STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 05/21/2024, Surveyors conducted 2 complaint investigations and a verification visit at SV North Nine Acres in Oconto. Additional information was gathered through 06/17/2024. Both complaints were substantiated. As a result of the investigation and verification visit, 13 deficient practices were identified. Two out of thirteen deficient practices were repeat violations. Under statutory provisions, a $200 revisit fee is being assessed for the follow-up licensing visit. Census: 17	{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.	N 158		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure investigations were completed when neglect and potential misappropriation findings were brought to their attention for 2 of 2 residents reviewed (Residents 1 and 2). No investigation was completed when the neglect of Resident 2 was reported. When Resident 1 was found not to have Schedule II medication in his/her system, as was supposed to be by medical provider order, the provider conducted an investigation tailored to the resident being responsible. When the results of the investigation lead to the potential conclusion misappropriation of medication by the employees had taken place, the provider did not complete an investigation into the findings. Findings include: On 05/13/2024, the department received a complaint alleging the provider was not investigating allegations brought to their attention. Resident 2 On 05/21/2024, Surveyor began an investigation into allegations of neglect for Resident 2. Surveyor found no documentation of the provider conducting an investigation into the allegation had taken place. Surveyor conducted interviews regarding the neglect that occurred on the evening of 05/11/2024 into the morning of 05/12/2024 and reviewed associated text message conversations. On 05/29/2024 at 10:20 AM, Surveyor interviewed Caregiver K. Caregiver K discussed	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 2	N 158		

the incident of neglect for Resident 2 and stated after the incident was brought to Manager A and Administrator C's attention, "There was no investigation. Nobody asked me anything about it."

On 05/29/2024 at 11:15 AM, Surveyor interviewed Caregiver I. Caregiver I discussed the incident of neglect of Resident 2 and stated on May 12th at 8:12 AM Manager A texted him/her. Surveyor reviewed the text exchange between Caregiver I and Manager A, dated 05/12/2024 at 8:12 AM:

Manager A- "Did it look like anybody was changed last night? Was [Resident 10] soaked this morning?"

Caregiver I- "[Resident 2] a mess and [Resident 10] soaked." " ... [Resident 2] said [s/he] had a blowout in the middle of the night and [Caregiver O] came in[sic] took [his/her] call light away and left the room so [sic] knows how long [s/he] has been laying in it."

Manager A- "OK, I'm sorry that [explicative] me off because [Resident 2] knows [sic] and [Resident 2] is very smart and with it. I will be talking with [him/her] because that is not what we're gonna [sic] do I don't care how short we are."

Caregiver I- "I know, and you could smell it in the hallway so there's no way you missed the smell in [his/her] room."
During the interview Caregiver I stated, "I never heard anything about it after, there was no investigation. It was just wrong ... if I found my [mom/dad] like that I would have state in here right away."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 3 On 05/29/2024 at 12:00 PM Surveyor interviewed Former Caregiver H. Former Caregiver H stated s/he was employed from 04/18/2024 through 05/12/2024 when s/he left his/her position as a result of the neglect s/he found occurring at the facility. Former Caregiver H stated Manager A was made aware of the incident right away and s/he texted Administrator C. Surveyor reviewed the text conversation between Former Caregiver H and Administrator C (dated 05/13/2024 per interview with Former Caregiver H) at 12:19 PM: Former Caregiver H- "... walking in on Sunday. [Resident 2] was my last person to get up I didn't get [him/her] until 8 when I started walking down [his/her] hallway I could smell BM I had walked into [his/her] room and [s/he] was covered head to toe [sic] and the wall [sic] in [his/her] BM. I had asked why [s/he] didn't use [his/her] call light not realizing [his/her] call light was on [his/her] table over [his/her] chair. [S/he] had said [s/he] had no way of getting ahold of anyone and no one came and checked on [him/her.] I tried my best to wipe [him/her] up but wanted to get [him/her] in the shower regardless. When we were in the shower I asked when [s/he] had the BM whether it was that morning or that night [sic] [s/he] had stated [s/he] did last night after getting into bed. That highly upset me because I could smell it getting closer to [his/her] room so I don't know how night shift couldn't smell it ..." Administrator C - "OK so who worked Saturday night? Responsible for the mess? [Caregiver O]?" Former Caregiver H- "I believe [Manager A] and [Caregiver O][sic] I know came in at 6 [sic][s/he] said it happened that night so whomever put [him/her] into bed it happened shortly after that.	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 4 [Caregiver I] had texted [Manager A] about it. after I cleaned [Resident 2] up." Administrator C- "Did [Caregiver K] train yesterday?" Former Caregiver H- "Yes. [S/he] also helped clean up [Resident 2.]" During the interview Former Caregiver H stated s/he was never contacted for an investigation and believed the provider did not complete one. On 06/03/2024 at 10:46 AM, Surveyor interviewed Manager A. Manager A stated s/he didn't remember the incident of neglect of Resident 2 that was discovered and reported on 05/12/2024. Manager A stated s/he recalled s/he got a text but that, "There's so many minor issues like that, it's hard to remember. I mean I heard about feces and [him/her] being covered in them, but I didn't know about the call light ... They could have included it in the text and maybe I didn't read it all. I'm not sure I don't really remember." Manager A confirmed Resident 2 is on 2-hour bed checks but stated s/he was unsure if the Task Administration Record was completed for that night 05/11/2024-05/12/2024. After Manager A thought about it, s/he stated s/he recalled calling Administrator C regarding the incident and that Administrator C stated they would meet with the staff who worked overnight, but I didn't remember the staff's name. Manager A was unable to provide a call log to show that s/he called Administrator C regarding the neglect of Resident 2 or documentation of 2-hour checks completed. Manager A stated there was "no investigation started." Manager A did not recall talking to the staff as a follow up and stated s/he doesn't "usually deal with discipline with the staff. That	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 5 would be [Administrator C.]" During the exit interview on 06/03/2024 at 12:40 PM with Administrator C and LPN F present, Manager A stated s/he did not recognize the situation as neglect and stated s/he did not consider conducting an investigation because "it's happened before with [Former Caregiver U] so I just thought it was the same," Manager A clarified, "[Former Caregiver U] was written up for not doing resident cares when [s/he] worked too." Although Manager A did not give associated dates, times, and circumstances his/her interview revealed s/he was aware of similar situations occurring with former staff members that were serious enough to write up the staff member for, but were also not reported as neglect. Manager A reviewed and verified the text conversation documentation between him/herself and Caregiver I where it was revealed s/he was aware of the neglect. Manager A stated s/he was aware the reported incident was an allegation of neglect and did not offer an explanation as to why an investigation was not conducted. Manager A confirmed Caregiver O was still an employee at the facility and that no discussion, review, or disciplinary action had been taken or discussed with the employee regarding the incident. Manager A confirmed no investigation was conducted, no documentation of the reported neglect or resident condition was entered into the resident record, and no report to the Department, the local police authority, or the Office of Caregiver Quality had been made. On 06/03/2024 at 11:18 AM Surveyors interviewed Administrator C. Administrator C confirmed s/he was made aware of the neglect of Resident 2 via a text by Former Caregiver H and stated, "no investigation was completed.	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 6 [Manager A] and I talked about the incident, and we determined whoever worked that night should be written up." Administrator C reviewed the text communication sent from Caregiver I to Manager A on 05/12/2024 and stated s/he was not aware of the allegation that Caregiver O took the call light away from Resident 2. Administrator C stated s/he was aware Resident 2 required 2-hour checks for incontinence. Administrator C stated, "I can confirm that no investigation was done by me or anyone else. ... I did not speak to [Caregiver O] about the incident, and [s/he] is still working here." Administrator C confirmed no investigation was conducted, no documentation of the reported neglect or resident condition was entered into the resident record, and no report to the Department, the local police authority, or the Office of Caregiver Quality had been made. Resident 1 Resident 1 was admitted to the facility on 08/05/2022 with diagnoses including amputation of Right lower leg, chronic pain syndrome, DVT with recurrent history, history of chronic GI bleed, depression, cocaine abuse in remission, and diabetic left toe amputation. Resident 1 is his/her own person and began hospice services on 02/29/2024. In March of 2023 Resident 1 was receiving gabapentin and hydromorphone tablets for pain management and lorazepam as needed for anxiety. Resident 1 had "pain contract" (Schedule II medication agreement) dated 11/15/2021 with his/her primary provider at the time, Dr. Q. The contract was specific for the use of Lyrica. Surveyor requested to review all Schedule II medication agreements and found no current agreement with the current providers (APNP R and hospice MD S) or for his/her current medications from Dec 2023- June 2024 including gabapentin, hydromorphone, and/or	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 7 lorazepam. On 05/21/2024 Surveyor interviewed Resident 1 at approximately 10:30 AM. Resident 1 discussed a situation that occurred in March of 2023 when the provider conducted an investigation into an allegation made by staff that Resident 1 was "pocketing" his/ her medication. Surveyor note: "Pocketing" medication is a slang term used to describe hiding prescribed medication in ones mouth to avoid swallowing the medication. Pocketing can be used to "save" the medication until another dose is administered to cause a "high" or can be used to divert the medication to be given/ sold to another person whom the medication is not prescribed for. On 05/21/2024 at approximately 12:30 PM Surveyor interviewed Manager A, LPN F, and Administrator C. Administrator C confirmed the facility was not licensed to care for resident with specific Alcohol and Other Drug Abuse (AODA) and the caregivers have not had training specific to AODA. Manager B described Resident 1 as continually seeking pain medication and stated s/he would call for his/her medication to be given as soon as it was available. Administrator C and LPN F also shared their opinions that Resident 1 regularly sought pain medication. Surveyor asked Manager A, LPN F, and Administrator C for all documentation associated with the investigation conducted in March of 2024 and all associated resident records. Initial allegation: Surveyor reviewed Resident 1's record and noted a statement in the investigation interview of Former Caregiver U, "3/20 I was concerned that [Resident 1] was getting high and was pocketing	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 8	N 158		

meds due to the way [s/he] was acting." There was no associated documentation of how the resident was "acting" and no associated documentation of actions taken to help Resident 1 in case it was a medical change in condition or health monitoring provided for Resident 1 after Former Caregiver U noted a potential change in condition.

