pool of blood at the R (right) side of the residents [sic] head. Writer notified Hospice via telephone. Writer and RA assisted resident to [his/her] feet (per Hospice). Writer began to apply pressure to the area of the resident [sic] head that was bleeding awaiting Hospice arrival." According to an incident report, dated 05/25/2025 at 1:45 AM, Caregiver C reported, "Wren [sic] writer entered residents [sic] suite to administer scheduled comfort medication, writer observed the resident laying [sic] on the restroom floor on [his/her] right side. Writer radioed for assistance, [sic] writer and RA attempted to assess for injuries and observed a pool of blood beneath the right side of the residents [sic] head. Hospice was notified via telephone and advised writer to assist the resident to [his/her] feet as the Hospice RN was en route to the community." The incident report noted that Resident 1 was sent to the emergency room on 05/25/2025.	N 165		

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N 165	Continued From page 2 According to an emergency department "After Visit Summary," dated 05/25/2025, Resident 1 was treated for a "Traumatic injury of head" and received 3 sutures and 4 staples in the back of head. On 06/25/2025 at approximately 2:01 PM, Director A verified via e-mail that the provider did not report Resident 1's 05/25/2025 fall to the Department. On 06/25/2025, Surveyor checked Department files. Department files did not contain a self-report for Resident 1's fall on 05/25/2025.	N 165		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by:	Y3244		

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Y3244	Continued From page 3	Y3244		

Based on record review and interview, the provider did not ensure residents received adequate and appropriate care within the capacity of the facility.

Findings include:

The facility is licensed to serve up to 36 residents in the following client groups: emotionally disturbed/mental illness, advanced aged, traumatic brain injury, physically disabled, terminally ill, and irreversible dementia/Alzheimer's disease.

The facility has a secure unit that provides supervision and cares for up to 15 residents and the provider refers to the secure unit as Radiance.

On 03/21/2025, the department received a complaint alleging staffing and care concerns.

On 06/24/2025, Surveyor reviewed the provider's schedule (February 2025 through June 2025). The schedule noted two caregivers consistently worked the NOC (overnight) shift.

On 06/24/2025 at approximately 11:25 AM, Surveyor interviewed Services Director (SD) D. SD D verified the provider's schedule (February 2025 through June 2025). SD D confirmed that two caregivers worked the NOC shift and one of the two caregivers worked on the secure unit during the NOC shift.

On 06/24/2025 at approximately 12:15 PM, Surveyor interviewed Hospice Nurse (HN) E. Surveyor asked HN E about resident care. HN E reported that hospice had 4 to 5 residents at the facility. HN E stated that hospice increased their

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shower aide services for Resident 1. HN E reported that due to care concerns reported by Guardian F, hospice provided additional showers for Resident 1 for a few months prior to Resident 1 dying on 05/30/2025.

On 06/24/2025 at approximately 12:31 PM, Surveyor interviewed Hospice Caregiver (HC) G. Surveyor asked HC G about resident care. HC G reported, "When I visited in the morning, [Resident 1] would be saturated - really wet and not changed when I arrived for visits. I visited at least one time a week for a few months - usually around 8:00 AM." HC G stated that HC G usually visited Resident 1 before breakfast. HC G commented, "I questioned if [Resident 1] was being checked every two hours (because) no one is that wet if they are being checked; the bed would be soaked to the mattress protector." Surveyor asked HC G about staffing. HC G stated that HC G has heard staff talking about being "short staffed" at times. HC G reported, "I feel [NOC] shift didn't check [Resident 1] during [NOC] shift." HC G verified that Resident 1 resided in the secure unit of the facility.

On 06/24/2025 at approximately 2:05 PM, Surveyor interviewed Caregiver H. Surveyor asked about staffing and resident care. Caregiver H indicated that Caregiver H worked the AM shift. Caregiver H stated, "[Caregiver C] is too afraid to wake [Resident 2] during the [NOC] shift because [Resident 2] gets mad and hits." Caregiver H reported that Resident 2 was usually soaked with urine and his/her bedding was soaked when Caregiver H worked the AM shift. Caregiver H commented that Resident 2 would be urine soaked "a lot" when Caregiver H worked. Caregiver H stated that Resident 2 and Resident 3 were a two-person assist with cares and

