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	0018379	A. BUILDING: _____ B. WING _____	C 03/03/2025

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TEES DIRECT CARE	6755 NORTH 55TH STREET MILWAUKEE, WI 53223

(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 03/03/2025, Surveyor completed a complaint investigation at Tee's Direct Care. As a result, 5 deficiencies were identified. One complaint was substantiated. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 incidents were reported to the Department for Resident 1, when there was significant change in a resident's status. Resident 1 self-harmed her/himself on 4 occasions and was taken to the hospital by police, and the provider did not report the incidents to the Department. This is a repeat deficiency from Statement of Deficiency (SOD) 29PB11, dated 03/23/2023. Findings include: On 12/20/2024, the Department received a	M 134		

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

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complaint alleging a resident self-harmed her/himself and staff did not call for immediate medical attention. The complaint reported the resident was hospitalized.

On 01/13/2025, Surveyor reviewed Department records. Surveyor did not locate evidence the provider submitted any self-reports in 2024 or 2025.

On 01/14/2025, at 9:40 AM, Surveyor interviewed Licensee A. Licensee A reported an incident occurred on 12/15/2024 with Resident 1. Resident 1 swallowed thumb tacks and was hospitalized. Licensee A confirmed s/he did not submit a self-report.

On 01/14/2025, at approximately 11:50 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/14/2023. Resident 1's incident reports from 10/08/2024 - 01/14/2025, identified Resident 1 had physical and verbal behaviors towards staff and other residents. Resident 1 self-harmed on 10/18/2024, 10/21/2024, 11/11/2024 and 12/15/2024, police were called, and Resident 1 was transported to a hospital each time.

Example 1:
Surveyor reviewed an incident report dated 10/18/2024, at 12:35 PM, written by Lead Caregiver D. The incident report documented on 10/18/2024, at 12:35 PM, Resident 1 was upset and destroyed her/his room, putting holes in the wall. Resident 1 wrapped pants around her/his neck and tried choking her/himself. Resident 1 scratched her/his face. When staff tried to calm her/him down s/he became more upset and spit at and hit Lead Caregiver D. The police were called and took Resident 1 to a mental health

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M 134	Continued From page 2	M 134		

hospital. The report noted abrasions on Resident 1's face, both on the left and right cheek.

Example 2:
Surveyor reviewed an incident report dated 10/30/2024, at 5:41 PM, written by Caregiver C. The incident report documented on 10/21/2024, at 5:41 PM, Resident 1 was upset and went into her/his room and threw things around. Resident 1 was using profane language towards staff. Resident 1 broke a Tic Tac container and was trying to cut her/his neck, while stating s/he was going to kill her/himself. Resident 1 stated s/he was going to kill everyone in the house. Resident 1 left the home through the back door exit. Caregiver C attempted to stop Resident 1 and Resident 1 threw a barbeque grill at Caregiver C. Resident 1 continued walking down the street. Police were called and took Resident 1 to a hospital.

Example 3:
Surveyor reviewed an incident report dated 11/11/2024, at 7:12 PM, written by Caregiver C. The incident report documented on 11/11/2024, at 6:00 PM, Resident 1 had a blood sugar reading of 44. Resident 1 was told by Caregiver C s/he had to wait 15 minutes. Resident 1 asked for soy sauce and Caregiver C told her/him s/he could not eat yet. Resident 1 was upset and threw her/his plate of food at Caregiver C. Resident 1 flipped over chairs and another resident's walker. Resident 1 went into the bathroom and beat her/his head on the door. Resident 1 was flipping things over in the bathroom and was screaming, stating s/he was going to drink the soap. Resident 1 tried to leave the residence and Caregiver C stretched out her/his arms to block Resident 1 from leaving. Resident 1 bit Caregiver C on the arm. Resident 1 grabbed a metal object off the

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wall and hit Caregiver C in the leg. The report stated Resident 1 was taken to a mental health hospital by police.

Example 4:
Surveyor reviewed an incident report dated 12/16/2024, written by Caregiver B. The incident report documented on 12/15/2024, Resident 1 and Caregiver C got into a verbal argument and Resident 1 attempted to exit the home. Caregiver B and Caregiver C stopped her/him from exiting the home. Resident 1 retreated to her/his room and made threats of suicide. The report stated, "[S/he] stated [s/he] had nails in [her/his] mouth and started clicking it against [her/his] teeth before swallowing it and showing [Caregiver B] that [s/he] had swallowed it [sic]." Lead Caregiver D arrived at the home. The report stated, "[Caregiver B] stated again that there was a nail in [Resident 1's] mouth that [s/he] had by then swallowed. But everyone thought that [s/he] had been lying about the nail because they thought that they had picked them all up so police or an ambulance was NOT called [sic]." On 12/16/2024, at approximately 8:00 AM, Resident 1 told Caregiver B s/he had swallowed 3 more nails after Caregiver B left the previous evening. Caregiver B called police and Resident 1 was taken to the hospital.

On 01/14/2025, at 11:45 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was out of town during the incident on 12/15/2025 and put Lead Caregiver D in charge. On 12/15/2024, Licensee A was contacted by staff and made aware of the incident but was not made aware Resident 1 had swallowed thumb tacks. On 12/16/2025, Caregiver B reported to Licensee A, Resident 1 swallowed thumb tacks and Licensee A advised Caregiver B to call 9-1-1