Surveyor reviewed a communication log from Resident 1's primary provider (APNP R) on 03/20/2024 authorizing an order for a urine drug screen. The drug screen came back negative for his/her schedule II medications. An observation note dated 3/21/2024 10:45 AM Regional Administrator B notes, "Received a call from [Manager A] that [Resident 1] was screened at [his/her] MD office per [his/her] narcotic contract and came back negative for opioids and benzodiazepines. However [sic] we show that [s/he] has been receiving those medications as prescribed. It is believed [s/he] pocketed [his/her] medications as this was brought to the attention of a hospice worker yesterday by one of our staff members. Hospice is aware as well ... drug screening will be performed by [LPN F.]"

Further communication notes between the provider and the medical provider's office note the presumption of Resident 1 pocketing medication and do not address the discrepancy of the evidence. Had Resident 1 been pocketing medication to get a "high" s/he would have tested positive for the medication in his/her system. This is corroborated by a called that was placed by LNP F to Pharmacist HH on 03/22/2023 noted in Resident 1's observation notes, "[Pharmacist HH] stated that [Resident 1] is prescribed hydromorphone IR short acting and that the half-life of this medication is approximately 2.6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 9	N 158		

hours. I explained that the resident is testing negative for opiates. [Resident 1] was observed taking hydromorphone at approximately 8:00 AM this morning. I told [Pharmacist HH] that I urine tested [Resident 1] this morning at around 10:30 AM. [Pharmacist HH] stated that the hydromorphone should be showing up positive on a urine drug screen."

Surveyor reviewed the investigation and noted the interview was comprised of 2 questions to the staff. Neither question addressed potential caregiver misconduct/ medication diversion. Surveyor reviewed the written investigation statements on 03/22/2024 and noted the following interview statements:

Question 1: "When [Resident 1] was giving [sic] [his/her] medications [sic] have you watched [him/her] take [his/her] medication? And [sic] how did you watch [him/her] take them or [sic] what did you do to know that [s/he] took them?

All 7/7 medication-passing caregivers (Caregivers T, N, FF, L, EE, GG and U) wrote statements noting they actively watch the resident take all of his/her medication at the time of administration, including Former Caregiver U who put forth the allegation the resident was pocketing medication.

Question 2: "Have you ever had any suspicion that [Resident 1] was pocketing any pills in [his/her] mouth or in [his/her] room?"

Caregiver T, "NO [sic]"
Caregiver DD, "No, I have not."
Caregiver N, "I do not. I always ask if they are down."
Caregiver FF, "No. Never have I had suspicions."
Caregiver L, "No, [sic] always takes in front of me

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 10	N 158		

then I will sit and talk or go back to playing cards." Caregiver EE "No, [s/he] takes all [his/her] meds at one time from the med [sic] cup." Caregiver GG, "ABSOLUTELY NOT IN ANY WAY SHAPE OR FORM!!!!! [sic.]"

On 06/03/2024, Surveyors interviewed Manager A, Administrator C, and LNP F at 12:40 PM. The Administrators discussed Resident 1's history of illicit drug use and continued to discuss the investigation in relation to the presumption of Resident 1 being guilty of pocketing medication. Manager A stated due to their conclusion that Resident 1 "must have been pocketing medication" Resident 1 was taken off of his/her prescriptions for pain management on 3/20/2024 and was potentially being removed from hospice services. The evidence collected by their investigation was reviewed:

1. There was 1 allegation by Former Caregiver U who is not qualified to assess the resident and has had no training by the provider in AODA. There was no follow-up documentation or health monitoring to support the allegation.
2. 7/7 caregivers interviewed (other than Former Caregiver U who alleged the pocketing) attested they watched Resident 1 take his/ her medication and denied any suspicion of Resident 1 diverting medication.

3. The laboratory evidence that the medication was not in Resident 1's system as evidence s/he was not pocketing the medication to double up on the dose as it would have been found in his/ her system.

4. Resident 1 had been forth coming about previous drug use and was willing to be tested.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 11 Administrator C stated, as evidence that the medication was not misappropriated by staff, that the narcotic log was complete. Administrator C then conceded that if caregivers were involved in medication diversion the narcotic log could be manipulated and the evidence would be supported by the laboratory findings. After a review of the findings, Administrator C and LPN F acknowledged the evidence did not implicate Resident 1 as pocketing medication but instead lead to the potential that caregivers had been involved in misappropriation of the medication, which was not investigated. Administrator C reviewed the 2 questions asked during the investigation and stated, "This doesn't address caregiver misconduct at all." Administrator A stated s/he had not been involved in the investigation and had not realized the investigation had been tailored to look into the resident pocketing the medication as the only potential circumstance. Administrator C stated due to the findings, an investigation needed to be conducted into the potential misappropriation of medication by the staff. The provider conducted an investigation that was tailored to the only outcome being the resident responsible for medication diversion. Despite evidence to the contrary, the provider concluded the resident had been diverting the medication and as a result, Resident 1 was threatened to have his/her hospice contract terminated and APNP R discontinued his/her gabapentin, hydromorphone, and lorazepam on 03/20/2024. The provider did not conduct an investigation into the potential misappropriation of medication by the caregivers as the evidence of the first investigation led to.	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 158	Continued From page 12 Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0346 DHS 83.32(3)(b) Rights Of Residents: Confidentiality N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment Y3234 DHS 50.09(1)(e) Treatment Y3244 DHS 50.09(1)(L) Care	N 158		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on staff interviews, observations and record review, the licensee did not ensure the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) 5ZR211, dated 12/17/2019. The facility is licensed to serve up to 20 residents who may be advanced age, physically disabled, have irreversible dementia/Alzheimer's disease, and/or be terminally ill. Findings Include: Prior to conducting the on-site facility visit, Surveyor reviewed the survey history and noted the following:	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 196	Continued From page 13 On 09/07/2023, with additional information gathered through 09/08/2023, The Division of Quality Assurance conducted an on-site investigation of 1 complaint investigation, a standard survey, and a verification visit at SV North Nine Acres. The complaint was substantiated. Four out of five deficient practices were corrected and 1 out of 5 were recited. Four deficient practices were identified in total. As a result of the visit, 4 deficiencies were cited in SOD #LRTJ12 dated 09/08/2023. The Statement of Deficiency and Notice and Order letter was sent to the provider via certified electronic mail on 12/11/2023. The licensee was ordered to comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 and special orders as soon as practicable and without delay, within 45 days of receipt. The notice of special orders included: "SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that SV North Nine Acres: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to ensure all resident care staff protect and promote each resident's right to live in a home that is safe, clean, and comfortable. WITHIN 45 DAYS of receipt of this notice, the licensee shall provide training to all Managers and resident care staff on the corrective actions that will be (or have been) implemented to	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 196	Continued From page 14	N 196		

resolve each environmental deficiency identified in Statement of Deficiency LRTJ12. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content."

On 05/21/2024, Surveyors asked to review all documentation for the required training. Manager A, Administrator C, and LPN F were interviewed at approximately 11:00 AM. Administrator C gave Surveyor a copy of meeting notes from January 2024 with Caregiver L's name written on top. The notes from the meeting discussed general needs for keeping the facility clean. There was no associated training or outline of course content. Administrator C and Manager A both stated the meeting notes with Caregiver L's name on top was the only record they had of the meeting occurring. There was no list of those in attendance or associated date. Administrator C and Manager A stated specific training and documentation had not been completed and therefore there was no record within employee files.

The ordered employee training and documentation of training for the environmental deficiency identified in statement of Deficiency #LRTJ12 was not completed.

Two of 2 complaints investigated from 05/21/2024 through 06/17/2024 were substantiated and the following 13 deficiencies were identified, including 2 repeat violations:

