STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525670	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oconto Health and Rehab Center	101 First St Oconto, WI 54153

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not provide adequate supervision to prevent accidents for 1 resident (R) (R1) of 3 sampled residents. On 6/8/24, R1 exited the facility without signing out and told staff when found that R1 intended to walk to a location in another city that was 37 miles from the facility. On 6/14/24, R1 exited the facility without signing out and told staff when found that R1 intended to walk to the same location. On 7/30/24, R1 left the facility and was found by police walking on a county highway that was 1.4 miles from the facility. On 8/6/24, R1 exited the facility without signing out and was found by police after 9:00 PM walking into on-coming traffic on an interstate highway off-ramp that was over 1.5 miles from the facility. On 8/18/24, R1 left the facility and was found by police walking on a country road approximately 4 miles from the facility. The road was on the opposite side of the highway from the facility and there were overpasses which R1 likely walked under. The facility did not provide adequate supervision to prevent R1 from exiting the facility without signing out on 6/8/24, 6/14/24, and 8/6/24. In addition, the facility did not have a system to monitor R1's whereabouts (including on 7/30/24 and 8/18/24) despite the fact R1 refused to wear a Wanderguard and continually left the facility. The facility's failure to implement safety interventions for a resident and provide supervision to prevent the resident from exiting the facility without staff knowledge created a reasonable likelihood for serious harm which lead to a finding of Immediate Jeopardy (IJ) that began on 7/30/24. Nursing Home Administrator (NHA)-A was notified of the IJ on 8/27/24 at 4:58 PM. The IJ was removed on 8/28/24, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: (continued on next page)

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

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Elopements and Wandering Residents policy, with a revision date of 9/16/23, indicates: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing unique factors contributing to wandering or elopement risk .If a resident is determined to be at risk for elopement or known to wander or elope: i. The resident's picture will be placed in the Wander Communication Binder. ii. If an alert bracelet system is used and deemed to be appropriate the bracelet will be applied .4. The Interdisciplinary Team (IDT), together with the resident's representative, should attempt to determine situations that may trigger a desire to leave and individual expressions in which staff should know could be a sign the resident may wander .6. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering: a. Residents will be evaluated for risk of elopement and unsafe wandering upon admission and throughout their stay by the IDT. b. The IDT will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the risk or to minimize risks associated with hazards will be added to the care plan and communicated to appropriate staff. d. Adequate supervision in accordance with evaluations will be provided to help prevent accidents or elopements .f. The effectiveness of interventions will be evaluated, and changes will be made as needed .8. Procedure Post-Elopement: a. A nurse will perform a physical evaluation, document, and report findings to the physician .c. A Social Services Designee will re-assess the resident and make any referrals for counseling or psychological/psychiatric consults . On 8/27/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including Huntington's disease (a neurodegenerative disease exhibited by problems with mood or mental abilities and a general lack of coordination), diabetes mellitus, chronic kidney disease, and depression. R1's Minimum Data Set (MDS) assessment, dated 6/3/24, stated R1's Brief Interview for Mental Status (BIMS) score was 12 out of 15 which indicated R1 had moderate cognitive impairment. R1's medical record indicated R1 was responsible for R1's healthcare decisions. R1's care plan, dated 6/25/24, indicated R1 had decreased safety awareness and insight and contained the following interventions: ~ Arrange for transportation if R1 requests to go to appointments, the Department of Motor Vehicles (DMV), [NAME] Bay, etc. (initiated 7/22/24); ~ Continue to remind R1 to sign out when leaving the facility (initiated 8/6/24); ~ Distract R1 if agitated by offering pleasant diversions, structured activities, food, conversation, television, or book (initiated 6/25/24); ~ Identify pattern of behaviors: Is R1 looking for something? Does it indicate the need for more exercise? Intervene as appropriate (initiated 6/25/24); ~ Staff will inform local police if R1 has been away from facility over 2 hours (initiated 8/5/24). R1's care plan also indicated R1 had impaired cognitive function or thought processes, had difficulty distinguishing between television and reality, lacked understanding of distance between places, had decreased safety awareness (initiated 6/3/24) and was at risk for self-inflicted, life-threatening injury related to a history of suicidal intent (initiated 6/10/24) (related to an attempted suicide in 2015). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's medical record contained the following assessments: ~ On 2/27/24, R1 was assessed at high risk for falls and low risk for elopement. ~ On 6/1/24, R1 was assessed at moderate risk for falls and low risk for elopement. ~ On 7/31/24, R1 was assessed at low risk for elopement. ~ On 8/20/24, R1 was assessed at low risk for elopement. Surveyor reviewed a Wander Communication Binder at the nurses' station. The binder contained pictures and information regarding three residents, but did not include R1. ~ A progress note, dated 6/8/24 at 3:53 PM indicated R1 ambulated out the front door pushing R1's wheelchair. R1 sat outside talking to other residents and then decided to leave the facility. Staff found R1 down the street walking toward Main Street. R1 stated the food was salty and R1 was heading to an emergency room (ER) in another city. R1 was brought back to the facility. Staff redirected R1 several times but R1 was fixated on going to another city and was placed on 15 minute checks. A corresponding police report, dated 6/8/24 at 6:30 PM, indicated staff reported that R1 was at a location on Main Street approximately 0.4 miles from the facility attempting to buy soda and staff needed R1 to return to the facility. An officer transported R1 back to the facility. Staff stated R1 had Huntington's disease and randomly left the facility when no one was looking. ~ Progress notes, dated 6/14/24 at 8:02 AM and 2:05 PM indicated R1 exited the front door, walked toward the bridge, and stated R1 was walking to a hospital. R1 was transported to the hospital for evaluation. R1 returned from the hospital at 2:00 PM and stated R1 would go back to the hospital if R1 was given any more antibiotics. ~ R1's medical record indicated between 6/15/24 and 6/30/24, R1 refused most oral medications but allowed insulin administration. A progress note, dated 6/17/24, indicated R1 stated R1 hoped R1 got a super big infection that puts me in the hospital. ~ An Examining Physician's Report (Adult Guardianship), dated 6/26/24, completed and signed by R1's physician, indicated R1 had Huntington's disease which caused progressive dementia and physical impairments, worsening memory, a flat affect, wandering and aggressive behavior, and R1 did not understand R1's memory or judgement impairments. The report indicated R1's incapacity was permanent and progressive. A SLUMS (St. Louis University Mental Status) Examination, dated 6/26/24, indicated R1 scored 12 (a score of 1-19 indicates dementia). ~ A police report, dated 7/11/24 at 5:31 PM, indicated at approximately 5:15 PM, an officer was dispatched to a business approximately 1.5 miles from the facility for a welfare check for R1 who stated R1 was a customer and walked 4 miles with R1's wheelchair. While the officer was en route, the officer observed R1 walking with a wheelchair approximately 1 mile from the facility. Due to the heat and distance, the officer offered R1 a ride back to the facility. (There was not a corresponding progress note in R1's medical record.) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ A progress note, dated 7/30/24 at 8:01 PM, indicated a concerned citizen reported they saw R1 pushing a wheelchair far from the facility. The Assistant Director of Nursing (ADON) was notified. The note indicated staff would check for R1 at bedtime and notify the police if R1 was not there. ~ A progress note, dated 7/30/24 at 8:27 PM, indicated staff received a call from the police department that R1 was found in traffic outside the city. The writer informed the officer that R1 was R1's own person, signed R1's self out, and staff could not force R1 to return. The officer stated R1 did not want to return to the facility and the officer would bring R1 back to the city and call R1's emergency contact. A corresponding police report, dated 7/30/24 at 8:08 PM, indicated an officer was dispatched to an intersection of county highways approximately 1 mile from the facility. Dispatch stated R1 was alternating between pushing R1's wheelchair south on the highway and sitting in the wheelchair to take a break. A car with hazards lights was following R1 approximately 1.4 miles from the facility. The officer observed R1 on the side of the road. The citizen stated they called the police and tried to give R1 a ride back to the facility, but R1 refused. The officer identified R1 from previous contact. R1 stated R1 was going to a county psychiatric institution because the facility did not take care of R1. The officer informed R1 that walking on a county highway was a safety hazard. The officer called the facility, asked staff to pick up R1, and was told no. Staff stated there was nothing they could do because R1 was R1's own person. The officer contacted R1's