STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 11/29/2023, Surveyor conducted an onsite visit at Joyful Hearts to investigate one complaint. Additional information was gathered through 12/19/2023. The complaint was substantiated and six new deficiencies were identified. Census: 4	M 000		
M 218	88.04(2)(b) AWAKE STAFF FOR CONTINUOUS CARE The licensee shall ensure that he or she or a service provider is present and awake at all times if any resident is in need of continuous care. This Rule is not met as evidenced by: Based on interviews, observation, and record review, the licensee did not ensure that a service provider was present and awake at all times if any resident is in need of continuous care. Resident 1 had diagnoses to include Down Syndrome and a history of suicide attempts. Manager A was the primary live-in caregiver and slept during the overnight hours. On 11/17/2023, during the overnight hours, Resident 1 wrapped a cord around his/her neck in an apparent suicide attempt. Manager A was not aware of the incident until the following morning. Continuous care is defined as 88.02(9) "Continuous care" means the need for supervision, intervention or services on a 24-hour basis to prevent, control and ameliorate a constant or intermittent mental or physical condition which may break out or become critical during any time of the day or night. Note: Examples of persons who need continuous care	M 218		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

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M 218	Continued From page 1	M 218		

are wanderers, persons with irreversible dementia, persons who are self abusive or who become agitated or emotionally upset and persons whose changing or unstable health condition requires monitoring."

Findings include:

On 11/29/2023 at 10:05 AM, Surveyor interviewed Manager A. While describing Resident 1, Manager A stated Resident 1 had suicidal tendencies. Manager A stated Resident 1 had just been taken off of "suicide watch" after an incident on 10/23/2023 when s/he expressed thoughts of suicide. Manager A stated, "[S/he] is my most time consuming and [s/he] needs a lot of attention and awareness." During the interview, Manager A provided Surveyor with Resident 1's Daily Planner Document. Manager A stated, "Grey areas are times that I am not available. If [s/he] needs something during the grey time [s/he] holds off during the times that I am doing things to ask for things. If I am in my office here or when I am walking away and I am talking to myself."

On 11/29/2023 at 11:05am, Surveyor interviewed Manager A and Licensee B. Surveyor asked about the greyed out area on the Daily Planner Document beginning at 9:00 PM through the rest of the night. Licensee B stated that was when staff was "off duty ...we are not a 24 hour facility." Licensee B further explained Manager A was the primary live-in caregiver and s/he slept during 3rd shift. Licensee B stated s/he and 2 other staff only worked occasionally to cover for a few hours to provide Manager A with some downtime.

Surveyor reviewed staff scheduled provided by Manager A on 12/12/2023. In October of 2023,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

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M 218	Continued From page 2 Manager A was the primary caregiver for all shift during 25 out of 31 days. In November of 2023, Manager A was the primary caregiver for all shifts during 19 out of 30 days. On 11/29/2023 at approximately 1:00pm, Surveyor reviewed Resident 1's complete record. Resident 1 was admitted on 06/17/2022 with a history of Down Syndrome, sleep apnea, morbid obesity, mood disorder, gender dysphoria, and suicidal ideation. The record contained a document titled "CLIENT RIGHTS LIMITATION OR DENIAL DOCUMENTATION" which included justification for limiting Resident 1's access to his/her computer (limitation effective on or before 08/14/2023). The justification was due in part to the provider's belief that increased computer time resulted in increased suicidal ideation. It read, " ... [Resident 1] has had suicidal thoughts and attempts; for example, has wrap [sic] a coat around neck and tightened it, comments of taking pills and or asking for medications not needed like Benadryl, Melatonin and more or less of prescription medication." On 11/29/2023 at 2:55pm, surveyor interviewed Resident 1. Resident 1 said "I did something dangerous, I went to the mental hospital. Then I could not live in my apartment anymore and plus disability. I did something dangerous it was to myself." On 12/05/2023 at approximately 1:00pm, Surveyor interviewed Manager A and Licensee B. Manager A volunteered information that Resident 1 discussed self-harm frequently when first admitted. Manager A stated, "When [s/he] was first here [s/he] was constantly talking about it.	M 218		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 218	Continued From page 3 Once or twice a month [s/he] would say that [s/he] wants to choke [him/herself] with a shoelace." On 12/13/2023 at 11:30am, Surveyor interviewed Case Manager C who confirmed Resident 1 was at continued risk for suicide and made an attempt very recently. Upon request on 12/18/2023, Manager A provided surveyor with an e-mail s/he sent to Case Manager C on 11/18/2023 regarding the aforementioned attempt. The email read in part, "[Resident 1] came to talk to me about 11:10am today. [Resident 1] stated that [Resident 1] tried to Strangle [sic] self before bed last night...I said, so what did you use to do that. [Resident 1] stated the laces from my boots...Friday night [Resident 1] went to bedroom about 8:45pm had light on till about 9:50pm. I checked on [Resident 1] about 11:00pm before I went to bed." IN SUMMARY: Resident 1 had continuous care needs because s/he was known to be at risk for suicide, a risk that could manifest anytime during the day or night. The licensee did not ensure a staff member was awake to provide supervision or services on a 24 hour basis. Manager A was a live-in caregiver and would sleep during the overnight hours. Resident 1 was provided a written schedule, informing him/her that Manager A was "off duty" daily beginning at 9:00 PM. At an unknown time during the overnight hours on 11/17/2023, Resident 1 wrapped a cord around his/her neck. Manager A was not aware of the incident until 11:10 AM the following morning when Resident 1 self-reported the incident.	M 218		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