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M 134	Continued From page 4 immediately. Licensee A was not aware the police came to the home and completed an Emergency Detention report for Resident 1. Licensee A reported s/he knew Resident 1 had been taken to the hospital and was hospitalized from 12/16/2024 - 12/21/2024. Licensee A reported s/he did not get a chance to self-report to the Department. Licensee A confirmed self-reporting requirements and stated s/he would submit a self-report for the incident on 12/15/2024. Surveyor requested Licensee A submit self-reports for all required incidents which occurred after 10/08/2024, the date of the facility's last survey. On 01/29/2025, Licensee A submitted a self-report for the incident which occurred on 12/15/2024. As of 02/26/2025, Licensee A has not submitted self-reports for the incidents on 10/18/2024, 10/21/2024, and 11/11/2024.	M 134		
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 1 of 1 resident's (Resident 1) health was monitored in relation to her/his diabetes. On 10/24/2024 and 11/11/2024, incident reports were completed by staff, which indicated Resident 1's blood sugar levels were high and/or low, resulting in hospitalization.	M 448		

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M 448	Continued From page 5 Findings include: On 01/14/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 09/14/2023, with diagnoses including diabetes type 2 - insulin dependent diabetes mellitus (IDDM). Resident 1's Medication Administration Record (MAR) for February 2025 identified current prescriptions included the following: Diabetes management - - insulin glargine-yfgn, inject 0.14 milliliters (mLs) under the skin 2 times daily - gabapentin 300 milligram (mg) capsule (cap), take 1 cap by mouth 2 times daily - insulin lispro 100 unit/mL injection, inject under the skin 3 times a day before meals - per sliding scale: blood glucose <70 no insulin, 71-90 5 units, 91-130 10 units, 131-150 11 units, 151-200 12 units, 201-250 13 units, 251-300 14 units, 301-350 15 units, 351-400 16 units, 401-450 17 units, 451 or above 18 units Resident 1's individual service plan (ISP), dated 12/18/2024, documented Resident 1 required staff to manage/administer medications and diabetes per physician orders. Resident 1 was on a sliding scale for her/his diabetes management. Resident 1 required insulin administrations 4 times per day, and her/his blood sugars were to be checked 3 times daily. Example 1 Incident report dated 10/24/2024, at 7:51 AM, written by Caregiver G, reported on 10/24/2024, at 7:17 AM, Resident 1 had an incident, which was classified as "ER Visit." The report description stated, "[Resident 1] was vomiting since 4:30 AM. Staff checked resident blood	M 448		

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sugar was 487, Staff notified [Licensee A] then proceeded to call 911. [Resident 1] passed out on [her/his] bed then Had a seizure. Medical came and checked [her/his] blood sugar then called to get [her/him] escorted to a hospital (sic)." The report also documented medications which were passed in the 12 hours prior to 10/24/2024, at 7:17AM. Three medications were passed to Resident 1 in the 12-hour period, none of which were used to manage her/his diabetes.

Resident 1's October 2024 medication administration record (MAR) indicated the same as the incident report. On 10/23/2024, Resident 1's MAR indicated Resident 1 refused all physician ordered medications. Resident 1's blood sugar values on 10/23/2024 were documented as the following:
8:26 AM - 417, refused insulin administration
12:30 PM - 347, refused insulin administration
9:10 PM - Refused to have blood sugar test taken and refused insulin administration

There were no annotations in the MAR indicating whether staff re-checked his/her blood sugar level 2 hours later to assess whether his/her medical provider needed to be updated of the occurrence. A note written by Caregiver C stated, "[Resident 1] refuse care today. [S/He] refused to eat, get [her/his] blood sugar checked. Refuse all cares and Medications [sic]."

Example 2
Incident report dated 11/11/2024, at 7:12 PM, written by Caregiver C, reported on 11/11/2024, at 6:00 PM, Resident 1 had an incident, which was classified as "Behavior - Danger to Others." The report description stated, " . . . But [Resident 1's] blood sugar was 44 and [s/he] had to wait 15 minutes. So I started talking with [Resident 4]

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because it was [her/his] birthday. Thats [sic] when [Resident 1] asked can [s/he] have some soy sauce. I stated [s/he] couldn't eat yet. That's when [s/he] got mad shot [her/his] plate of food at me. Flip over the chairs. [S/He] flipped over a resident's walker. After that [s/he] went into the bathroom and started beating [her/his] head on the door and flipping over the things in the bathroom and was screaming, [s/he] was about to drink the soap. Then [s/he] came out of the bathroom and stated [s/he] was about to leave so I stretch my arms out to block [her/him] from leaving. That's when [s/he] bit me on my arm. After that [s/he] grab a metal thing off the wall and hit me in my leg. All while [s/he] was doing this [s/he] calling me [expletive] [sic]. Resident statement: Member was mad [s/he] couldn't eat until [her/his] sugar level was checked again. Member wanted to eat right away and mad because [s/he] was told [s/he] had to wait for next sugar check [sic]."

Resident 1's November 2024 MAR indicated her/his blood sugar values on 11/11/2024 were the following:
9:44 AM - 355, given 6 units of insulin
12:11 PM - 315, given 6 units of insulin

The blood sugar value of 44, which was indicated in the incident report, was not recorded in Resident 1's record. The only records of blood sugar checks were at 9:44 AM and 12:11 PM. There were no annotations in Resident 1's MAR indicating blood sugar checks or medication administration were completed after 12:11 PM on 11/11/2024.

On 01/14/2025, at 10:30 AM, Surveyor interviewed Resident 1. Resident 1 reported the following:

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M 448	Continued From page 8 Her/His diabetes is not well managed. When her/his blood sugars are low s/he acts like a "drunk person," shaking, falling, and feeling tired. Caregivers did not provide snacks when s/he had low blood sugars. On 01/14/2025, at approximately 12:00 PM, Surveyor interviewed Licensee A. Surveyor inquired about the incident which occurred with Resident 1 on 10/24/2024. Licensee A reported medication administrations were not signed off on 10/23/2024 for Resident 1. There was a note written by Caregiver C, which reported Resident 1 refused to take insulin and refused cares on 10/24/2024. Surveyor inquired about the incident which occurred with Resident 1 on 11/11/2024. When asked why Resident 1 had to wait to eat with a low blood sugar value, Licensee A stated, "they probably gave [her/him] a cocktail." S/He explained when Resident 1's blood sugar was low, s/he was typically given what they called a cocktail to stabilize her/his blood sugar. Licensee A confirmed that information was not noted in Resident 1's record or in the incident report. It was unclear to Licensee A what the caregivers did for Resident 1 to help manage her/his diabetes on 10/24/2024 and 11/11/2024. Licensee A reported Resident 1's record did not show notes or a medication pass on 11/11/2024. Licensee A reported Resident 1's diabetes was managed using the sliding scale provided by her/his physician and by monitoring Resident 1's diet. S/He informed Surveyor Resident 1's diabetes was difficult to manage due to Resident 1 not wanting to follow her/his physicians orders at times.	M 448		