N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect
Based on record review and interview the provider did not ensure investigations were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 196	Continued From page 15 completed when neglect and potential misappropriation findings were brought to their attention for 2 of 2 Residents reviewed (Resident 1 and 2.) No investigation was completed when the neglect of Resident 2 was reported. When Resident 1 was found not to have Schedule II medication in his/her system, as was supposed to be by medical provider order, the provider conducted an invention tailored to the resident being responsible. When the results of the investigation lead to the potential conclusion misappropriation of medication by the employees had taken place, the provider did not complete an investigation into the findings. N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws Based on staff interviews, observations and record review, the licensee did not ensure the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. This is a repeat deficiency. See Statements of Deficiency (SOD) 5ZR211, dated 12/17/2019. N0203 DHS 83.14(2)(h) Posting: License, Deficiencies, Revocations Based on observation and interview, the provider did not ensure the notice of enforcement was posted until a final determination was made. N0346 DHS 83.32(3)(b) Rights Of Residents: Confidentiality Based on record review and interview the provider did not ensure 3 of 3 residents reviewed (Resident's 1, 6, and 7's) private health information was kept confidential. Additionally, the provider denied Resident 1 and his/her family access to his/her own medical record.	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 196	Continued From page 16 N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment Based on observation, interview, and record review the provider did not ensure Resident 2 was free from neglect. Resident 2 requires regular checks for incontinence and was left unchecked and covered in his/her own bm overnight. N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication Based on record review and interview the provider did not ensure all medication was given as prescribed by Resident 1's medical provider. Resident 1 received Resident 6's Lantus insulin. N0355 DHS 83.32(3)(K) Rights Of Residents: Self Determination Based on record review and interview the provider did not ensure Resident 1's autonomy was supported. Resident 1 was not allowed to take his/her pain medications outside of the facility to spend the weekend with family. N0427 DHS 83.38(1)(c) Leisure Time Activities Based on observation and interview, the provider did not ensure a daily activity program to meet the interests and capabilities of residents was provided. N0450 DHS 83.41(2)(c) Nutrition: Menus Based on record review and interviews, the provider did not ensure deviations from the planned menu were documented. N0481 DHS 83.43(1) Environment, Safe, Clean and Comfortable Based on observation and interview, the provider did not ensure a living environment that was safe, clean, comfortable, and homelike.	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 196	Continued From page 17 This is a repeat deficiency and is being cited for the third time. See Statements of Deficiency (SOD) LRTJ11 dated 10/18/2022 and LRTJ12 dated 12/11/2023. Y3234 DHS 50.09(1)(e) Treatment Based on observation, record review, and interview the provider did not ensure Resident 1 was treated with dignity and respect. Resident 1 endured allegations of medication diversion, presumption of guilt, imposed medical testing, lack of privacy, and a restrictive and hostile living environment. The provider used their position over the resident to restrict his/her freedoms and coerce him/her into accepting circumstances that did not honor his/her dignity and rights. Y3244 DHS 50.09(1)(L) Care Based on observation, record review, and interview, the provider did not ensure Resident 3 and Resident 10 received adequate and appropriate care within the capacity of the facility. Z 0010 DHS 50.065(2)(bb) Determine Final Disposition Of Charge Based on record review and interview the provider did not ensure 1 of 2 Caregivers reviewed (Caregiver O) had a complete background check following the procedures in s. 50.065, Stats., and ch. DHS 12. Caregiver O was convicted of 947.01 Disorderly conduct within 5 years of hire and the provider did not make every reasonable effort to contact the Clerk of Courts to obtain a copy of the record as required. Cross Reference: N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 196	Continued From page 18 N0203 DHS 83.14(2)(h) Posting: License, Deficiencies, Revocations N0346 DHS 83.32(3)(b) Rights Of Residents: Confidentiality N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0355 DHS 83.32(3)(K) Rights Of Residents: Self Determination N0427 DHS 83.38(1)(c) Leisure Time Activities N0450 DHS 83.41(2)(c) Nutrition: Menus N0481 DHS 83.43(1) Environment, Safe, Clean and Comfortable Y3234 DHS 50.09(1)(e) Treatment Y3244 DHS 50.09(1)(L) Care Z 0010 DHS 50.065(2)(bb) Determine Final Disposition Of Charge	N 196		
N 203	83.14(2)(h) Posting: license, deficiencies, revocations The licensee shall post the CBRF license, any statement of deficiency, notice of revocation and any other notice of enforcement action in a public area that is visually and physically available. A statement of deficiency shall remain posted for 90 days following receipt. Notices of revocation and other notices of enforcement action shall remain posted until a final determination is made. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the notice of enforcement was posted until a final determination was made. Findings Include: Surveyor reviewed the Notice of Enforcement	N 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 203	Continued From page 19 Action letter that was sent to the provider on 12/11/2023. The order included instructions for posting: "POSTING OF NOTICES According to Wis. Admin. Code DHS §§ 83.13(3)(a) and 83.14(2)(h), each facility shall immediately upon receipt post next to its CBRF license, and in a public area that is visually and physically available, any citation/statement of deficiency, notice of revocation, notice of non-renewal, and any other notice of enforcement action. Citations and statements of deficiency shall remain posted for ninety (90) days following receipt. Notices of revocation, non-renewal, and other notices of enforcement action shall remain posted until a final determination is made." On 05/21/2024 at 9:30 AM, Surveyor conducted a tour of the facility while observing for compliance with the enforcement orders from SOD LRTJ12 dated 09/08/2023. Surveyor observed the notice of enforcement action, which is required to be posted until a final determination is made, was not posted in the facility. On 05/21/2024 at 12:15 PM, Surveyor interviewed Administrator C. During the interview, Administrator C acknowledged the notice of enforcement action was not posted. Administrator C stated s/he was unaware the notice of enforcement action was required to be posted after 90 days. Administrator C reviewed the directive detailed in the order for posting and acknowledged the enforcement action was still required to be posted. Additionally, Administrator C was able to recall previously discussing the posting requirements with Surveyor at the time of the last survey. Since the previous survey	N 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 203	Continued From page 20 discussion, the provider did not implement a way to ensure the notice of enforcement action was posted as required. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 203		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 3 of 3 residents reviewed (Residents 1, 6, and 7's) private health information was kept confidential. Additionally, the provider denied Resident 1 and his/her family access to his/her own medical record. Findings include:	N 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 346	Continued From page 21 On 05/22/2024, Surveyor reviewed Resident 1 records including observations notes and investigation reports. Surveyor noted the record contained documentation of breeches in resident's right of confidentiality: Resident 6 Observation notes 05/21/2024 2:00 PM written by Caregiver T, "resident [sic] came up to staff and stated [s/he] was leaving to go to [the store] to buy an [sic] another resident [Resident 6] sugar donuts. staff [sic] explained that we do not think [sic] resident can do that because [sic] resident is a diabetics [sic] and sugars were [sic] strike the sugars up. staff [sic] informed house manager right away." On 06/03/2024, Surveyors interviewed Administrator C at 11:15 AM. Administrator C reviewed the records. Administrator C stated the observation note detailed a breech in confidentially of Resident 6's medical information. Administrator C stated his/her disappointment that the staff did not uphold Resident 6's confidentiality and stated reeducation to the staff would be conducted. Resident 7 An undated investigation report written by Administrator C from August of 2023 Administrator C notes his/her interview questions and response with Resident 1 regarding Resident 7: Resident 1 response, "[Resident 7] was never involved in drugs but drives me all over the place. [S/he] knows where [s/he] is going as long as I tell [him/her] how to get from place to place." Administrator C's response, "[Resident 1] do you know that [Resident 7] has a Dx [sic] that creates a venerable [sic] situation?"	N 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 346	Continued From page 22 Resident 1's response, "yes [sic]" Administrator C's response, " ...Understand you cannot ask [Resident 7] to take you anywhere from this day forward." On 06/03/2024, Surveyors interviewed Administrator C at 11:15 AM. Administrator C reviewed the records. Administrator C acknowledged the interview s/he conducted with Resident 1 detailed a breech in confidentially of Resident 7's medical information. Administrator C stated, "Yes" that s/he was aware the interview s/he conducted contained a breech in Resident 7's private health information. Resident 1 On 05/21/2024 at approximately 10:40 AM, Surveyor interviewed Resident 1. Resident stated s/he previously lived with Family Member G and Family Member G is frequently involved in his/her medical decisions. Resident 1 stated the provider is aware s/he has approved his/her Family Member G as representative to be included in his/her private medical care and have access to his/her medical information. Resident 1 detailed an incident when s/he was not allowed to leave the facility with his/her medication to visit Family Member G for the weekend. Resident 1 stated the provider told him/her and Family Member G the physician ordered the medication could only be given by the provider at the facility. Resident 1 stated when s/he had Family Member G ask for a copy of the order, Manager A did not let Family Member G see the order and refused to provide a copy. Surveyor interviewed Family Member G on 5/22/2024 at 10:21 AM. Family Member G stated	N 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 346	Continued From page 23	N 346		

s/he reached out to Manager A and told him/her that s/he wanted to bring Resident 1 home for the weekend. Family Member G stated, "[Manager A] told me absolutely not because they have a doctor's order that states that the medication can only be given in the facility and I said I have never heard of that, that the medicine absolutely had to be given at the facility ... I've been a nurse for a long time ... and never have we declined for the family to be able to administer the medication ... So what? [S/he's] [his/her] own person and [s/he's] just not allowed to ever go anywhere because otherwise [s/he'll] just have to be in pain? ... I asked to see the order ... we wanted a copy ... [Manager A] refused."

On 05/21/2024, Surveyor requested Resident 1's medical record including all medication orders and associated medical provider directives. Surveyor reviewed corresponding medical provider notes and orders. The orders received contained no specification from the prescribing physician that the medication only be given at the facility.

On 06/03/2024 at approximately 12:40 PM, Surveyor interviewed Manager A with Administrator C present. Manager A acknowledged Family Member G as an approved representative for Resident 1 and corroborated Family Member G did ask to see and for a copy of the order. Manager A stated a copy of the order was not provided to Resident 1 or his/her representative Family Member G. Manager A reviewed the provided record and acknowledged there was not an order to only administer the medication at the facility.

Cross Reference:
N0196 DHS 83.14(2)(a) Licensee Ensures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 346	Continued From page 24 Facility Complies With Laws	N 346		
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 observation, interview, and record review the provider did not ensure Resident 2 was free from neglect. Resident 2 requires regular checks for incontinence and was left unchecked and covered in his/her own bm overnight. Finding include: On 05/13/2024, the Department received a complaint alleging residents were not being cared for and were being neglected. Resident 2 was admitted to the facility on 09/07/2023 with diagnoses including anxiety disorder, sleep apnea, cerebral palsy, chronic vascular disorders of the intestine, osteo arthritis, and displaced fracture of lateral malleolus of right fibula, closed fracture with routine healing. Resident 2's Individual Service Plan, (ISP) (undated) noted Resident 2 "is oriented to time and place requires no staff assistance to redirect	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 348	Continued From page 25	N 348		

or reorient is able to comprehend and retain a request and does not always recognize when to make decisions but follows directions" with a desired goal of providing a "safe environment and a feeling of security." The ISP noted Resident 1 was at risk for falling, required total assistance for dressing and toileting, had limited mobility requiring a wheelchair and a sit/ stand lift for all transfers. Resident 2's ISP identified him/her as requiring bed checks every 2 hours and as needed for incontinence.