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M 230	Continued From page 4	M 230		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on interview and record review, the licensee permitted a condition of risk which placed the health, safety and welfare of residents at substantial risk of harm. The licensee did not implement a process to ensure allegations of abuse or resident rights violations were immediately responded to and investigated. Findings include: Surveyor reviewed records from Wood County Adult Protective Services (APS) received on 12/05/2023. According to the records, Wood County APS received, investigated and substantiated 2 complaints involving Manager A's treatment of Resident 1. In June 2023, APS substantiated allegations Manager A swore while communicating with Resident 1 and was implementing punishments in the form of 15 minute time outs. In September 2023 APS substantiated allegations Manager A would direct harsh words at Resident 1 when s/he was frustrated, such as "get out of my face" and "damn it [Resident 1] this is enough." On 11/29/2023 at 10:05 AM, Surveyor interviewed Manger A. Manager A stated Resident 1 had made allegations Manager A swore at him/her, but Resident 1 "misreads" situations and	M 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 230	Continued From page 5	M 230		

Manager A said s/he only swore at his/her computer and not residents. Manager A also described an incident when Resident 1 alleged Manager A acted inappropriately by yanking Resident 1's laptop out of Resident 1's hands. Finally, Manager A confirmed APS and the managed care organization (MCO - funding source) had been talking to and working with Manager A and Licensee B over recent months due to concerns about Resident 1's rights being violated.

On 11/29.2023 at 10:10 AM, Surveyor asked Manager A what s/he does if someone raised a concern or made an allegation against him/her. Manager A replied, "I let [the MCO] know and the [guardian]...[Licensee B] is aware when allegations happen. I inform [him/her] right away of allegations."

On 11/29/2023 at 11:05 AM, Surveyor interviewed Licensee B. Licensee B confirmed s/he had knowledge of APS invovlement at least twice since June 2023 due to concerns over Manager A's treatment of Resident 1 and Resident 1's right's being violated. Licensee B commented, "We are going through this very long process of how many rights [Resident 1] actually has... [Resident 1] has an imagination...[s/he] makes accusations." Surveyor observed Licensee B was smiling and using a mocking tone while describing Resident 1. Licensee B said, "You just breathe through it. [Resident 1] is offended no matter what you say."

Licensee B did not provide Surveyor documentation of investigations into the aforementioned concerns identified by APS. Surveyor asked Licensee B if s/he had a policy on responding to allegations of abuse and Licensee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 230	Continued From page 6 B said s/he did not. Surveyor asked if there was a process to document allegations and Licensee B said, "I would say no." Cross Reference: N0548 DHS 88.10(3)(a) Fair Treatment N0556 DHS 88.10(3)(e) Self-Direction	M 230		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on observation and interview, House Manager A and Licensee B did not complete 15 hours of training related to health, safety and welfare of residents, fire safety. first aid, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. Between 04/13/2022 (initial licensure) and 11/14/2023, neither House Manager A nor Licensee B completed any training. Findings include:	M 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 244	Continued From page 7	M 244		

The Department received a complaint alleging resident rights concerns.

On 04/13/2022, the provider was licensed to serve up to 4 residents from the following client groups: physically disabled, emotionally disturbed/mental illness, irreversible dementia/Alzheimer, advanced age, traumatic brain injury and developmentally disabled.

On 11/29/2023 at 11:05 AM, Surveyor conducted an onsite visit and interviewed Manager A. Manager A explained s/he is the primary caregiver and receives occasional relief from Licensee B and 2 other part time caregivers. On 12/01/2023 Manager A emailed Surveyor the staff roster:
Manager A - hire date 04/13/2022, start date 06/01/2022
Licensee B - hire date (blank), start date 06/01/2022

On 11/29/2023, Surveyor reviewed Resident 1's complete record. The record included a "letter of history" authored by Manager A which read in part, "[Resident 1] moved in June 17, 2022... had a history of Trisomy 21, Mental Retardation...Mood Disorder, Gender Dysphoria, Suicidal Ideation, with history of emergency room and [mental health facility] visits, and excessive calls to Crisis Intervention." [sic-all]

Note: "Gender dysphoria is the feeling of discomfort or distress that might occur in people whose gender identity differs from their sex assigned at birth or sex-related physical characteristics. Transgender and gender-diverse people might experience gender dysphoria at some point in their lives. However, some transgender and gender-diverse people feel at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

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M 244	Continued From page 8	M 244		

ease with their bodies, with or without medical intervention. A diagnosis for gender dysphoria is included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a manual published by the American Psychiatric Association. The diagnosis was created to help people with gender dysphoria get access to necessary health care and effective treatment. The term focuses on discomfort as the problem, rather than identity." Source: https://www.mayoclinic.org/diseases-conditions/gender-dysphoria, retrieval date 01/04/2024.

