STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018903	A. BUILDING: _____ B. WING _____	C 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BEGINNINGS 4	**23495 HWY 64 CORNELL, WI 54732**

(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
M 000	INITIAL COMMENTS On 11/07/2023, Surveyor conducted a complaint investigation at New Beginnings 4. Data was collected through 11/08/2023. The complaint was substantiated. One deficiency was identified. Census: 4	M 000		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by: Based on record review and interview, staff did not ensure Resident 1's right to self-direction was respected and promoted when staff forced Resident 1 to take a shower against his/her choice. Findings include: On 09/11/2023, the Department received a complaint alleging staff violated a resident's rights.	M 556		

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

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M 556	Continued From page 1 On 11/07/2023 at approximately 12:15 p.m., Surveyor interviewed Manager A. Surveyor asked if s/he was aware of an incident when staff forced Resident 1 to shower. Manager A confirmed s/he was aware and provided Surveyor with documentation of the incident along with employee files. Surveyor asked Manager A to explain the incident. Manager A told Surveyor Resident 1 had been away at camp for a week. The next morning, after s/he returned, staff made Resident 1 get up to shower per Resident 1's normal routine. Resident 1 had been incontinent but did not want to get up as s/he was exhausted from camp. Staff then made Resident 1 get out of bed and into the shower, which made Resident 1 upset. Manager A confirmed the staff members were Caregiver C and Caregiver D. Surveyor asked how management found out the incident occurred. Manager A said Caregiver C and Caregiver D completed an incident report and reported the incident to House Manager (HM) B. HM B educated staff that they did not handle the situation appropriately and notified Resident 1's guardian, Family Member (FM) E, and case manager. Manager A said s/he was out of the state when the incident occurred. Manager A said that after this incident, all staff were mandated to complete a 2-hour resident rights training conducted by a representative from the managed care organization. On 11/07/2023, Surveyor reviewed Resident 1's record. Resident 1 had diagnoses including: intellectual disabilities, mood disorders, anxiety, depression, psychosis, and hallucinations. Resident 1's behavioral support plan (BSP) and	M 556		

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M 556	Continued From page 2	M 556		

individual service plan (ISP), dated 04/21/2023, indicated Resident 1 had a history of physical aggression, verbal aggression, and property destruction. Resident 1's goal was identified as: "Future goals of [Resident 1] are to establish stability, follow [his/her] daily routine, and to maintain a healthy diet."

BSP for Verbal Aggression

The causes of verbal aggression read: "Not getting [his/her] way, not wanting to do things (chores, shower, etc.), phone calls, not understanding situations, attention seeking." The BSP included the following: "Redirection and Support: Give [Resident 1] [his/her] space and some time to calm down. Trying to discuss the situation will only elevate [him/her] until [s/he] is ready to talk once [s/he] calms ... Try to redirect [Resident 1] to focus on [his/her] goals, house activities [s/he] enjoys, upcoming activities, and events ... Positively suggest calming choices for [Resident 1] ... Change subject to something positive in [his/her] life. If speaking with [Resident 1] seems to agitate [him/her] staff should not continue to try to talk to [him/her] and give [him/her] space ... Follow PRN (as needed) Protocol if re directions are unsuccessful and [Resident 1] has not requested a PRN on [his/her] own ... If [s/he] does not calm staff will continue to monitor closely for possible physical aggression, and property destruction, etc."

BSP for Physical Aggression

The causes of Resident 1's physical aggression read: "Elevated verbal aggression, mood swings, not getting [his/her] way, seeking attention, jealousy of peers, being frustrated, not understanding situations." The BSP included the

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M 556	Continued From page 3	M 556		

following: "Redirection and Support: Staff may positively suggest calming choices for [Resident 1] ... Reassure [him/her] that we want [him/her] here and that [s/he] can talk with staff about what is bothering [him/her] when [s/he] is ready. Staff will tell [Resident 1] they are here to help [him/her] cope and come up with ways to deal with [his/her] frustration. Follow PRN Protocol ... In the event [Resident 1] does not calm our internal crisis team will be called in which consists of off duty staff and management. They provide fresh faces and fresh re directions ..."