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transfers (both residents resided in the secure unit of the facility). Caregiver H stated, "It would benefit [Resident 2] if there were a [NOC] (shift) float. S/He lays in his/her urine. [Resident 2] was soaked more than usual today (06/24/2025). [NOC] shift - [Caregiver C] said s/he tried waking [him/her] (Resident 2) at 12:00 AM and 3:00 AM and [Resident 2] didn't get up. [S/HE] was soaked with urine. [S/He] laid from 12:00 AM to 6:15 AM not being toileted." Caregiver H stated, "When I work, most of the time [Resident 2] is soaked through [his/her] pants (and) sometimes [s/he] is soaked through the bed. Sometimes [s/he] sleeps in [his/her] chair and the pad is soaked through the chair. We shampoo the chair if needed."

On 06/24/2025 at approximately 2:50 PM, Surveyor interviewed Caregiver I. Caregiver I reported that s/he worked at the facility for the past year and a half, during the PM shift. Surveyor asked about staffing and resident care. Caregiver I stated, "Residents get confused at times. We redirect residents as needed." Caregiver I reported that Resident 2 and Resident 3 required the assistance of two staff with cares and transfers (in the secure unit of the facility).

On 06/24/2025 at approximately 3:45 PM, Surveyor interviewed Caregiver J. Surveyor asked about staffing and resident care. Caregiver J reported, "About two weeks ago, we came in and [Resident 2] and [Resident 5] were very wet - more than they usually are in the mornings."

On 06/25/2025 at approximately 9:05 AM, Surveyor interviewed Caregiver K via telephone. Caregiver K reported that s/he had worked the NOC shift for the past 10 months. Surveyor asked about staffing and resident care. Caregiver K reported that two staff worked the NOC shift

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and one of the 2 staff worked with the residents in the secure unit and one staff worked the rest of the building. Caregiver K reported that s/he left the secure unit and went to "the other side sometimes to help out." Caregiver K commented that s/he would spend "an hour or so" helping his/her co-worker with residents "on the other side" of the building. Caregiver K reported, "Most nights it is calm and resident behaviors vary." Caregiver K stated, "While I was busy with cares, [Resident 4] went outside this morning around 5:30 AM (06/25/2025). Caregiver K reported, "While I was doing cares in a resident's room, [Resident 4] exited through the dining room door into the fenced-in courtyard and exited through the fence and went to the front of the building. I got done with my cares and heard the door alarm. As I checked to see where [Resident 4] was, s/he was walking into the front of the building. My other co-worker was busy with a water pass on the other side of the building. I feel three staff would be more useful and helpful. We don't really need a third staff from 10:00 PM to 3:00 AM; we could use a third staff person after 3:00 AM to help supervise the wanderers." In addition, Caregiver K stated, "You had to keep an eye on [Resident 1] because s/he urinated quite a bit." Caregiver K commented, "Some residents can be changed and then soil and soak through. I think the residents that are soiling - it would be better to have more staff (and) there was not enough people working during the later part of [NOC] shift because the wandering started happening around 4:00 AM and today (06/25/2025) was the first time [Resident 4] got outside." Caregiver K reported, "We are busy with behaviors and preventing behaviors." Caregiver K stated that Resident 2 and Resident 3 (in the secure unit) required the assistance of two people with cares and transfers.

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Y3244	Continued From page 7 On 06/25/2025 at approximately 11:55 AM, Surveyor interviewed Caregiver C via telephone. Caregiver C reported that s/he had worked the NOC shift for the past 3 years. Caregiver C confirmed that two staff worked the NOC shift. Caregiver C reported, "Things are manageable, but sometimes it gets a little hairy, especially on the dementia unit (secure unit)." Caregiver C reported that there were residents that were fall risks and elopement risks. Caregiver C commented, "It would be nice to have three staff on [NOC] shift." Caregiver C reported that there were residents that "start fighting with you" while trying to provide cares and toileting assistance. Caregiver C stated that Resident 2 and Resident 3 required the assistance of two staff with cares and transfers. Caregiver C reported, "I have to wait sometimes to get help from another caregiver with cares." Caregiver C stated that Resident 6 did not like Caregiver C toileting him/her and sometimes Resident 6 waited to get assistance from a female caregiver. Caregiver C reported that Resident 4 tried to get outside sometimes when Caregiver C worked. The provider did not ensure residents received adequate and appropriate care within the capacity of the facility.	Y3244		