Upon request on 12/18/2023, Manager A provided Surveyor with documentation of the provider's guidelines for responding to residents at risk for suicide. The document was titled, "Suicide Watch/Self-Harm Guidelines." Surveyor noted the response to suicidal statements or attempts was broad, overly restrictive and not indvidualized.

The document read in part, "These are the steps the home does if any resident states or attempts to harm themselves in any manner. Staff has the right to determine the level of removal or length of time/days...1st Attempt or Threat of self-harm. This is done for 3-5 days depending on the severity. 1. All sharp objects, strings, cords, shoe laces, toothbrush, pens / pencils, any clothing with strings, and all hangers are all removed from the resident's room. 2. All liquids are removed from resident's room - shampoo, conditioner, soap, colognes/perfumes, mouthwash, toothpaste, deodorant, etc....3. The resident is limited to the amount of time alone in their room. 4. The resident must tell staff why they are going in their room...6. If the person is one who is known to choke themselves with items; clothing and bedding can also end up being removed...2nd or More - Attempt or threat of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 244	Continued From page 9	M 244		

self-harm This is done for 5-7 days and could be extended 1. All items listed above are removed from room. 2. The resident is not allowed in their room except to sleep...5. The resident's room could have everything remove (i.e. furniture) except for the bed mattress depending on the person and severity..."

During an interview with Manager A on 12/19/2023 at 3:39 PM, s/he explained s/he developed the guidelines which applied to any resident at risk for suicide. Manager A confirmed Resident 1 was admitted in June 2022 with a known history of at least 1 suicide attempt. In August 2022, Manager A was informed by Resident 1's therapist that Resident 1 "had rough day" and needed "a little extra attention because of the event that happened during therapy session." Manager A said, "It took me 3 days...to get it out of [Resident 1] (who eventually said), '...I tied my jacket around my neck and was trying to choke myself during therapy.'" Manager A stated in response to Resident 1's disclosure, Manager A implemented the guidelines "with all possessions removed for 3 days...I had taken all of [his/her] clothes from [him/her], all [his/her] electronic devices, sharp objects out of the room. [Resident 1] was left with the desk, bed, chair and (CPAP) breathing machine." Manager A said the guardian felt the interventions were too restrictive and increased Resident 1's negative thoughts and stress and asked that all belongings be returned. Manager A complied with the guardian's request but had the guardian sign a new document which read in part, "I....the guardian of [Resident 1], Request that [s/he] be removed from all suicide watches and self-harm watches. I request that staff does intervene if they see or hear [him/her] attempting any harm to self...I will take full responsibility if anything happens to said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 244	Continued From page 10	M 244		

person. I also will not hold Joyful Hearts/Joyful Hearts LLC the (Adult Family Home) or their staff who is caring for [him/her] liable for anything including the death of said person."

Surveyor noted the document did not identify any steps the provider would take to monitor Resident 1's risk for suicide or interventions they would implement if there were indications of increased risk.

During the 12/19/2023 interview with Manager A, Surveyor also inquired about Resident 1's diagnosis of gender dysphoria. Manager A described how Resident 1 frequently changes his/her mind about his/her preferred name (male name, female name or gender neutral name) and preferred pronoun. Manager A said at times s/he (Manager A) gets frustrated by this and commented, "this mixed one (referring to Resident 1), is causing me an issue."

On 12/19/2023 at 3:39 PM, Surveyor conducted a follow up interview with Manager A and requested documentation of all training completed by Manager A and Licensee B since licensure on 04/13/2022 in the following areas:

resident rights and suicide prevention
treatment appropriate to residents with developmental disabilities, gender dysphoria and/or transgender individuals

Manager A stated since licensure on 04/13/2022 until 11/14/2023, neither s/he nor Licensee B had training in any of the topics. S/he said on 11/15/2023, s/he and Licensee B participated in a 2 hour resident rights training provided by the funding source which was a result of concerns about restrictions in the home and how they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 244	Continued From page 11 infringed on resident rights. Manager A said prior to the 11/15/2023 training, the last time either s/he or Licensee B had any training was in 2019 or 2020 and s/he did not have documentation of it. Cross Reference: M0218 DHS 88.04(2)(b) Awake Staff for Continuous Care M0424 DHS 88.06(3)(f) Review of ISP M0424 DHS 88.10(3)(e) Self-Direction	M 244		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1's individual service plan (ISP) was updated with a description	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 424	Continued From page 12 of the services the provider would offer to meet Resident 1's needs related to suicide risk and diagnosis of gender dysphoria. Findings include: On 11/29/2023 at approximately 1:00 PM, Surveyor reviewed Resident 1's complete record. The record included a "letter of history" authored by Manager A which read in part, "[Resident 1] moved in June 17, 2022...had a history of Trisomy 21, Mental Retardation...Mood Disorder, Gender Dysphoria, Suicidal Ideation, with history of emergency room and [mental health facility] visits, and excessive calls to Crisis Intervention." [sic-all] During an interview with Manager A on 11/29/2023 at 10:10 AM, s/he said Resident 1 "has a lot of struggles" and is "emotionally up and down." Manager A said Resident 1 spends a significant amount of time talking about his/her gender identity and this is the source of many of his/her struggles. Manager A went on to explain Resident 1 had a "preferred name" which was different than his/her "real name." During this interview, and subsequent interviews on 12/18/2023 at 12:30 PM and 12/19/2023 at 3:39 PM, Manager A also described Resident 1 as being at risk for suicide. Manager A explained prior to admission, Resident 1 had a suicide attempt that necessitated police intervention and a period of hospitalization. Manager A said since admission, Resident 1 has continued to discuss suicide and displayed suicidal tendencies. Manager A recalled a recent incident when Resident 1 told Manager A during the previous night (11/17/2023) s/he tried to strangle him/herself with a cord.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 424	Continued From page 13 On 11/29/2023 at 2:55 PM, Surveyor interviewed Resident 1. Surveyor asked a general question about the care and treatment s/he receives. Resident 1 replied, "It is hard to communicate about my gender because [Manager A] only sees me as a human being. I also get confused a lot because I am disabled." Resident 1 said things would be better at the home if the staff would understand the residents better and approach them in a different way. Resident 1 said on a recent Friday, "I took a lace from my boot and I wrapped it around my neck...I tried to hurt myself to end the pain that is inside your body. It is because I am trans and I am fighting against that, to not harm myself." Surveyor reviewed Resident 1's most current ISP dated 10/23/2023 for needs and individualized interventions related to suicide risk and the diagnoses of gender dysphoria. Both topics were referenced in a section titled "BEHAVIORAL INTERVENTION." Surveyor noted the interventions were vague and at times confusing or contradictory. Examples include: Suicide Risk - "[Resident 1] is starting to talk about self-harm again. Staff is talking with [Resident 1] and starting to do frequent checks when in room." Gender Dysphoria - "Staff is working with [Resident 1] with gender. [Resident 1] wants to be labeled male or female put [sic] does not want staff to use he or she." The next sentence contradicted this and read, "[Resident 1] does like the fact that staff will not use labels like he, she, they, them and uses names instead." The ISP noted staff respond by telling Resident 1, "everyone is a Human Bing and deserves to be treated nicely and with respect." [sic - all]	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

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M 424	Continued From page 14 However, it also documented in the ISP this approach is not effective because "[Resident 1] feels staff is not supporting gender when doing this." Surveyor noted the ISP did not: identify Resident 1's known history of suicide attempts, including the incident that occurred on 11/17/2023 specify the frequency of the checks as part of a suicide prevention plan identify specific, individualized strategies for working with Resident 1 when s/he expressed thoughts of self-harm identify Resident 1's stated request to use a preferred name (42 times throughout the document Resident 1's "real name" was written) include a signature from Resident 1 indicating his/her involvement in and agreement with the plan Cross Reference: M0218 DHS 88.04(2)(b) Awake Staff for Continuous Care M0230 DHS 88.04(2)(f) Condition Which Represents Risk Of Harm M0244 DHS 88.04(5)(a) Training - 15 Hours Within 6 Months M0548 DHS 88.10(3)(a) Fair Treatment	M 424		
M 548	88.10(3)(a) Fair Treatment Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality.	M 548		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 548	Continued From page 15 This Rule is not met as evidenced by: Based on observations, interviews, and record review, Licensee B did not ensure Resident 1 was treated with courtesy, respect, and full recognition of their dignity and individuality. Facility is licensed to serve up to 4 residents with diagnoses to include advanced age, developmentally disabled, emotionally disturbed/mental illness, dementia/Alzheimer's, physically disabled, and traumatic brain injury. Findings Include: On 09/19/2023, the department received a complaint alleging verbal abuse and resident rights violations. On 11/29/2023 Surveyor reviewed Resident 1's facility file. Resident 1 was admitted to facility on 06/17/2022 with diagnoses which include Down Syndrome, obstructive sleep apnea, mood disorder, and gender dysphoria. Upon admission, Resident 1 had a known history which included suicidal ideation and past attempts of suicide. Resident 1 had documented preferences to not be referred to by his/her birth name or gender. Example 1 - Signage Identifying Gender Identify On 11/29/2023 at 11:05am, Surveyor interviewed Manager A and Licensee B. Licensee B volunteered information about a situation where Resident 1 placed a sign on his/her door and Manager A removed it. Licensee B stated, "If you go through all of the documentation with all of the people involved you will find that [Resident 1] has an imagination ...[Resident 1] put a pride poster on his/her door ...we said [s/he] had to take it down from [his/her] door to not upset the other residents." During a follow up interview with	M 548		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 548	Continued From page 16	M 548		