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M 570	Continued From page 9	M 570		
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 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 record review, observation, and interview, the provider did not ensure 1 of 1 resident was safeguarded from environmental hazards when items were kept within the home, accessible to Resident 1, which had been previously used by Resident 1 to self-harm. Findings include: On 12/20/2024, the Department received a complaint alleging a resident self-harmed her/himself and staff did not call for immediate medical attention. The complaint reported Resident 1 was hospitalized. The facility is licensed to serve up to 4 residents in the client groups traumatic brain injury, developmental disability, irreversible dementia/Alzheimer's, advanced age, emotionally disturbed/mental illness, terminally ill, and physically disabled.	M 570		

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M 570	Continued From page 10 On 01/14/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 09/14/2023, with diagnoses including multiple psychological disorders and intellectual disability. Resident 1's individual service plan (ISP), dated 12/18/2024, documented Resident 1 required 24-hour supervision. Resident 1's ISP stated, " . . . Suicidal Tendencies - Resident Needs: Resident has suicidal thoughts/tendencies. When upset [s/he] requires attention, when member is told no, when member can't get [her/his] point across; Frequency: 3x (times) every day; Resident Desired Outcomes: To have proper precautions/care in place to alleviate suicidal thoughts/tendencies. Room proof with no glass, string, sharp objects etc. Bathroom no soaps, liquids, shower gels etc. . . . " Caregiver B wrote an incident report, dated 12/16/2024, which documented on 12/15/2024 Resident 1 made suicidal statements and swallowed nails. On 01/14/2025, at 9:40 AM, Surveyor interviewed Licensee A. Licensee A reported Resident 1 had an incident on 12/15/2024, where s/he self-harmed. Resident 1 removed the thumb tacks, which were securing her/his curtains to the wall, and swallowed the thumb tacks. On 12/16/2024, Resident 1 told staff s/he had swallowed more nails. Resident 1 was transported to the hospital for treatment. On 01/14/2025, Surveyor toured the home and observed the following: - Resident 1's room had curtains which were held up by 2 thumb tacks. - The living room and resident bathroom had jars	M 570		

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M 570	Continued From page 11 of air freshener gel beads. - The bathroom had a container of Softsoap hand soap. On 01/14/2025, at 11:45 AM, Surveyor interviewed Licensee A. Licensee A reported the following: On 12/15/2024, Licensee A left Lead Caregiver D in charge while s/he was out of town. When Licensee A was notified of the incident, s/he advised her/his staff not to put the thumb tacks back in Resident 1's room. Surveyor informed Licensee A of her/his observations. Licensee A did not have an explanation and was not aware the thumb tacks were still present in Resident 1's room. Surveyor inquired why Resident 1 did not have a curtain rod for the curtains and Licensee A reported s/he had used it to self-harm. Surveyor inquired about the air freshener gel beads. Licensee A confirmed the information documented in Resident 1's ISP and confirmed the air freshener gel beads were an environmental hazard for Resident 1 due to her/his history of self-harm. Licensee A reported the thumb tacks and gel beads would be removed. Licensee A reported Resident 1's one-on-one staff should have been accompanying Resident 1 within the home to prevent her/him from self-harm.	M 570		
M 572	88.10(3)(m) Freedom from Abuse Freedom from abuse. To be free from physical, sexual or mental abuse, neglect, and financial exploitation or misappropriation of property. This Rule is not met as evidenced by:	M 572		

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M 572	Continued From page 12	M 572		

Based on interview and record review the provider did not ensure 1 of 1 resident (Resident 1) was free from physical and mental abuse. Caregiver C had a physical and verbal altercation with Resident 1. As a result, Resident 1 self-harmed and was taken to the hospital by police.

Findings include:

DHS 88.02(18) states, "'Mental abuse'" means a single or repeated act of force, harassment, including sexual harassment, deprivation, neglect or mental pressure which reasonably could cause mental anguish or fear, which may include persistent or excessive negative comments, threats, deliberate inducement of anxiety or singling out a resident for inappropriate criticism or encouraging the resident's peers to do the same."

DHS 88.02(23) states, "'Physical abuse'" means the willful infliction of physical pain or injury or unreasonable confinement, including but not limited to direct beating, choking, sexual touching, unreasonable physical restraint or pain without physical marks."

On 12/20/2024, the Department received a complaint alleging a resident self-harmed her/himself and staff did not call for immediate medical attention. The complaint reported the resident was hospitalized.

Interview with Resident 1:

On 01/14/2025, at 10:06 AM, Surveyor interviewed Resident 1. Resident 1 stated, "[Caregiver C] and [Lead Caregiver D] beat me up." Resident 1 reported Caregiver C pushed and

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kicked her/him. Lead Caregiver D kicked her/him on the posterior and pulled her/his left arm. Resident 1 reported Caregiver C and Lead Caregiver D verbally abused her/him. During the altercation, Caregiver C or Lead Caregiver D stated, 'I hope they [expletive] you in your [posterior] and in your mouth.' Both caregivers made other similar statements towards Resident 1 throughout the altercation. Resident 1 reported s/he told police s/he wanted to die, and s/he swallowed the nails due to the way Caregiver C and Lead Caregiver D were treating her/him. At 10:14 AM, Resident 1 showed Surveyor her/his room. Surveyor observed a bracket for a closet rod, but the rod was not there. Resident 1 reported Caregiver C and Lead Caregiver D took the rod and hit and jabbed her/him in the stomach with it. Resident 1 reported s/he tried to call Licensee A during this incident, but the caregivers took the phone away from her/him. Resident 1 reported s/he needed to speak with Licensee A about this but had not been given the opportunity to.

