STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015686	A. BUILDING: _____ B. WING _____	C 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYES 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 03/25/2024, Surveyor conducted a complaint investigation at Keyes House, a CBRF in Deforest. One deficiency was identified. The complaint was substantiated. Census: 8	N 000		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was provided 30-day written advance notice of an involuntary discharge and that a suitable living arrangement able to meet the needs of Resident 1 was available prior to discharging him/her. Findings include:	N 326		

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

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N 326	Continued From page 1 On 03/25/2024, Surveyor completed a complaint investigation alleging the provider discharged a resident without providing a 30-day notice and ensuring a suitable living arrangement was found prior to discharge. On 03/25/2024 at approximately 9:00 a.m., Director B identified Resident 1 as an individual that had discharged from the provider's facility in the past 60 days. Director B stated Resident 1 was sent to the hospital and did not return to the facility. On 03/25/2024 at approximately 9:15 a.m., Surveyor interviewed Caregiver C. Caregiver C stated Resident 1 had a history of behaviors, which included being "knit picky" with food and making fun of other residents. Caregiver C stated Resident 1 seemed unhappy at the facility and would state the facility was not the right place for him/her. Caregiver C stated one day when s/he was working s/he went to Resident 1's room to get him/her for breakfast and found him/her in bed with a plastic bag over his/her head. Caregiver C stated Resident 1 was startled when Caregiver C walked in. Caregiver C stated s/he immediately went to get Director B and Resident 1 got ready for breakfast. Caregiver C stated s/he had not previously heard Resident 1 make suicidal statements. On 03/24/2024 at approximately 9:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 02/14/2023 with diagnoses of mild cognitive impairment, depression and suicidal ideation. Resident 1's progress notes, dated 12/10/2024 to 02/29/2024, included the following: - 02/22/2024: Feeling more depressed, but no	N 326		

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N 326	Continued From page 2	N 326		

plans of harm.
- 02/28/2024: Made comments of wanting to leave or get kicked out of the facility. Stated s/he wanted to be taken to the morgue. Had no plans to harm him/herself.
- 02/29/2024: Found with plastic bag over his/her head. Sent to Emergency Room.

Resident 1's record included a letter from Administrator A to Resident 1's Health Care Power of Attorney and Managed Care Organization, dated 02/29/2024. The letter stated, " ...Our facility does not assess, nor admit any resident with suicide attempts in their history, or after they have been admitted to our facility. This is outside our program statement and scope of services provided. The resident needs more medical, psychiatric, and staff oversight than we can provide. Additionally, [Resident 1] [him/herself] no longer wants to be here which makes this situation also an issue of resident rights. We must issue [Resident 1] a notice of not being able to return from the hospital. It is a voluntary discharge (or mutual discharge) because this is what [Resident 1] wants as well technically ..." The letter goes on to list the reasons for an involuntary discharge per Chapter 83.

On 03/24/2024 at approximately 10:10 a.m., Surveyor interviewed Director B. Director B stated Resident 1 had a history of behaviors, including picking on other residents and stating s/he wanted to leave the facility. Director B stated psychiatry saw Resident 1 routinely and the facility was working on arrangements for Resident 1 to see a psychologist, but no arrangements had been made at the time of discharge. Director B stated after Resident 1 was found with a plastic bag over his/her head Resident 1 stated s/he

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didn't want to live at the facility and if the plastic bag was the way out s/he was going to use it. Director B stated Resident 1 was sent to the hospital following the suicide attempt and did not return to the facility. Surveyor asked Director B if s/he followed up with Resident 1 after his/her ER visit to see if s/he wanted to return to the facility. Director B replied, "No." Director B stated the hospital wanted Resident 1 to return to the facility, but the facility did not have staff to monitor Resident 1 24-hours per day and could not meet his/her needs. Director B stated s/he referred hospital staff to communicate with Administrator A regarding Resident 1 while Resident 1 was hospitalized.

On 03/24/2024 at approximately 10:20 a.m., Surveyor interviewed Administrator A. Administrator A stated Resident 1's discharge was "voluntary and involuntary." Administrator A stated given Resident 1's suicide attempt and verbalizations that s/he wanted to leave the facility, Resident 1 wanted to discharge. Surveyor asked if Resident 1 was given the choice to return to the facility. Administrator A replied, "No. We do not accept residents with a history of suicide attempts." Surveyor asked Administrator A if the provider completed an assessment to confirm they were unable to meet Resident 1's need. Administrator A replied, "No. No need to." Administrator A stated the facility would have been unable to change staffing patterns to meet Resident 1's needs and did not have the support available to care for Resident 1.

On 03/24/2024 at approximately 10:40 a.m., Surveyor reviewed hospital documentation, which included the following:

- 02/29/2024 History and Physical: "In the ER,

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N 326	Continued From page 4 [s/he] was seen by psychiatry, who did not feel [s/he] warranted an inpatient admission to psychiatry, as [s/he] denied current suicidal feelings, stated it was just because [s/he] was upset with and frustrated by [his/her] current situation. They described [him/her] as forward thinking and interested in medications or therapy for [his/her] depression. Therefore, there was a plan to discharge [him/her] back to [his/her] CBRF from the ER. However, [the facility] refuses to take [him/her] back ..." - 03/01/2024 Social Work Note: "[The provider] is unwilling to collaborate on a plan for patient's return and is unwilling to follow process of issuing a 30-day notice ..." The note went on to state Resident 1's managed care organization staff believed Resident 1 would not be happy at any facility and that they had many care conferences with Resident 1 and the provider and ultimately Resident 1 has recognized that the provider's facility was better than other places Resident 1 had been to. The note stated the provider had issued a discharge notice. The note stated Resident 1 informed the social worker s/he wanted to return to the provider's facility and was upset when s/he was informed that may not be possible. The note stated Resident 1's Health Care Power of Attorney felt Resident 1 "burnt [his/her] bridge" with the provider. - 03/01/2024 Psychiatry Note: "At this time psychiatric hospitalization is not recommended. Currently, patient denies suicidal ideation. Patient denies imminent intent or plan to hurt themselves or others. Patient does contract to be safe until future follow up visits. Patient is future oriented, seeking help, and seemingly wanting to improve. There is not sufficient evidence for involuntary treatment at this time. On 03/25/2024 at approximately 11:00 a.m.,	N 326		

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N 326	Continued From page 5 Surveyor reviewed concern with Director B that Resident 1 was discharged from the facility without a 30-day written advance notice of an involuntary discharge and without a suitable living arrangement being found. Director B stated s/he understood Surveyor's concern and reiterated that the facility was unable to meet Resident 1's needs.	N 326		