Manager A and Licensee B on 12/18/2023 at 12:30 PM, Manager A further explained no residents were upset by the sign, rather s/he felt it would be confusing to them and/or not consistent with their beliefs.

During the aforementioned record review, Surveyor reviewed a document authored and signed by Manager A dated 10/22/2023. The document detailed an incident involving a sign posted on Resident 1's door and removed by Manager A. Resident 1 put a sign on the outside of his/her bedroom door. It listed 2 names s/he preferred to be addressed as and a preferred pronoun (opposite of birth pronoun.) Manager A wrote, "[Resident 1]...did not ask to put it up. It is on the outside for all to see, defacing private property ... said nothing to [him/her] as there is an ISP (Individualized Service Plan) meeting coming."

Surveyor reviewed the service agreement entered in to at the time of Resident 1's admission. The service agreement was silent to the ability to decorate doors.

The record also contained a document titled, "Rules of the House: Resident's Responsibilities" signed by Resident 1's legal guardian on 06/29/2022. On 12/06/2023, Manager A provided surveyor with an updated version of the rules. The version also did not prohibit door decorations.

On 11/29/2023 at 12:52 PM, while in the dining room common space, Surveyor observed a different resident's door had a handmade decoration on the outside. Licensee B confirmed the observation and said the resident had made the decoration and was allowed to put it on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

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M 548	Continued From page 17 door. On 11/29/2023 2:55 PM, Surveyor interviewed Resident 1. Resident 1 said s/he would like to put a sign on his/her door. Resident 1 realled a time when s/he had a sign posted on his/her door with 2 different names and pronouns listed. Resident 1 stated, "[Manager A] made me take the sign down and it made me feel bad." On 12/13/2023 at 11:30am, Surveyor interviewed Care Manager C and Nurse F from Resident 1's managed care organization (MCO - funding source.) Nurse F recalled the aforementioned situation. S/he confirmed there was an ISP meeting the following day on 10/23/2023 when the sign was mentioned briefly. Manager A informed the team s/he removed the sign; however s/he did not attribute its removal to other residents being upset. Nurse F said Resident 1's preference to place on sign on the door in the future was not discussed during the meeting and a plan to address this was not developed. Example 2- Misgendering During the aforementioned record review, Surveyor reviewed a document titled "letter of history" authored by Manager A which read in part, "[Resident 1] moved in June 17, 2022...had a history of Trisomy 21, Mental Retardation...Mood Disorder, Gender Dysphoria, Suicidal Ideation, with history of emergency room and [mental health facility] visits, and excessive calls to Crisis Intervention." [sic-all] According to WebMD: "..No matter who you are, each person has their own gender identity...in some cases, another person might mistake your gender identity and refer to you incorrectly. If	M 548		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

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M 548	Continued From page 18	M 548		

you're transgender, nonbinary ...this may happen to you more often. We call this misgendering, and it can have major impacts on people's health, especially over time ...In some situations, people may purposely misgender someone to harm them. But in other cases, you might accidentally refer to someone by the wrong name or pronoun. Some examples of misgendering include:

(1) Deadnaming. If you're transgender ...you may choose to change your name to better fit your identity. This means you'd no longer like to go by the name you were given at birth. But sometimes, people either mistakenly or purposely call you by your old name ...This can be very hurtful to people who've changed their name. It can bring up trauma or invalidate their identity. It's crucial that you make the effort to call someone by their chosen name.

(2) Using the wrong pronouns .... Someone's pronouns aren't just a preference. They're an important part of their identity. It's respectful to make the effort to use a person's correct pronouns. Keep in mind that someone may change their pronouns throughout their life as well ...

Impacts of misgendering include:

Gender dysphoria. If others fail to refer to you by your identity, you may feel uneasy. Over time, this can create inner confusion and chaos between your assigned sex at birth and your gender identity. Experts refer to this as gender dysphoria. Gender dysphoria can also result from internal tension from a mismatch between biological sex and gender identity.

