STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017507	A. BUILDING: _____ B. WING _____	C 09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS ON DAKOTA	9801 WEST DAKOTA ST WEST ALLIS, WI 53227

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M 000	INITIAL COMMENTS On 09/22/2022, Surveyor completed a standard survey, a complaint investigation, and a self-report review. As a result, 4 deficiencies were identified. The complaint was unsubstantiated. Census: 4	M 000		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 6 required locations in the home contained smoke detectors. The smoke detector at the door leading to the enclosed stairway was missing from the bracket. Resident 2's bedroom smoke detector was missing from the bracket. Findings include:	M 334		

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

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M 334	Continued From page 1 On 09/14/2022, at 11:44 AM, Surveyor observed the enclosed stairway leading to the basement. There was a bracket for a smoke detector, but there was not a smoke detector present. On 09/14/2022 at 12:11 PM, Surveyor observed Resident 2's bedroom. Resident 2's bedroom did not contain a smoke detector. On 09/14/2022, at 12:15 PM, Surveyor interviewed House Manager (HM) C regarding the missing smoke detectors. HM C reported s/he had been the manager of the home for the past 3 months and did not recall noticing the smoke detectors missing. HM C confirmed there were no smoke detectors at the door leading to the enclosed stairway or in Resident 2's bedroom. HM C reported s/he would tell the maintenance department about the missing smoke detectors and get some installed.	M 334		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure monitoring health for 1 of 1 resident who required psychiatric care and medications to manage behavioral symptoms. Resident 1 had a diagnosis of unspecified mood disorder and required medication for treating his/her symptoms. Resident 1 did not have a new prescription to ensure psychiatric medication was	M 448		

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in his/her pharmacy delivery. Resident 1 missed 4 psychotropic medications for 2 days, which may have led to a behavioral episode requiring police intervention and emergency room treatment.

Findings include:

On 09/15/2022, Surveyor reviewed Resident 1's record and identified the following:
-Resident 1 was admitted to the facility on 10/21/2019.
-Resident 1's Individual Service Plan (ISP), dated 03/27/2020, identified Resident 1 required the support of a psychiatrist. Resident 1's ISP identified Resident 1 required staff assistance with medication administration. Resident 1's ISP stated, "Therapies...Psychiatric care...Continue to encourage the use of medication and professionals to address emotional and behavioral issues...Encourage and monitor over health and address any medical related needs...Service Provider Responsible: Staff."
-Resident 1's Medication Administration Record (MAR) for the period 09/09/2020-10/09/2020, identified Resident 1 did not receive aripiprazole 20 milligrams (mg), risperidone 4 mg, paroxetine hydrochloride 40 mg, and trazodone hydrochloride 50 mg on 09/09/2020 and 09/10/2020.
-Resident 1's incident report, dated 10/02/2022, identified Resident 1 had a behavioral episode on 09/10/2020 and the police were called to the home and had to use force to keep Resident 1 and others around him/her safe from himself/herself. Resident 1 had weapons and went after staff. Staff tried to protect themselves and grabbed the nearest object, a folding chair, and hit Resident 1 with the chair. The police used force to take Resident 1 down and it was identified Resident 1 had multiple lacerations to

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his/her scalp which required emergency room treatment, including approximately 20 sutures.
-Resident 1's record did not include any physician notes from psychiatric appointments.
-Resident 1's record did not include any documentation of the medical treatment Resident 1 received when s/he went to the emergency room on 09/10/2020.
-Resident 1's record identified a physician appointment, dated 09/21/2020, which identified Resident 1 had a suture/staple removal.
On 09/21/2022, Surveyor reviewed information from the pharmacy regarding Resident 1's lapse in psychotropic medications in September 2020. The pharmacy sent a fax to Resident 1's psychiatrist on 08/25/2022, which identified they did not have orders on file to fill aripiprazole 20 mg, risperidone 4 mg, paroxetine hydrochloride 40 mg, and trazodone hydrochloride 50 mg for the medication cycle beginning 09/09/2020. The pharmacy received physician orders for the medications on 09/11/2022, 2 days after the new cycle began and Resident 1 did not have his/her psychotropic medication.

On 09/21/2022, at 1:13 PM, Surveyor interviewed Program Manager (PM) B regarding Resident 1. PM B reported Resident 1 had a guardian since s/he moved into the facility on 10/21/2019. Resident 1 reported s/he had a psychiatric physician who treated Resident 1's due to his/her mental health diagnosis. PM B reported the pharmacy identified Resident 1 did not have prescriptions from the psychiatrist to fill Resident 1's psychiatric medications on 08/25/2020 for the medication cycle beginning 09/08/2020. PM B reported s/he called the psychiatrists office to ensure they send an order to the pharmacy so there would not be a lapse in medication. PM B reported the physician's office staff reported