Incident Reports:

On 01/14/2025, at approximately 10:15 AM, Surveyor reviewed the following 3 incident reports, which were provided by Licensee A:

1. Incident report dated 12/15/2024, at 2:10 PM, written by Caregiver C, reported on 12/15/2024, at 1:30 PM, Resident 1 had an incident, which was classified as "Behavior - Danger to Others." The report description stated, "[Resident 1] got upset because another resident was talking to another caregiver, and [s/he] called my name, so I told [her/him] [s/he] wasn't talking to me, So, [s/he] gets upset go into [her/his] room and start banging [her/his] head on the wall I follow

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[her/him] into [her/his] room. and [s/he] tried to slam the door in my face which caught my arm. Once [s/he] saw that [s/he] couldn't close [her/his] door [s/he] brushed pass me to attempt to go out the back door, so I stopped [her/him] from going out the back door that's when [s/he] spit in my face and started calling my [parent] and I [expletive]. Then [s/he] went back into [her/his] room and grabbed a plastic oval thing and started trying to cut [her/his] neck, face, etc. [sic] . . . " Caregiver B was listed as a witness to this incident. The response to the incident included notification to Lead Caregiver D on 12/15/2024, at 2:10 PM. " . . . [S/He] came to talk to [Resident 1]. . . . " The report documented Resident 1 did not sustain any injuries.

2. Incident report dated 12/15/2024, at 3:37 PM, written by Caregiver C, reported on 12/15/2024, at 3:37 PM, Resident 1 had an incident, which was classified as "Behavior - Property Destruction." The report description stated, "[Resident 1] tore up the screen that's in [her/his] room. One of the residents came out of [her/his] room and stated [s/he] was scared. [Resident 1] then attempted to walk up to [her/him] and screamed [expletive]. Then [s/he] focuses the attention back on me telling me to move from in front of [her/his] room door. I stated, '[Resident 1] I have to stand here to make sure you don't hurt yourself,' [s/he] started walking toward me yelling and screaming I don't care [expletive] and spit on me again. That's when the other caregiver [Caregiver B] said, '[Resident 1] don't spit.' [S/He] then started yelling at [Caregiver B] the same words (sic). . . . " Caregiver B was listed as a witness to this incident. The response to the incident included notification to Lead Caregiver D on 12/15/2024, at 3:00 PM. " . . . [S/He] came to talk to [her/him] with the Boss also speaking with

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the resident. . . . " Notification was also made to Licensee A on 12/15/2024, at 3:00 PM. " . . . Spoke with the resident. . . . " The report documented Resident 1 did not sustain any injuries.

3. Incident report dated 12/16/2024, at 1:08 PM, written by Caregiver B, reported on 12/15/2024, Resident 1 had an incident, which was classified as "Behavior - Danger to Self." The report description stated, " . . . [Caregiver C] then told [Resident 1] that [s/he] shouldn't have been in me and [Resident 2's] conversation and that we've had numerous conversations with [her/him] about minding [her/his] business. [Resident 1] began to get loud and attempted to go out the house door when [Caregiver C] and myself went to stop [her/him] [s/he] spit in [Caregiver C's] face and ran into [her/his] room saying [s/he's] going To [sic] kill [her/himself] and calling Me [Caregiver C] and [Resident 3] [expletive], [Caregiver C] went to [Resident 1's] room door after [Resident 1] tried to close it and lock [her/him] out. when [sic] [s/he] got to the door [Resident 1] was tearing the screen out the window in [her/his] room and yelling out of it 'help me [s/he's] abusing me'. at [sic] that moment i [sic] went into [Resident 1's] room where [Caregiver C] stood at the door calling management for help. [Resident 1] then fell to the floor when [s/he] seen me and attempted to take [Caregiver C] on the floor with [her/him] and [s/he] stated [s/he] had nails in [her/his] mouth and started clicking it against [her/his] teeth before swallowing it and showing me that [s/he] had swallowed it. i [sic] stated that [s/he] had a nail in [her/his] mouth but we couldnt [sic] get it out because [s/he] wouldnt [sic] open [her/his] mouth or spit it out and we knew [s/he] would bite us if we attempted to take it out. [Lead Caregiver D] arrived and asked [Resident 1] what

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was going on and [Resident 1] got violent and loud with [Lead Caregiver D] as well. i [sic] stated again that there was a nail in [Resident 1's] mouth that [s/he] had by then swallowed. But everyone thought that [s/he] had been lying about the nail because they thought that they had picked them all up so police or an ambulance was NOT called. i [sic] came into my shift at 8am [sic] this morning and [Resident 1] had stated [s/he] swallowed 3 more after i [sic] left lastnight [sic]. i [sic] called police immediately and they took [her/him] to the hospital [sic]." Caregiver C was listed as a witness to this incident. The response to the incident included notification to Lead Caregiver D on 12/15/2024, at 3:15 PM, and Licensee A on 12/15/2024, at 3:35 PM. " . . . Wasnt [sic] made aware of nails, [Licensee A] advised [Lead Caregiver D] to make intervene and decide if [Resident 1] should go out. [Lead Caregiver D] did not send [Resident 1] out [sic]. . . . " The report documented Resident 1 did sustain injuries. " . . . Notes: [Resident 1] scratched face and neck. . . . " Skin tears to the upper right cheek/ear and right side of neck were documented on the report.