Mental health impacts. The effects of gender

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

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M 548	Continued From page 19	M 548		

dysphoria can be so strong that they lead to depression and anxiety. When the effects of misgendering impact a person's mental health, they may begin to develop low self-esteem, isolate themselves from their social circles, or show more risky behavior. One study showed that transgender people ages 15-21 showed 71% fewer symptoms of severe depression if they were able to choose their name, compared to young transgender people who weren't able to choose ...The same study found that transgender people who could choose their name were less likely to think about suicide. People who could choose were also 65% less likely to attempt suicide than those who couldn't choose their name ..." Source: https://www.webmd.com/sex/health-effects-misgendering, retrieval date 01/09/2024.

During interviews with Manager A and Licensee B on 11/29/2023, 12/05/2023, and 12/18/2023, Surveyor observed Manager A and Licensee B used a pronoun that was different from Resident 1's preferred pronoun 159 times. During the interview on 11/29/2023 at 11:05 AM, Licensee B stated, "[He/she] is offended no matter what you say." Manager A told Surveyor s/he told Resident 1, "People are going to be confused and frustrated in the house ...we cannot call you different names every day."

On 11/29/2023 at 2:55pm, Surveyor interviewed Resident 1 who stated, " ...When [Manager A] uses [non-preferred pronoun] it makes me feel uncomfortable when [s/he] refers to me as [non-preferred/birth gender] ... [Manager A] said the next place I would be is a lock down facility."

Example 3- Inappropriate/Disrespectful Communication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 548	Continued From page 20 During the aforementioned interview on 11/29/2023, Manager A described a recent encounter with Resident 1. Manager A stated, "[S/he] asked for a copy of the paperwork. I said son of a [explicit] why did you." Resident 1 responded, "Why did you call me that?" Manager A said s/he told Resident 1, "I was talking to my computer." Manager A explained to Surveyor, "[S/he] misreads every once and a while ...I admit that I swear at my computer sometime, but it is not at them." During the aforementioned interview with Resident 1, Surveyor asked if staff treat Resident 1 with respect and dignity. Resident 1 replied, "Somewhat, but not a lot." Resident 1 also stated, "It has been a little rocky with [Manager A] and [his/her] tone of voice ...when [s/he] is mad, [s/he] will swear." Resident 1 then listed 5 swear words Manager A uses. Surveyor asked if the names were directed at Resident 1 and s/he replied, "I don't know." Resident 1 went on to say that Manager A does not respect his/her preferences, including Resident 1's preferences to eat healthier food than Manager A likes to eat. Resident 1 said s/he was unhappy living at the facility and s/he wished s/he could choose the staff, that staff would understand "boundaries" and approach residents in a safe way. On 12/05/2023 at 09:30 AM, Surveyor interviewed Wood County Adult Protective Services (APS) Staff E. APS Staff E said their agency has been involved with the provider over the past 6 months after receiving complaints of Manager A engaging in verbal abuse and resident rights violations towards Resident 1. APS Staff E said their investigations substantiated some of the reported concerns including Manager A yelling	M 548		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 548	Continued From page 21 at Resident 1, "Get the hell out of my face!" APS Staff E stated, "My main concern is [Manager A]'s communication style, the yelling and how [s/he] approaches difficult clients. I feel [s/he] needs more training ...At first [s/he] was yelling about chores, [s/he] didn't understand that they are not mandated to do that. (S/he could say), "Would you please help?' versus, 'You have to' and screaming and yelling." Manager A admitted to APS Staff E s/he would tell Resident 1, "Get the hell out of my face." APS Staff E commented, "[Manager A] needs a break and is burned out and frustrated." On 12/05/2023 at 9:56 AM, APS Staff E sent Surveyor documentation of their involvement with the provider. According to the documentation, APS received, investigated and substantiated 2 complaints involving Manager A's treatment of Resident 1. In June 2023, APS substantiated allegations Manager A swore at Resident 1 and was implementing punishments. In September 2023 APS substantiated allegations based on Manager A's admission s/he would direct harsh words at Resident 1 when s/he was frustrated, such as "Get out of my face." In addition, House Manger A told APS said there "were times [s/he] needed to remove [him/herself] from [Resident 1]'s view and will lock [him/herself] in the office. This was pointed out to [Manager A] as Staff Abandonment and isolation and should not happen ...[Resident 1] should always have access to staff." [sic - all] Example 4 - Punishments During an interview on 11/29/2023 at 11:41am, Manager A said s/he would tell Resident 1, "I have had enough, leave me alone." and would tell Resident 1 to go to his/her room because,	M 548		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 548	Continued From page 22 "Nobody wants to hear you scream." During the aforementioned APS record review, Surveyor noted the following: -- 06/21/2023: "[Resident 1] has chores within the home and currently [s/he] will state [s/he] is not doing them. [The provider] has some punishment form they can try such as 15min [sic] wall time out ..." -- 06/23/2023: "[MCO Case Manager C] and I discussed the [provider]'s response to [Resident 1]'s behavior with timeouts ...[Case Manager C] thought they had addressed the timeouts and corrected this so it was not happening anymore ...this will be re-addressed by [Case Manager C]. -- 07/06/2023: "substantiated (complaint) due to punishment [Manager A] was giving [Resident 1]." IN SUMMARY: The licensee did not ensure Resident 1 was treated with courtesy, respect, and full recognition of their dignity and individuality. Resident 1 had a documented preferences to not be referred to by his/her birth name or gender. Resident 1 placed a sign on his/her door that displayed his/her preferred names and pronouns, which Manager A removed. Surveyor observed multiple interviews where Manager A and Licensee B referred to Resident 1 using a pronoun that was different from Resident 1's preferred pronoun. Resident 1 told Surveyor, when non-preferred pronouns are used, it makes him/her feel "uncomfortable." Resident 1 said s/he was unhappy living at the facility and wished the staff understood "boundaries" and approach resident in a safe way. Prior to the departments involvement, APS substantiated 2 complaints involving Manager A's treatment of Resident 1. This included abandoment, directing harsh words at Resident 1, requiring house chores, and	M 548		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 548	Continued From page 23 administering time outs. Cross Reference: M0218 DHS 88.04(2)(b) Awake Staff for Continuous Care M0230 DHS 88.04(2)(f) Condition Which Represents Risk Of Harm M0244 DHS 88.04(5)(a) Training - 15 Hours Within 6 Months M0424 DHS 88.06(3)(f) Review of ISP M0556 DHS 88.10(3)(e) Self-Direction	M 548		
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 observations, interviews, and record review, the provider did not ensure Resident 1 had the opportunity to make decisions related to care, activities, and other aspects of life. From 06/17/2022 until at least 08/14/2023, the provider restricted Resident 1's access to his/her own bedroom, allowing only 1 hour per day during awake hours.	M 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

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M 556	Continued From page 24 Beginning on approximately 06/17/2022 and continuing through at least 12/04/2023, the provider limited Resident 1's access to his/her computer to 1 - 2 hours per day. Neither of the restrictions were documented in Resident 1's most recent Individual Service Plans (ISPs) dated 04/14/2023 or 10/23/2023. Findings Include: On 9/19/2023, the department received a complaint alleging verbal abuse and resident rights violation. Facility is licensed to serve up to 4 residents with diagnoses to include advanced age, developmentally disabled, emotionally disturbed/mental illness, dementia/Alzheimer's, physically disabled, and traumatic brain injury. On 11/29/2023 at approximately 1:00 PM, Surveyor reviewed Resident 1's complete record. Resident 1 was admitted on 06/17/2022 with diagnoses to include Down Syndrome, OSA (obstructive sleep apnea), morbid obesity, mood disorder, gender dysphoria, and suicidal ideation. Resident 1 has a court appointed guardian. Example 1 - Computer Restrictions On 11/29/2023 at 10:10 AM, Surveyor interviewed Manager A. S/he volunteered information regarding computer restrictions imposed on Resident 1. Manager A explained that Resident 1 is transgender and "can't decide who [s/he] is or what [s/he] is." Manager A said if Resident 1 spends too much time on the computer researching gender identity s/he becomes obsessive about gender and is at increased risk	M 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

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M 556	Continued From page 25	M 556		

for self-harm. (Surveyor note: Manager A also described other contributing factors to risk for self-harm including Resident 1 being out of work for most of 2023.) Manager A went on to say, "We have to give [him/her] a time limit on it," or s/he gets "wound up." Manager A described Resident 1's reaction to restrictions in general and said, "If you take a lot of things away from [him/her] [he/she] gets very overly frustrated and upset and angry." Manager A gave an example of a time when Resident 1 was holding his/her (own) laptop and Manager A grabbed it from him/her which upset Resident 1. Manager A demonstrated by yanking a laptop out of Surveyor's hands.

On 11/29/2023 at 11:05 AM, Licensee B stated, "You will find that [Resident 1] ...is all messed up in the head. [S/he] wants to be [the gender opposite of birth gender.]...we are trying to limit [his/her] time on the computer without impeding [his/her] rights."

During the interview with Manager A on 11/29/2023 s/he offered a document for Surveyor to review titled, Client Rights Limitations or Denial Documentation (CLRDD) dated 08/14/2023. Manager A said form was implemented after Managed Care Organization (MCO - funding source) advised them to document the computer restrictions that had been in place for months prior. Surveyor noted the following:

-- Limitation/denial reviewed 08/31/2023 by Manager A with decision to continue to limit computer use to 1.5 hours daily. The next review date was scheduled on 09/11/2023, however no review was documented on that date, or any date thereafter.
-- The form prompted for the resident signature acknowledging receipt of the form and the ability

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

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JOYFUL HEARTS	1704 E MCMILLAN MARSHFIELD, WI 54449

(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 556	Continued From page 26	M 556		

to have a hearing or a meeting for the opportunity to dispute facts or to explain their position on the matter. The resident signature section was blank and no hearings/meetings with the resident were documented on the form.
-- The form contained a section titled "Condition for Restoring Right(s) - Explain the specific conditions required for restoring or granting the right." Conditions included daily staff checklists, care team meetings every two weeks, and increasing computer time when the entire care team feels resident 1 is more stable with emotions.

