STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011326	A. BUILDING: _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLF RIVER CBRF	**N2222 WHITE CEDAR ROAD NEOPIT, WI 54150**

(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 04/01/2025, Surveyor conducted a standard survey, self-report review, and 2 complaint investigations at Wolf River CBRF. Additional information was gathered through 04/09/2025. As a result, the complaint was substantiated and 3 deficient practices were identified. Census: 4	N 000		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on record review and interview the Administrator did not provide adequate supervision to ensure Resident 1 received care and treatment appropriate to meet his/her behavioral needs or supervision of employees to ensure Resident 1's behavioral needs were met with appropriate interventions. The administrator did not ensure the resident's needs were appropriately care planned for or implemented by the employees and, as a result of the behavioral needs not being met, the resident received a 30 day involuntary discharge.	N 214		

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

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N 214	Continued From page 1 Findings Include: On 10/07/2024, the Department received a complaint alleging resident's behavioral needs were not being met. On 04/01/2025 at approximately 11:00 AM, Surveyor interviewed Director A and RN B and reviewed Resident 1's record. Surveyor reviewed records including the Individual Service Plan (ISP,) Medication Administration Record (MAR,) Observation notes (OBN,) Nurses Notes (NN,) Behavioral Flow Charts (BFC,) and Incident Reports (IR.) Resident 1 was admitted to the facility on 05/02/2014 with diagnoses including dementia, depressive disorder, and anxiety. Copies of 2 ISPs were given to Surveyor by Director A. The first ISP had multiple dates of review and /or updates handwritten across the top, "5/2/2020 [sic,] 11/2020 [sic,] 5/2021[sic,] 2-10-2022[sic,] 8-15-2023 [sic.]" The first ISP had a section titled "Specific Behaviors" that noted, "Disturbances at times create need for staff intervention. [Sic] has diagnosis of anxiety ..." " ...does have behavior charting q [sic] shift ...." " ...8/15/2023 on 6/13/2023 mental status questionnaire done [sic] score 9 points. No or mild impairment. Done by [RN E] [sic.]" Director A stated the second ISP (dated 08/15/2024) was the current ISP. Under "Specific Behaviors" this ISP noted, "Disturbances/ aggression at times staff need to intervene. [Sic] has DX [sic] of anxiety which can cause [him/ her] to be demanding and [sic] wants things done now. [Sic] Gets upset easily if [s/he] don't [sic] get what [s/he] wants. Try and [sic] redirect. [Sic] Show signs of attention seeking behaviors at times." Neither ISP lists interventions for behavioral management other than staff intervention and	N 214		

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attempting to redirect the resident with no further directives or resident specific notes. Director A verified s/he did not have POA (power of attorney) C signed copies of Resident 1's ISPs for 2020-2024. Director A provided Surveyor with additional BFC via e-mail on 04/08/2025. The BFCs were completed for January through October in 2022 and then resumed completion in January 2025. Director A stated s/he was unaware why the BFC documentation had not been completed between October 2022 through to January 2025.

On 04/01/2025 at approximately 12:00 PM, Surveyor interviewed Director A and RN B. Director A stated Resident 1 had a "long history" of behaviors related to his/her diagnosis and that s/he had instructed the staff to begin more detailed charting of the behaviors around approximately June 2024. Director A stated it was not as a result of increased behaviors but as a provider initiative to increase their documentation of the behaviors. Director A stated it was not intended to be a behavioral plan however recognized if the resident's behaviors were significant enough to warrant an increase in documentation, a behavioral plan or detailed ISP assessment would have been appropriate for the resident. Director A stated Resident 1 was given a 30-day involuntary discharge on 09/16/2024. Surveyor reviewed the discharge letter cited behavioral and care issues as reasons for the involuntary discharge. The discharge indicated the provider could no longer meet Resident 1's behavioral needs as, "there is imminent risk of serious harm to the health or safety of the resident other residents or employees as documented in the residence record."

Surveyor reviewed Resident 1's OBS

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documented descriptions of verbal altercations between Resident 1 and staff/ other residents but did not include the use of different interventions for behavior management. The staff document increased behaviors, their presumptions about Resident 1's motivations, and engaging in back-and-forth arguments with the resident instead of meeting his/her behavioral needs with appropriate interventions. Examples of documentation in the observation notes:

06/02/2024, Caregiver G describes Resident 1 telling him/her about a situation that occurred the previous evening. Caregiver G documented, " ... (Sounded like [s/he] is trying to get someone in trouble- [sic]) ... *[sic] And [sic] also came out trying to complain about the pad situation with [Caregiver H.]"

