STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016486	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAHR CIRCLE HOME	**7 BAHR CIRCLE MADISON, WI 53719**

(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 04/02/2024, with information gathered through 04/08/2024, Surveyor conducted a complaint investigation at Bahr Circle Home. One deficiency was identified. Complaint was substantiated. Census: 3	M 000		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on observation, record review and interview, the licensee did not provide services determined for 1 of 1 resident's Individual Service Plan (ISP). Resident 1 required 1:1 supervision, which was not provided, and de-escalation guidelines outlined in his/her Behavior Support Plan (BSP) were not followed. Findings include: The provider was licensed to care for up to 3 residents within the client groups: irreversible dementia/Alzheimer's, traumatic brain injury, advanced aged, developmentally disabled, physically disabled and emotionally	M 436		

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

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M 436	Continued From page 1 disturbed/mental illness. On 03/26/2024, the Department received a concern alleging that residents did not have adequate supervision and BSPs were not being followed. On 04/02/2024, at approximately 8:45 AM, Surveyor conducted an onsite complaint investigation. Surveyor interviewed Caregiver G who explained to Surveyor, on 03/26/2024, s/he was working at the neighboring home (county based). (The provider's home is in a duplex setting with the state monitored home on one side and a county monitored home on the other side.) Staff were trying to roll cigarettes for Resident 1 and was unable to operate the machine, so s/he went next door to ask for Caregiver G's assistance. Resident 1 is not allowed next door as s/he does not get along with the residents there. Caregiver G stated, "[Resident 1] followed [Caregiver I] into the home and I was trying to explain to [him/her] that [s/he] was not allowed in this home and [s/he] needed to go back to [his/her] side of the building. [Resident 1] became upset and started kicking me, hitting me, swearing, so I called the cops." Caregiver G explained Resident 1 had been moved to another home on 04/01/2024. Surveyor drove to Resident 1's new home. Resident 1 was sleeping upon his/her arrival (9:05 AM). Surveyor reviewed Resident 1's record. Resident 1's BSP, dated 02/06/2024, documented: "Member is being provided a 1:1 staff due to the severity of [his/her] aggression. The 1:1 will have [Resident 1] follow a schedule and participate in meaningful activities ..." "Staff/residents should keep their distance from	M 436		

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M 436	Continued From page 2	M 436		

[Resident 1] if [s/he] is becoming upset."
"Staff will disengage and approach [him/her] later. [Resident 1] will often go to [his/her] room or take a nap. Staff will later knock on [his/her] bedroom door and ask if [s/he] wants to talk/address what happened. [Resident 1] often calms down after [s/he] goes to [his/her] room or takes a nap."

On 04/03/2024 at 7:37 AM, Surveyor emailed Licensee A, Care Coordinator (CC) B, and House Manager (HM) C and asked what staff members were working on 03/26/2024, the date of law enforcement involvement with Resident 1. CC B stated Caregiver J and Caregiver K. Surveyor stated that it had been reported that Caregiver I was involved in the incident. CC B stated Caregiver I did not work that day.

On 04/03/2024 at 9:43 AM, CC B emailed Surveyor, Licensee A, CC B, and HM C and stated, "Further checks made with the schedulers revealed that it was in fact [Caregiver I] on shift and not [Caregiver J]."

On 04/03/2024, at approximately 10:15 AM, Surveyor interviewed Resident 1's managed care organization (MCO) Care Manager (CM) D. CM D stated, "[Resident] 1 was doing great until this incident. [Resident 1] does receive 1:1 supervision." CM D stated s/he had received a report from the provider regarding the incident. CM D stated that there were specific staff that worked with Resident 1 to maintain consistency. Surveyor asked if s/he was familiar with [Caregiver I]. CM D stated s/he did not know who that staff member was, and Caregiver I was not mentioned in the report that had been submitted.

