STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525617	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Paul Elder Services, Inc	316 East 14th Street Kaukauna, WI 54130

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure the environment was free from abuse for 7 residents (R) (R2, R4, R10, R11, R3, R1, and R9) of 11 sampled residents. R2 was involved in 8 resident-to-resident altercations between 1/25/25 and 5/29/25. The facility added interventions to R2's care plan and moved residents who might trigger R2 off the unit in an attempt to prevent future incidents, however, the interventions implemented failed to prevent further resident-to-resident altercations and instances of abuse. Findings include: The facility's Resident Protection and Prevention and Investigation of Abuse, Neglect, Misappropriation, Exploitation, Caregiver Misconduct, and Injuries of Unknown Source policy, revised 10/2022, indicates: .4. Corrective Action: .b. When the individual implicated in the alleged conduct is a resident, family member, or visitor, the facility documents that it has taken appropriate steps to respond to the incident and to address the conduct or behavior to prevent harm or injury to other residents. Attachment A titled Code of Federal Regulations Under Abuse indicates: For a definition for willful refer to the interpretive guidelines at F689 where under Resident-to-Resident Altercations it notes: A resident-to-resident altercation should be reviewed as a potential situation of abuse .Willful means the individual intended the action itself, regardless of whether or not the individual intended to inflict injury or harm. Even though a resident may have a cognitive impairment, he/she could still commit a willful act. On 6/16/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease with early onset, dementia with psychotic disturbance, major depressive disorder, anxiety disorder, and primary insomnia. R2's Minimum Data Set (MDS) assessment, dated 4/22/25, indicated R2 was rarely/never understood. The MDS also indicated R2 had physical and verbal behavioral symptoms directed toward others on 4-6 days of the week but less than daily during the lookback period. R2's admission MDS, dated [DATE], indicated R2 had physical and verbal behavioral symptoms directed toward others on 1-3 days of the week during the lookback period. The MDS also indicated R2's behaviors impacted others by putting others at significant risk for physical injury, intruding on the privacy or activity of others, and significantly disrupted the care or living environment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, initiated 1/25/25, indicated R2 was involved in a resident-to-resident altercation and was triggered by loud social environments, loud voices and direct tones, when peers corrected or attempted to tell R2 what to do, and by witnessing physical contact between others. When triggered, R2 might attempt to physically correct others' actions. The care plan contained an intervention to reassure R2 when providing care to peers in R2's vicinity. The care plan also indicated R2 attempted to help others at times which was not always liked by peers. Surveyor noted the care plan had been updated over time and was last updated on 6/3/25. On 6/16/25, Surveyor reviewed incidents that occurred between R2 and other residents since R2's admission. Incident #1: On 6/16/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and dementia. R4's MDS assessment, dated 5/1/25, indicated R4 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R4 had severe cognitive impairment. R4 had an activated Power of Attorney for Healthcare (POAHC). R4 passed away at the facility on 6/5/25. A facility-reported incident (FRI) submitted to the State Agency (SA) indicated on 1/25/25 at approximately 12:00 PM, R2 was walking down the hallway past R4's room. R4 was in the doorway of the room and R4 yelled at R2 with an escalated voice to go away. R2 reacted and tapped R4 on the top of the head. R4 yelled for staff who were in a room assisting another resident. When staff responded, R4 was in a wheelchair in the doorway and R2 was standing next to R4. R4 informed staff that R2 hit R4 on the top of the head after R4 told R2 to go away. The Interdisciplinary Team (IDT) and Expressive Action Team reviewed the incident. The facility implemented interventions to redirect R2 away from R4's room and use 1:1 support if R2 was in a negative mood. Staff education was completed. On 6/16/25, Surveyor reviewed R2's care plan and noted the following intervention was added on 1/28/25: If I am entering my peers' rooms, please redirect me in order to keep myself and others safe. On 1/25/25, an intervention was added that indicated: It is important for my peers to greet me with respect and kindness. I may become upset with a direct tone. Please help respond to my needs or guide my peers if I become upset. Incident #2: On 6/16/25, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and