On 12/07/2023 at 8:14 PM, Manager A emailed Surveyor a review schedule supplement form which documented bi-weekly reviews between 08/31/2023 and 12/04/2023. The form did not document Resident 1's involvement in the bi-weekly reviews. The restriction started at 1.5 hours, increased to 2 hours, then decreased to 1 hour on 10/23/2023. As of 12/04/2023, the 1 hour restriction remained in place.

On 12/05/2023 at 9:30 AM, Surveyor interviewed Wood County Adult Protective Services (APS) Staff E. ASP Staff E said their agency has been involved with the provider over the past 6 months after receiving complaints of Manager A engaging in verbal abuse and resident rights violations towards Resident 1. APS Staff E described multiple meetings regarding rights restrictions with Resident 1's care team that did not include Resident 1.

On 12/05/2023 at 9:56 AM, APS Staff E sent Surveyor documentation of their involvement with the provider. The documentation summarized multiple discussions with Manager A concerning computer access and limiting use. The

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	0018848	A. BUILDING: _____ B. WING _____	C 12/19/2023

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M 556	Continued From page 27	M 556		

documentation did not indicate Resident 1 was involved in the discussions.

On 12/13/2023, Surveyor interviewed MCO Case Manager C. S/he stated there were bi-weekly meetings with the care team regarding computer use restrictions in place for Resident 1. Case Manager C stated Resident 1 was not involved in the bi-weekly meetings about the restrictions.

On 11/29/2023, Surveyor reviewed Resident 1's most current ISP dated 10/23/2023. The ISP was silent to computer use and the limitation of rights. The ISP was signed by Case Manager C and Guardians D, but did not include a signature from Resident 1 or Manager A. The last ISP signed by Resident 1 was from 04/14/2023. That version of the ISP was also silent to the risks related to computer use or any attempted interventions to mitigate potential risk.

During interviews with Manager A on 12/05/2023 and 12/18/2023, s/he said Resident 1 was present for the 10/23/2023 ISP meeting but confirmed Resident 1 did not sign the ISP. Manager A acknowledged the ISP was silent to Resident 1's risks and needs surrounding computer use and did not document the restrictions that had been imposed. In addition, Manager A confirmed Resident 1 did not sign the CLRDD form. Manager A did not describe other opportunities for Resident 1 to dispute the need for the restrictions or his/her position on the matter.

Example 2 - Restricted Room Access

During the forementioned record review, Surveyor noted the CLRDD supplement documentation dated 08/14/2023, detailed

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M 556	Continued From page 28	M 556		

restrictions limiting Resident 1's access to his/her bedroom. The document read in part, "[Resident 1] will be limited to one hour of personal time in [his/her] room ...will discuss increasing room time depending on how things go."

During the onsite visit on 11/29/2023 at 2:54 PM, Surveyor observed Resident 1 in the common area of the home. Surveyor asked Resident 1 if s/he would be willing to show Surveyor his/her room and to speak privately. Surveyor observed Resident 1 look to Manager A and ask for permission to talk with Surveyor in his/her room.

On 12/18/2023 at 12:30 PM, Surveyor interviewed Manager A and Licensee B. Manager A confirmed that beginning at admission on 06/17/2022, Resident 1 was only allowed 1 hour of time in his/her room, except at night to sleep. Manager A stated the restriction was in place "until we started all that rights stuff and found out that was incorrect ...come to find out, that's removing resident rights."

The aforementioned ISPs dated 04/14/2023 and 10/23/2023 did not document the restriction imposed on Resident 1's access to his/her bedroom or the reasons for it.

IN SUMMARY: The licensee did not ensure Resident 1 had the opportunity to make decisions related to his/her care. Restrictions were put in place limiting computer access to approximately 1 to 2 hours per day. Resident 1 was also limited to one hour of "personal time" in his/her room. Multiple meetings involving Resident 1's care team occurred to develop and determine restrictions placed on Resident 1. Resident 1 was not involved in the aforementioned meetings nor given the opportunity to dispute facts leading to

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M 556	Continued From page 29 restrictions. The most recent ISP was silent to restrictions in place and did not include a signature from Resident 1. Cross Reference: M0218 DHS 88.04(2)(b) Awake Staff for Continuous Care M0230 DHS 88.04(2)(f) Condition Which Represents Risk Of Harm M0244 DHS 88.04(5)(a) Training - 15 Hours Within 6 Months M0424 DHS 88.06(3)(f) Review of ISP M0556 DHS 88.10(3)(a) Fair Treatment	M 556		