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M 448	Continued From page 4 Resident 1 had an appointment in September 2020 and the appointment would be prior to the new medication cycle so there would not be a lapse in medication provided. The psychiatrist's office staff did not disclose the appointment date. PM B reported they had difficulty obtaining information from the provider since the pandemic began (March 2020). PM B reported all appointments were via telehealth and the psychiatrist called Resident 1 directly on his/her personal phone, without communicating with the provider. PM B reported s/he did not know when Resident 1 had psychiatric appointments or Resident 1's treatment plan regarding his/her mental health with the psychiatrist. PM B confirmed there was no information included in Resident 1's record regarding psychiatric appointments. PM B reported prior to the switch to only telehealth appointments, PM B took Resident 1 to all appointments and was able to obtain more information regarding Resident 1's mental health treatment. On 09/22/2022, at 9:44 AM, Surveyor interviewed Licensee A regarding Resident 1. Licensee A reported it was difficult obtaining any information from Resident 1's psychiatric doctor. Licensee A reported they would work with the physician so the provider knows all components of the treatment plan and can support Resident 1 with his/her appointments.	M 448		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The	M 570		

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M 570	Continued From page 5 adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure hot water was kept at a safe temperature for resident use for 1 of 1 bathroom faucet in the home. The hot water at the bathroom faucet was measured at 130° Fahrenheit (F). The adult family home was licensed by the Department, effective 08/01/2019, to admit up to 4 residents in the client groups of advanced age, irreversible dementia/Alzheimer's Disease, developmentally disabled, and physically disabled. Findings include: On 09/14/2022, at 12:02 PM, Surveyor measured the temperature of the hot water in the residents' bathroom. The hot water measured at 130°F. Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in	M 570		

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M 570	Continued From page 6 which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017.) On 09/14/2022, at 12:15 PM, Surveyor interviewed House Manager (HM) C regarding residents' access to the hot water. HM C reported all residents had independent access to the water in the bathroom. HM C reported residents of the home had developmental disabilities and cognitive deficits which may prevent them from adjusting the water to a safe temperature. HM C reported s/he did not have access to a thermometer to test the water temperature. HM C reported s/he will tell the maintenance department to adjust the water temperature. On 09/20/2022, at 10:10 AM, Surveyor interviewed Program Manager (PM) B regarding hot water temperatures in the home. PM B reported they tested the water temperatures monthly. PM B reported the previous month s/he did not have access to a thermometer to take the water temperature during his/her auditing site visit. PM B did not know the water was 130°F. PM B reported the provider tried to keep the water temperatures between 110°F and 115°F.	M 570		
M 610	88.11(1) REPORTING OF ABUSE AND NEGLECT A licensee or service provider who knows or has reasonable cause to suspect that a resident has been abused or neglected as defined in s. 46.90 or 940.285, Stats., shall	M 610		

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immediately contact the licensing agency. Providing notice under this subsection does not relieve the licensee or other person of the obligation to report an incident to law enforcement authorities. If the licensee has reason to believe a crime has been committed, the incident shall immediately be reported to law enforcement authorities.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the licensing agency was immediately notified when there were allegations of caregiver misconduct affecting 1 of 4 residents in the home. Resident 1 was hit in the head by a caregiver on 09/10/2020 and the provider did not report the incident until 10/02/2020, 22 days after the incident occurred.

Findings include:

On 09/14/2022, Surveyor reviewed Resident 1's misconduct incident report, dated 10/02/2020, written by Program Manager (PM) B. There was an incident involving Resident 1 and 2 caregivers. On 09/10/2020, at 7:00 PM, Resident 1 was injured by Previous Caregiver (PC) F during Resident 1's behavioral event.

On 09/15/2022, Surveyor reviewed the provider's investigation of the incident, dated 09/11/2020. On 09/10/2020, at 7:00 PM, Resident 1 was upset and went after PC F with a knife. PC F reported s/he grabbed the closest item to him/her

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to try to stop Resident 1. The item was a collapsible lawn chair. PC F hit Resident 1 in the head with the collapsible lawn chair. The police were called and had to use force to stop Resident 1 since s/he was so aggressive. Resident 1 was taken to the hospital by ambulance and received approximately 20 stitches in multiple areas of his/her head. Staff had been in contact with management due to Resident 1's heightened behavior and staff were aware of the incident.

On 09/20/2022, at 10:18 AM, Surveyor interviewed Program Manager (PM) B regarding the provider's reporting protocols. PM B reported s/he did not know to report caregiver misconduct until Resident 1's family care team informed him/her about the reporting requirements. PM B confirmed the incident was not reported timely and they will work to ensure all reportable incidents will be reported as required.

On 09/22/2022, at 9:40 AM, Surveyor interviewed Licensee A regarding reporting requirements. Licensee A reported s/he knew of the requirement to report misconduct to the licensing agency immediately. Licensee A reported the incident with Resident 1 was the first possible caregiver misconduct incident they experienced as a provider and have learned a lot as a result of the incident. Licensee A reported they would report all information as required in the future.