STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015688	A. BUILDING: _____ B. WING _____	C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUNG HOUSE	4141 SAVANNAH DRIVE DE FOREST, WI 53532

(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
N 000	Initial Comments On 07/25/2023, Surveyor conducted a complaint investigation and standard survey at Young House. The complaint was substantiated. 2 deficiencies were identified. Census 8	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on interview and record review the provider did not investigate allegations of possible abuse and neglect made by Resident 1.	N 158		

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

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N 158	Continued From page 1 Findings include: On 07/25/2023 at approximately 10:20 AM, Surveyor interviewed Resident 1 who stated there were been issues with medications, and that staff are not promoting independence. Resident 1 recalled an incident when sleeping staff were not answering call lights and that he/she was told they were lying about the incident. Resident 1 stated s/he waited for over 40 minutes for someone to answer their call light and there was no response so s/he called the police because s/he was scared. On 07/25/2023 at approximately 10:40 AM, Surveyor reviewed police reports. A police report dated 04/29/2023, documented that the police were dispatched to the facility regarding medications not being administered properly. The police report indicated that the facility did not administer methadone as it was prescribed as the medication appeared to be missing from the medications that were being administered. Manager A was notified the medication was missing from the pill boxes set up for Resident 1. Manager A was made aware that staff were dismissing Resident 1 when s/he was trying to tell staff that his/her medication was missing. Surveyor reviewed a police report dated 06/21/2023, when Resident 1 called the police department because nobody was answering his/her call light. The report stated when an officer arrived on scene there was a caregiver that was sleeping on the couch. The caregiver identified was Caregiver B. On 07/25/2023 at approximately 12:10 PM, Surveyor interviewed Manager A. Manager A	N 158		

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N 158	Continued From page 2 stated there was no investigations of neglect due to sleeping staff or for the missing medication concern. Manager A stated the allegations were deemed 'fake' so they were not investigated. Manager A stated s/he never received a copy of the police report.	N 158		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview the provider did not send a written report to the Department within 3 working days after law enforcement personnel were called to the community based residential facility as a result of an incident that jeopardized the health, safety and welfare of Resident 1. Findings include: On 07/25/2023 at approximately 10:20 AM, Surveyor interviewed Resident 1 who stated s/he had called the police to the building before due to a medication issue and neglect. Resident 1 recalled an instance when a caregiver who was sleeping on third shift didn't answer their call light	N 164		

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N 164	Continued From page 3	N 164		

for over 40 minutes. Resident 1 stated s/he has bad anxiety and when the caregiver didn't answer the call light s/he started to worry about what would happen if there was an emergency. Resident 1 then called the police because s/he was scared.

On 07/25/2023 at approximately 10:40 AM, Surveyor reviewed police reports. A police report dated 04/29/2023, documented the police were dispatched to the facility regarding medications not being administered properly. The facility did not administer methadone as it was prescribed as the medication appeared to be missing from the medications that were being administered. Manager A was notified the medication was missing from the pill boxes set up for Resident 1. Manager A was made aware that staff were dismissing Resident 1 when s/he was trying to tell staff that his/her medication was missing.

Surveyor reviewed a police report dated 06/21/2023, that documented Resident 1 had called the police department because nobody was answering his/her call light. The report stated when an officer arrived on scene there was a caregiver sleeping on the couch. The caregiver identified was Caregiver B.

On 07/25/2023 at approximately 12:10 PM, Surveyor interviewed Manager A. Manager A stated s/he did not report these incidents to the Department because they can't report all police contact at the facility..