emergency contact who stated they were in another city, recently had a medical issue, and couldn't drive. Approximately 15 minutes later, the officer convinced R1 to return to the facility. R1 whispered and some of R1's answers did not make sense. The officer requested an ambulance and R1 was transported to the hospital. ~ Progress notes, dated 7/30/24 10:45 PM and 11:30 PM, indicated the police found R1 in a traffic lane. R1 asked to be transported to a psychiatric institution or hospital. The police convinced R1 to go back to the facility, however, R1 refused to stay unless the facility gave R1 $25,000. R1 was transported to the hospital via ambulance at 9:00 PM and returned to the facility at 9:15 PM. R1 was treated for a urinary tract infection (UTI) with a one-time dose of antibiotics. ~ A Risk/Benefit Record, dated 8/1/24, indicated risk versus benefit education was provided by staff regarding R1 leaving the facility, notifying staff where R1 was going, and signing out. R1 was asked if staff could put a Wanderguard on R1's walker. R1 declined, but stated R1 would sign out and let staff know where R1 was going. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ A progress note, dated 8/6/24 at 10:40 PM, indicated R1 returned to the facility at approximately 10:17 PM via police escort. R1 was found on the interstate near oncoming traffic. R1 had no apparent injuries, refused vital signs, refused medication, and stated R1's body works fine. A corresponding police report, dated 8/6/24 at 9:10 PM, indicated a welfare check was conducted for R1 at an intersection (one of the streets ran along a river) approximately 1.2 miles from the facility. The officer was not able to locate R1 upon arrival. Dispatch received a call a few moments later that R1 was on an interstate highway. The officer observed R1 walking on the fog line of an interstate highway off-ramp that was over 1.5 miles from the facility. R1 was self-propelling R1's wheelchair into head-on traffic and it was dark. The officer stated R1 was difficult to understand and R1's mental state was not 100%. R1 stated R1 was going to a county psychiatric institution and was taking back roads to get there. When the officer stated R1 was on a major highway and could not ride or walk on the side of the highway, R1 became argumentative and additional officers arrived. R1 was adamant about walking on the highway to get where R1 was going. R1 wanted to go anywhere but the facility and stated staff did not care if R1 came back. The officer spoke to R1 for less than twenty minutes, but determined R1's mental status was compromised. The officer brought R1 back to the facility. R1 apologized and stated R1 had a difficult time going back to the facility due to the way R1 was treated by staff. ~ A progress note, dated 8/18/24 at 3:10 PM, indicated R1 was R1's own person and signed out of the facility. An off-duty employee reported R1 was near a gas station and grocery store by a busy highway. Staff called the non-emergent dispatch line and asked police to check on R1. An officer reported that R1 stated R1 was taking a walk and would be back. The officer reinforced to R1 that R1 could not walk on the highway. A corresponding police report, dated 8/18/24 at 3:03 PM, indicated an officer was dispatched to an area near a grocery store where R1 was walking with a wheelchair and the officer located R1 near the store's driveway. Staff stated they were worried that R1 was trying to walk to a city that was 16 miles from the facility. R1 stated R1 wanted to go to the DMV in another city. The officer informed R1 that the DMV was closed and would reopen on 8/20/24. R1 stated R1 had a paper copy of R1's drivers license and wanted a card. The officer stated the officer didn't want to see R1 walk to another city and get hit by a car. R1 stated R1 would get food from the grocery store and go back to the facility. The officer called the facility and stated the officer would wait with R1 until staff picked up R1. Staff stated R1 was R1's own person and was free to walk around when R1 wanted. ~ A progress note, dated 8/18/24 at 5:50 PM, indicated a citizen called the facility and reported R1 was on a country road heading to the DMV in another city. The writer asked the citizen to stall and small talk with R1. The writer called the non-emergent dispatch line and updated them on R1's diagnosis of Huntington's disease, R1's location, and R1's description. The writer told dispatch they were concerned for R1's safety. A corresponding police report, dated 8/18/24 at 5:49 PM, indicated officer received a call that R1 was walking on a country road that was on the opposite side of an interstate highway from the facility. R1 left the facility several times recently attempting to go to other cities. R1's explanations for leaving the facility usually didn't make sense and R1 used a wheelchair to walk at a slow pace. Dispatch paged a county crisis worker and stated the officer was concerned that R1 would get lost in the dark and/or hit by a car. The crisis worker stated the facility was responsible for taking care of R1. The officer called the facility and asked staff to pick up R1. Approximately 30 minutes later, another officer responded to R1's location on the country road and transported R1 back to the facility. The officer reported R1 was walking down the middle of the road with no safety equipment to increase visibility for traffic. The report indicated there was continued neglect for R1's well-being as staff understood R1 was a potential threat to R1's safety but continued to let R1 leave unsupervised stating R1 was R1's own person. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ Progress notes, dated 8/18/24 at 6:21 and 6:40 PM, indicated the writer spoke with an officer who contacted the county's Human Resources and stated there was nothing they could do because it was the facility's responsibility to make sure R1 returned. The writer contacted the Director of Nursing (DON) and made arrangements for staff to pick up R1 in the facility's van. A corresponding police report, dated 8/18/24 at 5:49 PM, indicated an officer was dispatched to a county road due to an elderly person wheeling northbound in the road in a wheelchair. R1 stated R1 was going nowhere in particular but did not want to be at the nursing home anymore. The officer transported R1 back to the facility. ~ A progress note, dated 8/20/24 at 12:28 AM, indicated R1 left the facility without signing out at approximately 8:10 PM. Non-emergency services were contacted at approximately 8:15 PM. R1 returned to the facility unescorted at approximately 8:20 PM. At approximately 8:25 PM, police arrived and stated the facility was not allowed to call the sheriff's department for this anymore. (There was no police report associated with the note.) ~ A progress note, dated 8/22/24 at 3:28 PM, indicated the writer spoke with R1 who stated R1 liked the facility and staff were nice and helpful, but R1 wanted to go to another city. R1 stated R1 liked to walk and needed 2 Diet Cokes per day but had no money. On 8/27/24 at 9:00 AM, Surveyor observed R1 in bed. On 8/27/24 at 9:12 AM, Surveyor interviewed Adult Protective Services Worker (APSW)-C via phone who verified APSW-C received information from the facility regarding guardianship for R1. APSW-C stated there was a residency concern regarding what county was responsible for R1. APSW-C stated the facility had not asked APSW-C for guidance on how to keep R1 safe while guardianship was in process. APSW-C stated APSW-C would have suggested the facility implement door monitors, walk with R1 outside for safety, encourage R1's return to the facility, and work with R1's physician on medication. On 8/27/24 at 9:45 AM, Surveyor interviewed R1 who was in bed. R1 expressed no concerns regarding staff treatment, stated I'm just getting older and stated R1 had no way to get anywhere because R1 had no money. R1 had a flat affect and provided short answers to Surveyor's questions. On 8/27/24 at 11:41 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who stated LPN-E worked at the facility for approximately nine months and could not recall if the facility did elopement drills. When asked about R1's elopement status, LPN-E stated R1 was R1's own person and could sign R1's self out. LPN-E stated when the police brought R1 back, staff checked R1 for injuries and reminded R1 to sign out and let staff know when R1 left. On 8/27/24 at 12:06 PM, Surveyor interviewed NHA-A who reviewed sign out forms for R1 since admission. NHA-A stated R1 starting exiting the facility in mid-June without signing out or letting staff know after R1's friend got sick and could no longer see R1 or take R1 out of the facility. When Surveyor indicated several sign-out entries by R1 contained illegible dates and times, NHA-A verified many of R1's entries were illegible. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/27/24 at 12:59 PM, Surveyor interviewed DON-B. When asked what the facility did to keep R1 safe, DON-B stated staff checked on R1 to see if R1 went where R1 said R1 was going and stated, If (R1) agrees to come with us, we'll give (R1) a ride back. DON-B stated staff spoke with the police department and agreed if R1 was gone for more than two hours, staff would call the police to check on R1. DON-B indicated there was no documentation of the conversation but stated the Fire Chief was there. DON-B stated in June of 2024, a Certified Nursing Assistant (CNA) was on a walk with R1 and called the facility because R1 wanted to go to another city. DON-B met the CNA and R1 at an elementary school approximately 0.5 miles from the facility. The CNA called the rescue squad and R1 was adamant with the Fire Chief that R1 wanted to walk to another city. R1 stated R1 knew the city was 45 miles away and it would take R1 a couple days to get there which was why R1 had water and a sweatshirt. DON-B verified walking on an interstate highway was a safety threat and stated, That's why we set up if gone for more than two hours to call police. DON-B verified a lot can happen in two hours and there were concerns for R1's safety. DON-B stated if R1 