On 04/03/2024 at 10:48 AM, Surveyor emailed Licensee A, CC B and HM C and requested the

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M 436	Continued From page 3	M 436		

report that was sent to Resident 1's care team regarding the 03/26/2024 incident. CC B forwarded the following report: "Hello Team, An error was observed with the staff who was on schedule at [home] when [Resident 1] was physically aggressive toward another staff. Please see the updated report."
"After the [Resident 1] had [his/her] 4 pm cigarette, the caregiver tried making some before [his/her] next scheduled time because [s/he] was out, but the machine was broken and could not make them. [Resident 1] became agitated about this and rapidly motioned [his/her] fingers to smoke. The caregiver went next door to use their machine and [Resident 1] followed. When asked not to enter the facility [s/he] became physically aggressive and hit the staff several times on [his/her] left hand and kicked [him/her] on [his/her] right leg. [S/He] was redirected again but became more aggressive and the police were called by the attacked staff at 4:10 pm. The police arrived at 4:20 pm and spent 15 mins trying to convince [Resident 1] to return to [his/her] facility. [Resident 1] went to [his/her] room, but aggressively paced back and forth making hand gestures in frustration as [s/he] repeatedly tried calling [his/her] guardian on the computer. The incident was reported to the office and a manager quickly went there to support them. The police monitored the situation until 4:40 pm then left. It took [Resident 1] over an hour to calm down, after which [s/he] had [his/her] dinner at 5:20 pm then stayed in the living room, then went to [his/her] room. There was no further incident."

Surveyor noted the incident report stated management went to assist, but the incident report originally sent to Resident 1's care team did not contain accurate information.
Surveyor noted Resident 1's ISP stated s/he was

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M 436	Continued From page 4	M 436		

to have 1:1 supervision, but Caregiver I, who was his/her designated caregiver, went to the adjoining home, leaving Resident 1 without 1:1 supervision. Resident 1 chose to go to the adjoining home after Caregiver I left, which resulted in the altercation.

On 04/03/2024, at approximately 12:05 PM, Surveyor interviewed Police Officer (PO) H. PO H stated s/he responded to the provider's home, 03/26/2024, regarding a physical altercation between a resident and a staff member. After assessing the situation and convincing Resident 1 to return to his/her home, PO H requested to review Resident 1's binder that contained his/her BSP. PO H stated Resident 1's BSP stated that s/he was to receive 1:1 supervision and that when his/her behaviors were escalated, staff were to disengage with Resident 1 and allow him/her to return to his/her room, as this often would de-escalate the situation. PO H stated Resident 1 retreated to his/her room, but staff continued to engage with him/her. PO H stated, "Police then left the home, hoping that would also assist with de-escalating Resident 1's current behaviors."

On 04/03/2024 at 6:33 PM, Surveyor emailed Licensee A, CC B, and HM C and stated, "The police officer stated they observed [Caregiver I] follow [Resident 1] into [his/her] room after [s/he] went there to calm down which caused more agitation for [Resident 1]. The police officer was reciting the BSP that was on file at the home which stated [Resident 1] was to be allowed the opportunity to calm down alone, which appeared to them did not happen." CC B responded, "To address [Resident 1] becoming more agitated after going into [his/her] room. [Resident 1] was trying to call [Guardian E] on [his/her] computer without success, and that made [him/her] more

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M 436	Continued From page 5 agitated. [Caregiver I] was only there to offer support and ensure [his/her] safety." On 04/08/2024 at 10:45 AM, Surveyor emailed Licensee A, CC B, HM C, CM D, Guardian E and MCO RN F and asked for clarification regarding management not knowing which staff members were involved in a resident-to-staff altercation resulting in law enforcement involvement if staff are submitting incident reports. CC B stated, "The incident report was not created by the staff. It was created by the member of the management team in the office." Surveyor asked how management knew what information to put into the incident report. CC B stated, "It was received verbally through a third party before the actual entry was made on the system."	M 436		