anxiety disorder. R10's MDS assessment, dated 5/7/25, indicated R10 was rarely/never understood. R10 passed away in the facility on 5/15/25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A FRI submitted to the SA indicated on 2/12/25 at approximately 2:30 PM, R10 stood up from a wheelchair in the dayroom and stated R10 needed to use the bathroom. Staff approached R10 so R10 would not self-ambulate. R2 was assisting the nurse on duty and followed the nurse when the nurse approached R10. When R10 threw R10's arms out to the side as if R10 was losing balance, R10's arms made contact with staff and possibly R2. The report indicated R2 reacted to situations quickly and when R2 thought R10 hit staff, R2 wrapped R2's arms and hands around R10. R2 let go when asked by staff. R10 and R2 were provided 1:1 support. An intervention was added to provide reassurance to R2 regarding the safety of peers and staff when providing care to others in R2's vicinity. R2's care plan was updated with additional resident-to-resident triggers and interventions. Staff were educated to ensure interventions were in place. A progress note, dated 2/12/25 at 1:07 PM, indicated the writer interviewed R2 after the altercation and R2's spouse walked around the neighborhood with R2. R2 approached R10 with the writer and shook R10's hand. R10 had no recollection of the incident and did not show any signs of distress. On 6/16/25, Surveyor reviewed R2's care plan and noted the following intervention was added on 2/12/25: When my peers are receiving cares within my vicinity, please reassure me that everything is okay and that everyone is safe. Incident #3: A FRI submitted to the SA indicated a second altercation with R4 occurred on 2/15/25 at approximately 4:30 PM in the day room during dinner. R4 swore at staff because R4 wanted salt with dinner. Staff turned around to retrieve the salt from a cabinet. When staff turned back around, they noted R2 had quickly stood up and hit R4 who hit R2 back. R4 attempted to kick R2 but no contact was made. R2 was redirectable, however, R4 continued to attempt to hit R2 while staff separated the residents. The FRI further indicated R2 was usually friendly and pleasant, enjoyed socializing with others, and had positive interactions with staff and peers. Since R2 moved to the unit, R2 was interested in walking around the neighborhood, offering handshakes, engaging with peers, and initiating interactions with residents and staff. R2's expressive actions came on quickly, especially when R2 was overwhelmed with excessive stimuli. The FRI indicated R2 had altercations in the past, may respond to situations that R2 perceives as disrespectful, and could often be redirected with a calm, gentle voice and active engagement. R2 responded positively to calming activities in a structured and peaceful environment when agitated. The exercise bike, walks, and conversations about football were effective. A progress noted, dated 2/16/25 at 3:05 PM indicated R4 was upset about the resident-to-resident altercation and was hard to redirect that day. A progress note. dated 2/17/25 at 7:07 AM, indicated R4 mentioned the altercation several times that morning. R4 indicated R4 yelled at R2 and told R2 to never do that again. Staff reminded R4 that R4 was safe. R4 slept for the first half of the shift but had difficulty sleeping later on. A Social Service progress note, dated 2/17/25 at 3:03 PM, indicated the writer met with R4 after the altercation. R4 was tired and did not sleep well. R4 indicated R4 had an altercation with R2. R4 indicated R4 felt safe and denied that anyone harmed R4. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 2/19/25 at 12:29 PM, indicated R4 did not recall the incident at that time but had moments of recollection throughout the week. On 6/16/25, Surveyor reviewed R2's care plan and noted the following intervention was added on 2/15/25: Offer me music headphones with spa music during my meals if the environment is loud or I am triggered by noise around me. Staff education included to attempt to keep R2 and R4 away from each other, anticipate their needs, and provide salt on R4's meal tray. Incident #4: On 6/16/25, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and anxiety disorder. R11's MDS assessment, dated 5/30/25, had a BIMS score of 4 out of 15 which indicated R11 had severe cognitive impairment. R11 had an activated POAHC. A FRI submitted to the SA indicated on 2/23/25 at approximately 12:50 PM, R11 walked to the doorway of R11's room and R2 walked past. R2 swung R2's arm out and hit R11 in the face/chin. R11 fell backwards onto R11's bottom and had a cut on the chin. R11 was provided 1:1 support. Staff took R2 for a walk and provided incontinence care for R2. The FRI indicated Nursing [NAME] Administrator (NHA)-A followed up with R11 and R2 throughout the week. R2 did not recall the incident and showed no signs of distress. R11 recalled the incident but felt safe and was