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M 000	INITIAL COMMENTS On 02/13/2024, with information gathered through 04/29/2024, Surveyor conducted a standard licensure survey and 2 complaint investigations at Bettes Flats. Twenty-five deficiencies were identified. Two of 2 complaints were substantiated. Census: 2	M 000		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke,	M 114		

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

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M 114	Continued From page 1 refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 personnel files reviewed included a complete background check as required. Caregiver U did not complete a new Background Information Disclosure (BID) form upon hire when the provider utilized a prior background check completed within the prior 4 years. Licensee A did not conduct a background check for Co-Owner B when s/he began working in the capacity of a service provider. Findings include: Example 1: Caregiver U On 02/14/2024, Surveyor reviewed Caregiver U's record. Caregiver U was hired 07/31/2023. [His/her] file contained a completed background within the previous 4 years, including the following background information: BID report was dated 06/01/2021. DOJ report was dated 06/08/2021.	M 114		

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M 114	Continued From page 2 IBIS letter was dated 06/08/2021. Surveyor identified Caregiver U's BID report was not updated upon hire. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Administration C stated s/he may have given a wrong hire date. On 04/27/2024 at 10:33 AM, Surveyor emailed Licensee A and Administration C. Surveyor re-sent the staff roster that had been provided to the Surveyor and asked for hire dates to be verified. On 04/29/2024 at 11:03 AM, Administration C responded. Caregiver U's hire date did not change. Example 2: Co-Owner B On 02/16/2024 at 9:53 AM, Surveyor emailed Licensee A and Administration C and requested Co-Owner B's complete background check, due to [his/her] involvement with resident cares. On 02/19/2024 at 8:52 AM, Co-Owner B emailed Surveyor and stated, "I apologize that this has not been done before as I had thought that an owner was not under this same requirement as a caregiver." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Co-Owner B stated, "After this survey process, you are right, I	M 114		

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M 114	Continued From page 3 do provide cares to the residents."	M 114		
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 report to the Department, within 24 hours, a significant change in status for 3 of 3 residents. Resident 1 experienced a medical emergency, was hospitalized, and the provider did not notify the Department. Resident 3 sustained a closed right ankle fracture, and the provider did not notify the Department. Resident 4 possibly eloped and [his/her] whereabouts were unknown for approximately 3 to 4 hours and the provider did not notify the Department. Findings include:	M 134		

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M 134	Continued From page 4 Example 1: Resident 1 On 02/21/2024, at approximately 4:30 PM, Surveyor interviewed Resident 1's Family Member (FM) D. FM D stated there was an incident, 01/31/2024, where Resident 1 had experienced an altered mental state and there were concerns it had to do with [his/her] lack of medication administration. FM D stated Resident 1's medications were administered by the provider's staff. On 02/28/2024, Surveyor reviewed the sheriff department report regarding the 01/31/2024 incident: "01/31/2024 2:29 AM [Resident 1] is currently upstairs in the main floor, in an altered mental state, having delusions, "don't know what [s/he's] trying to do" claiming [s/he] had a stroke, has schizo affective disorder, [Provider] is not managing [his/her] medication. Caller doesn't know if [s/he] is attacking anyone, but [s/he] is angry because no one is believing [him/her] ... I arrived on scene and spoke with [FM D] via phone. [S/he] informed me that [Resident 1] has schizo affective disorder and that [his/her] medicine has not been working properly and [s/he] is currently in an altered mental state and was giving the staff at [home] a hard time as [s/he] was confused and [s/he] believed [s/he] was back in [state name]. [FM D] requested that [Resident 1] be transported to [hospital] where [s/he] will meet them and get [him/her] checked out." On 03/01/2024, Surveyor reviewed medical documentation supplied by FM D which documented: "Pt's (patients) presentation and ED (emergency department) work-up discussed with [hospital]	M 134		

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who will admit for continued cares including possible NRSG consultation given hx (history) of VPS (ventriculoperitoneal shunt) (shunt to treat hydrocephalus [neurological disorder caused by an abnormal buildup of cerebrospinal fluid in the ventricles deep within the brain]."
"Primary reason for admission/Working diagnoses: Altered mental status, nonintractable (won't go away/not responding to medication) headache, unspecified chronicity (long lasting) pattern."
"Concern for worsening schizoaffective in setting care concerns at pt's living facility."

Example 2: Resident 3

On 02/13/2024, at approximately 2:00 PM, Surveyor observed Resident 3 in a walking boot. Surveyor asked Resident 3 what happened. Resident 3 stated s/he broke [his/her] ankle.

On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 3's managed care organization (MCO) Care Manager (CM) S. CM S stated s/he had been informed that Resident 3 tripped on [his/her] bed, resulting in [his/her] broken ankle. CM S provided Surveyor with [his/her] documentation that stated:
"01/09/2024 - Update by AFH (adult family home) that member kicked the foot of [his/her] bed a few days ago and a few days later [s/he] was limping, saying [his/her] foot hurt. Member was seen in the ER (emergency room) and has a closed right ankle fracture. ER provided a boot. ... Member has closed fracture of distal end of right fibula."

On 02/26/2024, Surveyor reviewed Resident 3's record.

Resident 3's record did not contain an incident

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report, or an observation note that documented Resident 3 had sustained a potential injury.

Example 3: Resident 4

On 02/02/2024, the Department received a concern that a resident had eloped from the home and staff were unaware.

On 02/14/2024, Surveyor reviewed Resident 4's record.

Resident 4 moved into the home, 06/22/2023, with diagnoses including anxiety, depression, and traumatic brain injury.

Resident 4's "6 Month Assessment," dated 11/13/2023, documented:
"Wandering Risk: Requires supervision and redirection from staff to help prevent wandering episodes. Not exit-seeking/no previous concerns of elopement."
"Elopement Risk: Requires supervision and redirection from staff to prevent elopement episodes. Exit-seeking and requires checks throughout day/night."

On 02/16/2024, Surveyor reviewed Resident 4's police record which documented:
"12/20/2023 15:57 (3:57 PM) Residence [sic: resident] has been missing since lunch time last seen 12pm-1pm. unknown what [s/he] was last seen wearing or direction or travel."

On 04/11/2024, Surveyor reviewed the providers department file and determined there were no written reports since licensure, 04/12/2022.

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview

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M 134	Continued From page 7 with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Licensee A stated s/he was not aware of the self-report forms until recently. Cross Reference: M0218 DHS 88.04(2)(b) Awake Staff For Continuous Care Cross Reference: M0462 DHS 88.07(3)(c) Medication Assistance Cross Reference: M0580 DHS 88.10(3)(p) Prompt and Adequate Treatment	M 134		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review and interview, Licensee A did not ensure that the home and its operation complied with all laws governing the home and its operation. Staff reported not receiving adequate training to complete resident cares. Co-Owner B misrepresented the provider when Resident 1 was in the hospital. Licensee A and Co-Owner B dismissed Manager F during the survey process and asked that s/he sign a non-disclosure form. Twenty-five deficiencies were cited. Findings include: The provider was licensed, 04/12/2022, to serve 4 residents within the client groups of	M 216		

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developmentally disabled, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, terminally ill, traumatic brain injury, and physically disabled.

Example 1: Training

The provider was licensed, 04/12/2022, to serve 4 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, terminally ill, traumatic brain injury, and physically disabled.

On 10/04/2023, the Department received a concern that staff were not accurately trained.

On 02/14/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver X. Caregiver X stated, "There was no training. No care plans. Just get placed on the floor. Thank goodness I had prior experience!"

On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Caregiver H stated, "There is no official training. Staff usually start at [home] with the hospice patients. Not all of us are comfortable with that. Providing comfort care is hard. We are rotated through the homes, and you are just supposed to know the residents."

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "[Manager F] would provide training with a PowerPoint but [s/he] did not train one-on-one with new staff. There is no training; staff are just put on the floor and expected to figure it out."

On 02/25/2024, at approximately 9:45 AM,

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Surveyor interviewed previous Caregiver J. Caregiver J stated that upon hire, care plans are not shared with staff. Caregiver J stated, "You are on a need-to-know basis. I had no experience with a hospice patient, and you are just placed in the home with no additional guidance. I was working on my own on day two in the home with the residents that have behaviors." Caregiver I explained, "[Manager F] teaches the CBRF (community-based residential facility) courses. I completed the Standard Precautions on 10/24/2023 and/or 10/26/2023 training with [Manager F]. I was charged $75. [Manager F] took the test for me. I do not want to get myself in trouble, but I want to be honest."

On 02/26/2024, at approximately 10:20 AM, Surveyor interviewed Resident 5's Power of Attorney (POA) Q. POA Q stated, "There is always new staff coming through the home. I want to know if they are trained to work with residents who have a traumatic brain injury. Based on how most of them react around the residents, I would say no."

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Caregiver M stated, "They just assume you know what to do because you have prior experience, but every resident is different. You should have a basic understanding of the resident before you approach them. Same with medications; they never showed me med pass, they just said you have previous training, do it."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N also explained there were concerns with [Manager F] not properly training staff. [Manager F] was an approved trainer for the

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M 216	Continued From page 10 CBRF department approved courses. The provider requested staff complete these courses. Manager N stated, "[Manager F] was not completing the courses as outlined and was taking the tests for the staff. I discussed this with Co-Owner B and [s/he] said [s/he] would take care of it, but [s/he] was allowed to continue [his/her] process." On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Caregiver L stated, "I do not recall any specific training regarding residents, especially hospice. I never shadowed an employee; you are just placed on the schedule. I was never given a care plan until [Manager E] was hired - [s/he] said I will not put you back onto the schedule until you read all of this - [s/he] knew none of the staff had read them and it was a big deal to [him/her] to have everybody become familiar with the ISPs. I have never seen [Manager F] provide cares for a resident, let alone show another staff member how to care for a resident." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated, "We do not see the ISPs. We are told, you have experience, why do you need to see the ISPs?" On 03/06/2024, at approximately 4:45 PM, Surveyor interviewed Resident 1. Resident 1 stated, "[Caregiver GG] picked me up by my ankles, it was like [his/her] first day, [s/he] didn't know that it was wrong. [S/he] wasn't properly trained. I don't blame any of the staff; they aren't trained." On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed previous Caregiver V.	M 216		

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Caregiver V stated s/he did not receive any training, because management told [him/her] that s/he had previous experience and should not need additional training. Caregiver V stated, "If you questioned a resident's care, [Manager F] might show you that person's ISP. It was a hit or miss."

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Caregiver Z stated, "I didn't receive training. You are just thrown on to the schedule and expected to know what to do. I had never worked with an electronic medication administration record system. Every facility I worked at was still using paper. I had to figure it out on my own." Caregiver Z stated, "A lot of the staff were not trained. Then [Manager F] would be trying to do medication training over the speakers, not face-to-face." Caregiver Z stated, "[Manager F] would witness staff struggling with a resident during a behavioral outburst and [s/he] would not step in and provide guidance."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Caregiver G stated, "Staff weren't trained on how to provide proper cares to residents. What was acceptable and what wasn't." Caregiver G and previous Caregiver K stated, "Also, when there was an actual activity person, they often did not know how to work with the residents, so, if a resident was 'difficult,' they would just put them back into their room."

On 04/10/2024, at approximately 5:00 PM, Surveyor interviewed Caregiver G and Caregiver K. Caregiver G and Caregiver K stated, "There have been employees that barely understood English, so when they were receiving training,

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[Manager F] and [Licensee A] would help provide the answers for these staff members. Other times, we would be called in for last minute training for skype training being put on by [Trainer EE]. Staff would be texting [Licensee A] to get the answers. How do you know if your staff is properly trained?"

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F (Caregiver/Manager F). Licensee A, Co-Owner B, Administration C and AED F communicated amongst themselves and discussed what changes needed to occur regarding training for staff. Caregiver/Manager/AED - Honestly, he has changed positions so many times, I was trying to reference what he was to the person that was interviewed. Even during the survey process he went from a Caregiver to the AED.