Documented on all 3 incident reports were the responses to the incident. Caregiver B and Caregiver C indicated in their reports Resident 1 did not receive first aid; did not have her/his vitals taken; did not get transferred to the hospital or emergency room (ER); did not refuse treatment/transport; and her/his physician, family, or representative were not notified. The reports also documented Resident 1 did self-harm by banging her/his head on the wall, cut her/his neck and face with a "plastic oval thing," and swallowed nails; stated s/he was going to "kill" her/himself; attempted to leave the home; damaged the screen on her/his bedroom window,

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and was violent, loud, and used profanities towards the caregivers and other residents.

Interview with Licensee A:

On 01/14/2025, at 11:45 AM, Surveyor interviewed Licensee A. Licensee A reported Resident 1 had a one-on-one staff assigned, which was often Caregiver C. Licensee A reported s/he was unaware of any incident in which staff abused Resident 1. Licensee A reported Resident 1 typically tells her/him everything. On 12/15/2024 Licensee A was traveling back from out of town and Lead Caregiver D was put in charge of the facility. Resident 1 went into her/his room and swallowed thumb tacks and did not tell anyone until the following day. Resident 1 was then taken to the hospital. On 12/21/2024, Resident 1 returned from the hospital. On 12/23/2024, Licensee A held a training and meeting with staff regarding this incident.

Surveyor requested incident reports for Resident 1, dating back through 10/08/2024. Licensee A provided Surveyor with 9 total incident reports dated, 10/12/2024, 10/18/2024, 10/21/2024, 10/24/2024, 10/30/2024, 11/11/2024, two dated 12/15/2024, and 12/16/2024. Of the 9 incident reports, 3 reports were related to the incident Resident 1 described in her/his interview. See record review for further information regarding this.

Resident 1's Behavioral Health Progress Notes Record Review:

On 01/21/2025, at 11:17 AM, Surveyor received and reviewed a Progress Notes Report from Milwaukee County Behavioral Health Services for

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Resident 1. The report stated Resident 1 was admitted on 12/17/2024 and discharged on 12/18/2024. An evaluation at Columbia St. Mary's Hospital was completed with Resident 1, by Advanced Practice Social Worker (APSW) H and Emergency Services Clinician (ESC) I. The report was written by ESC I and stated the following:

" . . . [ESC I] and [APSW H], traveled to Columbia St. Mary's hospital to conduct the evaluation. [ESC I] read the rights of detention to the patient prior to assessing [her/him]. [S/He] immediately began to list a number of concerns regarding [her/his] current residential provider. [S/He] stated that the staff have beat [her/him] up, pushed, and scratched [her/him]. They used derogatory language toward [her/him].

In summary, [s/he] stated that they 'treat me like an animal and they call me retarded.' The patient proceeded to recount some of the past abuse that [s/he] has endured while growing up . . . After providing the patient the opportunity to share these stories, [s/he] spontaneously stated 'I don't want to die, I want to live.' [ESC I] clarified that [her/his] self-injurious behaviors were correlated with dissatisfaction about [her/his] current residential provider. [S/He] denied any current thoughts of self-harm and believes that the staff at the hospital are providing [her/him] with good care while showing respect . . . [S/He] was fully oriented to person, place, time, and situation . . . [her/his] thoughts were coherent and organized. [S/He] initially self-reported [her/his] mood as 'depressed,' which was congruent with [her/his] affect while [s/he] shared [her/his] recent concerns and prior trauma history. As the interview progressed, [her/his] affect brightened as [s/he] expressed appreciation for being respected and heard. There was no overt

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evidence of auditory or visual hallucinations. [S/He] denied current thoughts of self-harm or suicide and there was no evidence of dangerousness toward others.

Based on this assessment and the collateral information, it is [ESC I's] opinion that the patient's self-injurious behaviors were highly correlated with expressed concerns related to [her/his] residential provider. [S/He] has returned to [her/his] baseline and involuntary inpatient hospitalization is not necessary nor would it ameliorate the concerns that [s/he] has raised. As such, [ESC I] made the decision to drop the existing emergency detention . . .

[ESC I] also placed a follow up call to the patient's legal guardian. [ESC I] shared the patient's self-reported concerns and allegations of abuse regarding the residential placement. The guardian stated that [s/he] and the Family Care team 'investigate every matter.' In fact, they have already addressed the concern that the patient's residential provider did not act sooner when the patient stated that [s/he] had ingested a nail. The guardian expressed agreement that inpatient hospitalization was not warranted at this time . . .

Reported client swallowed 5 metal nails. Reportedly client did this in a suicide attempt because 'group home caregiver punched [her/him] in the face and scratched [her/him].'"

Review of Emergency Detention Report:

On 01/21/2025, at 11:35 AM, Surveyor received and reviewed the Statement of Emergency Detention report. The report was written by Police Officer (PO) E, on 12/16/2024, at 8:50 AM, and stated the following:

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M 572	Continued From page 20 " . . . Myself and [PO J] were dispatched to a suicide attempt at [Tee's Direct Care]. Upon arrival I spoke to [Caregiver F]. [Caregiver F] stated on 12-15-2024 at approximately 1Pm [sic], [s/he] witnessed [Resident 1] eat a half inch nail and swallow it. [Caregiver F] stated [s/he] did not call for medical attention on 12-15-2024 for [Resident 1]. [Caregiver F] stated when [s/he] arrived to work on 12-16-2024 at 8:00 AM, [Resident 1] told [her/him] [s/he] ate more nails. While we were on scene, [Resident 1] stated, 'I wanna die' [sic]. . . " Review of Resident 1's Hospital Records: On 02/12/2025, at 7:38 PM, Surveyor received and reviewed hospital reports from Columbia St. Mary's Hospital. The records documented Resident 1 was admitted on 12/16/2024 and discharged on 12/21/2024. The hospital records documented the following: Resident 1's visit diagnoses included, swallowed foreign body, hyperglycemia, alleged assault, suicidal ideation, and type 1 diabetes mellitus with diabetic polyneuropathy. 12/16/2024 - ". . . Postoperative Diagnosis and Clinical Impression: Nail in colon, removed. Procedure: Colonoscopy with foreign body removal. . . . Hospital Course: . . . who presents from [her/his] home accompanied by Milwaukee Police Department after ingesting 5 nails at [her/his] group home in a suicide attempt. Apparently did this as [s/he] was having conflicts with a worker at the group home, got into a scratching/physical altercation with [her/him] making her feel suicidal and leading to swelling (sic) nails. Swallowed 1	M 572		