not afraid of R2. All other residents on the neighborhood were interviewed with no concerns. Staff determined incontinence could have been the root cause of R2's expressive actions. The investigation indicated R2 was incontinent around lunch time. Staff assisted R2 with cares and provided lunch, however, R2 was agitated and stood during lunch. When staff offered R2's scheduled Tylenol, R2 threw it across the room. Staff were in the common area with R2 when another resident called for assistance. Staff approached the resident but still had R2 in view. R2 walked toward the hallway past the first and second resident rooms near the day room. When R2 approached the second room, R11 entered the doorway and R2 hit R11. R2 was incontinent at the time of the altercation and was assisted with cares. An intervention was added to see if R2 was incontinent if R2's mood began to change and indicated cares could be a trigger for R2. If R2 was not in a good mood, staff should take R2 for a walk and reapproach. A resident-to-resident incident report submitted to the SA as part of the facility's investigation indicated while R11 ambulated into the hallway by R11's room, R2 was walking toward but was behind R11. When R11 turned around, R11 and R2 were face-to-face. R2 made a fist and punched R11 in the chin which caused R11 to fall back onto R11's bottom. The report indicated R2 was agitated during lunch, didn't want to sit down, and paced the halls. An intervention was added to check R2 for incontinence when R2 seemed agitated and offer a walk. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A witness statement from a nurse indicated R11 was walking out of R11's room by the side rail when another resident (R2) was walking toward R11 but was behind R11. The statement indicated when the nurse turned around, the nurse saw (R2) make a fist and hit R11 with a closed fist in the chin. R11 fell back onto R11's bottom. The following interventions were added: Ensure R2 is not incontinent, even if R2 was just assisted to the bathroom. If R2 is not accepting cares and is beginning to become upset, the nurse will designate someone to walk with R2 off the neighborhood and approach R2 again when R2 returns to the neighborhood. Walks usually help R2's mood which may allow cares to be accepted. If an associate is not available on the neighborhood, the nurse will call other neighborhoods to see if someone is available to assist. On 6/16/25, Surveyor reviewed R2's care plan and noted the following intervention was added on 2/23/25: If I appear uncomfortable or upset, please assess for incontinence. If my mood is impairing my ability to accept cares, please walk with me off of the neighborhood. Walking helps my mood. Once I return home, please reapproach me and provide cares. Incident #5: On 6/16/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, anxiety disorder, and major depressive disorder. R3's MDS assessment, dated 4/17/25, had a BIMS score of 2 out of 15 which indicated R3 had severe cognitive impairment. A FRI submitted to the SA indicated on 3/28/25 at approximately 9:30 AM, R2 and R3 were in the day room eating breakfast. R2 was standing next to R3 when R3 started yelling. R2 reacted by hitting R3 on the cheek. No injuries were noted. An immediate intervention was to offer R2 active engagement, including walking around the neighborhood. A Resident-to-Resident Behavior Incident Report indicated R3 was in a wheelchair in the day room near the table. R2 stood near R3 who yelled out. R2 hit R3 in the face and knocked R3's glasses off. On 6/16/25, Surveyor reviewed R2's care plan and noted the following intervention was added on 3/31/25: Please offer me an activity or engagement opportunity if we are on the neighborhood with downtime or if my peers are experiencing expressive actions of their own. Incident #6: A FRI submitted to the SA indicated on 3/30/25 at approximately 5:45 PM, R4 was in R4's room when R2 walked by. (The FRI indicated R2 and R4 had altercations in the past and R4 did not like when R2 was in R4's room.) When R4 saw R2 in R4's room, R4 yelled at R2 to get out of the room and wheeled toward R2. R2 pushed and struck R4's head. R4 punched and kicked at R2. Staff interviews indicated R4 recalled the event and stated R4 disliked R2. An intervention was added to ensure R2 did not enter R4's room. R4 was moved to a different unit on 4/2/25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/16/25, Surveyor reviewed R2's care plan and noted the following intervention was added on 3/31/25: Please offer me an activity or engagement opportunity if we are on the neighborhood with downtime or if my peers are experiencing expressive actions of their own. Incident #7: On 6/16/25, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and diabetes. R9's MDS assessment, dated 1/14/25, had a BIMS score of 4 out of 15 which indicated R9 had severe cognitive impairment. An MDS assessment, dated 4/16/25, indicated R11 had short-term