On 05/29/2024 at 10:20 AM, Surveyor interviewed Caregiver K. Caregiver K stated his/her first shift working was on the morning of 05/12/2024 with Former Caregiver H training him/her and Caregiver I present at the facility. Caregiver K stated upon arrival at 6:00 AM there was a noticeable BM odor in the facility. Caregiver K stated the odor became stronger as they approached Resident 2's room to get him/her up for the day. Caregiver K stated they found, "[Resident 2] had feces on [him/her] head to toe. [S/he] was covered in it. It was dried in areas, it was wet it in others. It was on the walls. We had to throw [his/her] sheets away. [Former Caregiver K] and I got [him/her] into the shower and [s/he] thanked us. [Resident 2] was so embarrassed. [S/he] told us [s/he] had been sitting in the feces for a while." Caregiver K stated his/her call light had been placed out of Resident 2's reach and that Resident 2 is a quiet person who could not be heard if s/he called out for help."

On 05/29/2024 at 11:15 AM Surveyor interviewed Caregiver I. Caregiver I stated, "On May 12th I was working and I stopped in to [Resident 2's] room because the other staff told me [s/he] was found covered in feces. It was bad. The room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 348	Continued From page 26	N 348		

was bad. Everyone knows that you have to check on [him/her] it's in [his/her] plan because [s/he's] incontinent. Also it's [his/her] demeanor to be embarrassed. Like if [s/he] is incontinent of urine, [s/he'll] be embarrassed and not want to come back out to the living room. This was [Caregiver K's] first day and first time meeting [Resident 2] and [s/he] was covered in bm. Just knowing [Resident 2] I can't imagine how embarrassed [s/he] was ... On May 12th at 8:12 AM [Manager A] texted me asking about it. I never heard anything about it there was no investigation. It was just wrong ... if I found my [mom/dad] like that I would have state in here right away."

Surveyor reviewed the text exchange between Caregiver I and Manager A dated 05/12/2024 at 8:12 AM:
Manager A- "Did it look like anybody was changed last night? Was [Resident 10] soaked this morning?"
Caregiver I- "[Resident 2] a mess and [Resident 10] soaked." " ... [Resident 2] said [s/he] had a blowout in the middle of the night and [Caregiver O] came in[sic] took [his/her] call light away and left the room so [sic] knows how long [s/he] has been laying in it."

Manager A- "OK, I'm sorry that [explicative] me off because [Resident 2] knows [sic] and [Resident 2] is very smart and with it. I will be talking with [him/her] because that is not what we're gonna [sic] do I don't care how short we are."

Caregiver I- "I know, and you could smell it in the hallway so there's no way you missed the smell in [his/her] room."

On 05/29/2024 at 12:00 PM Surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 348	Continued From page 27 Former Caregiver H. Former Caregiver H stated s/he was employed from 04/18/2024 through 05/12/2024 when s/he left his/her position as a result of the neglect s/he found occurring at the facility. Former Caregiver H stated an incident occurred overnight from 05/11/2024 into the morning of 05/12/2024 when s/he came into work for the morning shift at 6:00 AM. Former Caregiver H stated s/he began working with a trainee [Caregiver K] and Caregiver I was also present at the time. Former Caregiver H stated s/he entered the facility at 6:00 AM and noticed an odor of bm in the facility. Former Caregiver H stated s/he and Caregiver K began to get residents ready for the day on the Northern wing and by approximately 8:00 AM had worked down to the Southern wing where Resident 2's room is located. Former Caregiver H stated the odor was stronger and stronger the closer they approached Resident 2's room and stated it was noticeable by all. Former Caregiver H stated, "By the time I got to [Resident 2's] hallway I could smell a smell, I mean there's no way that anyone couldn't smell it ... I got to [his/her] room I opened the door it was just a horrific scene. It was in [his/her] hair, [s/he] had pieces in [his/her] hair and [his/her] toes, on [his/her] walls. It was dried. The chux pad had a dried ring, it had like a red tinge stain to it with the diarrhea, very foul smell, I guess acidic smelling ... I was like '[Resident 2,] how come you didn't call?... Use the call light? Like someone could have came' and [s/he] said [s/he] did not have [his/her] call light." Former Caregiver H stated at that time s/he noticed the call light was placed away from the bed on the other side of the room out of Resident 2's reach. Former Caregiver H stated, " [Resident 2] cannot get up by [him/herself] [s/he] needs help. [S/he's] very unstable on [his/her] feet. I noticed the call light was over by [his/her] chair. There is absolutely no	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 348	Continued From page 28	N 348		

way for [him/her] to even get to that. Even yelling, [s/he's] very soft spoken and not one to call out. Even if s/he did, no one would be able to hear [him/her] down the hallway ... [Resident 2] said the people who got [him/her] into bed put the call light over there ... whoever put [him/her] in the bed after dinner, so I don't know if it was [Manager A] or if it was [Caregiver O] but [Caregiver O] worked overnight and [Resident 2] has it in [his/her] care plan that [s/he's] supposed to be checked on every two hours ... This isn't the this is the first time, I've made complaints to [Manager A] multiple times that it seems people who have no Family that come and check on them and people who cannot help themselves get up every morning that I come in working after [Caregiver T [Caregiver O] [Caregiver V] and occasionally [Manager A] they are completely soaked ... with them being immobile by themselves, without having any help, being stuck in that bed is going to cause them bed sores." Former Caregiver H stated Resident 2's peri area skin was "So raw ... [him/her] skin was so red and blistering. [S/he] was in pain, [s/he] said [s/he] was in a lot of pain and [s/he] was very embarrassed. [S/he] was crying. I started crying. I actually had to step away. As a person who works in the care field it honestly hurts my feelings because me and [Resident 2] were really cool. [S/he] told me about [his/her] life situation and [s/he] has no one that comes and visits [him/her] or anything like that, so it really upset me ... [Resident 2] doesn't have family that comes in ... [Manager A] was told right away. I told [him/her] and I believe [Caregiver K] told [him/her,] but [Caregiver I] actually sent a text out to [Manager A.] I have made a complaint to [Manager A] verbally that this is ridiculous. I actually sent out a text message to [Administrator C.]"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 348	Continued From page 29 Surveyor reviewed the text conversation between Former Caregiver H and Administrator C (dated 05/13/2024 per interview with Former Caregiver H) at 12:19 PM: Former Caregiver H- " ... walking in on Sunday. [Resident 2] was my last person to get up I didn't get [him/her] until 8 when I started walking down [his/her] hallway I could smell BM I had walked into [his/her] room and [s/he] was covered head to toe [sic] and the wall [sic] in [his/her] BM. I had asked why [s/he] didn't use [his/her] call light not realizing [his/her] call light was on [his/her] table over [his/her] chair. [S/he] had said [s/he] had no way of getting ahold of anyone and no one came and checked on [him/her.] I tried my best to wipe [him/her] up but wanted to get [him/her] in the shower regardless. When we were in the shower I asked when [s/he] had the BM whether it was that morning or that night [sic] [s/he] had stated [s/he] did last night after getting into bed. That highly upset me because I could smell it getting closer to [his/her] room so I don't know how night shift couldn't smell it ..." Administrator C - "OK so who worked Saturday night? Responsible for the mess? [Caregiver O]?" Former Caregiver H- "I believe [Manager A] and [Caregiver O][sic] I know came in at 6 [sic][s/he] said it happened that night so whomever put [him/her] into bed it happened shortly after that. [Caregiver I] had texted [Manager A] about it. after I cleaned [Resident 2] up." Administrator C- "Did [Caregiver K] train yesterday?" Former Caregiver H- "Yes. [S/he] also helped clean up [Resident 2.]"	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 348	Continued From page 30 On 05/21/2024 at approximately 11:30 AM, Surveyor interviewed Resident 2. Surveyor observed Resident 2 was soft spoken and appeared uncomfortable/ hesitant openly discussing the incident or Caregivers involved. Resident recalled s/he had a bm on 05/11/2024 at the time s/he was put to be shortly after dinner around 6 PM. Resident 2 stated s/he was unable to call out for help and the call light had been across the room. Resident 2 stated no one came in to check on her throughout the night and s/he finally received assistance the next morning. Resident 2 expressed that s/he was embarrassed and felt helpless. On 06/03/2024 at 11:46 AM Surveyor interviewed Manager A. During the interview Manager A referred to the incident as "minor." Manager A did not recognize the situation as neglect and stated s/he did not consider conducting an investigation because "it's happened before with Former Caregiver U, so I just thought it was the same, Manager A clarified, "[Former Caregiver U] was written up for not doing resident cares when s/he worked too." Although Manager A did not give associated dates, times, and circumstances his/her interview revealed s/he was aware of similar situations occurring with former staff members that were serious enough to write up the staff member for but were also not reported as neglect. Cross Reference: N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws Y3244 DHS 50.09(1)(L) Care Z 0010 DHS 50.065(2)(bb) Determine Final Disposition Of Charge	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure all medication was given as prescribed by Resident 1's medical provider. Resident 1 received Resident 6's Lantus insulin. Findings include: On 05/13/2024, the Department received a complaint alleging residents were not receiving medications as prescribed by their medical providers. On 05/21/2024 at approximately 10:40AM, Surveyor interviewed Resident 1. Resident 1 stated there were times (unspecified when) when his/her Lantus insulin had not been ordered by Manager A in time and was not available at the facility to be given. Resident 1 stated various medication passers, including Caregiver I explained to him/her that his/her medication was not available and that s/he would be "borrowing" the Lantus insulin from another resident per Manger A's instruction. On 05/29/2024 at 11:15 AM, Surveyor interviewed Caregiver I. Caregiver I stated it was Manager A's responsibility to ensure medications were reordered for residents. Caregiver I stated	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 352	Continued From page 32 residents would frequently "run out" of medication and the medication passers were instructed by Manager A to "borrow" medications from other residents. Caregiver I stated there had been multiple (unspecified when) times, including 05/19/2024, when Resident 1 would run out of Lantus insulin, and s/he was instructed by Manager A to give Resident 1 another resident's medication. Surveyor reviewed a text message conversation on Caregiver I's personal phone dated 05/19/2024 8:15 AM between Caregiver I and Manager A, "Look in lock box in silver fridge. If none use one of [Resident 4's] and take [his/her] name off of it and I'll reorder it." Caregiver I stated s/he did as instructed by Manager A and gave Resident 1 Resident 4's medication. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws Y3244 DHS 50.09(1)(L) Care	N 352		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by:	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 355	Continued From page 33	N 355		

Based on record review and interview the provider did not ensure Resident 1's autonomy was supported. Resident 1 was not allowed to take his/her pain medications outside of the facility to spend the weekend with family.