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nail last night, 4 more this morning. . . . CT (computed tomography) chest/abd (abdomen)/pelvis showing 5 metal screw or bolts in left abdomen measuring approximately 2.8 centimeters (cm). . . . Assessment/Plan: Foreign body ingestion. Suicide ideation. Patient was in a physical altercation with a worker at [her/his] group home making [her/him] feel suicidal. "

Resident 1's Care Manager Patient Worksheet documented the following:
" . . . Patient states [s/he] has been having conflicts with a worker at the group home. [S/He] states the person was insulting and threatening [her/him] yesterday and they got into a physical altercation. [S/He] points to some scratches on [her/his] head and chest and states this is from the person's artificial nails. States that [s/he] was punched in the head and then fell down and hit [her/his] head on the ground, does not know if [s/he] lost consciousness. [S/He] felt suicidal and swallowed a nail that [s/he] found in the laundry room. This morning [s/he] states that [s/he] had another altercation with the same person and swallowed for [sic] more nails. . . . "

Clinical notes documented the following:
" . . . multiple scratch marks on [her/his] face, arms and chest. . . . "

12/18/2024 -
Resident 1 spoke with Tele-Behavioral Health and the following was documented:
" . . . Chief Complaint: suicide attempt, recurrent foreign body ingestion. . . . 'I was in the group home and the staff beat me up.' Describes physical altercation with staff member (makes specific claims of hitting with hands/ruler, scratching). Also reports verbal abuse. After this [s/he] swallowed several nails over 2 different

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occasions because 'I don't want to be living.' . . . When inquiring about precipitants [s/he] said that [s/he] was scared, became very labile/tearful. Referenced long hx (history) of abuse as a child. Feels abandoned by family, reportedly [parent] has told [her/him] throughout [her/his] life that [s/he] does not want [her/him] and that the pt (patient) is 'retarded.' Becomes quite emotional when discussing this and claims GH (group home) worker referred to her as 'retarded.'"

Review of Licensee A's Misconduct Investigation

On 01/29/2025, Licensee A sent an email to Surveyor, which contained a note written by Caregiver B, following her/his termination of employment. The note read the following:

"December 16th 2024, I reported an incident involving [Resident 1] swallowing nails on December 15th. On this day [Resident 1] and [Caregiver C] had a physical altercation. During that altercation [Resident 1] tried to leave and said [s/he] was gonna [sic] 'run away' when [s/he] opened the door [Caregiver C] pushed it closed and [Resident 1] spit on [her/him]. At that point [Caregiver C] muffed [Resident 1] and [s/he] ran to [her/his] room crying. Before swallowing the nails [s/he] was being provoked by [Caregiver C] and [Lead Caregiver D]. They were laughing at [her/him] and kicking [her/him]. [S/He] at one point started fighting [Caregiver C] who at that point started fighting back and taking pillows hitting [Resident 1] in [her/his] face with them [sic]. After swallowing the nails they said [s/he] will '[expletive]' them out and that they will cut [her/his] insides up. Both told me not to call police or [Licensee A]."

On 01/28/2025, Licensee A emailed Surveyor and

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reported s/he had conducted a follow-up investigation on the abuse allegations. S/He informed Surveyor Misconduct Incident Reports would be submitted for Caregiver B, Caregiver C, and Lead Caregiver D. Resident 1 reported the abuse allegations to Licensee A, and her/his statements were similar to what Caregiver B reported in the note s/he wrote to Licensee A.

Interview with Caregiver B:

On 02/13/2025, at 3:18 PM, Surveyor interviewed Caregiver B. Caregiver B reported the following:
- Caregiver B confirmed s/he wrote the note and left it for Licensee A. Surveyor clarified the word "muffed," which was written in the note. Caregiver B reported Caregiver C used an open hand to hit Resident 1 in the face. Resident 1 reported Caregiver C punched her/him in the face. Caregiver C took Resident 1's pillow and hit her/him in the face with it, while s/he was sitting on the bed. While hitting her/him, Caregiver C was yelling, 'shut up, shut up!' Resident 1 was yelling, 'stop, stop!' Caregiver C and Lead Caregiver D laughed at Resident 1 and walked out of the room. When Resident 1 returned from the hospital, Caregiver B observed scratches on her/his chest and a bruise under her/his eye. A work group chat from Licensee A reported 5 nails were found inside Resident 1 at the hospital. Caregiver B reported Caregiver C was always provoking Resident 1. Caregiver C often repeated the name calling when Resident 1 used profane language towards her/him. Caregiver B heard Caregiver C state, 'that's why you got [expletive]. They put their [expletive] inside your [expletive]. [Resident 1] is lying, nobody ever [expletive] [her/him].' Caregiver B stated, "It was so disturbing what [Caregiver C] was saying." Caregiver B reported s/he did not initially call the