memory impairment. A FRI submitted to the SA indicated on 4/29/25 at approximately 12:45 PM, Certified Nursing Assistant (CNA) staff were assisting another resident and the nurse needed to step off the unit. R2 walked up to R9 in the day room and attempted to pull R9's wheelchair away from the table. R9 yelled at R2 and R2 hit R9 on the arm. In response, R9 scratched R2's arm. Staff provided 1:1 support. An intervention was added to have R2 with staff if the day room could not be monitored. R9 was moved to a room closer to the nurses' station. R2 was provided 1:1 support throughout the night and into the morning of 4/30/25. The FRI indicated staff were educated not to leave the day room unattended. R2's care plan was updated with the resident-to-resident altercation. The FRI also indicated the Social Worker (SW) met with R9 in R9's room and the day room following the altercation to assess for signs and symptoms of psychosocial distress. The SW and R9 were in the day room when R2 walked in. R9 tensed and watched R2 as R2 entered. Some distress and worry were noted during the SW's interview with R9. An incident note, dated 4/29/25 at 2:16 PM, indicated R9's provider was updated on the altercation and that R9 had pain and swelling to the right hand/wrist area. An order was obtained for a portable X-ray of the right hand/wrist. A progress note, dated 4/30/25 at 10:28 AM, indicated the base of R9's right thumb was swollen and tender. The X-ray was negative. The note also indicated R9 was fearful of R2 and yelled at R2 to get away from me. R9 swore at R2 when R2 approached R9 in the day room. Staff separated the residents. A Social Services note, dated 4/30/25 at 1:13 PM, indicated the writer met with R9 following the altercation to assess for psychosocial distress. R9 indicated a peer (R2) caused physical harm and entered R9's room uninvited. When the peer was visible to R9, R9 appeared tense. Reassurance was provided and effective. On 4/30/25, NHA-A met with R9 following the SW's interview. R9 indicated R9 was okay and agreeable to a room change on 5/1/25. R9 was moved closer to the nurses' station and main entry of the neighborhood and was happy with the move. A progress note, dated 5/1/25 at 5:02 PM, indicated R9 was interested in moving rooms, however, later on R9 was upset and fixated on where the keys were to lock the door. R9 asked what good the move was if R9 could not lock the door. R9 was provided 1:1 support and expressed worry about another resident (R2) from the incident. R9's anxiety improved following reassurance and redirection. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/16/25, Surveyor reviewed R2's care plan and noted the following intervention was added on 4/29/25: I like to push other residents' wheelchairs around the neighborhood. Please help redirect me by having me help you with something else and please make sure I am within your sight when I am walking around the neighborhood or in the dayroom. I enjoy taking a walk off the neighborhood and spending time with other departments. On 6/16/25 at 12:45 PM, Surveyor interviewed R9 who had moved to another unit on 6/12/25. R9 indicated R9 moved to get away from a (resident) (R2) who grabbed R9's wrist and dumped garbage in R9's room. R9 indicated R9 moved closer to the nurses' station after the incident but didn't like that (resident) and moved to another room which was better. R9 indicated R9 felt safe now that R9 was in the new room. On 6/16/25 at 10:56 AM, Surveyor interviewed Med Tech (MT)-C who indicated R9 moved off the unit last week because of R2. MT-C indicated R9 was not entirely innocent, though, because R9 had started to provoke R2 intentionally. Incident #8: On 6/16/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and dementia. R1's MDS assessment, dated 4/18/25, indicated R1 had short-term and long-term memory impairment. A FRI submitted to the SA indicated on 5/29/25 at approximately 5:30 PM, R2 had a resident-to-resident altercation with R1 when R2 trialed a potential move to a new neighborhood. R2 finished supper, walked around the neighborhood, and looked out the window next to the table where R1 was sitting. R1 began to talk loudly which was normal for R1. R2 slapped R1 on the cheek. Staff escorted R2 out of the dining room and back to R2's unit. R2 was calm before and after the incident. Staff provided 1:1 support for R1 who calmed down. The intervention was not to move R2 to the new unit. A statement by CNA-H (which was part of a Resident-to-Resident Behavior/Incident Report) indicated CNA-H was sitting next to R1 and another resident and assisting them with supper. R2 was standing next to the other resident. R1 was yelling/talking and R2 moved around the table to look out the window. R2 then quickly moved toward and slapped R1. R2 showed no sign of frustration or anger. R2 moved too quickly for CNA-H to know R2 was going to slap R1. The incident report indicated R1 initially had a red cheek. A progress note, dated 6/3/25 at 8:16 AM, indicated R2 experienced agitation with physical aggression at times. Triggers included assistance with personal hygiene/cares, bathroom needs, loud noises, fast movements, loud or yelling voices, and a negative environment. At times R2's agitation/aggression appeared to be untriggered. During periods of agitation, staff continued to offer redirection and engagement opportunities. R2 was involved in several resident-to-resident altercations and the IDT recommended R2 move off the neighborhood. During a trial visit on another neighborhood, R2 was involved in a resident-to-resident altercation. The provider was notified and asked to provide treatment recommendations and complete a medication review. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/16/25, Surveyor reviewed R2's medical record and did not note any care plan interventions or documentation that indicated R2 was provided 1:1 support for extended periods of time other than walks, activities, and other engagement, redirection, etc. Surveyor requested 24-hour reports for the incidents on 3/28/25, 3/30/25, and 5/29/25. On 6/16/25, the facility provided schedules, dated 4/29/25, that indicated staff were assigned to 1:1 supervision with R2 from 4:00 PM to 7:00 AM on 4/30/25. In addition, the facility provided the following 24-hour report documentation: ~ On 3/29/25, R2 and R3 were on the 24-hour report related to the 3/28/25 incident. The report indicated resident-to-resident prevention was a top priority on R2's unit and CNAs must ensure engagement was active prior to leaving the day room for cares. The nurse should intervene if R2 became expressive near another resident. The report contained an instruction to call coordinators for assistance after lunch if needed and call another unit at 8:00 PM for CNA assistance with restlessness. ~ On 4/1/25, R2 was on the 24-hour report for incidents on 3/28/25 with R3 and on 3/30/25 with R4. The report indicated to monitor each resident for signs/symptoms of psychological distress. The report also indicated resident-to-resident prevention was a top priority on R2's unit and CNAs must ensure engagement was active prior to leaving the day room for cares. The nurse should intervene if R2 became expressive near another resident. The report contained an instruction to call coordinators for assistance after lunch if needed and call another unit at 8:00 PM for CNA assistance with restlessness. ~ On 5/30/25, the 24-hour report indicated R2 had a resident-to-resident altercation while on another unit on 5/29/25. In an email to the SA on 6/17/25 at 4:31 PM, the facility provided information that indicated R2's family visited 5-7 days per week for approximately 3 hours at a time, however, 1:1 support was not consistently documented. The email indicated the facility used support staff for R2, including staff who were already scheduled and from other departments. The facility indicated they used a collaborative approach which allowed them to meet R2's needs more effectively while being mindful of staffing demands. The facility provided dates and times when family visited, activities engagement support, examples of 1:1 support, restorative care, and other IDT support. On 6/16/25 at 10:03 AM, Surveyor interviewed CNA-F who indicated CNA-F was educated on interventions for R2. CNA-F indicated CNA-F had been 1:1 with R2 for a shift which involved mostly redirecting R2. CNA-F stated if R2 had a conflict with another resident, R2 would be 1:1 for usually a day or two. On 6/16/25 at 10:56 AM, Surveyor interviewed MT-C who indicated staff kept an eye on R2 and confirmed R2 had altercations with other residents. MT-C indicated R2 was not on 1:1 supervision but if R2 was agitated, staff provided 1:1 support. MT-C thought R2 was on 1:1 supervision for a period of time after altercations, but was not sure if staff documented when R2 was 1:1. MT-C indicated if R2 needed a 1:1 staff, the facility needed to bring a staff person in so unit staff could care for other residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/16/25 at 11:20 AM, Surveyor interviewed CNA-E who worked regularly on R2's unit. CNA-E stated R2 was not consistently provided 1:1 supervision, however, if R2 was anxious and had an altercation, a 1:1 staff was provided for a few days. CNA-E indicated staff are to keep an eye on R2. CNA-E indicated R2 had recently declined a bit and could not get up ad lib the last two days. CNA-E indicated if R2 needed a 1:1 staff on the AM shift, the facility would pull someone. If a 1:1 staff was needed on the night shift, it was tougher because there was no one extra to pull. CNA-E indicated the nurse would sit with R2 if R2 was restless. CNA-E confirmed education related to R2 and incidents and updates were on the CNAs' pocket notes. On 6/16/25 at 1:03 PM and 2:50 PM, Surveyor interviewed Clinical Coordinator (CC)-G who indicated the facility worked to find a root cause for the altercations