Example 2: Co-Owner B interaction with Resident Representative

On 02/21/2024, at approximately 4:30 PM, Surveyor interviewed Resident 1's Family Member (FM) D. FM D stated, "I received a call at 2:30 AM on 01/31/2024 that [Resident 1] was delusional and required immediate medical attention. I asked that [s/he] be sent to the hospital via ambulance. While at the hospital, [Co-Owner B] kept trying to call and text me. I was very upset with [him/her] because [s/he] had delayed in [Resident 1] receiving medical services. I just wanted [him/her] to leave me alone, so I just would not respond. I informed hospital staff that I did not want [Co-Owner B] near [Resident 1]. [Resident 1] showed up at the hospital and security got involved. The

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distressing part! The hospital staff were familiar with [Co-Owner B] and [his/her] antics. [Co-Owner B] told the hospital staff that I was not [Resident 1's] activated power of attorney (POA) and that [Co-Owner B] was a close intimate friend and should be with [Resident 1]. That was the final straw. I am always contacted regarding [Resident 1's] health by [Licensee A], [Co-Owner B], and staff members. Now, that I am upset with [Co-Owner B], [s/he] tries to come in here and say I should not be with my [brother/sister], I should not understand [Resident 1's] current medical emergency, so I know how to explain the situation to [him/her]. I had heard that [Co-Owner B] had a reputation for creating scenes and being banned from other hospitals, but I chose not to believe it until now. I knew [Resident 1] was not going back to that home!" FM D forwarded Surveyor a copy of [his/her] POA paperwork which identified FM D as Resident 1's designated representative if s/he should become incapacitated. This paperwork was submitted to Licensee A and Co-Owner B in 10/2023 and the provider's had utilized that document to determine that FM D was to assist Resident 1 in all of [his/her] medical decision making. FM D provided Surveyor with the text correspondence with Co-Owner B while FM D was at the hospital with Resident 1 on 01/31/2024:
01/31/2024 - 5:42 AM: "I really wish that you understood the trauma you have inflicted on [Resident 1] by mismanaging [his/her] medications. I have been in the ER (emergency room) since 2:30am. [S/He] will probably be transferred to [hospital] and it will take an unknown amount of time to undue the damage that has been done to [him/her] ... This entire fiasco could have been avoided if you had managed [his/her] care as the doctor ordered."
At 6:41am [Co-Owner B] tried calling me and I

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didn't pick up the phone. [S/He] left a message. I responded at 6:46 AM to [Co-Owner B] and [Licensee A]:
"Please put all communications in writing to me. To answer your question about where [s/he] is, they are getting ready to transfer [him/her] to the main campus from [hospital]. I have been with [him/her] since 2:30am. I will continue to be with [him/her]."
At 6:51am [Co-Owner B] texts: "Hello [FM B] Please call me asap. I am just hearing of this in the last 20 minutes."
At 6:57am FM D texts: "I am not calling you. You do not want to hear what I have to say."
At 7:05am [Co-Owner B] texts: "Actually, yes, i would like to hear whatever you have to say.
I have been wanting to talk to you since the meds incident happened. Please call so I can share some pertinent information."
At 7:11am FM D texts: "Please put your pertinent information in writing to me."
At 7:20am [Co-Owner B] texts: "I am at [hospital] in the ER (emergency room) waiting room.
I normally accompany/follow residents to the ER and hospital. I don't wish to make this awkward. My only desire is to help [Resident 1]. If you prefer I depart, I will. I would really like to see [Resident 1]. As for pertinent information, what I have to say is about people by name and prefer to speak of it."
At 7:25am FM D texts: "You are not allowed to have contact with [Resident 1]. Whatever you have to share about anyone or anything, please put it in writing to me."
At 7:30am [Co-Owner B] texts: "The ER lobby person informed me of no-visitors, except family so I am texting from the parking lot. The most critical thing when I hear any mention of potential stroke is to not waste a minutes time. An ambulance should be called immediately at the

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same time as alerting the POA and Manager. It is my understanding (having gone through this multiple times) that the first 5 hours after a potential stroke onset, a stroke reversal drug can be administered. Neither of the 2 nearby [hospital] area hospitals have the capabilities [Resident 1] needs. - Main [city] campus is the nearest place that [Resident 1] should have been transported to and at THIS point, I suggest this action be done immediately."
At 7:32am FM D texts: "I have this under control and am fully aware of what protocols need to be addressed. I do not need your advice. The doctors provide medical advice to my family."
At 7:36am [Co-Owner B] texts: "The item(s) that I wanted to "talk" to you about was my reviewing the recent meds situation and to better understand what people should be held accountable. Obviously, the Owner's are at the ultimate head of the stream. We did an investigation and have wanted to take a more dramatic action to ensure this type of thing is not repeatable. Since you are in this field, your opinion on the actions ahead would be very much appreciated. "
At 7:39am FM D texts: "There is no need for us to continue this conversation any further. The damage has been done. I do NOT wish to speak with you or [Licensee A] any further about this matter. I have been EXTREMELY patient and understanding since [s/he] moved there. I am done.
After speaking with the hospital ER receptionist who I called earlier to share that [Co-Owner B] is not allowed to see [Resident 1], [s/he] shared that the hospital is very aware of [Co-Owner B] and [s/he] has been banned from being on the hospital grounds. [s/he] asked that I call back in 10 minutes because [s/he] saw [him/her] walking up. I called back and [s/he] shared that [s/he]

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M 216	Continued From page 16 asked to see [Resident 1]. [s/he] told [him/her] that family is only allowed to visit [him/her]. [S/He] told [him/her] that I was not the POA and [s/he] was a very close and intimate friend and just wanted to make sure [s/he] was ok. [S/he] repeated that family is only allowed to visit [him/her]. I then sent [Co-Owner B] this text at 7:51am: "Who do you think you are saying that I am NOT [Resident 1's] POA and that it is in the works?!? I AM [his/her] POA and I am in the process of ACTIVATING it. They have the documents and SO DO YOU BOTH!!! You LIED to the hospital about your relationship with [Resident 1]. What are you trying to pull?" At 7:58am [Co-Owner B] texts: "We strive to be accurate. This is one item I wanted to personally discuss with you a few days ago, but you were unavailable. When I heard [Resident 1] was being taken to the hospital, again, I wanted to discuss this with you. Currently, we have [Resident 1] being [his/her] own person. If we are wrong, we would GLADLY apologize and change our information. As you are in the hospital now, I would hope that this matter could be easily cleared-up. We have treated you as the POA in most every manner but clarity on this is needed." At 8:01 am [Co-Owner B] texts: "As for my stated relationship with [Resident 1] (spoken to the hospital today) I told them that I was the owner of the group home that [Resident 1] resides at. I can't see how that is a lie." At 8:01am, FM D texts: "Please stop! You have no idea what you are talking about and truly do not understand the gravity of what your actions have caused. I have been and will continue to be [his/her] POA. YOU ARE NOT TO HAVE ANY CONTACT WITH [RESIDENT 1]. " At 8:03am [Co-Owner B] texts: "I will gladly comply."	M 216		

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M 216	Continued From page 17 At 3:27pm, in a text with [Licensee A] and [Manager E], [Co-Owner B] texts: "Hello [FM D]. Might you have an update on [Resident 1's] condition? I heard (second hand) that it likely was not a stroke but that [his/her] blood had issues?" At 3:36pm FM D texts: "No update at this time. Waiting on bed availability to transfer." At 3:40pm [Co-Owner B] texts: "Does [s/he] look or feel baseline yet?" At 3:41pm FM D texts: "Why are you asking that? It will take a VERY long time for [him/her] to recover from this. As soon as I am able, I will be moving [his/her] belongings from [home]. [S/He] will not be coming back there." At 3:42pm [Co-Owner B] texts: "I'm sorry. I have not seen [him/her] since yesterday and do not know the extent of [his/her] situation. Moving from [home] is unfortunate (we will surely miss [him/her]) but understandable." At 5:02pm [Co-Owner B] texts: "A few other [Resident 1] health-related items that were (and still are) being discussed around [his/her] care team that had to do with [his/her] staff's observations and concerns that have been..."different" with [Resident 1] in later/recent days. There were a few "rumored" occurrences that were not charted because it was unsubstantiated observation from a visitor in [community room]. A few days ago, [Resident 1] asked me to take [him/her] to [store] and the junk food bought items [s/he] bought were consumed at a high rate. As (I mentioned) few of us have seen the recent condition of [Resident 1], the caregivers have been buzzing today about how or what or why this is happening. Our lead med-passer checked and re-checked everything, and [s/he] has [his/her] own observations but many of us (myself included) just wanted to share a back-and-forth informational conversation about	M 216		

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[Resident 1]. [S/He] has a special place in the hearts of many at [provider] and since they/we all are intimately familiar with [his/her] changes and daily situations, they asked me to ask you to either meet with a few of us in person or on a group phone call of 3 or 4 of us. I realize that for a few days and earlier today, you had not wanted to talk but for the sake of knowledge on [Resident 1's] past several days, everyone here prefers a fluid, sharing discussion.
02/01/2024 at 12:42pm [Co-Owner B] texts: "Good Morning Might you have any news on [Resident 1] you can share? Has [s/he] been transferred yet to main campus?"
At 12:50pm FM D texts: "I am ceasing all communication with you in reference to [Resident 1's] care as [s/he] will no longer reside at [provider]."
At 1:00pm [Co-Owner B] texts: "Items that [Resident 1] consumed prior this incident are a concern we wished to share."
At 1:01pm FM D texts: "They are not the concern. Please stop."
At 1:02pm [Co-Owner B] texts: "Were [his/her] blood sugars greatly elevated?"
At 1:02pm FM D texts: "Again, this has NOTHING to do with blood sugar or anything [s/he] ate. PLEASE STOP!"
On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director (AED) F. Surveyor asked for clarification on what occurred during Resident 1's hospitalization. Licensee A stated, "Yes, there was an incident with [FM D]. I was not told [Resident 1] had gone to the hospital and I want to be firsthand. Anytime a resident goes to the hospital, I ride along or follow. I called [FM D] and s/he didn't answer, so I went to the emergency room. I asked if [FM D] was there

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and I was informed s/he was. I informed hospital staff that [FM D's] POA status had not been activated, which upset [FM D]. The nurse told me that [FM D] did not want me there, so I left." AED F stated FM D was not the activated POA. Surveyor asked if FM D was Resident 1's representative and always made [his/her] medical decisions and if the provider shared Resident 1's medical information with FM D. Licensee A started communicating with Co-Owner B and stated, "[FM D] was upset because you told them [s/he] was not the activated POA." Co-Owner B stated, "Well, [s/he] wasn't. I have to remember everything I do reflects my business." Surveyor asked if Co-Owner B had incidents at hospitals with other residents and their family members. Co-Owner B stated there was a misunderstanding at a hospital that was related to my [mother/father] and is not a reflection on the residents.
Example 3: Non-disclosure Forms
On 02/19/2024, at approximately 7:50 AM, Surveyor received a call from Manager E. Manager E stated s/he had just been informed that [his/her] employment was being terminated. Manager E stated, "[Licensee A] and [Co-Owner B] presented me with this form and asked me to sign it. I am looking at it and here it is a non-disclosure form asking that I not discuss the home or them outside of the facility. They promoted [Manager F] to [EAD F]. I don't think they want me talking to you, but I going to continue to. You need to know what is going on in those homes."

On 03/06/2024, at approximately 12:00 PM, Surveyor interviewed Co-Owner B. Surveyor asked for clarification of the described concern. Co-Owner B stated, "I am sure [Manager E] would agree that [s/he] was not a good fit for our

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M 216	Continued From page 20 homes and we need to ensure that gossip/lies do not get spread. I have to think about the reputation of the homes and myself." Example 4: Cites On 02/13/2024, with information gathered through 04/22/2024, Surveyor conducted a complaint investigation. As a result of the survey, 23 deficiencies, including this one, were identified: Licensee/Owner: -Licensee A allowed documentation to be amended/deleted to ensure the appearance of resident care/medication administration was being provided. -Licensee A did not report to the Department when resident property was misappropriated and/or when residents sustained an injury requiring medical treatment. -Licensee A did not investigate when residents/staff alleged misconduct by staff members and a resident sustained injuries-of-unknown origin. -Licensee A did not ensure staff members were properly insured when transporting residents with their personal vehicles. -Licensee A did not ensure residents were provided cares by staff who were not impaired by illicit drugs. -Licensee A did not ensure residents personal information was kept confidential. Resident Care: -One of 4 residents did not have a room conducive to their non-ambulatory status. - Two of 2 resident records did not include comprehensive individual service plans. - Four of 4 residents did not receive organized activities.	M 216		

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M 216	Continued From page 21 - Two of 2 residents did not receive transportation to medical appointments and/or assistance during medical appointments. -One of 1 resident's edema was not monitored. -Two of 3 residents records were not reviewed with their care team or resident representatives. -Two of 2 residents did not receive ordered physical therapy/exercises. -Two of 2 residents had personal items misappropriated. -One of 1 resident received delayed health services due to staff misconduct. Environment: -Licensee A did not ensure food was readily available for preparation. -Licensee A did not ensure food was prepared and stored in a sanitary way. -Licensee A did not ensure toxic chemical compounds were secured. Employees: -Two of 2 employees did not have complete background checks completed. -One of 1 employees did not complete 8 hours of continuing education. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Licensee A stated concerns that the survey process resulted in several findings. Cross Reference: Adjust after edits ... M0114 DHS 88.03(3)(b) Criminal Records Check M0134 DHS 88.03(5)(e)1. Significant Change To The Resident M0216 DHS 88.04(2)(a) Responsibilities M0230 DHS 88.04(2)(f) Condition Which	M 216		

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M 216	Continued From page 22 Represents Risk Or Harm M0240 DHS 88.04(4)(a) Insurance - Vehicle M0246 DHS 88.04(5)(b) Training - 8 Hours Annually M0278 DHS 88.04(3)(b) Free of Hazards M0406 DHS 88.06(3)(b) Persons Involved With ISP & Assessment M0408 DHS 88.06(3)(c) Assessment Identify Needs & Abilities M0410 DHS 88.06(3)(d) Individual Service Plan M0426 DHS 88.07(1)(a) Resident Care-General Requirements M0430 DHS 88.07(1)(c) Activities and Services M0438 DHS 88.07(2)(b) Services Directed to Goals M0444 DHS 88.07(2)(b)3. Transportation to Medical M0448 DHS 88.07(2)(b)5. Monitoring Health M0450 DHS 88.07(2)(b)6. Notification of Changes M0470 DHS 88.07(4)(a) Nutrition M0474 DHS 88.07(4)(c) Food Prepared and Stored Sanitary Way M0548 DHS 88.10(3)(a) Fair Treatment M0552 DHS 88.10(3)(c) Confidentiality M0556 DHS 88.10(3)(e) Self-Direction M0572 DHS 88.10(3)(m) Freedom From Abuse M0580 DHS 88.10(3)(p) Prompt and Adequate Treatment Z0055 2 - DHS - 13.05 (3) (a) Entity Allegation Reporting Requirements	M 216		
M 218	88.04(2)(b) AWAKE STAFF FOR CONTINUOUS CARE The licensee shall ensure that he or she or a service provider is present and awake at all times if any resident is in need of continuous care.	M 218		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that s/he or a service provider were present and always awake for residents who required continuous care.

Licensee A had 3 licensed homes under one roof and staff scheduling does not identify that each home is to have their own scheduled staff.

Findings include:

The provider was licensed, 04/12/2022, to serve 4 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, terminally ill, traumatic brain injury, and physically disabled.

On 02/13/2024, at approximately 3:50 PM, Surveyor interviewed Lead Caregiver P. Surveyor asked if s/he had concerns about staffing levels. Lead Caregiver P stated, "There is always a staffing issue. Staff are floating to where they are needed."

On 02/14/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver X. Surveyor asked if Caregiver X had concerns regarding the staffing levels in the home. Caregiver X stated, "Staff in this home, which is 1, is often pulled to assist the [upstairs home (there are two adjoining homes)] that has the hospice patients."

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Surveyor asked if Caregiver I had concerns regarding the staffing levels in the home.

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Caregiver I stated there is often one med passer for all 3 homes. Caregiver I stated, "If I was working and was the med passer, then one of the homes would not have a staff member, usually [home being surveyed], because these residents are considered 'independent.' The staff member is always asked to go help the [home upstairs]."

On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated, "We are always short staffed. Staff is pulled from [home being surveyed] because those residents are more independent. You would also be trying to figure out who is doing med pass, you will be texting management, and nobody will answer."

On 02/25/2024, at approximately 10:35 AM, Surveyor interviewed Resident 6's Power of Attorney (POA) HH. POA HH stated, "I was visiting yesterday and there was only one staff member working upstairs, where [Resident 6] resides. So, they ask the staff from the [downstairs home] to assist."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Surveyor asked if s/he had any concerns with the staffing levels in the home. Manager N stated, "There was never enough staff for the [upstairs home], so staff would be pulled from the other homes that were single staffed to assist, leaving those homes with no staff present."

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked if Caregiver M had any concerns regarding staffing levels. Caregiver M stated, "One staff member for three people who are elopement risks, [Resident 1], [Resident 2], and

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[Resident 4], in one house. Also, management is not going to come in and cover if your replacement doesn't show. So, if I have to pass meds for all the homes, because I am the only med passer in the building, it is going to leave one of the homes without adequate staff."

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if s/he had any concerns regarding staffing levels. Caregiver L stated, "I have covered two homes at the same time. We are always short staffed."

On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed Caregiver V. Caregiver V stated, "Sometimes there were times when there was no staff in [home being surveyed and adjoining home]. If you can't work a double because someone was a 'no show,' then you are fired because they (management) don't want to come in. I would have to do med pass in all 3 buildings because I was the only med passer available."

On 03/22/2024, Surveyor reviewed the staff schedules, dated 12/31/2023 to 02/17/2024, provided by Administration C which documented the following:
Dates the adjoining home only had one staff member scheduled for the 7:00 AM to 3:00 PM shift which supported caregiver statements of times when staff from surveyed home and/or another adjoining home would need to assist them, leaving their home unstaffed: 01/14/2024, 01/22/2024, 02/02/2024 (also no staff in second adjoining home), 02/17/2024.

Dates the adjoining home only had one staff member scheduled for the 3:00 PM to 11:00 PM

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shift which supported caregiver statements of times when staff from surveyed home and/or another adjoining home would need to assist them, leaving their home unstaffed: 01/01/2024, 01/15/2024, 01/20/2024, 1/30/2024, 1/31/2024, 02/16/2024 (also no staff in second adjoining home and surveyed home, leaving one staff member for all 3 homes.)

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Caregiver Z stated, "Yes, we would have to leave [home being surveyed] to assist other staff."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Caregiver G and Caregiver K stated they had observed staff bring in pillows to sleep with when they were scheduled for the third shift. This is not a sleep facility."

On 04/09/2024, at approximately 4:45 PM, Surveyor interviewed Resident 1. Resident 1 stated, "Staff were always hanging out upstairs, in the other homes."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Co-Owner B stated, "When we find out, we show up! I come in or [Licensee A]." Surveyor asked if [Co-Owner B] has worked as a caregiver by covering a shift as s/he had commented earlier that s/he was not a caregiver. Co-Owner B stated, "It happens but it is for a short amount of time, until someone else arrives." Co-Owner B stated, "I have come in to find everyone hanging out in the [upstairs home]. They are talked to; this is not allowed." Licensee A stated, "Med Passers are not covering

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M 218	Continued From page 27 all 3 homes." Co-Owner B and Licensee A stated there is always one person assigned to each home. Surveyor asked if staff relied on the other licensed homes staff to assist them, leaving their scheduled home unattended. Co-Owner B and Licensee A stated they would not ask staff to do this.	M 218		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation, interview and record review, the licensee permitted a condition of risk which placed the health, safety, and welfare of residents at substantial risk of harm. Resident 2 was allowed to wander the homes even though s/he displayed behaviors that were harmful to residents and staff. Licensee A and Co-Owner B did not provide assistance when Resident 2 acted physically aggressive towards a resident putting them in harms way. Resident 2 was allowed to leave the home unsupervised when [his/her] individual service plan stated s/he was to be supervised. Licensee A and Co-Owner B gave Resident 2 access to razors knowing Resident 2 would carve [his/her] face with them.	M 230		

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Resident 4 left the home and staff were unaware of [his/her] whereabouts for approximately 3 to 4 hours. Staff were unsure of Resident 4's supervision requirements.

Staff did not have keys to the home and Resident 2 would lock them out.

The licensee did not implement a process to ensure staff are not under the influence of illicit drugs while caring for residents.

Findings include:

This provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, physically disabled, emotionally disturbed/mental illness, developmentally disabled and advanced aged.

Example 1: Resident 2 - Behaviors

On 02/13/2024, the Department received a concern alleging residents were allowed to harm other residents and staff.

On 02/14/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver X. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver X stated, "[Resident 2] wanders. There was no training, no care plans, just get placed on the floor. I don't know [his/her] triggers that cause [his/her] outbursts."

On 02/14/2024, at approximately 11:20 AM, Surveyor interviewed Caregiver F. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed

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to wander into the other adjoining homes. Caregiver F stated, "If [s/he] doesn't get [his/her] way, [s/he] will yell. [S/he] can get physical. I think [s/he] should stay in [his/her] own home. This is not a good placement for [him/her]."

On 02/14/2024, at approximately 11:55 AM, Surveyor interviewed Co-Owner B. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Co-Owner B stated Resident 2 did have violent outbursts and admitted s/he had been physically assaulted by Resident 2. Resident 2 had used large metal items to throw around when s/he had become upset. Co-Owner B stated, "We don't take people who are violent or sexual. We were telling the family [s/he] may need to leave, but we worked with [his/her] medications. We only had issues [his/her] first couple of weeks here. These behaviors quickly dissolved when the 'magic formula' was figured out with [his/her] meds." Surveyor asked if it was inappropriate for [Resident 2] to wander into all of the homes. Co-Owner B stated, "If there was an issue it would be reported. Look at the reports. There are no concerns."

On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver H stated, "[S/he] gets upset if you close a door [s/he] doesn't want closed, then [s/he] will start slamming it. [S/he] should be in a psych ward. [S/he] beats up staff. [S/he] will use anything [s/he] can get [his/her] hands onto to use as a weapon. I can't believe there are unsecured knives in the home. If [s/he] fights us, then

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M 230	Continued From page 30 [Co-Owner B] takes [him/her] to get treats. So Wrong!" On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver I stated, "[Resident 2] shouldn't be there. [Resident 2] should not be allowed to roam through the houses. [Manager E] told me it was [his/her] right to wander into each of the homes. My question is, 'If the homes weren't adjoining, [s/he] wouldn't be able to do that.' [Resident 9] has even rolled in between [Resident 2] and staff with his/her wheelchair, telling [Resident 2], No! [Co-Owner B] rewards [Resident 2] during these behaviors. [S/he] gets to go on a road trip, get some food, etc." Surveyor commented that s/he had seen unsecured knives in the home. Caregiver I stated, "Yes, knives are unsecure. These concerns are brought to [Co-Owner B], but [s/he] won't listen; treats staff like they do not know what they are doing. Staff are on edge now around [Resident 2]; not knowing if [s/he] is going to strike them or just tap them. Then [Co-Owner B] says you can't act afraid of [him/her]." On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver T. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver T stated, "[Resident 2] will grab vases, broomsticks, anything [s/he] can get [his/her] hands onto to use as a weapon. And don't touch the door to the home, [s/he] will get sweaty, puffy, [s/he] gets so upset."	M 230		

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M 230	Continued From page 31 On 02/25/2024, at approximately 10:35 AM, Surveyor interviewed Resident 6's Power of Attorney (POA) HH who stated Resident 2 can be combative. On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver J stated, "[Resident 2] should not be there. It isn't [his/her] fault, but [s/he] shouldn't be there. [S/he] is extremely combative. Around Halloween, when I was working, [s/he] chased me around the home with a decorative seasonal sign. [S/he] was upset that [s/he] had been removed from [the adjoining home], so [s/he] was battling everyone. I called [Co-Owner B], who arrived, and then [s/he] is questioning me, like it is my fault that [Resident 2] is upset. [Co-Owner B] is stating, '[Resident 2] doesn't get aggressive/combative unless instigated.' Well, [s/he] was told no, so [s/he] blew up. I have logged these observations/incidents, but I don't know if they are still there as reports disappear. Then [Co-Owner B] will blow up our group chat telling everyone, basically, never tell [Resident 2] No! Let [him/her] do [his/her] thing until [s/he] is done doing [his/her] thing." Caregiver J explained a situation where Co-Owner B, who observed a behavioral incident involving Resident 2, did not properly assist staff with redirecting Resident 2. Caregiver J stated, "[Resident 2] was out of control, Crazy! [S/he] was determined to harm [Caregiver M], who was 7 or 8 months pregnant. [Lead Caregiver P] and I were able to get [Caregiver M] into the adjoining home; away from [Resident 2's] home and locked the doors. [Resident 2] thought [Caregiver M] had taken away [his/her] razor. [Licensee A] was watching	M 230		

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all of this happening. Then, all of a sudden, we turn around and [Resident 2] is in the home we had locked ourselves in. Here, [Co-Owner B] led [him/her] there. Why! We were keeping [Caregiver M] safe. They had walked in through the garage doorway. [Resident 2's] behaviors are out of control, management doesn't want to accept that, and then we cannot even keep ourselves safe. [Co-Owner B] will just blame it on the staff."

On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 2's managed care organization (MCO) Care Manager (CM) S. CM S stated, "[Co-Owner B] stated that [Resident 2] was physical with staff at times but that was because staff did not know how to de-escalate a situation or know what [his/her] triggers were; impression it was never [Resident 2]'s fault but rather the staff's; staff were preventing [him/her] from what [s/he] was trying to do." Surveyor explained the concerns with [Resident 2] having access to all the homes considering [his/her] violent behaviors. CM S stated, "This is not what [Co-Owner B] tells me." CM S informed Surveyor a behavior support plan for Resident 2 was not in place.

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver M stated, "Staff leave because they don't want to deal with [Resident 2]. [S/he] has physical outbursts. Management is scared to take something from [him/her]. I don't tell [him/her] no. If [s/he] is outside and you take something out of [his/her] room, [s/he] will know it happened and [s/he] will take it out on anybody in

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the area. [S/he] will use whatever [s/he] can reach as a weapon. Scary, since the knives aren't locked up. [S/he] goes into all the other homes. [S/he] walks around and will get mad at other staff if [s/he] doesn't like what they are doing in their homes. Then, when [Resident 2] acts out, [Co-Owner B] takes [him/her] for a car ride or out for a treat, so one starts to wonder if [Resident 2] knows this will happen and deliberately acts out!" Caregiver M explained there was a situation where [Resident 2] had taken [Resident 5's] electric razor. Caregiver M stated, "[Co-Owner B] told me to get the electric razor back from [Resident 2]. I went to [Resident 2's] room and as soon as [s/he] seen me, [s/he] blew up. [Caregiver J] tried to help me by locking me into the adjoining home and then [Co-Owner B] let [Resident 2] in through the back door. Then [Resident 2] charges and tries to attack me again. Thank goodness Caregiver J and Lead Caregiver P were there. [Licensee A] didn't do anything. [Co-Owner B] tried to blame it all on me. Why didn't [Co-Owner B] deal with the razor situation! [S/he] always says [s/he] is the only one that can control [Resident 2] and that us staff do not know what we are doing."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Manager N stated, "I progressed noted during Thanksgiving that [Resident 2] tried to break glass with chairs. This is not the proper environment for [him/her]. They let [him/her] do whatever. They tried to make [him/her] stay in [his/her] room, that will upset [him/her], so [s/he] will try to leave the building. [S/he] does act aggressively, will use anything as a weapon, can't

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believe knives are unsecured. Staff have been locking [the adjoining homes] to protect those residents. [S/he] has tried to attack me. [S/he] has taken one of the lamps out of the community room and throw it at me. You can tell [Co-Owner B] and [Licensee A], but you will be reminded it is your fault and they will 'sweep it under the rug,' like it never happened." Manager N stated there was an incident where Resident 2 was determined to harm a staff member. Manager N stated, "[Resident 2] was determined to hurt [Caregiver M]. [S/he] said 'kill you.'" Manager N stated, "[Co-Owner B] and I got into a verbal altercation because it got so intense." Manager N stated Resident 2 thought Caregiver M had taken [his/her] razor.

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver L stated, "The first day I worked with [him/her] [s/he] hit me with a binder. I was told, basically, let [Resident 2] do whatever [s/he] wants to do. [Co-Owner B's] whole thing is just let [Resident 2] do what [s/he] wants to do. I have documented several times that [Resident 2] has acted inappropriately but when I look in ECP (electronic computer program), I do not see them there. I don't know what happens to them." Surveyor reviewed Resident 2's 06/2023 to 02/2024 observation notes with Caregiver L. Caregiver L's name did not appear. Caregiver L stated shockingly, "I am always charting on [his/her] behaviors. [S/he] has behaviors every other day. [S/he] is allowed to wander into the other homes. I don't let [him/her] do this, so [Resident 2] doesn't like me. [S/he] is definitely a danger to staff and residents, but then [Co-Owner

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M 230	Continued From page 35 B] treats [him/her] to calm [him/her] down, which irritates the other residents." On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver O stated, "You have to let [him/her] do what [s/he] wants. [S/he] goes and tries to fight staff if [s/he] doesn't get [his/her] way. [S/he] will be physically aggressive towards residents, try to fight them. [S/he] should stay in [his/her] home." On 03/02/2024, at approximately 11:10 AM, Surveyor interviewed Caregiver U. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver U stated, "[Resident 2] is [Resident 2], [s/he] wants things to go [his/her] way. I have never had bad interactions with [him/her] but I have seen [him/her] push other caregivers." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver W stated, "[Resident 2] beats up [Co-Owner B], beats up staff. [S/he] will tear this place apart. [S/He] would use anything as a weapon. There is no redirecting [him/her]. [Co-Owner B] will say, 'Oh [s/he] doesn't know.' [Co-Owner B] will always cover up for [him/her] and of course bring [him/her] treats, so then other residents are upset, 'why don't we get that.' Playing favoritism!"	M 230		

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M 230	Continued From page 36 On 03/06/2024, at approximately 12:00 PM, Surveyor interviewed Co-Owner B. Surveyor asked for clarification of the incident where Resident 2 was reported to be attempting to harm Caregiver M and Co-Owner B placed Resident 2 in the home where Caregiver M had gone to gain safety. Co-Owner B stated s/he knew how to redirect Resident 2 and was not aware of putting any staff members in danger. On 03/06/2024, at approximately 3:00 PM, Surveyor interviewed Licensee A. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Licensee A stated, "[S/he] is good, but you can't go against [him/her]. Do not tell [him/her] no. People seem more relaxed since [s/he] moved out." On 03/08/2024, at approximately 10:50 AM, Surveyor interviewed Caregiver V. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver V stated, "[Co-Owner B] has gotten physical with [Resident 2], so then [Resident 2] retaliated and hit [Co-Owner B] over the head. I am like [Co-Owner B] does not know how to handle [his/her] behaviors. [Co-Owner B] lies. [Resident 2] was always having behaviors. Those knives need to be secured." Caregiver V stated, "I don't blame [Resident 2] for not wanting to be in [his/her] home. It is like a dungeon down there. The only light into the home is if the resident is sitting in their bedroom." On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Surveyor asked if Resident 2 displayed	M 230		

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aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver Z stated, "[His/her] first day here [s/he] was very behavioral. We were never given any guidance on how to provide cares for [him/her]. The only way you learned about a behavior was after it happened."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Surveyor asked if Resident 2 displayed aggressive behaviors and if s/he should have been allowed to wander into the other adjoining homes. Caregiver K stated, "[Co-Owner B] had documented in 'Home Base' (scheduling program) telling everyone that [s/he] sped 80 miles an hour to get to the home to calm [Resident 2] down. It is an outright lie that [Co-Owner B] would say [s/he] didn't know about [Resident 2's] behaviors. [Resident 2] will take anything to make it a weapon; shouldn't have knives around [him/her]. Residents would be mad because [Co-Owner B] was always doing special things with [Resident 2], like going to get ice cream, going for a car ride, etc. That was [his/her] way of redirecting [him/her]."

On 04/09/2024, Surveyor reviewed Resident 2's record.

Resident 2 moved into the home on 06/07/2023.

Resident 2's individual service plan, dated 12/18/2023, documented:
"Aggressive/Combative: Requires supervision and monitoring to help manage/redirect aggressive/combative behaviors. If [s/he] feels like [s/he] is caged when Caregiver prevent [him/her] from walking around, [s/he] will hit caregiver. Give [him/her] some space. Do not

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disallow [him/her] from walking to visit [adjoining home or community room]."
"Destructive/Abusive" No guidelines identified.
"Self-Abusive Behavior" No guidelines identified.

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Surveyor stated s/he had been informed that Resident 2 was an elopement risk, a 1:1 staffing requirement, and s/he was allowed to come and go from the home as s/he pleases. Co-Owner B stated, "Well, this brings in the question of how do we allow one staff member to leave with a resident? That would leave a home with no staff." Co-Owner B explained that if residents sign out, then there is record of where the resident is. Surveyor asked if Resident 2 was a risk for elopement. Surveyor did not receive a response.

Example 2: Resident 2 - Elopement

On 01/31/2024, from approximately 10:00 AM to 2:45 PM, on 02/13/2024, from approximately 12:30 PM to 5:30 PM, and on 02/14/2024, from 9:15 AM to 3:30 PM, Surveyor observed Resident 2 move freely between all 3 homes and come and go outside.

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked if Resident 2 was a risk for elopement or wandering. Caregiver M stated, "[Resident 2] is an elopement risk but [s/he] is allowed to go outside by [him/herself]. [S/he] shouldn't be outside by [him/herself]."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N.

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M 230	Continued From page 39 Surveyor asked if Resident 2 was a risk for elopement or wandering. Manager N stated Resident 2 was an elopement risk. On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if Resident 2 was a risk for elopement or wandering. Caregiver L stated, "[Resident 2] is allowed to roam anywhere, the other homes, outside, people in the neighborhood know [him/her]. [S/he] is an elopement risk, nobody wants to fight with [him/her]. [Co-Owner B] says just let [him/her] do what [s/he] wants." On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O Surveyor asked if Resident 2 was a risk for elopement or wandering. Caregiver O stated, "[Resident 2] walks up and down the street all day, sometimes [s/he] goes far." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Surveyor asked if Resident 2 was a risk for elopement or wandering. Caregiver W stated, "Management shouldn't let [him/her] roam around outside. They tell us to just watch [him/her] but we are inside with the other residents." On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Surveyor asked if Resident 2 was a risk for elopement or wandering. Caregiver Z stated, "[S/he] was allowed to wander off wherever. There have been times we see [him/her] trying to hitchhike." On 04/09/2024, Surveyor reviewed Resident 2's record.	M 230		

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M 230	Continued From page 40 Resident 2 moved into the home, 06/07/2023, with diagnosis of cognitive impairment. Resident 2's "Annual Assessment: ISP," dated 12/18/2023, documented: "Wandering Risk: Requires supervision and redirection from staff to help prevent wandering episodes. Not exit-seeking/no previous concerns of elopement. To have proper supervision and redirection techniques in place to prevent wandering." "Elopement Risk: (blank)" On 04/09/2024, Surveyor reviewed Resident 2's managed care organization (MCO) records provided by his/her Care Manager (CM) S which documented: "Behavioral Health: Frequency of elopement: Weekly; Severity of elopement: Mild; Severity of wandering: moderate - member will go outside and sit on the porch and staff supervise; Has continuous or unpredictable behavior while awake, 1:1 staffing required continuous or immediate intervention constitutes a risk the health and safety of the Member or others (1:1 supervision)." Surveyor was informed during the survey process that Resident 2 does not receive 1:1 supervision: 02/14/2024 at 11:20 AM, Caregiver F stated Resident 2 did not receive 1:1 supervision. 02/25/2024 at 10:35 AM, Resident 6's Power of Attorney HH stated when s/he visited Resident 6, Resident 2 was allowed to move about from home to home without any supervision. 02/26/2024 at 12:30 PM, Managed Care Organization (MCO) Care Manager S stated s/he was not aware that Resident 2 was not receiving 1:1 supervision. 03/02/2024 at 11:10 AM, Caregiver U stated s/he	M 230		

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had not seen Resident 2 receive 1:1 supervision.

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Surveyor stated s/he had been informed that Resident 2 was an elopement risk, and s/he was allowed to come and go from the home as s/he pleases. Co-Owner B stated, "Well, this brings in the question of how do we allow one staff member to leave with a resident? That would leave a home with no staff." Co-Owner B explained that if residents sign out, then there is record of where the resident is. Surveyor asked if Resident 2 was a risk for elopement. Surveyor did not receive a response.

Example 3: Resident 2 - Razors

On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver T. Surveyor asked if there were concerns with Resident 2 harming him/herself with bladed razors. Caregiver T stated, "[Co-Owner B] bought [Resident 2] razors and then [Resident 2] would carve [his/her] face. [Co-Owner B] says it makes [him/her] happy. Staff have given [him/her] the whole bag of razors because [s/he] was becoming upset. Just happened last week, still marks on [his/her] face, so much blood. [S/he] shouldn't have them."

On 02/25/2024, at approximately 10:35 AM, Surveyor interviewed Resident 6's Power of Attorney (POA) HH. POA HH stated [s/he] has observed [Resident 2] with slices on [his/her] face from the razors. It is bad! [S/he] carries disposable razors in [his/her] pants pocket. I have caught [him/her] outside, in the fountain,

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slicing [his/her] face by 'trying to shave.' [S/he] will clean the razor off in the snow. I have gone out and told [him/her] not to do that."

On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 2's MCO CM S. Surveyor explained the concerns with [Resident 2] slicing [his/her] face, shaving outside. CM S stated, "This is not what [Co-Owner B] tells me. [S/he] states sometimes [Resident 2] will 'knick' [him/herself] shaving. [Co-Owner B] stated the only reason [his/her] face would bleed is because [s/he] shaved over a pimple."

On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 2's managed care organization (MCO) Care Manager (CM) S. CM S stated, "[Co-Owner B] stated that [Resident 2] was physical with staff at times but that was because staff did not know how to deescalate a situation or know what [his/her] triggers were; impression it was never [Resident 2]'s fault but rather the staff's; staff were preventing [him/her] from what [s/he] was trying to do.

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked if there were concerns with Resident 2 harming him/herself with bladed razors. Caregiver M stated, "[Resident 2] had razors in [his/her] room. [S/he] will put snow on [his/her] face and try to shave. So many open wounds from using sharp razor. [S/he] doesn't have hair on [his/her] face but [s/he] tries shaving [him/herself] four times a day. Staff should do it but [s/he] won't let anyone help [him/her]."

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if there were concerns with Resident 2

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harming him/herself with bladed razors. Caregiver L stated, "[Resident 2] wants to cut [his/her] own hair; [s/he] will use the cheap razors. I told [Co-Owner B] not to give [him/her] those razors; [Co-Owner B] should not be buying them. [Resident 2] is so rough on [his/her] face, cuts and scratches, bald on the side due to how hard [s/he] shaves."

On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. Surveyor asked if there were concerns with Resident 2 harming him/herself with bladed razors. Caregiver O stated, "They buy [him/her] razers, [s/he] cuts up [his/her] face because [s/he] won't allow staff to do it. [Co-Owner B] and [Licensee A] just let [him/her] do it, [s/he] will fight if you try to take the razors away."

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Surveyor asked if there were concerns with Resident 2 harming him/herself with bladed razors. Caregiver W stated, "[Co-Owner B] gave [him/her] the razors back; [his/her] face is 'trippin.'"

On 03/08/2024, at approximately 10:50 AM, Surveyor interviewed Caregiver V Surveyor asked if there were concerns with Resident 2 harming him/herself with bladed razors. Caregiver V stated, "[Resident 2] keeps razors and [s/he] uses other people's razors."

On 04/09/2024, Surveyor reviewed Resident 2's record.

Resident 2 moved into the home, 06/07/2023, with diagnosis of cognitive impairment.

Resident 2's "Annual Assessment: ISP," dated

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12/18/2023, documented:
"Self-Abusive Behavior - (blank)"

Resident 2's 2024 "Observation" notes documented:
"01/08 - Went out to get some new razors to be shaved. ... [Resident 2] already had the razor in [his/her] hand and did not want to let staff see it in order to help [him/her] properly shave. ... [Resident 2] shaved [his/her] own self until [s/he] started to bleed [s/he] was told more than three times to stop and that was enough [s/he] did not want to listen."
"02/02 - I heard [him/her] in the restroom with [his/her] shavers. I went in there [s/he] was scraping [his/her] face too hard I redirected [him/her] ... I cleaned the blood off the sink ... once I finished cleaning and went into the kitchen [s/he] went back and repeatedly shaved [him/herself] roughly until [s/he] was bleeding."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Surveyor asked if Resident 2 should be allowed to have access to razors with blades, since cognitively s/he cannot understand that s/he is harming him/herself. Co-Owner B stated options were being discussed. Surveyor asked if Co-Owner B had purchased the razors for Resident 2. Co-Owner B stated it was a resident right.

Example 4: Resident 4

On 02/02/2024, the Department received a concern that a resident had eloped from the home and staff were unaware.

On 02/13/2024, at approximately 3:50 PM,

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M 230	Continued From page 45 Surveyor interviewed Lead Caregiver P. Surveyor asked if s/he had concerns regarding Resident 4's supervision levels. Lead Caregiver P stated, "[Resident 4] had attempted suicide prior to placement; that is why [s/he] was in our care. I arrived at 3:00 PM and a caregiver stated [s/he] was missing. I searched the building. [S/he] hadn't signed out. I was informed [s/he] was on suicide watch and was an elopement risk. So, we called the Sheriff. They found [him/her] on [highway]." On 02/14/2024, at approximately 11:20 AM, Surveyor interviewed Caregiver F. Surveyor asked if s/he had concerns regarding Resident 4's supervision levels. Caregiver F stated, "I was comfortable with [him/her] leaving the facility. [S/he] had no suicidal episodes that [s/he] was aware of. Anytime [s/he] left the facility, [s/he] was always with [his/her] [spouse]." On 02/16/2024, Surveyor reviewed Resident 4's record. Resident 4 moved into the home, 06/22/2023, with diagnoses including anxiety, depression, and traumatic brain injury. Resident 4's "6 Month Assessment," dated 11/13/2023, documented: "Wandering Risk: Requires supervision and redirection from staff to help prevent wandering episodes. Not exit-seeking/no previous concerns of elopement." "Elopement Risk: Requires supervision and redirection from staff to prevent elopement episodes. Exit-seeking and requires checks throughout day/night." "Suicidal Tendencies: (blank)."	M 230		

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M 230	Continued From page 46 On 02/16/2024, Surveyor reviewed Resident 4's police record which documented: "12/20/2023 15:57 (3:57 PM) Residence [sic: resident] has been missing since lunch time last seen 12pm-1pm. Unknown what [s/he] was last seen wearing or direction or travel." On 02/18/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Surveyor asked if s/he had concerns regarding Resident 4's elopement. Caregiver H stated, "Why did nobody know that [s/he] left the building. I didn't even realize [s/he] was suicidal. Nobody ever told me that! Shouldn't staff know if they have a resident who has suicidal tendencies! We were told [s/he] could come and go as [s/he] pleases. [S/he] was just supposed to sign out. If [s/he] was suicidal, why didn't staff stop [him/her]!" On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Surveyor asked if s/he had concerns regarding Resident 4's elopement. Caregiver I stated, "I was told by [Manager E], [Resident 4] was allowed to take a walk and was on a 2-hour timeframe. I was informed [s/he] was suicidal and that was one of the main reasons [s/he] had moved into the home. [Resident 4] was required to sign out and had to be back in two hours. I was working in [the upstairs home] that day. We were doing narc count and [Caregiver M] said, 'I have a concern. [Resident 4] has been gone for 3 hours.'" On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 4's managed care organization (MCO) Care Manager (CM) S. Surveyor asked if s/he had any concerns with the supervision levels Resident 4 received by staff and how [his/her] elopement was handled. CM S	M 230		

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stated, "Prior to placement, [Resident 4] was homeless and spoke of suicide but stated [s/he] would never act on it. [Resident 4] was not a big communicator, so communication could be an issue, need to speak with [him/her] face-to-face. I am not sure if [s/he] would always need to be supervised, but I was told when [s/he] leaves the home, [s/he] is usually with a family member. The provider should have looked for [him/her] as soon as they knew [s/he] was suicidal."

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked if s/he had concerns regarding Resident 4's alleged elopement. Caregiver M stated, "I'm in the kitchen, making lunch, and [Resident 8] (who resides in another home) wants help; [Resident 1] wants help, like there is [feces] everywhere. [Resident 4] says I am going to [sub shop]. I tell [him/her] to make sure you sign out. Later, I'm like 'hmmmm,' [s/he] didn't sign out. [Caregiver J] comes in and says [s/he] will give [him/her] a call. I don't know [Resident 4's] number. We found out [s/he] left [his/her] phone in the room. Police found [him/her] on the road. I guess [s/he] said [s/he] was suicidal. Then I find out [Manager E] drove past [him/her], not because [s/he] was looking for [him/her], but why didn't [s/he] stop and check on [him/her]."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Surveyor asked if s/he had any concerns with the supervision levels Resident 4 received by staff and how [his/her] elopement was handled. Manager N stated s/he was not informed Resident 4 was suicidal and an elopement risk until after the incident.

On 03/02/2024, at approximately 9:20 AM,

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M 230	Continued From page 48 Surveyor interviewed Caregiver L. Surveyor asked if s/he had any concerns with the supervision levels Resident 4 received by and how [his/her] alleged elopement was handled. Caregiver L stated, "I did not know [s/he] was suicidal until after [his/her] elopement." On 03/02/2024, at approximately 11:10 AM, Surveyor interviewed Caregiver U. Caregiver U stated, "I had no idea [s/he] was suicidal. [S/he] was an introvert. [Resident 4] would walk to the gas station." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Surveyor asked if s/he had any concerns with the supervision levels Resident 4 received by and how [his/her] alleged elopement was handled. Caregiver W stated, "[Resident 4] was not independent. I don't know how they let [him/her] go to the store. There was no notation that [s/he] was suicidal. I learned when [s/he] left and did not come back after a certain amount of time. I would never let [him/her] go anywhere!" On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Surveyor commented Resident 4's ISP stated s/he was an elopement risk, was not suicidal, and most staff stated Resident 4 could leave the home if s/he signed out. Co-Owner B stated, "Well, this brings in the question of how do we allow one staff member to leave with a resident? That would leave a home with no staff." Co-Owner B explained that if residents sign out, then there is record of where the resident is. Surveyor asked if Resident 4 was a risk for elopement. Surveyor did not receive a response.	M 230		

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M 230	Continued From page 49 Example 5: Staff - Keys On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated, "[Resident 2] kept locking us out of the home because [s/he] didn't want anybody going into [his/her] area. We didn't have keys, so we would have to find someone with the master set of keys to let us in." On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 2's MCO CM S. CM S stated, "[Co-Owner B] stated there were concerns that [Resident 2] would sleep everywhere which would result in certain areas of the homes being locked. I was not aware of [him/her] locking [his/her] 'home' and staff not having immediate access." On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Caregiver M stated, "[Resident 2] always locks [the home] door. Have to go find staff in another home to unlock the door." On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. Caregiver O stated, "[Resident 2] will lock the doors and the staff don't have keys. Have to go find staff in another home to unlock the door." On 03/02/2024, at approximately 11:10 AM, Surveyor interviewed Caregiver U. Caregiver U stated, "[Resident 2] will lock people out of [home], [s/he] doesn't want people to come down there, so [s/he] will lock the door." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W	M 230		

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stated, "[Resident 2] doesn't want anyone in [his/her] area, so [s/he] locks the door to the home."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Co-Owner B stated staff could walk outside and around to the other door to the home. Surveyor asked if the secondary door could also be locked. Co-Owner B did not respond.

Example 6: Drugs

On 10/04/2023, the Department received a concern that alleged staff members were doing drugs in the home that resulted in law enforcement contact.

On 01/31/2024, at approximately 11:30 AM, Surveyor interviewed Co-Owner B and Manager R. Surveyor stated s/he was investigating an allegation that staff were doing illegal drugs in the home in 09/2023. Co-Owner B acted shocked that such an incident would occur in [his/her] home. After a bit, Co-Owner B stated, "Oh that must be regarding previous Caregiver Z." Co-Owner B stated that s/he suspected for months that Caregiver Z was working under the influence but could not prove it. Co-Owner B explained, "[S/he] seemed unfocused/distant/stare off into space/late for work." Co-Owner B stated when s/he was informed that staff were suspicious of another staff member engaging in illicit drugs at work, s/he contacted the police. When the police arrived, s/he denied the drugs were [his/hers] and refused to take a drug test. [S/he] was sent home that day. Caregiver Z was given a drug test on another day which came back negative.

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Co-Owner B stated, "Police were unable to confirm drug that was found in the home." Surveyor asked if the provider had conducted an internal investigation. Co-Owner B stated, "Our internal investigation was contacting law enforcement. We do not tolerate that type of activity in our home."

On 01/31/2024, at approximately 12:50 PM, Surveyor interviewed Caregiver F (Assistant Executive Director F). Caregiver F explained s/he was the manager during the time staff were suspected of doing drugs in the home. Caregiver AA and Caregiver BB had contacted [him/her] that drugs were being consumed in the vacant resident private bathroom, located in adjoining home. Caregiver F stated s/he called Co-Owner B and Co-Owner B called the police. The police tested the powder residue that was on the bathroom countertop and determined it was cocaine. Caregiver F stated, "[Caregiver Z] denied the drugs were [his/hers] but I sent [him/her] home. [S/he] was to do a drug test but [s/he] wouldn't come in." Surveyor asked why only Caregiver Z was asked to give a drug test. Caregiver F stated, "Due to [his/her] actions, [s/he] had slurred speech, couldn't stay focused." Surveyor asked if Caregiver Z, Caregiver AA, and Caregiver B worked in the home again. Caregiver/Manager F stated Caregiver Z was removed from the schedule. Surveyor asked if staff rotated between the 3 homes, since the homes are under one roof. Caregiver F stated staff did rotate between the 3 homes. Surveyor requested the staff schedule for September 2023 of individuals who worked the assigned schedule.

On 02/01/2024 at 6:57 AM, Surveyor requested from Licensee A any internal documentation regarding the alleged allegation of drugs in the

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home due to staff from 09/2023. Licensee A responded with a statement that read:
"On Monday 9/25/2023, [Caregiver AA] reported to [Manager F] that [s/he] thinks [Caregiver Z] was high on cocaine. [S/he] thought it was suspicious because [Caregiver Z] had the window open in the private suite's bathroom (Resident 1). [Caregiver AA] said [s/he] saw some white powder on the bathroom counter. [S/he] immediately got dizzy when [s/he] took a whiff of the countertop residue. [Manager F] informed [Co-Owner B]. [Co-Owner B] called [Sheriff's Office]. Officer showed up. [S/He] spoke with [Caregiver Z] for a while and could not prove that [Caregiver Z] was the user. [Caregiver Z] did not appear to be high on drugs per the officer. The officer went to test the counter in the bathroom for elicit substances and concluded that it was positive for cocaine. Both [Caregiver Z] and [Caregiver AA] refused to be drug tested. [Caregiver Z] started work at 3pm. [S/he] was sent home at 5:45pm. On Tuesday 9/26/2023, [Caregiver Z] consented to be drug tested. The result was negative. It was not able to be 100% determined if [Caregiver Z] used cocaine during work time."

On 02/02/2024, Surveyor requested the sheriff reports, from 09/01/2023 to 10/31/2023, from the county sheriff department that pertained to the address of the home.

On 02/02/2024 at 8:39 AM, Surveyor emailed Licensee A and requested Caregiver Z's drug test results and the provider's drug policy. Licensee A submitted the drug policy and a picture of a drug testing pee cup that contained what appeared to be urine. Surveyor responded to Licensee A and requested additional evidence of test results. As of 02/10/2024 at 8:00 AM, Surveyor did not

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M 230	Continued From page 53 receive additional documentation. The providers "Drug and Alcohol Testing" policy documented: "In support of our commitment to a safe work environment free from the use or effects of illegal drugs and/or alcohol. The Company, in its sole discretion, reserves the right to test any employee for illegal drugs at any time, or alcohol should there be reason to suspect that an employee may be using illegal drugs or may be under the influence of alcohol due to, but not limited to, an employee's conduct, appearance, behavior, speech, or body odors indicative of drug or alcohol use. The Company reserves the right to terminate an employee if drug or alcohol test results are positive." On 02/06/2024, Surveyor reviewed the sheriff's reports which documented: "09/25/2023 17:13:29 (5:13 PM) - Caller states that they believe one of the employees is using Cocaine at work - [s/he] seems impaired per On-Duty Manager (Manager F), found white powdery residue on counter. Suspect is [Caregiver Z] ... I met with [Manager F] regarding a white substance [s/he] found located on the counter of one of the bathroom sinks. [Manager F] and employee [Caregiver AA] believed that their co-worker [Caregiver Z] was in the bathroom earlier using an illegal drug as [s/he] emerged from the bathroom acting weird. I met with and spoke to [Caregiver Z] who admitted to using THC, Cocaine and Heroin in the past but stated [s/he] hasn't used any at work. With the bathroom being used by all staff and residence and with a minute amount of residue on the sink there was no positive identifying way to establish possession. [Caregiver Z] did not have any property on scene and was asked to leave the	M 230		

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workplace by [Manager F] upon my testing and identification of the white residue which tested positive for cocaine."
(Surveyor noted Co-Owner B stated the police were unable to determine the drug.)
(Surveyor noted to utilize vacant private bathroom, one would have to walk through the room. Other residents were not allowed to use the private bathroom.)
"10/21/2023 09:04:02 (9:04 AM) - [Caller] stated that staff has been using drugs in the parking lot."

On 02/13/2024, at approximately 3:50 PM, Surveyor interviewed Lead Caregiver P. Lead Caregiver P stated previous Caregiver V and Co-Owner B initiated the drug test for Caregiver Z.

On 02/14/2024, at approximately 11:20 AM, Caregiver/Manager F stated that staff had contacted [him/her] regarding the concern, and s/he stated that 911 needed to be called.

On 02/14/2024, at approximately 11:55 AM, Surveyor interviewed Co-Owner B. Surveyor asked who was responsible for conducting internal investigations. Co-Owner B stated, "If a staff member or a resident brings a concern to me, I immediately tell them to stop and I bring in another person, usually the manager, to listen to the concern. We often have 3-way calls. I expect the managers to write the required incident reports and to conduct the internal investigations."

On 02/14/2024, at approximately 1:30 PM, Surveyor interviewed Licensee A. Surveyor asked if Caregiver Z was allowed to return to work. Licensee A stated, "Yes, s/he came in the next day and took a drug test. The test came

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back negative, so, I kept [him/her] on the schedule. Then management told me that I should probably remove [her/him] from the schedule."

On 02/16/2024, Surveyor reviewed the staff schedule which documented:
Caregiver Z remained on the schedule:
09/26/2023 7AM - 3PM
09/28/2023 7AM - 3PM
09/30/2023 7AM - 3PM and 11PM to 7AM
Caregiver AA remained on the schedule:
09/26/2023 3PM - 11PM
09/27/2023 3PM - 11PM
09/28/2023 3PM - 11PM
09/29/2023 3PM - 11PM
Caregiver BB remained on the schedule:
09/26/2023 3PM - 11PM
09/27/2023 3PM - 11PM
09/28/2023 3PM - 11PM
09/29/2023 7AM - 3PM
09/30/2023 3PM - 11PM

On 02/19/2024, at approximately 7:50 AM, Surveyor interviewed Manager E. Surveyor discussed the concern that staff members were engaging in illicit drugs while on the schedule. Manager E stated s/he was informed by Licensee A and Co-Owner B that if staff are smoking illicit drugs in their cars and not in the home, then there was no concern. Manager E stated s/he could not understand or accept that because those individuals would then come into the home, under the influence, and attempt to care for their residents. Manager E stated s/he had asked Caregiver F, who was the manager during the 09/25/2023 incident, if they had completed an internal investigation and s/he was informed, no.

On 02/21/2024, at approximately 4:30 PM,

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Surveyor interviewed Family Member CC. Family Member CC stated, "I had a couple of visits to [provider] where I smelled marijuana walking into the building in late afternoon. When I asked staff about the smell, they told me there were residents who smoked it. I remember telling them I had never heard of such a thing, and they responded that it was for medicinal purposes."

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated s/he would express [his/her] concerns to Manager F that staff were coming in to work under the influence. Caregiver I stated, "You could just smell the marijuana scent." Caregiver I stated Manager F told [him/her], "If we say anything, then we are not going to have any staff."

On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver T. Caregiver T stated, "[Resident 3] would become upset about [Caregiver GG] smoking on the side of the home (there are stairs on the side of the home that go to the lower level where staff/residents smoke) and when [s/he] would come in, the whole place smelled like marijuana. [Caregiver GG] was asked to take a drug test and [s/he] said no, unless [Co-Owner B] is going to take one. Police were involved. I got blamed for [Resident 3] making an issue about it. We were basically told if you need to smoke that stuff, do it in your car."

On 03/06/2024, at approximately 2:15 PM, Surveyor and county sheriff Detective Y observed staff members for the second shift arriving at the home. Detective Y and Surveyor observed a strong marijuana like aroma emanating from two of the staff members. Staff members interacted with Licensee A and Surveyor observed no

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comments directed at staff members regarding the aroma and possibility of working under the influence of an illegal drug.

On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed previous Caregiver V. Caregiver V stated Caregiver Z was the only staff member that completed a drug test. Caregiver V stated, "I think they had it out for [Caregiver Z]. They didn't test anybody else. Every time [Caregiver Z] came into the building, they would drug test [him/her]. They never drug tested anybody else. I think that is harassment!"

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed Caregiver Z. Caregiver Z stated, "I was drug tested by the police, came back negative. Drug tested again by [previous Caregiver G], came back negative. Drug tested again by [Caregiver V], came back negative. It was harassment. The thing is, I was working in the home by myself and then two people show up, new employees (Caregiver AA and Caregiver BB). They are scheduled in the other homes, but they have to come into this home to use the bathroom? Why don't they use the bathroom in their home? Why was I the only one tested and I was the only one suspended?" Surveyor asked if s/he was aware of staff working in the home under the influence of an illegal drug. Caregiver Z stated, "They (Co-Owner B and Licensee A) never talk about the individuals who smell like marijuana; they are picking these staff members up to work; they know they are high, but they never say anything."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed Caregiver G and previous Caregiver K. Caregiver G stated s/he had given Caregiver Z a drug test and it had come back

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negative. Caregiver G stated, "I believe that [Co-Owner B] had an issue with Caregiver Z. [S/he] was a hard worker and would always jump in and do the work that the shift prior to [him/her] had left behind. I would tell [him/her], we need to report this, and [s/he] would just take care of it." Caregiver K stated, "There were always staff members under the influence of marijuana working at the home. We would say something to [Co-Owner B] and [Licensee A] and we would just be told, 'We will take care of it.'" Caregiver K stated, "[Maintenance DD] would come in and tell them that [s/he] would go pick up staff to come to work and they would be so 'high.'"

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F (Manager/Caregiver F). Surveyor reviewed the incident regarding the cocaine found in the home. Surveyor explained that s/he was informed that Caregiver Z was scheduled to work in the home, but two staff members from the adjoining homes, kept coming into the home to utilize the bathroom. Co-Owner B stated, "That is not acceptable. They have their own bathrooms." Surveyor asked for explanation as to why only one staff member was tested when it was reported that other staff members were in the home where the cocaine was found. Licensee A stated, "Because the other staff said it was [Caregiver Z]." Co-Owner B stated, "[Caregiver Z] was like a zombie, like in a frozen mode, there was powder on the kitchen sink. [S/he] would go outside and disappear." Surveyor asked why the behavioral concerns of Caregiver Z had not been addressed prior to this incident. Co-Owner B stated, "We didn't have proof." Licensee A stated, "We should have tested everybody. Not

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M 230	Continued From page 59 just assumed staff were telling us the truth." AED F was observed nodding [his/her] head in agreement. Surveyor then addressed the concerns with staff working in the home under the influence of an illegal drug. Surveyor explained [his/her] observations during [his/her] visits of smelling a strong odor of what appeared to be marijuana on staff members and being informed that the concern cannot be addressed as there is already a shortage in staff. Surveyor observed AED F again nodding [his/her] head in agreement. Licensee A stated, "How do we know if they smoked marijuana prior to their shift."	M 230		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, a registered nurse or a physician's assistant, for 1 of 2 employee files reviewed (Caregiver U), indicating that the service provider had been screened for illness detrimental to residents, including tuberculosis (TB) within 90	M 232		

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M 232	Continued From page 60 days before the start of providing services. Findings include: On 02/14/2024, Surveyor reviewed Caregiver U's record, Caregiver U was hired 07/31/2023. His/her file did not contain results for a communicable disease screen or a TB test result since s/he started providing services. Caregiver U's record contained a covid test result. On 03/06/2024, at approximately 1:00 PM, Surveyor commented to Licensee A that Caregiver U's record did not contain a communicable disease screen. As of 04/10/2024 at 5:00 PM, Surveyor did not receive any additional documentation.	M 232		
M 240	88.04(4)(a) INSURANCE-VEHICLE Vehicle. An applicant for an initial license or a renewal of a license who plans to transport residents in his or her vehicle shall provide the licensing agency with a certificate of insurance documenting liability insurance. If a service provider transports residents under the direction of the licensee the service provider shall have vehicle insurance and a valid driver's license and, if requested by the licensing agency shall provide evidence to the licensing agency on 12 month intervals of a vehicle in safe operating condition on a form provided by the	M 240		

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M 240	Continued From page 61 licensing agency. This Rule is not met as evidenced by: Based on observation, record review, and interview, the home did not ensure every service provider (Caregiver Z, Caregiver G, and Caregiver K) transporting residents under the direction of the Licensee had current auto insurance and a safe operating vehicle. Findings include: On 01/04/2024, the Department received a concern that alleged residents were missing medical appointments due to lack of transportation. The provider was licensed, 04/12/2022, to serve 4 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, terminally ill, traumatic brain injury, and physically disabled. On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Surveyor could overhear Caregiver Z speaking with the passenger in [his/her] car, making comments, the brakes won't release. Surveyor asked if we should speak another time. Caregiver Z stated, "Just give me a minute, I am sorry, I have a piece of [explicative word] car and I just need to give it a minute." After a moment, Caregiver Z stated s/he was ready. Surveyor asked if s/he had been asked to transport residents in [his/her] own personal vehicles. Caregiver Z stated, "Yes! And as you can tell, I don't have the most reliable vehicle. I was always transporting [Resident 2] to the store."	M 240		

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M 240	Continued From page 62 On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Surveyor asked if they were asked to transport residents in their own personal vehicles. Caregiver K stated, "I had been contacted by [Co-Owner B] to transport residents in my van for a community event, because the bus was broke down. I have been contacted last minute to transport residents to medical appointments because there was nobody else to take them." Caregiver G stated, "Everybody has missed medical appointments at one time due to no transportation. We would be calling staff who weren't working to come in and take residents to appointments using their own vehicles, including myself. Management always knew what was going on." On 04/10/2024, Surveyor requested Caregiver Z's, Caregiver G's, and Caregiver K's proof of auto insurance while transporting residents from Licensee A and Administration C. Administration C stated that the provider's auto insurance had an endorsement that allowed staff to drive residents in their own vehicle. Administration C provided Surveyor with an insurance policy dated 09/21/2020. Surveyor asked if there was an insurance policy with this endorsement for 2022 and 2023. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Co-Owner B and Licensee A stated staff should not be transporting residents in their own vehicles. Administration C stated the provider's insurance included a rider to cover staff if they did use their own vehicle.	M 240		

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M 240	Continued From page 63 As of 04/18/2024 at 10:00 AM, Surveyor did not receive any additional documentation.	M 240		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 caregiver completed 15 hours of training approved by the licensing agency related to fire safety, health, safety and welfare of residents, resident rights, and treatment appropriate to residents served prior to or within 6 months after starting to provide care independently. Caregiver U did not have training in resident rights and treatment appropriate to residents served. Findings include: The provider was licensed, 04/12/2022, to serve 4 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, advanced aged,	M 244		

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M 244	Continued From page 64 irreversible dementia/Alzheimer's, terminally ill, traumatic brain injury, and physically disabled. On 02/14/2024, Surveyor reviewed Caregiver U's record. Caregiver U was hired 07/31/2023. Caregiver U's record did not contain any training records in resident rights and treatment appropriate to residents served. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director (AED) F. Licensee A, Co-Owner B, Administration C and AED F communicated amongst themselves and discussed what changes needed to occur regarding training for staff.	M 244		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 2 of 2 staff member (Licensee A and Co-Owner B) received at least 8	M 246		

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M 246	Continued From page 65 hours, per calendar year, of continuing education training related to the health, safety, welfare, rights, and treatment of residents every year, during the calendar year 2022 and 2023. Findings include: The provider was licensed to provide cares for up to 4 residents in the care groups: developmentally disabled, advanced aged, physically disabled, irreversible dementia/Alzheimer's, and emotionally disturbed/mental illness. On 02/16/2024 at 9:53 AM, Surveyor emailed Licensee A and Administration C and requested Co-Owner B's continuing education for 2022 and 2023, due to [his/her] involvement with resident cares. On 02/19/2024 at 8:52 AM, Co-Owner B emailed Surveyor and stated, "I apologize that this has not been done before as I had thought that an owner was not under this same requirement as a caregiver." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director F. Co-Owner B stated, "After this survey process, you are right, I do provide cares to the residents." On 04/27/2024, Surveyor requested Licensee A's continuing education for 2022 and 2023. On 04/29/2024, Surveyor reviewed Licensee A's continuing education. Licensee A did not complete continuing education in resident rights in 2023.	M 246		

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M 278	88.05(3)(b) FREE OF HAZARDS The home shall be free from hazards and kept uncluttered and free of dangerous substances, insects and rodents. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure that the home was a safe environment and that residents were safeguarded from environmental hazards. Toxic chemicals were not securely stored under the kitchen sink. Findings include: This provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, physically disabled, emotionally disturbed/mental illness, developmentally disabled and advanced aged. On 03/06/2024, at approximately 1:15 PM, Surveyor toured the home and observed under the kitchen sink the following toxic chemicals/cleaning compounds that were not securely stored: -A gallon jug of bleach -A 32 fluid ounce bottle of mold and mildew stain remover -A 12 ounce can of powdered cleanser -A 14.5 ounce spray can of oven cleaner -A 9.7 ounce spray can of furniture polish	M 278		

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M 278	Continued From page 67 On 03/06/2024, at approximately 1:15 PM, Surveyor toured the home and observed under the kitchen sink the following toxic chemicals/cleaning compounds that were not securely stored: -A 32 fluid ounce bottle of urine stain & odor remover -A 32 fluid ounce bottle of mold and mildew stain remover -A 28 fluid ounce bottle of grout & tile cleaner -A 32 fluid ounce bottle of foaming bath cleaner -A gallon jug of bleach -A 32 fluid ounce bottle of cleaner with bleach -A 14.5 ounce spray can of oven cleaner -A 9.7 ounce spray can of furniture polish Surveyor had discussed this concern on 02/13/2024, at approximately 2:45 PM, with Manager D. Manager D stated s/he would inform the maintenance staff that a lock would need to be added to the kitchen sink cabinet. Surveyor reviewed his/her interviews to determine if a resident would be at risk if they had access to cleaning compounds/chemicals: On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver T. Caregiver T stated, "[Resident 2] will grab vases, broomsticks, anything [s/he] can get [his/her] hands onto to use as a weapon." On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated, "[Resident 2] is extremely combative. Yeah, [s/he] will use whatever [s/he] can get [his/her] hands on to to harm another person." On 04/09/2024, Surveyor reviewed Resident 2's managed care organization (MCO) records	M 278		

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M 278	Continued From page 68 provided by his/her Care Manager (CM) S which documented: "06/01/2023 - Has continuous or unpredictable behavior while awake, 1:1 staffing required continuous or immediate intervention constitutes a risk to the health and safety of the Member or others ..."	M 278		
M 400	88.06(2)(c)7 CONDITIONS OF TRANSFER OR DISCHARGE Conditions for transfer or discharge and the assistance a licensee will provide in relocating a resident. This Rule is not met as evidenced by: Based on record review and interview, information in the service agreement concerning conditions for transfer or discharge of a resident did not specify the assistance a licensee will provide in relocating 1 of 1 resident reviewed. A 30-day written notice of involuntary discharge was issued to Resident 2, dated 02/26/2024. The written service agreement did not specify the assistance the licensee would provide in relocating Resident 2. Findings include: On 03/02/2024, at approximately 11:00 AM, Surveyor interviewed Detective Y who had been investigating an allegation of abuse by Resident 2. Detective Y stated s/he had been in contact with Resident 2's family who informed [him/her] that Resident 2 had been given a 30-day notice and the family was going to move [him/her] out immediately.	M 400		

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M 400	Continued From page 69 On 03/02/2024, Surveyor requested Resident 2's 30-day discharge notice and admission agreement from Licensee A and Administration C. Resident 1 was admitted to the facility, 06/07/2023, with diagnosis of cognitive impairment. Resident 1's record contained a document that stated: "02/26/2024 ... Recently, during a State inspection, a [fe/male] resident informed officials that [Resident 2] was still (repeatedly) attempting AND even touching the [fe/male] resident's private upper area. This came as a surprise to myself and is what has triggered this notice to you. Because we do not allow violently or sexually aggressive people to reside in any [provider homes], we are giving this formal 30 day notice for [Resident 2] to vacate ... This 30 day notice is the start." The notice did not describe assistance the licensee would provide in relocating Resident 2, the name, address, and phone number of the advocacy agency or the name, address, and phone number of the Division of Quality Assurance. Resident 2's "Service Agreement," dated 05/26/2023, contained department contact information under the grievance section. The information listed was inaccurate. The information provided documented resources located in Milwaukee and referenced the southeastern regional office. The provider's home is in the northeastern region, based in Green Bay. The agreement did not document conditions for discharges or transfers nor outlined	M 400		

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M 400	Continued From page 70 that either party (licensee or resident/resident representative) may terminate the resident's occupancy with a thirty (30) day written notice to the other party. The service agreement did not specify the assistance the licensee would provide in relocating residents in the event of discharge or transfer. On 03/07/2024 at 1:26 PM, Surveyor emailed Licensee A and Administration C stating the concerns identified in Resident 2's discharge paperwork and admission agreement. Administration C requested the Chapter 88 regulation language regarding what is required in a service agreement and conditions of transfer or discharge which Surveyor provided.	M 400		
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 the Individual Service Plan (ISP) for 3 of 3 resident (Resident 1, Resident 2, and Resident 4) records reviewed were developed together with the placing agency,	M 406		

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M 406	Continued From page 71 the person being admitted or person's guardian / designated representative and the provider. Findings include: On 02/24/2024, Surveyor reviewed Resident 1's, Resident 2's, and Resident 4's record. Example 1: Resident 1 Resident 1 moved into the home, 08/24/2023, and was his/her own person. Resident 1 was represented by a managed care organization (MCO) Care Manager (CM). Resident 1's "Initial Assessments" (individual service plan), dated 08/24/2023 and 09/06/2023, did not contain Resident 1's signature, the CM's signature, nor the provider's signature. Example 2: Resident 2 Resident 2 moved into the home, 06/07/2023, and was represented by Guardian JJ. Resident 2's "Annual Assessment: ISP," dated 12/18/2023, did not contain Guardian JJ's nor the provider's signature. Example 3: Resident 4 Resident 4 moved into the home, 06/22/2023, was his/her own person and represented by MCO CM S. Resident 4's "Initial Assessment" (individual service plan), dated 08/24/2023, did not contain Resident 4's signature, CM S's signature, nor the provider's signature	M 406		

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M 406	Continued From page 72 Resident 4's "6 Month Assessment" (individual service plan), dated 11/13/2023, did not contain Resident 4's signature, CM S's signature, nor the provider's signature. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Licensee A and AED F stated that signatures would be captured by all individuals during the resident's care conference meetings.	M 406		
M 408	88.06(3)(c) ASSESSMENT IDENTIFY NEEDS & ABILITIES The assessment shall identify the person's needs and abilities in at least the areas of activities of daily living, medications, health, level of supervision required in the home and community, vocational, recreational, social and transportation. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 1 individual service plan (ISPs) reviewed identified the resident's need in level of supervision required in the home. Resident 4's record did not identify that s/he had been assessed for suicidal ideations, due to his/her history, and developed supervision guidance.	M 408		

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M 408	Continued From page 73 Findings include: On 02/04/2024, the Department received a concern that a resident had eloped from the home and staff did not know his/her whereabouts for approximately 3 to 4 hours. On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Surveyor asked if Resident 4 had a history of suicide. Caregiver I stated s/he had been informed that Resident 4 was suicidal. Caregiver I stated, "[Resident 4] had attempted suicide prior to moving into the home and that was why [s/he] was in the home." On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 4's managed care organization (MCO) Care Manager (CM) S. CM S stated, "Prior to placement [s/he] was homeless and [s/he] spoke of suicide but stated [s/he] would never act on it." CM S explained to Surveyor that Resident 4 had attempted suicide and due to his/her injuries, s/he was placed in an assisted living home. On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked if s/he was aware that Resident 4 was suicidal. Caregiver M stated, "I didn't know [s/he] was suicidal until after [Resident 4] had eloped." On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Surveyor asked if Resident 4 had a history of suicide. Manager N stated, "I was told [s/he] had left the building and nobody knew [s/he] had left and that [s/he] had tried to commit suicide. I don't	M 408		

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understand why that wasn't in [his/her] ISP. I didn't know this until it happened."

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if Resident 4 had a history of suicide. Caregiver L stated, "After [his/her] elopement is when I found out [s/he] had [attempted suicide] [him/herself] which caused [his/her] traumatic brain injury and that was not typed up in [his/her] ISP. I had no idea[s/he] was suicidal."

On 03/02/2024, at approximately 11:10 AM, Surveyor interviewed Caregiver U. Surveyor asked if Resident 4 had a history of suicide. Caregiver U stated s/he had no idea Resident 4 was suicidal.

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Surveyor asked if Resident 4 had a history of suicide. Caregiver W stated s/he had no idea Resident 4 was suicidal.

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Surveyor asked if Resident 4 had a history of suicide. Caregiver G and Caregiver K stated Resident 4 wasn't supposed to have forks/knives due to [his/her] suicidal tendencies.

On 04/09/2024, Surveyor reviewed Resident 4's record.

Resident 4 moved into the home, 06/22/2023, with diagnoses including anxiety, depression, and traumatic brain injury.

Resident 4's pre-admission assessment, dated

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M 408	Continued From page 75 05/08/2023, documented: "Medical history: Attempted suicide with gun. Blind in left eye." Resident 4's "6 month assessment," dated 11/13/2023, documented: "Self-Abusive behavior" - No guidance was documented. "Suicidal Tendencies" - No guidance was documented. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Surveyor discussed concern regarding ISP individualization. AED F also explained the ISP requirements with Licensee A and Co-Owner B. AED F stated s/he would review all resident ISPs and assessments.	M 408		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following: This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Individual Service Plan (ISP) for 1 of 2 residents accurately identified current needs and abilities. Resident 2's ISP did not identify his/her sleep and bathing patterns.	M 410		

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M 410	Continued From page 76 Findings include: On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated, "[Resident 2] is always sleeping in the [community room], sleeps on the farthest bench. [S/he] sleeps everywhere. Then they started locking the door because [s/he] wasn't supposed to sleep in there. So then [s/he] slept in [the adjoining home]. Then locks were installed so [s/he] couldn't sleep in [the adjoining home]. So then [s/he] started sleeping in [his/her] home, but not in [his/her] room. 90% of the time on the couch." On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 2's managed care organization (MCO) Care Manager (CM) S. CM S stated, "There were concerns that [Resident 2] would sleep everywhere which would result in certain areas of the homes being locked." On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Caregiver L stated, "[Resident 2] will sleep wherever. [Co-Owner B] even thought if [s/he] played animal sounds in the lobby so [Resident 2] wouldn't sleep there. All that did was irritate the other residents." On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. Caregiver O stated, "[Resident 2] wants to sleep all the time and [s/he] wants all the lights off. If you turn them on [s/he] will get upset." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated, "Management take [him/her] out to the community and [s/he] smells. [His/her] clothes	M 410		

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are dirty. [S/he] deals with incontinence but refuses to wear [his/her] Depends. [S/He] would fight us if we tried to shower [him/her].

On 04/09/2024, Surveyor reviewed Resident 2's record.

Resident 2 moved into the home, 06/07/2023, with diagnosis of cognitive impairment.

Resident 2's "Observation" notes, dated 07/01/2023 to 02/14/2024, documented:
02/06/2024 - Refused dinner.
01/19/2024 - Tried to give [Resident 2] a shower [s/he] refused [s/he] kept shaking [his/her] head no.
01/16/2024 - Upon coming into my shift [Resident 2] was sleep in the recliner in the Livingroom. Slept through second shift today. Refused dinner tonight ... [Resident 2] is currently still sleeping.
01/06/2024 - Grabbed [his/her] blanket and went into [adjoining home] and laid down on the couch. Was redirected by staff to go to [his/her] home. Started yelling No, then [s/he] tried to go into [community room] and sleep on the couch.
01/04/2024 - Stayed in the living room at night. [S/he] slept in the chair in the Livingroom.
12/09/2023 - Resident refused shower.
12/07/2023 - When I arrived [Resident 2] was sleep on the couch [s/he] slept there all night.
12/04/2023 - Resident refused shower.
12/03/2023 6:30 AM - When I arrived [Resident 2] was sleep on the couch.
11/25/2023 5:45 AM - When I arrived [Resident 2] was sleeping on the top of the stairs on the floor [s/he] slept there until 2:30 AM then [s/he] came down to use the bathroom and then processed to go back upstairs where [s/he] slept.
11/21/2023 - Slept on couch the whole night.
11/19/2023 6:30 AM - When I arrived, [Resident

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M 410	Continued From page 78 2] was sleep on the couch [s/he] woke up at 1:30 went to the bathroom and went upstairs .... Was sleeping on the couch upstairs. [S/he] came back down at 3:30 then went back up when I went to check on [him/her] [s/he] was sleep on top of the stairs. 11/16/2023 7:45 PM - Continues to sleep at the top of the stairs (leads to the adjoining homes and the community room). [S/he] finally moves from the top of the stairs and moved over to the couch in the living room. 11/14/2023 10:45 PM - In the living room sleeping. 11/10/2023 - Slept in living room on couch all night. 11/09/2023 - Was up all night in the living room. 11/02/2023 - Recommend that [s/he] showers today. 11/01/2023 5:45 AM - Slept in the living room. 10/30/2023 - Woke up at 5:30 AM and took all of [his/her] things upstairs. Would not listen. Was redirected several times to go into [his/her] room and to say downstairs. [Resident 2] refused. 10/28/2023 - Took [his/her] blanket out of [his/her] room and [s/he] decided to sleep on the softa in the living room. 10/25/2023 - Is not sleeping in [his/her] bed [s/he] brings all of [his/her] belongings to [Community Room] ... This has been going on for about 2 weeks. ... Owner came at bedtime to lock [community room] door to have resident sleep in [his/her] room ...resident in room for about ten minutes then brought [his/her] comforter and pillow out and refused to go into [his/her] room. Resident asleep on couch at end of shift. 10/24/2023 - Slept upstairs last night [s/he] did not want to come downstairs to get in bed. 10/23/2023 - Slept upstairs last night [s/he] did not want to come downstairs to get in [his/her] bed.	M 410		

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M 410	Continued From page 79 10/21/2023 6:30 AM - Slept in [Community Room] for some reason. [S/he] did not want to come downstairs. 10/19/2023 11:00 PM - [Resident 2] is sleeping in [Community Room]. 09/24/2023 - Refused to let staff assist [him/her] with a shower. Resident 2's "Annual Assessment: ISP," dated 12/18/2023, documented: "Bathing - Requires staff monitoring, verbal prompts and cues with bathing/showering needs. Staff needs to point. [S/he] does not understand English." The ISP did not provide guidance related to Resident 2's sleep patterns. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Surveyor discussed concern regarding ISP individualization. AED F also explained the ISP requirements with Licensee A and Co-Owner B. AED F stated s/he would review all resident ISPs.	M 410		
M 430	88.07(1)(c) ACTIVITIES AND SERVICES The licensee shall plan activities and services with the residents to accommodate individual resident needs and preferences and shall provide opportunities for each resident to participate in cultural, religious, political, social and intellectual activities within the home and community. A resident may not be compelled to participate in these activities.	M 430		

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M 430	Continued From page 80 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure activities and services were planned for 3 of the 3 residents who reside in the home, which would accommodate individual resident needs and preferences. Findings include: On 01/31/2024, from approximately 10:00 AM to 2:45 PM, on 02/13/2024, from approximately 12:30 PM to 5:30 PM, and on 02/14/2024, from approximately 9:15 AM to 3:30 PM, while onsite, Surveyor did not observe any postings about resident activities or observe any group activities. On 02/02/2024, the Department received a concern alleging activities are not provided to residents. On 02/25/2024, at approximately 9:50 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated the only activities the owners scheduled "were activities related to holiday activities, birthdays, football party, sometimes take them to the other houses; no day-to-day activities on second shift. Then residents do things to "create attention." Caregiver J stated that s/he felt resident negative behaviors were due to "boredom." Caregiver J stated, "We were always short staffed, so residents who are more independent are expected to entertain themselves." On 02/25/2024, at approximately 10:35 AM, Surveyor interviewed Resident 5's Power of Attorney (POA) Y and Resident 6's POA HH, who were interacting with residents from the other homes in the common area. Surveyor asked if	M 430		

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there were enough activities provided to the residents. POA Y stated, "Staff are always sitting on their phones, not engaged with the residents. I will be there, and staff and management are sitting at the table talking about personal items, playing on their phone; nobody is paying attention to the residents. POA Y stated, "Staff will focus on cleaning, instead of interacting with the residents. Why can't they do cleaning during the night shift?" POA HH stated, "[Resident 2] displays behaviors but I think [s/he] is bored. [S/he] is always looking for something to do."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated, "I have never seen a building not have activities at all. They rely on family members to come in and do activities with the residents. Staff did not do activities with residents." Manager N stated, "There was never enough staff in the home."

On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. Caregiver O stated the owners would have a person come in to do activities with the residents, "I think once a week."

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated, "There was an activity person, but you never knew when [s/he] would show up and if [s/he] did show up, would [s/he] actually do an activity with the residents. There is no activity board and management does not tell us what we should do." Caregiver W stated, "When you were here on Valentine's Day, that was all show, the owners never buy Valentine's stuff for the residents. They rely on family members to do that. When us staff want to get balloons or a

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M 430	Continued From page 82 cake or something for a resident's birthday, we are told that is too expensive." On 03/08/2024, at approximately 10:50 AM, Surveyor interviewed Caregiver V. Caregiver V stated, "They (Licensee A and Co-Owner B) took [his/her] hours, [s/he] was supposed to do activities on Thursdays." On 04/09/2024, at approximately 4:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Caregiver K stated, "[Resident 2] would follow me around. I gave [him/her] things to do. I do think [his/her] behaviors are because [s/he] is bored. [Licensee A] doesn't allow staff to take the residents anywhere. It costs too much money. You can't go to the zoo, which is free, because you have to pay for the fuel to drive there. Staff would take the residents to the movies, in their own vehicle, and only ask that their ticket be paid for. Nope. That wasn't allowed either." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Co-Owner B stated, "We have started doing daily activities. Did you see the activity chart. We now do exercises at 9:30 AM."	M 430		
M 438	88.07(2)(b) SERVICES DIRECTED TO GOALS Services shall be directed to the goal of assisting, teaching and supporting the resident to promote his or her health, well-being, self-esteem, independence and quality of life. The services shall include but are not	M 438		

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M 438	Continued From page 83 limited to: This Rule is not met as evidenced by: Based on observation, interview, and record review, the Licensee did not ensure 1 of 1 residents were provided with services that assisted, taught, and supported the residents to promote his/her health, well-being, self-esteem, independence, and quality of life. Resident 2 did not speak English and staff were not provided guidelines on how to communicate with him/her. On 01/31/2024, during a previous survey at an adjoining home, 02/13/2024, 02/14/2024 and 03/06/2024, Surveyor observed Resident 2 wandering throughout the three adjoining homes. Surveyor noted Resident 2 did not speak with other residents or staff. On 02/14/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver X. Surveyor asked how staff communicated with Resident 2. Caregiver X stated, "I cannot understand a word [Resident 2] says. [S/he] will use hand gestures. There was no training." On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver T. Surveyor asked how staff communicated with Resident 2. Caregiver T stated, "[Resident 2] is difficult to communicate with. Nobody understands [him/her]. We just do our best to guess what [s/he] wants." On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed managed care organization (MCO), