STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019972	A. BUILDING: _____ B. WING _____	R 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW	246 GREEN VALLEY PLACE WEST BEND, WI 53095

(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 08/05/2025, Surveyors conducted a self-report review at Valley View, an Adult Family Home (AFH) in West Bend, WI. One deficiency identified. Census: 4	M 000		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's Individual Service Plan (ISP) contained a description of services the licensee would provide for 1 of 1 resident. Resident 1 self-harmed him/herself and potentially put other residents in danger when turning off power to the home. Staff needed to call law enforcement to assist for both incidents. Resident 1's ISP did not identify strategies the licensee and caregivers would provide Resident 1 to prevent self-harming behaviors. Findings include: On 08/05/2025, Surveyor reviewed police reports. Police reports identified the following: -"On 05/27/2025 at 1941 hours, [Officer] and [PO] were dispatched to Green Valley Place, for a Disorderly Conduct Complaint. The complainant,	M 412		

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

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M 412	Continued From page 1	M 412		

[Caregiver A] advised [Resident 1] was refusing [his/her] meds and shut off power to the residence. Upon arrival at 1946 hours, made contact with [Caregiver A] at the front of the residence. [Caregiver A] advised [Resident 1] had been picked up from [his/her family member's home] at 1800 hours. [Caregiver A] advised [Resident 1] immediately became angry with staff when [s/he] was picked up and began swearing at them. [Caregiver A] advised when [Resident 1] returned home, [s/he] initially refused to exit the transport van. [Caregiver A] advised when [Resident 1] as in the vehicle, it was time for [him/her] to take [his/her] prescribed mediations. [Caregiver A] advised [s/he] brought the medication out to the vehicle and [Resident 1] initially refused the medication by slamming the car door on [Caregiver A]. [Caregiver A] advised [Resident 1] eventually exited the vehicle and entered the residence. [Caregiver A] advised [Resident 1] became belligerent with staff by yelling at [him/her]. [Caregiver A] advised while [Resident 1] was mad, [s/he] went down into the basement of the residence and cut the power to the residence. [Officer] arrived on scene and spoke with [Resident 1] in the backyard of the residence. [Officer] knew [Resident 1] from prior professional contacts and knew [Resident 1] to be on a Chapter 51 placement at the residence. [Resident 1] advised [s/he] could hear another resident talking about [him/her] in [his/her] room. [Resident 1] advised [s/he] cut the power to the residence so the other resident could not talk to [his/her] friends about [him/her] anymore. [Officer] warmed [Resident 1] for [his/her] actions and advised [his/her] actions would have consequences at the residence. [Resident 1] advised [s/he] understood and did not have any questions. [Caregiver A] was advised of the disposition. [Caregiver A] advised [s/he] would

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M 412	Continued From page 2 continue to call the police when issues arose." On 05/28/2025 at 1010 hours, [Officer] dispatched to Valley View Adult Family Home reference a crisis intervention. [Officer] arrived and met with [Caregiver A]. [Caregiver A] reported that [Resident 1] has been banging [his/her] head against the kitchen table for over an hour. [Resident 1] is autistic and has suffered from lead poisoning which created memory issues. [Caregiver A] said they have already called [Resident 1's] guardian, but they were told its just a coping mechanism for [him/her]. [Caregiver A] said [s/he] called the police because [s/he] didn't think they could keep [Resident 1] safe. [Officer] entered the residence and met with [Resident 1], who was still seated at the kitchen table and was slowly banging [his/her] forehead against the table. [Resident 1] was not banging [his/her] head hard, but the continuous banging caused an abrasion on [his/her] forehead. [Resident 1] did not require medical assistance. [Officer] told [Resident 1] to stop and [s/he] complied. [Officer] asked [Resident 1] why [s/he] was banging [his/her] head. [Resident 1] said because [s/he] can't take the pain [s/he] is feeling inside. [Resident 1] said [s/he] tried listening to music, but that wasn't working. [Officer] asked [Resident 1] if [s/he] was feeling suicidal. [Resident 1] said [s/he] was not. [Resident 1] explained that [s/he] is not happy living at the facility. [Resident 1] said that [s/he] misses [his/her] friends from school and now [s/he] has no means of communicating with them. [Resident 1] said that [s/he] tried to talk to staff about how [s/he] was feeling, but they did not want to talk to [him/her]. [Officer] contacted Acute Care Services and spoke with Crisis Worker. Crisis Worker was familiar with [Resident 1] and advised that [Resident 1's]	M 412		

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M 412	Continued From page 3	M 412		

actions did not make [him/her] a danger to [him/herself] as [his/her] behavior was a coping mechanism for [him/her]. [Crisis Worker] advised that an assessment would not be required as staff should redirect [Resident 1's] behavior. [Officer] directed [Resident 1] to sit on the couch. [Resident 1] stood up, cleaned off [his/her] forehead, and moved to the living room couch. [Officer] advised [Caregiver A] of the outcome and suggested that they consider relocating [Resident 1] to a different facility where [s/he'd] be happier."

On 08/05/2025, Surveyors reviewed Resident 1's record and identified the following:
-Resident 1 was admitted to the facility on 08/12/2024 with diagnoses including anxiety disorder, attention deficit, hyperactivity disorder, autistic disorder, post traumatic stress disorder and bipolar disorder.
-Resident 1 had a guardian.
-Resident 1's ISP, dated 07/22/2025, did not include an assessment for self-harming behaviors.
-Resident 1's incident reports from 05/27/2025 through 05/28/2025 identified Resident 1 having verbal behaviors towards staff and other residents. Resident 1 turned off the entire power to the house and Resident 1 tried self-harming him/herself by banging his/her head on the kitchen table on 05/28/2025.
-Resident 1's Individual Service Plan (ISP), dated 07/22/2025, stated, "Behavioral Support Services, left blank. Special instructions: If having a hard time just give [Resident 1] space to cool down." Resident 1's incidents of self-harming was not in his/her ISP. There was no BSP (Behavioral Support Plan) in Resident 1's record.

On 08/05/2025 at approximately 12:00 PM,

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M 412	Continued From page 4 Surveyors interviewed Caregiver A and House Manager B. House Manager B stated the company started using a new system for their ISP's and the ISP dated 07/22/2025 is the most current ISP for Resident 1. Caregiver A and House Manager B confirmed the new ISP's do not identify Resident 1's behaviors and self-harming behaviors and what to do for an intervention when Resident 1 displays these behaviors.	M 412		