Findings include:
On 05/13/2024, the Department received a complaint alleging the provider was imposing restrictions on residents.

On 05/21/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 08/05/2022 with diagnoses including amputation of Right lower leg, chronic pain syndrome, DVT with recurrent history, history of chronic GI bleed, depression, cocaine abuse in remission, and diabetic left toe amputation. Resident 1 is his/her own person and began hospice services on 02/29/2024. In March of 2023 Resident 1 was receiving gabapentin and hydromorphone tablets for pain management and lorazepam as needed for anxiety. Resident 1 had 1 "pain contract" (Schedule II medication agreement) dated 11/15/2021 with his/her primary provider at the time, Dr. Q. The contract was specific for the use of Lyrica. Surveyor requested to review all Schedule II medication agreements and found no current agreement with the current providers (APNP R and hospice MD S) or for his/her current medications from Dec 2023- June 2024 including gabapentin, hydromorphone, and/or lorazepam.

On 05/21/2024, Surveyor interviewed Resident 1 at 11:01 AM. Resident 1 stated prior to living at the facility s/he lived with his/her Family Member G who is a Registered Nurse (RN.) Resident 1 discussed a situation that occurred "a few weeks ago" when s/he wanted to go spend the weekend

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 355	Continued From page 34 Family Member G's home. Resident 1 stated s/he was told by Manager A that s/he was not allowed to take his/her prescribed schedule II pain medication out of the facility per his/her prescribing physician's orders. Resident 1 stated s/he is his his/her own person and has no court ordered limitations in relation to his/her history of drug use. Resident 1 stated s/he was on hospice services and that Manager A stated it was a "policy between the facility and hospice" not to allow the resident to take his/her pain medication out of the facility. Surveyor interviewed Family Member G on 5/22/2024 at 10:21 AM. Family Member G stated s/he reached out to Manager A (date unknown) and told him/her that s/he wanted to bring Resident 1 home for the weekend. Family Member G stated, "[Manager A] told me absolutely not because they have a doctor's order that states that the medication can only be given in the facility and I said I have never heard of that, that the medicine absolutely has to be given at the facility ... so then I called out to the hospice team and I spoke to the nurse who is [his/her] care manager [Hospice RN W] and [s/he] said 'You know let me look into this. I will call the facility and talk with [Manager A] as well.' OK, so [Manager A] pretty much told [him/her] the same thing, that they have this doctor's order which prevents [him/her] from being able to. I said, 'well what do you want me to do?' and the hospice nurse told me that they had to go by what the facility rules were ... I've been a nurse for a long time ... and never have we declined for the family to be able to administer the medication ... So what? [S/he's] [his/her] own person and [s/he's] just not allowed to ever go anywhere because otherwise [s/he'll] just have to be in pain? ... I asked to see the order ... we wanted a copy ...	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 355	Continued From page 35	N 355		

[Manager A] refused ..." Family Member G stated s/he felt Manager A and Administrator C were being vindictive and controlling beyond what they had a right to do. "I mean [Resident 1] had lived with us before moving there. We are fully capable of helping [him/her] with [his/her] medication. [Resident 1] was going to be with us from Friday until Sunday and [s/he] tried. [S/ he] tried going between ibuprofen and Tylenol ... they allowed [him/her] to bring liquid gabapentin but they would not allow any of [his/her] other medicine so I ended up taking [him/her] back early on Sunday because [s/he] was just so miserable. There was so much family there ...[s/he] really wanted to be home but was just in so much pain I had to bring [him/her] back." Family Member G, who is involved with Resident 1's healthcare per Resident 1's permission, stated to his/her knowledge Resident 1 never signed an ISP agreeing to only receiving the Schedule II medications at the facility, and such an agreement would be in violation of his/her rights by asking him/her to sign his/her rights away.

On 05/21/2024 at approximately 2:00 PM, Surveyor interviewed Manager A, Administrator C and LPN F. Manager A stated Resident 1's medication had been order to be only given at the facility. Surveyor asked to review all Resident 1's medication orders from his/her primary provider (APNP R) and hospice provider (MD S.) Surveyor reviewed Resident 1's Medication Administration Record (MAR), Observation notes (ON), and Active and Discontinued Medication lists. No orders contained specific directives to only be given at the facility. At approximately 2:30 PM the discrepancy was brought to the Administrator's attention. Manager A then stated they were following hospice's and their own policy. Surveyor asked to review the policy and was told by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 355	Continued From page 36 Administrator C there was not a hospice or facility policy but stated they were told by the provider not to allow the resident to take the medication out of the facility. Manager A, Administrator C, and LPN F stated they were unaware of the limitation of a prescribing physician without a court order in relation to the resident's rights. Surveyor reviewed a communication log dated 02/07/2023 written by RN Z, "Staff did verify that upon return resident was confronted about excess doses of Lyrica to which resident "played stupid" and responded that [s/he] didn't think [s/he] took extra but couldn't explain why there were missing doses. I did discuss this with [NP BB] yesterday and [s/he] ordered that resident is not allowed to take any controlled substances out of the building with [him/her] on passes if [s/he] wants [his/her] controlled medications [s/he'll] have to be in the building at the times due. This has been care planned for [Resident 1.]" Surveyor found no associated order. Surveyor asked to review the Individual Service Plan (ISP) and noted the ISP (undated) noted, "Independent Living Restriction- Resident is not allowed to take any controlled substance out on pass with [him/her.] [S/he] may sign out all regular medications but cannot take anything that is controlled (locked in the narc box.)" The care plan was not signed, and per interview with Resident 1 and Family Member G, was not agreed to. Surveyor reviewed a provider communication log dated 08/04/2023: Administrator C notes to Resident 1's primary provider, " ... we have not been sending [his/her] Lyrica with [him/her] when [s/he] goes out of the facility. Please confirm if this is what needs to be	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 355	Continued From page 37 done or if we are to start sending it with [him/her.]" PA-C AA responds. "No, [his/her] Lyrica should not be sent with [him/her] if [s/he] goes out of the facility." Surveyor reviewed ON dated 04/01/2024 written by Manager A at 2:45 PM, " Hospice nurse W call to mention to [Manager A] ... medical director [MD S] also mentioned that [s/he] is not giving permission for the resident to take this medication outside of the building as [s/he] doesn't know what the resident is doing and who would be giving it to [him/her.]" On 05/21/2024 at approximately 2:00 PM Surveyor interviewed Manager A, Administrator C and LPN F. Surveyor asked to review all Schedule II medication contracts Resident 1 was entered into. The Administrators stated they were aware of only 1 pain contract. On 06/04/2024, Surveyor received 1 documented contract for review. Surveyor reviewed the pain contract dated 11/15/2021 was specific to the use of Lyrica which was discontinued, and was with a previous prescriber. The resident did not have any other additional pain contracts for his/her current prescribed medication with the hospice prescribing MD S or APNP R. Cross Reference: N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0346 DHS 83.32(3)(b) Rights Of Residents: Confidentiality Y3234 DHS 50.09(1)(e) Treatment	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 427	Continued From page 38	N 427		
N 427	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a daily activity program to meet the interests and capabilities of residents was provided. Findings include: On 05/21/2024 at approximately 10:35 AM, Surveyors toured the facility. Surveyors observed an activity calendar posted in the dining area. The activity calendar indicated "Bingo" at 1:00 PM on 05/21/2024. No activities were observed between 10:33 AM and 3:00 PM on 05/21/2024. On 05/21/2024 at approximately 10:38 AM, Surveyor observed 3 residents sitting in the dining area. Residents were seated at a table visiting. Surveyors asked if they would be playing bingo today, Resident 8 stated they don't play bingo	N 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 427	Continued From page 39	N 427		

there.

On 05/21/2024 at approximately 10:45 AM, Surveyors interviewed Resident 7. Resident 7 explained they don't have activities there, but they can watch the TV in the lounge area.

On 05/21/2024 at approximately 1:47 PM, Surveyor interviewed Resident 4. Resident 4 stated s/he enjoys watching the Milwaukee Brewers games, but he/she has not seen a game since the facility turned the cable off a month ago. Resident 4 "flipped" through the channels on his/her TV to show 6 channels were airing. Resident 4 explained that Manager A told him/her that the facility would have the channels he/she had right now which was described as basic cable. Resident 4 expressed how he/she is disappointed he/she cannot watch the baseball games. Resident 4 reported the facility has a new activity director, a family member of Manager A, and they work 3 times a week.

On 06/03/2024, Surveyors reviewed the facility's Admission Agreement (AA). The AA states basic cable service and activities including periodic outings are included under the services offered to the residents.