06/12/2024, Caregiver J (identified by Director A during an interview on 04/09/2025 at 10:20 AM.) wrote, " ... could hear [Resident 1] tell [Resident 2] to shut up so I went to see what was going on ... [Resident 2] was getting more agitated they were saying things to each other so I stepped between them and told [Resident 1] to go the other way and [s/he] says, 'I don't have to, I live here and I have every right to be here!' I said, 'But you're arguing.' [S/he] said, 'I don't give a [explicative,] we argue every day!![sic]' and walks into the front room by [Resident 3] and starts complaining. Before this [s/he] was taunting [Resident 2] for an hour, meanwhile I'm trying to keep [Resident 2] occupied and not be agitated. So I'm sure tomorrow will be my fault and [s/he] won't come out for meals again. [His/her] behaviors are escalating severely."

06/16/ 2024, Caregiver K wrote, " ... [Resident 1] started crying and says loudly 'I don't know why

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you are treating me like this' I asked [him/her] 'What do you mean?' and [s/he] says 'Being mean to me again' I said, 'How? What are you talking about?' [S/he] says, 'Oh you know you witch. You came to my room and I told you thank you and you didn't say anything!' I told [him/her] 'You didn't say nothing [sic] at all to me' and again Resident 1 says, 'I'm sick of you acting like this to me I'm going to report and write a complaint on [sic] you!' I said, 'OK, you do what you have to do, because I don't know what you are talking about.' Then [Resident 1] says, 'Everyone around here says you're mean to them and that you're a mean person' and I said again to [him/her] 'I don't know what you are talking about. Am I next in line to get accused of being mean to you?' and [s/he] says, 'Oh shut up! I'm reporting you!' Then about an hour and a half goes by and [Resident 1] comes out and finds me in a whole different tone and even [his/her] mood and the way [s/he] was carrying [him/herself] was different. [S/he] asks, 'Can I please get a cup of milk?' I got up and made [him/her] one and [s/he] took it back to [his/her] room. I was really nervous the rest of the day from that dramatic mood change."

08/10/2024, Caregiver K (identified by Director A during an interview on 04/09/2025 at 10:20 AM.) wrote, "[Resident 1] came out at 7:55 and said good morning I said good morning back ... I seen [sic] [him/her] going back to [his/her] room at 8:10 ... I feel like it is [his/her] plan to say I treated [him/her] some way."

08/17/24, Caregiver I wrote, "[Resident 1] [sic] making backhanded comments to [Resident 2] after I wiped the tables down after lunch. [Resident 3] said, 'Looks nice' [Resident 1] replied, 'Only if it stays that way.' I said, 'Keep your comments to yourself." [S/he] then said, 'I

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didn't mean it like that. I said that because we were going to be eating again." I said, 'I know how you meant it. That's unnecessary."

09/11/2024, Caregiver J (identified by Director A during an interview on 04/09/2025 at 10:20 AM) wrote Resident 1 requested a blanket as they were outside for a fire alarm, "I told [him/her] [s/he] has to wait because not everyone was out yet and that was my main priority. [S/he] shakes [his/her] head and says, 'just forget it' in an irritated tone. I told [him/her] [s/he] didn't have to be crabby and [s/he] changed [his/her] tone, 'No, I wasn't.'"

09/17/2024, Caregiver J described watching a bingo card for a resident and [Resident 1] becoming upset, "[Resident 1] said, 'Did you ask if it was OK that you watched a board for [Resident 2?]' I said, 'No, I figured since everyone won and it looked like [Resident 2] needed help I'd watch a board for [him/her.]' [Resident 1] said, 'Well I think that's unfair and cheating and you shouldn't do that.' I told [Resident 1,] 'Everyone won and it was the last game so I didn't see anything wrong with my actions.' [Resident 1] said, 'Well next time you can watch mine. You don't do anything for me.' I said, 'I do things for you. Whenever you ask I clean your room and do your laundry because I wanted to. I saw that you had laundry and I'm here to help you.' [Resident 1] said, 'Oh well if I could do my own I would.' I don't know exactly what [Resident 1] said because I walked away knowing I shouldn't continue going back and forth with [Resident 1.] I finished [his/her] laundry and continued doing what I had to to keep things short with [Resident 1.]"