didn't sign out, staff were to re-educate R1 when R1 returned to the facility. On 8/27/24 at 4:16 PM, Surveyor interviewed Social Services Designee (SSD)-F who had been in SSD-F's current role for approximately one year. SSD-F stated a month or two ago, R1 stated R1 wanted to go to another city and reconnect with family. SSD-F set up a meeting with R1 and the Aging and Disability Resource Center (ADRC) who spoke to R1, but stated they were not done with their assessment yet and had 30 days. SSD-F stated the IDT talked about R1's safety daily but SSD-F could not recall specifics. SSD-F stated the facility felt guardianship should be pursued which is why R1's physician completed guardianship exam documents. SSD-F verified SSD-F did not document the discussion with R1 but should have. SSD-F stated, It (R1's safety) was always talked about, but the big thing was (R1) was (R1's) own person and able to sign (R1's) self out so everyone was not sure if we were allowed to keep (R1) here. I know a few times staff has brought (R1) back. The failure to supervise a resident with impaired safety awareness, impaired cognitive function, and a history of exiting the facility without signing out or letting staff know the resident was leaving created a reasonable likelihood for serious harm which lead to a finding of Immediate Jeopardy. The facility removed the jeopardy on 8/28/24 when it completed the following: 1. Educated residents who leave the facility independently to sign out with their location and when they will return. 2. Offered R1 transportation to locations not within walking distance. 3. Updated the Wander Communication Binder. 4. Initiated monthly elopement drills. 5. Reeducated staff on the elopement/wander policy, including care planning and identification of potential elopement risks.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not provide appropriate medically-related social services for 1 resident (R) (R1) of 3 sampled residents. R1's hospital discharge summary indicated R1 had a history of a suicide attempt, was followed by a psychiatrist in the community, and had psychotropic medication discontinued while in the hospital prior to admission to the facility. The facility did not follow-up and assist R1 with the continuance of psychiatric services or attempt to expedite the guardianship process (example: request for emergency protective placement) in a timely manner when R1 left the facility multiple times and demonstrated unsafe behavior. Findings include: The facility's Elopements and Wandering Residents policy, with a revision date of 9/16/23, indicates: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing unique factors contributing to wandering or elopement risk .4. The Interdisciplinary Team (IDT) together with the resident's representative should attempt to determine situations that may trigger a desire to leave and individual expressions in which staff should know could be a sign the resident may wander .8. Procedure Post-Elopement .c. A Social Service Designee will re-assess the resident and make any referrals for counseling or psychological/psychiatric consults. On 8/27/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including Huntington's disease (a neurodegenerative disease exhibited by problems with mood or mental abilities and a general lack of coordination), diabetes mellitus, chronic kidney disease, and depression. R1's Minimum Data Set (MDS) assessment, dated 6/3/24, stated R1's Brief Interview for Mental Status (BIMS) score was 12 out of 15 which indicated R1 had moderate cognitive impairment. R1's medical record indicated R1 was responsible for R1's healthcare decisions. R1's care plan indicated R1 had decreased safety awareness and insight (initiated on 6/25/24); had impaired cognitive function or thought processes, difficulty distinguishing between television and reality, decreased safety awareness, and lacked understanding of distance between places (initiated on 6/3/24); and was at risk for self-inflicted, life-threatening injury related to history of suicidal intent (initiated on 6/10/24). ~ A progress note, dated 6/8/24 at 3:53 PM, indicated R1 ambulated out the front door pushing R1's wheelchair. Staff found R1 down the street. R1 stated the food was salty and R1 was heading to an emergency room (ER) in another city. When R1 returned, staff redirected R1 several times, however, R1 was fixated on going to another city and was placed on 15 minute checks. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ A police report, dated 6/8/24 at 6:30 PM, indicated staff reported R1 was at a location on Main Street approximately 0.4 miles from the facility attempting to buy soda and needed to return to the facility. Staff stated R1 had Huntington's disease and randomly left the facility when no one was looking. ~ A progress note, dated 6/14/24 at 8:02 AM, indicated R1 exited the front door, walked toward the bridge, and stated R1 was walking to the hospital. R1 was transported to the hospital for evaluation. ~ A progress note, dated 6/14/24 at 2:05 PM, indicated R1 returned from the hospital at 2:00 PM and stated R1 would go back to the hospital if R1 was given more antibiotics. ~ A progress note, dated 6/14/24 at 2:38 PM, indicated the hospital determined it was unclear if the change in R1's behavior was due to acute infection or the progression of R1's chronic neurologic condition such as normal pressure hydrocephalus (NPH) (a condition that happens when a person has too much of a certain kind of fluid in parts of the brain) or Huntington's disease. It was recommended to follow-up with Neurology in the next 1-2 weeks. ~ R1's medical record indicated between 6/15/24 and 6/30/24, R1 refused most oral medications but allowed staff to administer insulin. A progress note, dated 6/17/24, indicated R1 stated R1 hoped R1 got a super big infection that puts me in the hospital. ~ R1's medical record indicated staff notified R1's physician of R1's exits from the facility and medication refusals. A progress note, dated 6/17/24, indicated a Nurse Practitioner (NP) requested the Social Worker (SW) ensure R1's Power of Attorney for Healthcare (POAHC) documents were in place since they likely needed to be activated at some point. ~ An Examining Physician's Report (Adult Guardianship), dated 6/26/24, completed and signed by R1's physician, indicated R1 had Huntington's disease which caused progressive dementia and physical impairments, worsening memory, a flat affect, wandering and aggressive behavior, and R1 did not understand R1's memory or judgement impairments. R1 refused to complete a Power of Attorney (POA) document when R1 had capacity. The report indicated R1's incapacity was permanent and progressive. A SLUMS (St. Louis University Mental Status) Examination, dated 6/26/24, indicated R1 scored 12 (a score of 1-19 indicates dementia). ~ A Social Services note, dated 7/1/24 at 11:37 AM, indicated the writer spoke to an Adult Protective Services (APS) worker who provided a fax number to send the examining physician's report in order to start the guardianship process. ~ A police report, dated 7/11/24 at 5:31 PM, indicated at approximately 5:15 PM, an officer was dispatched to a business that was approximately 1.5 miles from the facility for a welfare check. R1 was outside the business and stated R1 had walked four miles with R1's wheelchair. While en route, the officer observed R1 walking with a wheelchair approximately one mile from the facility. ~ A progress note, dated 7/30/24 at 8:01 PM, indicated a concerned citizen reported they saw R1 pushing a wheelchair far from the facility. The note indicated since R1 was R1's own person and staff would check for R1 at bedtime and notify the police if R1 was not there. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525670	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oconto Health and Rehab Center	101 First St Oconto, WI 54153

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ A progress note, dated 7/30/24 at 8:27 PM, indicated staff were notified by the police that R1 was found in traffic outside the city. The writer informed the officer that R1 was R1's own person, signed R1's self out, and staff could not force R1 to return. ~ Progress notes, dated 7/30/24 at 10:45 PM and 11:30 PM, indicated the police found R1 in a traffic lane. R1 asked to be transported to a psychiatric institution or hospital. R1 returned to the facility but only agreed to stay if the facility gave R1 $25,000. R1 was transported to the hospital via ambulance at 9:00 PM per R1's request. R1 was treated with a single dose of intravenous (IV) antibiotics and returned to the facility at 9:15 PM. A corresponding police report, dated 7/30/24 at 8:08 PM, indicated an officer was dispatched to an intersection of county highways approximately 1 mile from the facility after a report that R1 was alternating between pushing R1's wheelchair south on the county highway and sitting in the wheelchair to take a break. A car with its hazards lights on was following R1 approximately 1.4 miles from the facility. The officer observed R1 on the side of the road. R1 stated R1 was going to a county psychiatric institution because the nursing home did not take care of R1. R1 whispered and some of R1's answers didn't make sense. The officer asked staff to pick up R1 and was told no. Staff stated there was nothing they could do because R1 was R1's own person. The officer convinced R1 to return to the facility. The officer requested an ambulance and R1 was transported to the hospital. ~ A progress note, dated 7/31/24 at 2:32 PM, indicated R1 had a flat affect (a sign of depression), ate breakfast and 25% of lunch, and stayed in bed most of the shift. ~ A progress note, dated 8/6/24 at 10:40 PM, indicated R1 returned to the facility at approximately 10:17 PM via police escort. R1 was found on the interstate near oncoming traffic. R1 refused vital signs and medication. A corresponding police report, dated 8/6/24 at 9:10 PM, indicated a welfare check was conducted for R1 at an intersection (one of the streets ran along a river) approximately 1.2 miles from the facility. The officer was