STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019303	A. BUILDING: _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN AFH	2019 ADDERBURY LN MADISON, WI 53711

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M 000	INITIAL COMMENTS On 02/27/2024, with information gathered through 02/29/2024, Surveyor conducted a complaint investigation at Martin AFH. Four deficiencies were identified. One of 4 deficiencies was a repeat violation. (See Statement of Deficiency (SOD) YD0E11). Complaint was unsubstantiated. Census: 2	M 000		
M 406	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. 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) Individual Service Plan (ISP) was reviewed at least once every six months by the provider, the resident and/or resident's guardian, or the placing agency. Findings include: On 02/27/2024, Surveyor reviewed Resident 1's	M 406		

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

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M 406	Continued From page 1 record. Resident 1's record contained a managed care organization (MCO) "Behavior Support Plan," dated 04/05/2023, which was signed by Resident 1 and Care Manager C. The ISP was not signed by the provider. Resident 1's record did not contain an ISP developed by the provider. Resident 1's record was due to be reviewed in 10/2023 and no evidence was in the record that the reviews had been completed. On 02/28/2024 at 3:05 PM, Surveyor emailed Licensee A and stated Resident 1's binder did not contain an ISP that identified required care guidelines. On 02/29/2024 at 4:04 PM, Surveyor emailed Licensee A and stated the survey window was closing. As of 02/29/2024 at 6:30 PM, no additional documentation was received.	M 406		
M 414	88.06(3)(d)2 LEVEL OF SUPERVISION Identification of the level of supervision required in the home and community. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident's Individual Service Plan (ISP) identified the level of supervision required in the home and community. Resident 1 had a history of elopement and his/her level of supervision at home was not documented.	M 414		

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M 414	Continued From page 2 Findings Include: On 02/12/2024, the Department received a complaint regarding levels of supervision at the Adult Family Home. On 02/27/2024, at approximately 10:40 AM, Surveyor interviewed Resident 1 and Caregiver B. Surveyor asked for clarification on the events that occurred on 02/12/2024 when it was reported that Resident 1 left the home without supervision. Resident 1 stated s/he wanted to go and buy cigarettes and Caregiver B stated s/he needed to wait. Resident 1 stated, "I do not have patience and I left." Caregiver B stated s/he could not follow Resident 1 as Resident 2 was in the building and Caregiver B was the only staff member in the home at that time. Caregiver B explained that when Resident 1's mood is in "a good place," s/he will allow him/her to walk outside, unsupervised, for like 5 minutes. Caregiver B stated, "As long as I can still see [him/her]." Caregiver B confirmed that Resident 1 had eloped from the facility in the past, but did not feel that Resident 1 required 1:1 supervision. On 02/27/2024, Surveyor reviewed Resident 1's record. Resident 1 moved into the home, 04/10/2023, with diagnoses including bipolar/manic depressive and manic with psychosis. Resident 1's "Behavior Support Plan," signed 04/05/2023, documented: "Elopement History: [Resident 1] has a history of eloping and going to places where [s/he] can buy alcohol if these places are nearby. Interventions from staff: Staff should avoid taking [Resident 1]	M 414		

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M 414	Continued From page 3	M 414		

to nearby liquor stores."

Resident 1's record did not contain an ISP.

Resident 1's record did not contain guidelines that outlined his/her required level of supervision.

On 02/27/2024, Surveyor received and reviewed Resident 1's police report which documented:
"02/12/2024 at 4:42 PM I was dispatched to [facility name]. ... The caller reported that a resident of the Adult Family Home ... had walked away approximately five minutes ago ... at approximately 4:49 PM a staff member of a [gas station] called to report that a subject was causing a disturbance and being verbally abusive. ... the suspect in the disturbance was ..., the same individual from this call. ...stated [s/he] had wanted to buy cigarettes, but [his/her] care staff members refused to go buy them for [him/her], so [s/he] left."
"I conducted a LERMS check of the address to determine whether there were additional, similar incidents at this residence home. I found the follow calls that involved [Resident 1] that required law enforcement intervention:
02/11/2024 - a staff member of the facility called 911 that [Resident 1] had jumped onto a bus and told staff [s/he] was going to the mall.
12/10/2023 - [Caregiver B] called 911 reporting that [Resident 1] had left the group home on foot and was heading to [gas station]. [Caregiver B] told the 911 Call Taker that [s/he] was alone and unable to follow [Resident 1].