Surveyor interviewed Director A on 04/08/2025 at

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N 214	Continued From page 6 3:48 PM. Director A confirmed s/he and RN B were responsible for reviewing the caregiver's charting and stated s/he was aware the caregivers had been charting subjectively within the resident's record. Director A acknowledged the caregivers documented approaches to the resident's behaviors did not follow appropriate interventions as they detailed arguing back and forth with the resident, escalating the situation, ignoring the resident, and at times documenting their personal presumption of the resident's motives. Director A stated the staff were taught to use staff interventions such as redirection, changing out caregivers, and "care in pairs" to address Resident 1's behaviors but confirmed there was not comprehensive documentation of the interventions in the ISP. Director A stated all of the caregivers had been trained in individual needs and services and responding to challenging behaviors but acknowledged this training did not appear to be implemented in the staff documentation of their interactions with Resident 1. Director A confirmed s/he had access to the documentation, was aware of its contents, and did not conduct reeducation with the caregivers in terms of behavior management and appropriate interventions and approach to meet Resident 1's needs. Surveyor interviewed POA C on 04/07/2025 at approximately 5:00 PM, POA C stated s/he first received the involuntary discharge letter on 09/23/2024 and held a phone conference with the provider including Director A on 09/23/2024 when Director A stated the provider had been documenting in a behavioral plan for the resident since June. POA C stated when s/he asked Director A why s/he had not been informed about the need for a behavioral plan Director A then stated it was not actually a behavioral plan but	N 214		

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that they had begun to document the residents' behaviors in June but did not consider it an official behavioral plan. POA C stated the behaviors documented since June were cited as reasoning for the involuntary discharge. POA C stated his/her frustration that when s/he asked Director A why s/he had not been updated about the need to document behaviors, the Director A stated it was not a change of condition, but then used the same documentation of behaviors as grounds for an involuntary discharge. POA C stated when s/he questioned the provider as to how they were addressing behavioral issues s/he was told by Director A, "We talked to [him/her] daily," however was given no specifics on how the behaviors are addressed, if any assistance or interventions were being provided, or any goals being set. POA C stated s/he received the requested observation notes from the provider and had concerns regarding how the staff were approaching Resident 1's behaviors. POA C stated the staff documented being argumentative back and forth with the resident, ignoring the resident, and their personal opinions. POA C stated the documentation was at times unprofessional, inappropriate for a resident's medical record, and exemplified no efforts had been made by the provider to implement appropriate interventions to manage Resident 1's behavioral needs prior to being given a 30-day discharge citing behavioral management as part of the reasoning. POA C expressed frustration stating the observation notes clearly showed a disconnect between documented assessment of the resident's needs versus how the employees are interacting with the resident and that the administrator had not recognized or intervened to reassess the needs with a behavioral plan or reeducate staff about appropriate interventions prior to issuing a 30-day involuntary discharge.

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N 214	Continued From page 8 Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved	N 214		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure the individual Service plan (ISP) for Resident 1 was comprehensive to meet his/her behavioral needs. The ISP from 2020 through 2024 had limited information regarding Resident 1's behavioral needs. The ISP did not comprehensively address resident wants and behavioral needs. Resident 1 was issued a 30-day involuntary discharge due to continued behaviors.	N 386		

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N 386	Continued From page 9 Findings Include: On 10/07/2024, the Department received a complaint alleging resident's behavioral needs were not being met. On 04/01/2025 at approximately 11:00 AM, Surveyor interviewed Director A and RN B and reviewed Resident 1's record. Surveyor reviewed records including the ISP. Resident 1 was admitted to the facility on 05/02/2014 with diagnoses including dementia, depressive disorder, and anxiety. Two copies of ISPs were given to Surveyor by Director A. The first ISP copy had multiple dates of review, "5/2/2020 [sic,] 11/2020 [sic,] 5/2021[sic,] 2-10-2022[sic,] 8-15-2023 [sic.]" Director A stated the dates indicated when the ISP had been updated and reviewed annually. The first ISP had a section titled "Specific Behaviors" that had what appeared to be 3 separate entries noted, "Disturbances at times create need for staff intervention. [Sic] has diagnosis of anxiety," followed by, "does have behavior charting q [sic] shift," then noted, "8/15/2023 on 6/13/2023 mental status questionnaire done [sic] score 9 points. No or mild impairment. Done by [RN E] [sic.]" The ISP was not signed by Resident 1 or POA C and the provider signatures did not have all corresponding review dates. Director A stated the second ISP copy (dated 08/15/2024) was the current ISP. Under "Specific Behaviors" this ISP noted, "Disturbances/ aggression at times staff need to intervene. [Sic] has DX [sic] of anxiety which can cause [him/ her] to be demanding and [sic] wants things done now. [Sic] Gets upset easily if [s/he] don't [sic] get what [s/he] wants. Try and [sic] redirect. [Sic] Show signs of attention seeking behaviors at times." The 8/15/2024 ISP was not signed by the resident,	N 386		

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POA C, or the provider. Neither ISP listed interventions for behavioral management other than staff intervention and attempting to redirect the resident with no further directives or resident specific notes. There was no documentation of desired outcomes, frequency/approaches to be used, measurable goals with specific time limits, or clear methods/ interventions for providing care.

On 04/01/2025 at approximately 12:00 PM, Surveyor interviewed Director A and RN B. Director A stated Resident 1 had a "long history" of behaviors related to his/her diagnosis and that s/he had instructed the staff to begin more detailed charting of the behaviors around approximately June 2024. Director A stated it was not as a result of increased behaviors but as a provider initiative to increase their documentation of the behaviors. Director A stated it was not intended to be a behavioral plan however recognized if the resident's behaviors were significant enough to warrant an increase in documentation, a behavioral plan or a detailed assessment within the ISP would have been appropriate for the resident. Director A stated Resident 1 was given a 30-day involuntary discharge on 09/16/2024. Surveyor reviewed the discharge letter cited behavioral and care issues as reasons for the involuntary discharge.

Surveyor interviewed POA C on 04/07/2025 at approximately 5:00 PM. POA C stated s/he first received the involuntary discharge letter on 09/23/2024 and held a phone conference with the provider including Director A on 09/23/2024. POA C stated s/he was unaware of any care plan (ISP) that had been made in recent years and had not been updated about any behaviors. POA C stated no ISP had been sent to him/her for review, approval, confirmation, or signature. POA C

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N 386	Continued From page 11 stated when s/he questioned the provider as to how they were addressing behavioral issues [s/he] was told by Director A "we talked to [him/her] daily," however was given no specifics on how the behaviors are addressed, if any assistance or interventions were being provided, or any goals being set. On 04/01/2025 at approximately 12:00 PM, Surveyor interviewed Director A and RN B. Director A stated the provider would use staff intervention, redirection, changing out caregivers, and "care in pairs" to address Resident 1's behaviors but confirmed there was not comprehensive documentation of the interventions in the ISP. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved	N 386		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The	N 387		

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N 387	Continued From page 12 resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not involve Resident 1's legal representative Power of Attorney (POA C) in developing the Individual Service Plan (ISP) and did not obtain POA C's signature of the plan acknowledging his/her involvement in understanding of and agreement with the plan. Findings Include: On 10/07/2024 the Department received a complaint alleging resident's behavioral needs were not being met. On 04/01/2025 at approximately 11:00 AM, Surveyor interviewed Director A and RN B and reviewed Resident 1's record. Surveyor reviewed records including the ISP. Resident 1 was admitted to the facility on 05/02/2014 with diagnoses including dementia, depressive disorder, and anxiety. Two copies of ISPs were given to Surveyor by Director A. The first ISP copy had multiple dates of review and /or updates handwritten across the top in what appeared to be varying inks and handwriting, "5/2/2020 [sic,] 11/2020 [sic,] 5/2021[sic,] 2-10-2022[sic,] 8-15-2023 [sic.]" Director A stated the dates indicated when the ISP had been updated and reviewed annually but could not verify who wrote what or when the individual updates within the document were made. The ISP was not signed by the resident or POA C. Former RN F signed the	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011326	A. BUILDING: _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLF RIVER CBRF	N2222 WHITE CEDAR ROAD NEOPIT, WI 54150

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N 387	Continued From page 13 ISP without a corresponding date of the signature to indicate when the review was signed. Former RN's D and E signed the ISP dated 08/15/2023. All 3 former RN's signed once and not separately for each year's required review (2020, 2021, 2022, and 2023.) Director A stated the second ISP copy (dated 08/15/2024) was the current ISP. The ISP was not signed by the resident, POA C, or the provider. When asked if there was another location the signatures might be, Director A stated the documents provided were where signatures would have been if they had been completed. Director A verified s/he did not have POA C signed copies of Resident 1's ISPs for 2020-2024. Director A stated the staff would call POA C to give any updates but that they frequently would leave a message to give a call back and would not receive a call back from POA C. Director A stated the provider would have e-mail communication with POA C as a result of POA C not responding to the phone messages. Surveyor requested Director A send any corroborating evidence such as e-mails or other documentation to verify if POA C had been included in the ISP planning. Director C sent a care plan (ISP) outline dated 08/12/2024 written and signed by Former RN D. Former RN D wrote POA C's name down as being a participant, but the document was not signed by POA C. During an interview with Director A on 04/08/2025 at 3:48 PM, Director A stated s/he was aware the submitted care plan outline did not provide verification that POA C was involved as it appeared POA C's name had been written in and no signature was obtained. Surveyor interviewed POA C on 04/07/2025 at approximately 5:00 PM. POA C stated s/he was unaware of any care plan (ISP) that had been made and stated the last care plan (ISP) meeting	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 387	Continued From page 14 s/he had been invited to was "years ago." POA C stated no ISP or care plan outline had been sent to him/her for review, approval, confirmation, or signature. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan	N 387		