On 06/03/2024 at approximately 1:10 PM, Surveyors interviewed Administrator C. Administrator C acknowledged that scheduled activities have not been happening as scheduled on the posted activity calendar. Administrator C stated that Activity Director N is scheduled 3 days a week and the days s/he is not scheduled, the facility does not do the scheduled resident activities. Administrator C explained that s/he was told that the cable boxes needed to be replaced and the cable company is at fault for it taking so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 427	Continued From page 40 long. Administrator C said Regional Administrator (RA)B is working on it. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 427		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure deviations from the planned menu were documented. Findings include: The facility is licensed to serve up to 20 residents who may be physically disabled, terminally ill, advanced aged, and/or dementia/Alzheimer. At the time of the survey, the census was 17 residents. On 05/13/2024, the Department received a complaint alleging concerns the facility does not have the necessary ingredients to prepare meals identified on the menu. On 05/21/2024 at approximately 1:47 PM, Surveyor interviewed Resident 4. Resident 4	N 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 450	Continued From page 41 stated the menu is often changed because the facility does not have the food to make what is on the menu. On 05/29/2024 at approximately 10:20 AM, Surveyor interviewed Caregiver K. Caregiver K reported s/he changed the menu often as the food indicated on the menu is not in the facility. On 05/26/2024, the facility menu indicated "stuffing" for dinner, there was no stuffing, Caregiver K substituted potatoes. On 05/28/2024, the facility menu indicated "roast beef", there was no roast beef, Caregiver K changed the menu to Shepherd's pie. On 05/29/2024, the facility menu indicated "ribs" but there were no ribs, Caregiver K changed the menu to spaghetti. Caregiver K reported Resident 1 was upset about having spaghetti instead of the ribs that was listed on the menu and asked why. Caregiver K explained to Resident 1 that they did not have any ribs to make so they had to make what was available. On 05/29/2024 at approximately 1:20 PM, Surveyors reviewed the Menu for May 2024. The menu indicated no changes to the dinner meals. The meals served on 05/26/2024, 05/28/2024 and 05/29/2024 deviated from the planned menu. On 06/03/2024, approximately 11:15 AM, Surveyor interviewed Administrator C. Administrator C acknowledged the findings. No further information was provided. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 450		
{N 481}	83.43(1) Environment safe, clean, and comfortable	{N 481}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 481}	Continued From page 42 Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that was safe, clean, comfortable, and homelike. This is a repeat deficiency and is being cited for the third time. See Statement of Deficiency (SOD) LRTJ11 dated 10/18/2022 and LRTJ12 dated 12/11/2023. Findings include: On 05/13/2024 and 05/15/2024, the Department received complaints alleging concerns with cleanliness. On 05/21/2024 at approximately 10:28 AM, Surveyors toured of the facility and observed the following: -strong odor like urine -carpeting is stained and worn. -walls are dirty and have holes -baseboards are chipped and dirty -common room furniture is stained -debris on the floor On 05/21/2024 at approximately 10:48 AM, Surveyor interviewed Resident 7 and Resident 1 in the hallway. Resident 7 stated the smell in here is from Resident 6's room and it never goes	{N 481}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 481}	Continued From page 43 away. Resident 1 stated the staff will mop the hallway and the smell gets worse, so we must keep our doors closed and our windows open. On 05/21/2024 at approximately 11:01 AM, Surveyors interviewed Resident 1. Resident 1 stated the smell of urine is so bad it hurts his/her throat. On 05/22/2024 at approximately 10:21 AM, Surveyors interviewed Family Member G. Family Member G reported the smell of urine is so strong that it burns their nostrils. Family Member G opens the window in Resident 1's room during the visit and Resident 1 stated it smells like this all the time. Family Member G explained they expressed their concerns regarding the strong odor to Manager A. On 06/04/2024 at approximately 10:46 AM, Surveyors interviewed Manager A and Administrator C regarding the strong smell of odor previously cited on 10/18/2022 and 09/08/2023. Manager A stated they cannot do anything about the odor because it is up to the owner. Manager A explained they purchased air freshener plug ins for the resident rooms to help with the smell and planned a staff meeting for today to discuss housekeeping tasks. Administrator C acknowledged the smell was very strong and they have tried many times to clean the carpet, but the smell comes back. Administrator A reported they talked with Regional Administrator (RA) B about the smell of the carpet and the stained furniture. Administrator A said s/he talked with RA B and they acknowledged the issue and plan to replace all the carpeting and will talk about what to do with the furniture.	{N 481}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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 481}	Continued From page 44 The provider was previously cited for concerns related to the presence of urine odors on 10/18/2022 and 09/08/2023. During the tour on 05/21/2024, surveyors identified the continuation of the odor permeating through resident rooms and hallways. Surveyors also identified other concerns such as stained and worn carpet, dirty walls, chipped baseboards, stained furniture, and dirty floors. Additionally, Resident 1 and Resident 7 expressed concern of the odor in their living environment. The provider did not ensure the environment was safe, clean, comfortable, and homelike. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	{N 481}		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint.	Z 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Z 010	Continued From page 45 If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 1 of 2 caregivers reviewed (Caregiver O) had a complete background check following the procedures in s. 50.065, Stats., and ch. DHS 12. Caregiver O was convicted of 947.01 Disorderly conduct within 5 years of hire and the provider did not make every reasonable effort to contact the Clerk of Courts to obtain a copy of the record as required. Finding include: On 05/13/2024, the Department received a complaint alleging the provider was employing staff without conducting complete background checks. Chapter 12 notes, "If a Background Information Disclosure form, a caregiver background check, or any other information shows that a person was convicted of any of the offenses immediately below within 5 years before the information was obtained, the department, county department, child welfare agency, school board, or entity, as	Z 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Z 010	Continued From page 46 applicable, shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgment of conviction relating to that conviction." On 05/21/2024, Surveyor reviewed Caregiver O's record and noted s/he was hired on 04/26/2024. Surveyor reviewed Caregiver O's Department of Justice (DOJ) report and noted Caregiver O was convicted of 947.01 Disorderly Conduct on 04/26/2023. On 05/21/2024, Surveyor interviewed Administrator C at approximately 11:00 AM. Administrator C stated s/he was in charge of hiring and obtaining background checks for the employees. Administrator C stated s/he was unaware of the requirements to contact the Clerk of Courts. Administrator C stated s/he did not contact the Clerk of Courts to obtain the final disposition of the charges. On 06/03/2024, Surveyor interviewed Administrator C at approximately 11:15 AM. Administrator C stated s/he had still not obtained the disposition of the final charges from the Clerk of Courts for Caregiver O. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	Z 010		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 47 provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on observation, record review, and interview the provider did not ensure Resident 1 was treated with dignity and respect. Resident 1 endured allegations of medication diversion, presumption of guilt, imposed medical testing, lack of privacy, and a restrictive and hostile living environment. The provider used their position over the resident to restrict his/her freedoms and coerce him/her into accepting circumstances that did not honor his/her dignity and rights. Findings include: On 05/13/2024, the Department received a complaint alleging residents were not being treated with respect and were having their rights limited. On 05/21/2024 at approximately 12:30 PM, Surveyor asked Manager A, LPN F, and Administrator C for Resident 1's Face Sheet (FS), initial and current Individual Service Plan (ISP,) 3 months of Observation Notes (ON) (March - May 2024,) Medication Administration Record (MAR)	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 48 (December 2023- June 2024,) Hospice Notes (HN,) provider orders and notes including any Schedule II medication contracts, and all associated investigations and incident reports. Treatment In the Common Space and Visitors On 05/21/2024, Surveyor interviewed Resident 1 at 11:01 AM. Resident 1 stated s/he had been issued a 30-day notice in the past and was aware the provider, including Manager A and Administrator C, did not "like" him/her. Resident 1 stated the administrators had been trying to remove him/her from the facility and frequently used the threat of "kicking [him/her] out" of the facility to get him/her to comply with their treatment of him/her. Resident 1 stated s/he is one of the only residents who is his/her own person and, as such, felt the need to advocate for the other residents. Resident 1 said in the past s/he would talk to "good staff" that s/he could trust about issues that were occurring at the facility regarding treatment of residents. Resident 1 stated (date unknown,) "I was in the dining area and [Manager A] came up to me and started yelling at me in front of everyone. I was so embarrassed. S/he told me s/he talked to [Administrator C] and [s/he] said, 'If you keep complaining about this place, you're gonna [sic] get a 30-day notice and get your [explicative] kicked out of here!' Resident 1 stated s/he did receive a 30-day notice but that s/he didn't ever know when they would be kicking him/her out, so s/he has to be careful about what s/he says and to who. Resident 1 stated there had been a few very caring caregivers in the past, but that they left employment and now s/he only has a few caregivers s/he feels like s/he can trust (Caregiver V, I, and K.) Surveyor interviewed Family Member G on	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 49 5/22/2024 at 10:21 AM. Family Member G stated s/he spoke with Resident 1 (date unknown) after s/he was told by Manager A that the provider would "kick [his/her] [explicative] out" if s/he continued to complain to staff or other residents. Family Member G stated Resident 1 was frustrated and embarrassed that it happened in front of other residents in the dining area. Surveyor interviewed Resident 4 on 05/21/2024 at approximately 2:30 PM. Resident 4 stated s/he and Resident 1 were friends and would have frequent discussions as Resident 4 reference him/herself and Resident 1 were both their own persons and some of the only residents without memory care needs living at the facility. Resident 4 stated s/he knew the provider had been trying to "kick [Resident 1] out" and stated Resident 1 was frequently treated poorly because of it. Resident 4 referenced Administrator C and Manager A treating Resident 1 differently, with suspicion because of his/her history of drug use and distain. Resident 4 stated the provider would try to restrict Resident 1, telling him/her who s/he could and couldn't complaint to and who s/he could or couldn't have visit. Resident 4 stated it was common knowledge that Administrator C did not get along with some of the former employees and did not want Resident 1 to have a former employee's child (Family Friend CC) in the facility visiting. Resident 4 stated s/he recalled Resident 1 coming to him/her after the incident when Resident 1 was yelled at in the dining room and recalled Resident 1 was "very upset about it." Regarding the restrictive treatment of the residents, Resident 4 stated, "We're adults you know." During the interview with Resident 1 on 05/21/2024 at 11:01 AM, Resident 1 discussed	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 50	Y3234		

Administrator C and Manager A not allowing him/her to have Family Friend CC to visit. Resident 1 stated Family Friends CC's parent had previously worked at the facility and was not on good terms with Administrator C. Resident 1 stated because of this Administrator C would not allow Resident 1 to have Family Friend CC visit him/her. Resident 1 became emotional recalling his/her relationship with Family Friend CC who s/he stated s/he was close with, enjoyed talking to and helping with his/her homework. Resident 1 stated s/he looked forward to visits and has been very sad that s/he is not allowed to. Resident 1 recalled a day near his/her birthday (May 16th) when s/he was having a cookout to celebrate and invited Family Friend CC over. Resident 1 stated s/he was outside with Family Friend CC when Manager A came up to him/her and told Family Friend CC that, per Administrator C, s/he had to leave the property. Resident 1 stated it made him/her and Family Friend CC feel badly as it was embarrassing, upsetting, and demeaning. Resident 1 stated s/he had been happy, and it ruined the whole celebration. Resident 1 stated since then the only way s/he was able to visit with Family Friend CC is if s/he goes outside to the edge of the property on the street to meet him/her for a visit.

On 05/21/2024, Surveyor interviewed Manager A and Administrator C with LPN F present at approximately 12:00 PM. Manager A confirmed s/he had been instructed by Administrator C to tell Family Friend CC to leave the property. Administrator C stated s/he was following the provider's policy of not allowing previous employees to enter the facility. Administrator C reviewed the state and federal regulations that allow for residents to have visitors of their choosing and supersedes any policy the provider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 51	Y3234		

had in place about previous employees not being allowed to visit. It was reviewed that it is Family Friend CC's legal guardian's choice if and when Family Friend CC can visit. Administrator C and Manager A disagreed. Administrator C stated, "So you are telling me if we have determined it is not in the resident's best interest to have this visitor I cannot stop [him/her] from visiting to protect [him/her?]" Administrator C and Manager A stated their opinions of Family Friend CC's character though neither administrator was able to provide a basis for their allegations and stated they understood but disagreed with the resident's right to visitors of his/her choosing and Family Friend CC's decisions being made by his/her guardian. Neither Administrator C or Manager A brought their concerns to be discussed by Resident 1's care team including the resident and his/her representative Family Member G in the conversation to address the perceived risk of visiting with Family Friend CC.

On 06/03/2024 at approximately 12:00 PM, Surveyor conducted an interview with Administrator C, Manager B and LPN C present at times. After stating s/he understood Resident 1's rights to visitors of his/her choosing, Administrator C stated hypothetical situations questioning if the scenario could be used to place a restriction on Resident 1's visitors. Administrator C and Manager A again reviewed residents rights and stated they understood Resident 1 had the right to visitors of his/her choosing, including overnight stays, privacy, and to be treated with dignity.

Drug Screening
On 05/21/2024, Surveyor interviewed Resident 1 at 11:01 AM. Resident 1 stated due to his/her history of drug use the provider (including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 52	Y3234		

Manager A, Administrator C, and LPN F) will remind him/her that s/he is under a Schedule II pain medication contract that allows them to drug screen him/her at will. Resident 1 stated s/he has been frequently tested and knows s/he cannot refuse without risking his/her pain medications be discontinued, loss of a medical provider, loss of hospice services, and/or being removed from the facility.

On 05/21/2023, Surveyor interviewed Manager A, Administrator C and LPN F at approximately 12:00 PM. Manager A, Administrator C and LPN F each reference Resident 1's "pain contract" as a source of authority to impose restrictions on Resident 1's medication administration and drug test Resident 1 at will. Surveyor requested to view the contract and was informed by Manager A and LPN F that they did not have a copy of the document. Surveyor asked for a description of what the contract entailed, and Manager A, Administrator C, and LPN F could not say. Surveyor requested a copy of all medication contracts and lab orders.

On 6/03/2024, the provider had not yet procured Resident 1's medical records as requested. Surveyor observed LPN F call APNP R's office and Bellin Medical Record Department and request Resident 1's medical record including all lab work and any documentation of Schedule II drug contracts between Resident 1 and the provider. On 06/04/2024 Surveyor received the records and reviewed Resident 1's medical record sent from APNP R's office records. Resident 1's record included lab results for drug screens obtained on 08/04/2023, 11/09/2023, and 03/20/2024. Surveyor reviewed 1 Schedule II drug contract dated 11/15/2021 was specific to Lyrica and signed by Resident 1 for Former

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 53	Y3234		

Medical Provider Q, not APNP R or Hospice MD S. Per Resident 1's MAR, Resident 1 was not prescribed Lyrica from December 2023 through June 2024. The contract was not current, was not with Resident 1's current prescribers, and did not include medications other than Lyrica.

Surveyor reviewed an order from APNP R on 08/01/2023, "Random drug screens if suspected to [sic] using drugs" and 03/20/2024 "Obtain urine drug screen stat!" followed by the provider's LPN Y, "Standing orders for urine drug screen are in epic. Phoned Sun valley homes and spoke with [Manager A] [s/he] is aware of the orders from [APNP R] ..." Per interview with Administrator C on 05/21/2024 at approximately 1:00 PM, the caregivers were not trained in Alcohol and Other Drug Abuse (AODA.) The untrained caregivers had been given presumptive authority to drug screen Resident 1 without impunity. Per interview with Resident 1, s/he was "asked" if s/he would provide a urine sample and only agreed under the threat that if s/he did not comply, s/he would lose his/her pain medication, medical provider, hospice service and /or be kicked out of his/her home.

On 06/03/2024 at approximately 12:00 PM, Surveyor interviewed LPN F with Manager A and Administrator C present. LPN F stated Resident 1 was aware of "[his/her] pain contract" and that it, with the standing order for drug screening, allowed for the provider to drug test the resident at will. LPN F was asked to provide a copy of the "pain contract" and stated there was not a copy of it on file in the resident's record. LPN F stated each time they would "ask" Resident 1 to provide a sample and s/he was agreeable. After a review of the implied threats to his/ her access to pain medication, belief that s/he had signed a legal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 54	Y3234		

schedule II medication contract document that was still active, and possibility of losing hospice service and/ or being kicked out of his/her home, LPN F acknowledged being agreeable under implied threat is not agreeing at will. LPN F further discussed that when providing a urine sample the provider would stand with the resident in the bathroom, which is not consistent with standard drug screening practices for adults with no court order or criminal charges.

Pain Medication
During the interview on 05/21/2024, Resident 1 stated s/he previously lived with his/her Family Member G (who is a Registered Nurse) and that Family Member G is involved in his/her care plan although s/he is his/her own person. Resident 1 stated s/he wanted to go home for a weekend to visit with family, but the provider would not allow him/her to take his/her pain medication along. Resident 1 stated when Family Member G questioned why not, Manager A stated there was an order from the "Dr" (unspecified which) and it is in the provider and hospices' policies not to allow the pain medication out of the facility. Resident 1 stated when s/he and Family Member G wanted to verify the order and policy Manager A refused and did not give them a copy. Resident 1 stated s/he tried to get through the weekend with Tylenol and ibuprofen, but it was so painful s/he had to return to the facility early.

Surveyor interviewed Family Member G on 5/22/2024 at 10:21 AM. Family Member G stated s/he reached out to Manager A (date unknown) and told him/her that s/he wanted to bring Resident 1 home for the weekend. Family Member G stated, "[Manager A] told me absolutely not because they have a doctor's order that states that the medication can only be given

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 55	Y3234		

in the facility ... I asked to see the order ... we wanted a copy ... [Manager A] refused ..." Family Member G stated s/he felt Manager A and Administrator C were being vindictive and controlling beyond what they had a right to do. Family Member G, who is involved with Resident 1's healthcare per Resident 1's permission, stated to his/her knowledge Resident 1 never signed an ISP agreeing to only receiving the Schedule II medication at the facility, and such an agreement would be in violation of his/her rights by asking him/her to sign his/her rights away.

Surveyor reviewed the Individual Service Plan (ISP) and noted the ISP (undated) noted, "Independent Living Restriction- Resident is not allowed to take any controlled substance out on pass with [him/her.] [S/he] may sign out all regular medications but cannot take anything that is controlled (locked in the narc box.)" The care plan was not signed, and per interview with Resident 1 on 05/21/2024 at 12:30 PM and Family Member G on 5/22/2024 at 10:21 AM, was not agreed to.

Surveyor reviewed a provider communication log dated 08/04/2023:
Administrator C notes to Resident 1's primary provider, " ... we have not been sending [his/her] Lyrica with [him/her] when [s/he] goes out of the facility. Please confirm if this is what needs to be done or if we are to start sending it with [him/her.]"

PA-C AA responds. "No, [his/her] Lyrica should not be sent with [him/her] if [s/he] goes out of the facility."

Surveyor reviewed ON dated 04/01/2024 written by Manager A at 2:45 PM, " Hospice nurse W call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 56 to mention to [Manager A] ... medical director [MD S] also mentioned that [s/he] is not giving permission for the resident to take this medication outside of the building as [s/he] doesn't know what the resident is doing and who would be giving it to [him/her.]" On 05/21/2024 at approximately 2:00 PM Surveyor interviewed Manager A, Administrator C and LPN F. Surveyor asked to review all pain /medication contracts Resident 1 was entered into. The Administrators stated they were aware of only 1 pain contract. On 06/04/2024, Surveyor received 1 documented contract for review. Surveyor reviewed the pain contract dated 11/15/2021 was specific to the use of Lyrica which was discontinued, and was with a previous prescriber. The resident did not have any other additional pain contracts for his/her current prescribed medication (reviewed December 2023-June 2024) with the hospice prescribing MD S or APNP R. Surveyor verified through record review that the pain contract was not current, was not with Resident 1's current provider and was specific to Lyrica. Additionally, Surveyor reviewed notes indicating MD S, PA-C AA, RN BB and APNP R would not allow his/her Schedule II medications to be removed from the facility though they had no court order or legal authority to order to do so. During an interview with Administrator C Manger A and LPN F on 06/03/20204 at approximately 1:00 PM, Administrator C acknowledged if a prescriber writes an order that is harmful, against the law, does not comply with the resident's rights, or is not within their scope of practice, it is the provider's responsibility to recognize the error and act accordingly.	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 57	Y3234		

Investigation
In March of 2024 and investigation was conducted regarding medication diversion. The initial allegation came from Former Caregiver U: Surveyor reviewed Resident 1's record and noted a statement in the investigation interview of Former Caregiver U, "3/20 I was concerned that [Resident 1] was getting high and was pocketing meds due to the way [s/he] was acting." There was no associated documentation of how the resident was "acting" and no associated documentation of actions or health monitoring provided for Resident 1 after Former Caregiver U noted a potential change in condition. Caregiver U had no AODA training and was not qualified to assess the resident.