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police when Resident 1 swallowed the nails because Lead Caregiver D told her/him not to. Lead Caregiver D stated, '[s/he's] just going to [expletive] it out. It's going to tear up [her/his] insides.' After Caregiver B wrote the incident report, Caregiver C and Caregiver D tried to get her/him to "switch it up." Since reporting the incident, Caregiver B received multiple threatening messages from the other staff.
- Caregiver B recalled the incident on 12/15/2024. On 12/15/2024, Caregiver B and Caregiver C were the staff working 8:00 AM - 8:00 PM at Tee's Direct Care. Caregiver C was assigned as Resident 1's one-on-one. Caregiver B confirmed s/he wrote an incident report on 12/16/2024, for the incident which occurred on 12/15/2024. Between 12:00 PM and 1:00 PM, s/he was having a conversation with Resident 2. Resident 1 yelled out about Caregiver C looking for someone. Caregiver C stated to Resident 1, 'That's what I told you about minding your own business.' Resident 1 was mad and yelled at Caregiver C. Caregiver B attempted to calm Resident 1 down. Resident 1 went into her/his room and slammed the door. Caregiver C followed Resident 1 and there was a loud noise which came from the room. Resident 1 was observed on the floor of her/his room and Caregiver C was falling. Caregiver B asked what happened and told Caregiver C to step out of the room. Caregiver C told her/him Resident 1 tried to hit her/him. Resident 1 attempted to walk out the back door of the residence and Caregiver C slammed the door closed before s/he could. Resident 1 turned around and spat in Caregiver C's face. Resident 1 and Caregiver C were verbally arguing. They went back to Resident 1's room and Resident 1 was again, observed on the floor. Caregiver C was yelling. Resident 1 yelled, 'I have a nail in my mouth!' Caregiver C continued to yell. Resident 1

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showed Caregiver B the nail. Resident 1 tore the screen to her/his bedroom window. Lead Caregiver D was called during the altercation and responded to the residence. When Caregiver D arrived, Resident 1 was on the floor, and s/he grabbed Resident 1's left arm attempting to get her/him off the floor. Caregiver B stated, "Everyone knows [Resident 1's] left arm is [her/his] weak arm." Caregiver B asked Caregiver C and Lead Caregiver D if s/he should call 9-1-1 since Resident 1 swallowed a nail. Caregiver C told her/him not to call because s/he was Resident 1's one-on-one and s/he would be sent home. Lead Caregiver D told her/him not to call and stated, '[s/he'll] just [expletive] it out.' During the incident, Caregiver B walked in and out of Resident 1's room repeatedly and heard "rumbling" coming from the room when s/he was away. Resident 1 fell asleep on the floor of her/his bedroom prior to Caregiver B leaving the facility for the evening.
- Surveyor inquired about the incident report Caregiver B wrote and the following was reported: Caregiver B walked into Resident 1's bedroom sometime during the incident to calm her/him down. Resident 1 usually calmed down when Caregiver B approached her/him. S/He observed Resident 1 clicking the nails on her/his teeth. S/He observed the back part of the nail hanging out from in-between her/his teeth and saw her/him swallow the nail. At an unspecified date/time, Resident 1 ripped her/his curtains and curtain rod down in her/his room. The nails s/he swallowed were from the frame of the window where the curtains had been hanging. On 12/16/2024, at 8:00 AM, Caregiver B entered the facility to start her/his shift. S/He observed Resident 1 sitting on the couch in the living room. S/He observed Resident 1 "going in and out of it," and her/his "eyes opening and closing." S/He

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asked Resident 1 if s/he was okay and s/he stated, 'no.' Resident 1 disclosed s/he had swallowed 4 more nails after Caregiver B left the previous night. When Caregiver B asked Resident 1 why s/he did that, Resident 1 reported Caregiver C and Caregiver G were laughing at her/him. Caregiver B stated, "I already didn't like what happened the day before." Resident 1 appeared lethargic and not her/his baseline. Caregiver B called Licensee A to report Resident 1 swallowed more nails. Licensee A told Caregiver B to call the police and send Resident 1 out. Caregiver B called the police and they responded, along with an ambulance. Resident 1 was transported to the hospital.

SUMMARY

In summary, on 12/15/2024, Resident 1 and Caregiver C were involved in a verbal and physical altercation, which resulted in Resident 1's hospitalization. Resident 1 swallowed 5 metal nails, during and after the altercation with Caregiver C. It was reported by Resident 1 s/he did self-harm due to Caregiver C and Lead Caregiver D's abusive treatment within the facility. Between 12/16/2024 and 12/21/2024, several in-hospital evaluations of Resident 1 were completed, and Resident 1 consistently reported the verbal and physical altercation with Caregiver C to various hospital staff and professional partners. Caregiver B was a witness to the incident on 12/15/2024, and corroborated Resident 1's statements. Licensee A was uninformed of the abuse allegations until the survey was opened. After Licensee A was made aware of the abuse allegations s/he interviewed Resident 1. Resident 1 confirmed with Licensee A s/he was abused by Caregiver C.

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M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) received prompt and adequate treatment. Resident 1 self-harmed with staff present and was not treated by a medical professional for approximately 19 hours. Follow up appointments were required after Resident 1 ' s hospital stay with his/her primary care physician and psychiatry (1 week after discharge and 2 weeks after discharge), but no appointments scheduled. Findings include: On 12/20/2024, the Department received a complaint alleging a resident self-harmed her/himself and staff did not call for immediate medical attention. The complaint reported the resident was hospitalized. On 01/14/2025, at approximately 12:00 PM, Surveyor reviewed Resident 1's record, and the following was identified: Resident 1 was admitted to the provider on 09/14/2023, with diagnoses including intellectual disability and multiple psychological disorders Facility incident report, dated 12/15/2024, at 2:10	M 580		

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PM, was completed by Caregiver C. The incident report documented the following:
- The incident occurred on 12/15/2024, at 1:30 PM, in the kitchen
- Resident 1 was a danger to others
- Resident 1 went into her/his room and banged her head on the wall
- Resident 1 attempted to exit the home and Caregiver C stopped her/him
- Resident 1 spit in Caregiver C's face and was using profane language
- Resident 1 went back into her/his room, grabbed a plastic oval object and attempted to cut her/his neck and face with it
- At 2:10 PM, Lead Caregiver D was called and notified of the incident