not able to locate R1 upon arrival. Dispatch then received a call that R1 was on an interstate highway. The officer observed R1 walking on the fog line of an interstate highway off-ramp that was over 1.5 miles from the facility. R1 was self-propelling R1's wheelchair into head-on traffic and it was dark. R1 was difficult to understand and R1's mental state was not 100%. R1 stated R1 was going to a county psychiatric institution and was taking back roads to get there. R1 stated R1 wanted to go anywhere but the facility and staff did not care if R1 came back. The officer spoke to R1 for less than twenty minutes, but determined R1's mental status was in need of evaluation. ~ A Social Services note, dated 8/7/24 at 10:18 AM, indicated an email was sent to a county APS worker regarding the status of R1's guardianship. ~ A Social Services note, dated 8/7/24 at 10:41 AM, indicated the writer spoke with R1 about signing with a Managed Care Organization (MCO) to help R1 find alternate placement. R1 and the writer spoke to a worker from the Aging and Disability Resource Center (ADRC) who stated they would meet with R1 on 8/12/24 at 1:00 PM. ~ A Social Services note, dated 8/13/24 at 11:56 AM, indicated the writer received an email from Adult Protective Services Worker (APSW)-C requesting documentation on R1. The writer emailed the requested documents. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ A progress note, dated 8/18/24 at 3:10 PM, indicated an off-duty employee reported R1 was near a busy highway. The writer asked police to check on R1. An officer reported that R1 stated R1 was taking a walk and would be back. A corresponding police report, dated 8/18/24 at 3:03 PM, indicated an officer was dispatched to an area near a grocery store to locate R1 who was walking with a wheelchair to a city that was 16 miles from the facility. R1 stated R1 wanted to go to the DMV in another city. The officer informed R1 the DMV was closed and would reopen on 8/20/24. R1 stated R1 had a paper copy of R1's drivers license and wanted a card. The officer called the facility and asked staff to pick up R1. Staff stated R1 was R1's own person and was free to walk around when R1 wanted. ~ A progress note, dated 8/18/24 at 5:50 PM, indicated a citizen reported R1 was on a country road heading to the Department of Motor Vehicles (DMV) in another city. The writer called dispatch who said they'd send an officer. The note indicated the writer would update R1's physician as R1 had perseveration with Huntington's disease. A corresponding police report, dated 8/18/24 at 5:49 PM, indicated R1 was walking on a country road that was on the opposite side of an interstate highway from the facility and R1's explanations for leaving the facility usually didn't make sense. Dispatch paged a county crisis worker who stated the facility was responsible for taking care of R1. The officer called the facility and asked staff to pick up R1. Approximately 30 minutes later, another officer responded to R1's location on the country road. The officer reported R1 was walking down the middle of the road with no safety equipment to increase visibility for traffic. The report indicated there seemed to be continued neglect for R1's well-being as staff continued to state R1 was R1's own person and let R1 leave unsupervised. A second police report, dated 8/18/24 at 5:49 PM, indicated an officer was dispatched to a county road due to an elderly person wheeling northbound in the road in a wheelchair. ~ Progress notes, dated 8/18/24 at 6:21 and 6:40 PM, indicated the writer spoke with an officer who contacted the county's Human Resources and stated there was nothing they could do because it was the facility's responsibility to make sure R1 returned. ~ A progress note, dated 8/22/24 at 3:28 PM, indicated the writer spoke with R1 to see if R1 was unhappy at the facility. R1 stated R1 liked the facility, but R1 wanted to go to another city. R1 stated R1 liked to walk and needed 2 Diet Cokes per day but had no money. The SW and Business Office Manager (BOM) were working on getting R1's Social Security fixed and getting R1 placed in another city. ~ A note, dated 8/23/24 at 9:18 AM, indicated R1 was not on psychotropic medication and had a history of behavior issues. R1's behavior included socially inappropriate behavior (yelling, spitting, public disrobing, public urination/defecation), repetitive behavior (chanting, continuous calling out, repetitive questions, pacing, etc.), refusing care/medication/treatment, and increased behaviors in the evening hours (Sundown syndrome). R1 had not received routine or as needed (PRN) psychotropic medication in the past 7 days and declined psychiatric evaluations. R1 had intact cognition but decreased safety awareness and displayed a lack of insight. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 9:12 AM, Surveyor interviewed Adult Protective Services Worker (APSW)-C via phone who verified APSW-C received information from the facility regarding guardianship for R1. APSW-C stated there was a residency concern regarding which county was responsible for R1. APSW-C stated the facility had not asked for guidance on how to keep R1 safe while guardianship was in process. APSW-C stated APSW-C would have suggested the facility implement door monitors, walk with R1 outside, encourage R1's return to the facility, and work with R1's physician regarding medication. When asked if the facility was aware of the county residency issue, APSW-C stated APSW-C was about to contact the facility prior to Surveyor's call. On 8/27/24 at 9:29 AM, Surveyor interviewed State Ombudsman (SO)-D via phone who stated the facility had not contacted SO-D regarding R1. When asked what advice SO-D would have given the facility, SO-D stated SO-D would have asked if the facility requested a psychiatric consult and suggested they talk with R1 to find out what R1 thought was wrong. SO-D also suggested the facility find someone who R1 felt comfortable opening up to, use a Wanderguard system, and/or find volunteers to take R1 on outings. SO-D stated, (R1) is ultimately (R1's) own person and has a right to make bad choices .They can't keep (R1) there from a resident right's perspective as (R1) is not protectively placed at this time, but they need to keep (R1) safe. On 8/27/24 at 9:45 AM, Surveyor interviewed R1 who was in bed. R1 had a flat affect and stated R1 was just getting older and had no way to get anywhere because R1 had no money. On 8/27/24 at 11:34 AM, Surveyor observed R1 in bed. The lights were off and the room was dark. R1 stated R1 was okay. Surveyor reviewed emails to/from Social Services Designee (SSD)-F and APSW-C from 8/7/24 to 8/27/24. On 8/7/24, SSD-F emailed APSW-C about the status of R1's guardianship. APSW-C indicated APSW-C had not received a fax regarding R1. On 8/8/24, APSW-C emailed SSD-F regarding R1's residency status and requested SSD-F send detailed information. On 8/13/24, SSD-F emailed APSW-C and indicated R1 was admitted to the facility due to weakness and a fall at R1's apartment. R1 was enrolled in an MCO who stated they would pay for R1 to return to R1's apartment but would not pay for long term care. R1 did not want to return to R1's apartment and chose to disenroll with the MCO. R1 currently wanted to move to another city and was brought back to the facility by police on a number of occasions when R1 tried to walk to another city. R1 also signed out of the facility and walked to the bank or store. R1 declined assistance with POA documentation and had one friend that visited occasionally on weekends. The next email, dated 8/27/24 at 8:29 AM from SSD-F to APSW-C, asked how things were going with R1's guardianship. On 8/27/24 at 12:59 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R1 should have protective placement which was the purpose for seeking guardianship and stated, If they are their own person, they have the right to make the choice to leave the facility, even if it's a poor choice. When asked about a psychiatric referral, DON-B said DON-B thought R1 had a psychiatric referral and then stated, (R1) refuses. (R1) doesn't want anyone to know what is going on in (R1's) head. During an interview on 8/27/24 at 1:44 PM, DON-B verified R1 did not have a psychiatric referral but stated R1 had a neurology appointment scheduled in October of 2024 which was the earliest appointment available. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 4:16 PM, Surveyor interviewed SSD-F who had been in SSD-F's current role for approximately one year and was trained by the prior SSD. SSD-F stated a month or two ago, R1 stated R1 wanted to go to another city and reconnect with family. SSD-F set up a meeting with R1 and the ADRC who spoke to R1, but stated they were not done with their assessment yet and had 30 days to complete it. SSD-F stated R1's physician completed an exam to start the guardianship process which SSD-F submitted. SSD-F stated SSD-F learned that day that APS thought a different county should handle R1's case. SSD-F contacted that county regarding the next steps. SSD-F did not provide an answer when asked why there was a 38 day delay (from 7/1/24 to 8/7/24) in response from APS regarding R1's guardianship. SSD-F stated SSD-F took direction from DON-B and Nursing Home Administrator (NHA)-A. Following a discussion of the information in R1's hospital discharge summary, SSD-F stated, I don't recall that. If I was supposed to do something with that I didn't know. SSD-F verified the psychiatric concerns listed in the discharge summary should have been followed-up on. SSD-F stated the facility felt guardianship should be pursued which is why R1's physician completed guardianship exam documents. SSD-F verified SSD-F did not document the discussion with R1 but should have. SSD-F stated, It (R1's safety) was always talked about, but the big thing was (R1) was (R1's) own person and able to sign (R1's) self out so everyone was not sure if we were allowed to keep (R1) here . SSD-F verified SSD-F was dependent on the facility for what knowledge SSD-F needed for the SSD role and stated, I don't know unless I ask. I have no issue learning.