Surveyor reviewed a communication log from Resident 1's primary provider APNP R's office: 03/20/2024 Medical Aide X, "[Hospice RN W] from Moments Hospice calling to report that a peer at the facility has reported that the patient has been using. [Hospice RN W] is not sure if this is accurate or not but wanted to report it in case [APNP R] wanted to have [him/her] tested."

APNP R (no time noted,) "Please obtain urine drug screen stat!"

LPN Y (no time noted,) "standing order for urine drug screen are in epic ..."

Surveyor reviewed Resident 1's " pain contract" (Schedule II Medication agreement) dated 11/15/2021 with his/her primary provider at the time, DR. Q. The contract was specific for the use of Lyrica and was not current. The contract stipulated the resident understood that a drug screen could "be requested at any time." A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 58	Y3234		

request for a drug screen is not equivalent to a court ordered drug screen and does not predicate a standing order for a drug screening based on 1 Caregiver's (who is not qualified to assess the resident) allegation.

Surveyor reviewed the communication log from Resident 1's primary provider:
03/20/20204 11:06 AM APNP R notes, " ... Sun valley is searching [his/her] room right now."

The provider does not have authority to perform searches of Resident 1's room.

When the drug screening test results came back, Resident 1 was negative for the ordered Schedule II medications in his/her system.

APNP R notes on 03/20/2024 8:35 PM, " ... will need to update Moments Hospice. I will no longer prescribe [his/her] gabapentin, hydromorphone, lorazepam, or other schedule call 2-5 meds. [S/he] has broken [his/her] pain contract." APNP R presumed the results were indicative of Resident1 being guilty of pocketing medication without any notion that the medication could have been being diverted by staff.

Surveyor reviewed the provider's investigation and noted the interview was comprised of 2 questions to the staff. Neither question addressed potential caregiver misconduct/ medication diversion. Surveyor reviewed the written investigation statements on 03/22/2024 and noted the following interview statements:

Question 1: "When [Resident 1] was giving [sic] [his/her] medications [sic] have you watched [him/her] take [his/her] medication? And [sic] how did you watch [him/her] take them or [sic] what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 59 did you do to know that [s/he] took them? Question 2: "Have you ever had any suspicion that [Resident 1] was pocketing any pills in [his/her] mouth or in [his/her] room?" Further communication notes between the provider and the medical provider's office note the presumption of Resident 1 pocketing medication and do not address the discrepancy of the evidence. The evidence collected by their investigation was reviewed: 1. There was 1 allegation by Former Caregiver U who is not qualified to assess the resident and has had no training by the provider in AODH. There was no follow-up documentation or health monitoring to support the allegation. 2. 7/7 caregivers (Caregivers T, DD, N, FF, L, EE, and GG) interviewed (other than Former Caregiver U who alleged the pocketing) attested they watched Resident 1 take his/ her medication and denied any suspicion of Resident 1 diverting medication. 3. The Administrators each described Resident 1 as regularly reporting pain and continually seeking pain medication, which does not fit with someone pocketing his/her medication to divert to another person or waiting to take the medication. 4. The laboratory evidence that the medication was not in Resident 1's system as evidence s/he was not pocketing the medication to double up on the dose as it would have been found in his/ her system. 5. The vulnerability of a recovering addict not to be believed and potential to be used as a scapegoat in drug diversion. Resident 1 had been forth coming about previous drug use and was willing to be tested.	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 60 Administrator C stated, as evidence that the medication was not misappropriated by staff, that the narcotic log was complete. Administrator C then conceded that if caregivers were involved in medication diversion, the narcotic log could be manipulated, and the evidence would be supported by the laboratory findings. The provider conducted an investigation that was tailored to the only outcome being the resident responsible for medication diversion. Despite evidence to the contrary, the provider concluded the resident had been diverting the medication and as a result, Resident 1 was threatened to have his/her hospice contract terminated and the medical provider discontinued his/her gabapentin, hydromorphone, and lorazepam on 03/20/2024. 2nd Investigation On 05/21/2024, Surveyor reviewed a separate investigation conducted by Administrator C in August of 2023 (not dated) into the staff and Resident 1 using drugs outside of the facility. The investigation had an interview Administrator C conducted with Resident 1 where s/he asks him/her to recount his/her weekend away from the facility in detail. Resident 1 was asked personal questions that were not relevant to the investigation including questioning where and with whom s/he slept. When Resident 1 stated s/he slept upstairs, Administrator C questioned how Resident 1 got up the stairs, as Resident 1 has an amputated lower leg. Resident 1 responded s/he "crawled up the stairs on his/her stump and knee." Resident 1 was interrogated with questions that were not pertinent to the investigation and were not respectful. On 06/03/2024 at approximately 11:20 AM,	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3234	Continued From page 61 Surveyor interviewed Administrator C. Administrator C reviewed his/her investigation documentation and confirmed the line of questioning was not pertinent to the investigation and could be viewed as demeaning towards Resident 1. Cross Reference: N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0346 DHS 83.32(3)(b) Rights Of Residents: Confidentiality N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment N0355 DHS 83.32(3)(K) Rights Of Residents: Self Determination	Y3234		
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.	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3244	Continued From page 62	Y3244		

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure Resident 3 and Resident 10 received adequate and appropriate care within the capacity of the facility.

Findings include:

On 05/21/2024, the Department received complaint information alleging residents were not getting care to meet their needs.

On 05/22/2024 at approximately 10:22 AM, Surveyor interviewed Family Member G. Family Member G reported s/he was at the facility to eat lunch with Resident 1 a week prior. Family Member G described one staff present in the kitchen preparing food for lunch and each resident received a piece of lasagna plated in front of them. S/he observed Resident 3 seated at the table but was not eating. Family Member G stated s/he comes to the facility for lunch often and noticed Resident 3 has her/his food cut up and staff or family assist to feed him/her. S/he stated on this day, only one staff was serving lunch, and observed Resident 3 waiting for assistance from staff for over 30 minutes. Family Member G reported their concerns to Manager A regarding 2 staff being present but one staff being asleep, resulting in Resident 3 not eating their plated food for over 30 minutes.

On 05/29/2024 at approximately 1:40 PM, Surveyor interviewed Family Member P. Family Member P stated they met Resident 3 at the facility for lunch on 05/25/2024. Family Member P reported Resident 3 was seated at a table in the dining room when s/he arrived. Staff brought Resident 3 a bacon, lettuce, tomato (BLT)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3244	Continued From page 63	Y3244		

sandwich that contained slices of bacon, lettuce, and tomato between 2 slices of bread. Family Member P described the BLT sandwich as uncut on a plate and Resident 3 never touched the sandwich or asked for help with eating. Family Member P stated s/he did not feel comfortable asking staff to assist Resident 3 as s/he was still assisting other residents. Family Member P requested a knife to cut up the sandwich and feed Resident 3.

On 05/21/2024, Surveyor reviewed Resident 3's record and noted s/he was admitted to the facility on 03/07/2024. Resident 3 had an activated power of attorney. Surveyor reviewed Resident 3's individual service plan (ISP) with print date 05/21/2024.
Surveyor noted - Special Diet...Resident requires specially prepared meals: foods to be cut small and nectar thickened liquids. Residents needs additional monitoring during mealtime due to resident being an increased choking risk.

On 05/21/2024 at 2:33 PM, Surveyor observed Resident 10 calling out from his/her room for help stating, "I have to go to the bathroom!" Surveyor observed Resident 10 calling out for help for greater than 20 minutes. Resident 10 appeared unable to ambulate by him/herself and had a brown substance smeared on his/her shirt. The call light was located across the room behind his/her bed where s/he could not reach it. Surveyor located Caregiver T and notified him/her that Resident 10 needed assistance. Caregiver T stated, "Oh [Resident 10?] [S/he] always yells out for help. S/he is ok ." Surveyor observed Resident 10 was not assisted for an additional 10 minutes.

On 05/21/2024 at approximately 1:47 PM, Surveyor interviewed Resident 4. Resident 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017750	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH NINE ACRES	229 VAN DYKE ST OCONTO, WI 54153

(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
Y3244	Continued From page 64 stated the residents are not being cared for so s/he helps as much as s/he can. S/he explained Resident 10 needs help and staff don't always assist her/him. Resident 4 stated staff talked about Resident 10 needing plenty of water, so s/he always reminds Resident 10 to drink water throughout the day. On 05/21/2024 at approximately 11:01 AM, Surveyors interviewed Resident 1. Resident 1 stated that Resident 4 and her/him are friends and often visit in the dining room. Resident 1 reported they heard Resident 10 screaming for help from their room while visiting and Manager A yelled at Resident 10 to shut up. On 06/03/2024 at approximately 11:30 AM, Surveyors interviewed Administrator C who acknowledged that resident care needs were not being met. Administrator C reported s/he met with Caregiver M after being reported for sleeping during his/her shift. Administrator C stated that all facility staff will be meeting with him/her at the facility today to discuss resident cares. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	Y3244		