with R2 and updated R2's care plan appropriately after each incident. CC-G indicated overstimulation could trigger R2 and meals were a busy time so staff provided additional support during those times. CC-G indicated the facility implemented appropriate interventions and worked hard to understand R2 who was impulsive. CC-G indicated the facility contacted the Aging and Disability Resource Center (ADRC) and used family and volunteers for support. CC-G indicated there should always be staff in the day room and indicated the facility talked to staff about ensuring the day room was monitored. When asked about 1:1 support for R2, CC-G indicated the facility offers 1:1 support in general and indicated there are more eyes and ears available for R2 when needed. CC-G indicated staff from various departments take R2 for walks and there are extra staff from 2:30 PM-6:00 PM and a float staff on the night shift. CC-G indicated staff are usually scheduled for 2 hours on one neighborhood and 2 hours on another, but can be pulled if needed. When asked why 1:1 support was not added to R2's care plan, CC-G indicated the facility probably could have added 1:1 support officially when it was implemented on 4/29/25 and 4/30/25 and stated 1:1 support is offered intermittently and as needed. CC-G indicated R9 was moved off the unit last week because R9 started becoming aggressive toward R2 by being loud and slamming doors. CC-G indicated if R2 was in R9's vicinity, R9 hollered and got loud which was a trigger for R2. CC-G indicated when an altercation occurred, R2 was on the 24-hour report for a period of time and the Expressive Action Team met to ensure appropriate interventions and follow-up were completed. On 6/16/25 at 2:28 PM, Surveyor interviewed CNA-D and CNA-E who were charting at a table in the day room while R2 was seated in a recliner. CNA-D and CNA-E indicated R2's interventions were helpful but did not prevent altercations between R2 and other residents. When asked about staffing the day room at all times and keeping an eye on R2, CNA-E indicated there were usually 2.5 CNAs on each shift, however, if another unit was short, staff were often pulled from their unit to assist elsewhere. When asked about calling staff for assistance when R2 was agitated, CNA-D and CNA-E indicated they can and do call for assistance which is sometimes provided and sometimes not. CNA-D and CNA-E indicated the unit can be very busy and if there is a lot going on, it is difficult to keep an eye on R2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525617	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Paul Elder Services, Inc	316 East 14th Street Kaukauna, WI 54130

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/16/25 at 2:44 PM, Surveyor interviewed NHA-A who indicated the facility discusses R2 at weekly meetings where staff submit concerns and ideas and the team reviews incidents, looks at root causes, and evaluates if interventions are effective. NH-A indicated residents are added to the 24-hour report board and staff are updated via CNA pocket notes. NHA-A indicated each altercation was different for R2 who did not like what R2 perceived as disrespectful behavior, including yelling, loud noises, and not acknowledging R2 when someone walked by. NHA-A indicated the facility did a week long trial with R2 with staff or family on a new unit, however, an altercation with R1 occurred at the end of the trial and R2 did not move. NHA-A confirmed R9 started expressive actions toward R2 and was moved off the unit. NHA-A indicated all staff were aware of R2 and the facility had staff with R2 when altercations occurred who were not expecting R2 to respond that way. NHA-A indicated while 1:1 supervision was not officially assigned, R2 was often a nurse's assistant and staff often brought R2 to NHA-A, the SW, or Director of Nursing (DON)-B. For official 1:1s, NHA-A indicated the facility provided a 1:1 staff initially until R2 adjusted to the unit and then provided a 1:1 staff through the evening and into the next day following the incident with R9 because R9 was upset. NHA-A indicated the 1:1 staff was in place until staff were able to fully assess R9. When Surveyor indicated Surveyor observed R2 in a recliner and staff indicated R2 could not get up on R2's own and needed more assistance for dressing, NHA-A indicated R2 had a similar change a couple of weeks ago and then bounced back. When asked about a consistent 1:1 staff, NHA-A did not feel a 1:1 staff would help or would have helped and indicated staff were next to R2 during the 5/29/25 incident. NHA-A also indicated R2 had a significant altercation with a staff member during a 1:1 time period and indicated a 1:1 staff could trigger R2. NHA-A indicated the facility provided reasonable interventions after each of R2's resident-to-resident altercations despite the fact R2 continued to be involved in resident-to-resident altercations that included physical aggression toward others.