Incident Report

The incident report, completed by Caregiver C, read:

Date and time of the incident: 09/02/2023 at 6:00 a.m.
Why do you feel this occurred? "[Resident 1] woke up in a very bad mood."
What redirections were tried? "Tried talking about camp."
What hold was used specifically? "2 person escort."
Length of hold(s): "from bedroom to the bathroom"
After Hold Signs/Symptoms of Adverse Effects: "Tired."
Explained: "[Caregiver D] and I ([Caregiver C]) went to get [Resident 1] up for [his/her] 6am shower. [S/he] started yelling at us to shut the lights off. [S/he] wasn't getting up. When we refused to shut the lights off & leave [his/her] room, [s/he] started yelling louder, calling us names, cussing, threatening to call [his/her] parents. I proceeded to get [his/her] clothes, [s/he] continued cussing at me. I took [his/her] clothes to the dining table, proceeded to try &

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M 556	Continued From page 4	M 556		

verbally get [Resident 1] up. [S/he] refused. I took [his/her] clothes to the bathroom & went back into [Resident 1's] room. I removed [his/her] blankets from [him/her]. [S/he] then sat up & threaten [sic] to punch me. I told [him/her] [s/he] needs to go shower or I will escort [him/her] to the bathroom. [S/he] continued to cuss/yell. [Caregiver D] and I then each took [him/her] by [his/her] arms and walked [him/her] to the bathroom. We sat [him/her] on the toilet where [s/he] continued to cuss, call names & threaten to punch us. [S/he] then grabbed the toilet tank lid & threatened to hit us with it. We took the toilet lid away. We had to physically take [his/her] sleep shirt off, asked [him/her] if [s/he] was going to take [his/her] pants off. [S/he] refused. We escorted [him/her] right into the shower. At that time [Resident 1] said [s/he] would only take [his/her] clothes off if I left [him/her] and [Caregiver D] alone. After talking with [Caregiver D], we both felt comfortable enough for me to leave the room. [Resident 1] took [his/her] shower properly."
The report indicated management, HM B, was contacted at 6:24 a.m. HM B signed the report on 09/02/2023.

On 11/07/2023, Surveyor reviewed Caregiver C and Caregiver D's employee files. The provider conducted caregiver background checks upon hire. Caregiver C and Caregiver D received training upon hire and both had prior experience as a caregiver. Caregiver C and Caregiver D attended the mandatory 2-hour resident rights training that took place after this incident occurred.

On 11/08/2023 at approximately 9:15 a.m., Surveyor interviewed HM B on the phone. HM B said that when s/he received the incident report on Resident 1, s/he interviewed Caregiver C and

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M 556	Continued From page 5	M 556		

Caregiver D separately. HM B said they both gave the same story which indicated the incident occurred as it was written. HM B said s/he informed Caregiver C and Caregiver D they did not handle the situation appropriately. S/he reviewed Resident 1's complete program, including Resident 1's ISP and BSP with Caregiver C and Caregiver D. HM B said s/he also spoke to Resident 1. HM B told Surveyor s/he reported the incident to Resident 1's guardian and case manager. HM B confirmed Caregiver C and Caregiver D were still employed at the facility and there have been no further concerns with Caregiver C or Caregiver D.

On 11/08/2023 at approximately 9:20 a.m., Surveyor interviewed Resident 1 on the phone. Surveyor asked Resident 1 how s/he liked the staff and specifically asked about Caregiver C and Caregiver D. Resident 1 told Surveyor: "They're okay." Surveyor asked Resident 1 if staff assisted him/her with showers. Resident 1 replied: "Sort of." Surveyor asked if s/he felt safe there. Resident 1 said, "Yes."

On 11/08/2023 at approximately 9:45 a.m., Surveyor interviewed FM E, who was Resident 1's legal guardian and sibling. FM E confirmed s/he was notified about the incident. S/he told Surveyor the staff that morning did not handle Resident 1 appropriately. FM E said HM B did handle the situation well. FM E stated HM B "immediately took action to correct" what happened. FM E said Resident 1 did not remember the incident occurring and explained that Resident 1 can get angry and mean towards staff. Surveyor asked FM E if s/he had any concerns related to Resident 1's care since this incident. FM E told Surveyor s/he did not have concerns. FM E said Resident 1 would be able to

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M 556	Continued From page 6 tell someone if staff were not treating him/her right. SUMMARY Resident 1 had an ISP and BSP that gave clear direction on how staff should have handled Resident 1's behaviors when s/he refused to get up at 6:00 a.m. to shower. Caregiver C and Caregiver D did not follow Resident 1's BSP. Caregiver C and Caregiver D escorted Resident 1 to the bathroom, removed his/her shirt, and escorted Resident 1 into the shower. Caregiver C and Caregiver D did not respect Resident 1's right to self-direction related to Resident 1's choice to not get up and shower at 6:00 a.m. The provider immediately put a plan of correction into place to protect Resident 1 and all other residents. The provider re-educated the staff involved and mandated resident right training for all staff.	M 556		