Facility incident report, dated 12/15/2024, at 3:37 PM, was completed by Caregiver C. The incident report documented the following:
- The incident occurred on 12/15/2024, at 3:37 PM, in the kitchen
- Resident 1 tore the screen in her/his room
- Resident 1 used profane language towards staff and other residents
- Resident 1 spat on Caregiver C
- Caregiver B attempted to intervene and Resident 1 used profane language towards her/him
- At 3:00 PM, Lead Caregiver D and Licensee A were notified of the incident

Facility incident report, dated 12/16/2024, at 1:08 PM, was completed by Caregiver B. The incident report documented the following:
- The incident occurred on 12/15/2025, in Resident 1's room
- Resident 1 and Caregiver C were involved in a verbal argument
- Resident 1 attempted to exit the home and

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Caregiver B and Caregiver C stopped her/him
- Resident 1 spat in Caregiver C's face
- Resident 1 ran to her/his room and stated s/he was going to kill her/himself
- Resident 1 tore out the screen in the window in her/his room
- Resident 1 fell to the floor and attempted to take Caregiver C down with her/him
- Resident 1 stated s/he had nails in her/his mouth and "clicked" them against her/his teeth
- Caregiver B observed Resident 1 swallow the nail(s)
- Lead Caregiver D arrived at the home
- Caregiver B told Caregiver C and Lead Caregiver D, Resident 1 had swallowed a nail(s)
- Ambulance or police were not called
- Caregiver B came in for her/his shift on 12/16/2024, at 8:00 AM, and Resident 1 told her/him s/he had swallowed 3 more nails after Caregiver B left on 12/15/2024
- Police were called and took Resident 1 to the hospital
- Licensee A was notified on 12/15/2024, at 3:35 PM
- Licensee A noted, "wasnt [sic] made aware of nails, [Licensee A] advised [Lead Caregiver D] to make intervene and decide if [Resident 1] should go out. [Caregiver D] did not send [Resident 1] out [sic]."
- A skin tear on Resident 1's right cheek and neck were noted

Resident 1's after visit summary (AVS) dated 12/16/2024 - 12/21/2024, stated the following:

" . . . - Reason for Hospitalization: Swallowed Foreign Body, Initial Encounter
- Your diagnoses also included: Suicide Attempt [hierarchical condition category] (Hcc), Schizoaffective Disorder, Bipolar Type (Hcc), . . .

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Foreign Body Ingestion . . .
- Follow-up and Referral Orders - Discharge follow-up: Psychiatry
- Follow up in: within 1 week
- Instructions: Follow up with primary psychiatrist for medication review . . .
- Follow up in: 2 weeks
- Follow-up appointment with primary physician
- Follow up in: within 1 week . . .
- Discharge activity: No restrictions, walking encouraged, stairs allowed
- Recommend one-on-one monitoring to prevent further foreign body ingestion . . . "

On 01/21/2025, at approximately 11:30 AM, Surveyor reviewed police reports, and the following was documented:

- The police call log reported the call for emergency assistance was made on 12/16/2024, at 8:26 AM.
- An emergency detention (ED) report was completed on 12/16/2024, at 8:50 AM, by Police Officer (PO) E.
- The ED report stated officers "were dispatched to a suicide attempt . . . "
- Caregiver F reported to PO E s/he witnessed on 12/15/2024, Resident 1 eat a half inch nail and swallow it.
- Caregiver F reported to PO E s/he did not call for medical attention on 12/15/2024.

On 01/14/2025 and 01/22/2025, Surveyor interviewed Licensee A. Licensee reported the following:

Licensee A confirmed Resident 1 should have been taken to the hospital immediately following the incident. Surveyor inquired about the hospital follow-up and referral orders. Licensee A

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reviewed the facility's documents and reported Resident 1 had not had any follow-up appointments, and none had been scheduled. Lead Caregiver D resigned on 12/27/2024, and it was her/his responsibility to schedule the follow-up appointments. Licensee A reported s/he was not made aware Resident 1 swallowed nails/thumb tacks until the day following the incident. When s/he was informed of this, s/he told Caregiver B to immediately call 9-1-1. Licensee A had relied on Lead Caregiver D, in her/his absence, to determine actions after the incident. Lead Caregiver D and Caregiver C did not report Resident 1 had swallowed nails/thumb tacks. A new policy was put in effect for making hospital calls, and a meeting/training was held with staff on 12/23/2024.

On 02/13/2025, at 3:18 PM, Surveyor interviewed Caregiver B. Caregiver B reported the following:

S/He knew Resident 1 had swallowed a nail and informed Caregiver C and Lead Caregiver D. Lead Caregiver D responded to the facility and made the decision not to call for medical attention for Resident 1. Caregiver B stated, "I wanted to call the day before, but the house manager (Lead Caregiver D) told me not to." Caregiver B confirmed Resident 1 was in need of medical attention after swallowing the nail, but none of the staff called 9-1-1 on the date of the incident.

Summary:

On 12/15/2024, at approximately 1:10 PM, Resident 1 began to have behaviors and self-harmed. Caregiver B witnessed Resident 1 swallow a nail(s) and told Caregiver C and Lead Caregiver D. Approximately 19 hours later, after Resident 1 told Caregiver B s/he swallowed more

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M 580	Continued From page 32 nails, an emergency call was placed. Resident 1 was hospitalized from 12/16/2024 - 12/21/2024. The hospital surgically removed 5 metal screws/bolts, measuring 2.8 centimeters, from Resident 1. Three follow-up visits with various physicians were recommended on the hospital discharge paperwork. At the time of the survey, Resident 1 had not been seen by a physician for follow-up and there were no appointments scheduled. Cross Reference: M0572/88.10(3)(m) - Freedom From Abuse	M 580		