On 02/28/2024 at 3:05 PM, Surveyor emailed Licensee A and stated Resident 1's binder did not contain an ISP that identified required care guidelines.
On 02/29/2024 at 4:04 PM, Surveyor emailed

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M 414	Continued From page 4 Licensee A and stated the survey window was closing. As of 02/29/2024 at 6:30 PM, Surveyor did not receive any additional documentation.	M 414		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1of 1 resident received the correct dosage of prescribed medications. Resident 1 was prescribed as-needed (PRN) Olanzapine and Risperidone but did not have specific physician orders defining when which medication should be administered. Findings include: On 02/27/2024, at approximately 10:35 AM, Surveyor observed Resident 1's medications which included: - blister card which contained 29 of 30 tablets of Olanzapine (medication for schizophrenia and bipolar disorder)	M 462		

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M 462	Continued From page 5 - blister card which contained 12 of 30 tablets of Risperidone (medication for schizophrenia and bipolar disorder) On 02/27/2024, Surveyor reviewed Resident 1's record. Resident 1 moved into the home, 04/10/2023, with diagnoses including bipolar/manic depressive and manic with psychosis. Resident 1's December 2023 and February 2024 Medication Administration Record documented: Olanzapine - Take 1 tablet by mouth twice daily as needed. Scheduled at 8:00 AM and 8:00 PM. Documented as administered 02/01/2024 to 02/16/2024 at 8:00 AM. The MAR did not document a rationale as to why the medication was administered. Risperidone - Take 1 tablet by mouth 3 times daily as needed for anxiety and agitation. Documented as administered 12/12/2023 to 12/17/2023 and 12/23/2023 and 12/24/2023. The MAR did not document a rationale as to why the medication was administered. On 02/27/2024, at approximately 11:10 AM, Surveyor interviewed Resident 1 and Caregiver B. Surveyor asked Caregiver B to explain how s/he knew which PRN was to be administered when Resident 1 was experiencing behaviors that would warrant a PRN. Caregiver B stated, s/he really did not know as both medications addressed the same behaviors. Resident 1 stated, "I am taking too many medications. Why do they keep giving me medications that make me feel funny. I know when I need my medications and then I get in trouble when I refuse the medications." Surveyor asked why	M 462		

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M 462	Continued From page 6 Resident 1 was administered his/her PRN Olanzapine for 17 days straight in February. Caregiver B stated, "When Resident 1 gets into one of [his/her] moods, it can take days before [s/he] is [him/herself] again." Caregiver B agreed that Resident 1 understands the medications that s/he is taking and when s/he may need them. On 02/27/2024 at 2:21 PM, Surveyor emailed Licensee A and stated there were concerns regarding Resident 1's PRN Olanzapine and Risperidone. Surveyor asked for clarification as to how staff know which PRN medication should be administered. On 02/28/2024 at 3:05 PM, Surveyor emailed Licensee A and stated there were concerns regarding Resident 1's PRN Olanzapine and Risperidone. Surveyor asked for clarification as to how staff know which PRN medication should be administered. On 02/29/2024 at 4:04 PM, Surveyor emailed Licensee A and stated the survey window was closing. As of 02/29/2024 at 6:30 PM, Surveyor did not receive a response or additional documentation.	M 462		
M 488	88.09(1)(d) RESIDENT RECORDS REQUIREMENTS A resident's record shall include all of the following: This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure a complete record for 1 of 2 residents (Resident 2) were maintained. This is a repeat deficiency. See Statement of	M 488		

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M 488	Continued From page 7 Deficiency (SOD) YD0E11, dated 05/08/2023. Findings include: On 02/27/2024, at approximately 10:20 AM, Surveyor arrived at the home to conduct a complaint investigation. Surveyor was greeted by Resident 1 and Caregiver B. Caregiver B informed Surveyor that s/he did not have access to all the resident records, only what was in the medication closet. Surveyor observed Resident 2 sleeping on the couch. Surveyor reviewed Resident 2's binder, which did not contain: -The service agreement. -TB (tuberculosis)/Free from communicable disease screen -The statement indicating that the resident rights and grievance procedures had been explained and copies provided to the resident and the resident's guardian. -The report of the admission health examination, including the screening for communicable disease and tuberculosis test. -The individual service plan (ISP) and all updates. -The physician's orders specifying who by name or position was permitted to administer the medication, under what circumstances, and in what dosage the medication was to be administered. -Evacuation Assessment On 02/27/2024 at 2:21 PM, Surveyor emailed Licensee A and stated there was no binder available for Resident 2, except his MAR and progress notes. On 02/28/2024 at 3:05 PM, Surveyor emailed Licensee A and stated there was no binder available for Resident 2, except his MAR and	M 488		

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M 488	Continued From page 8 progress notes. On 02/29/2024 at 4:04 PM, Surveyor emailed Licensee A and stated the survey window was closing.	M 488		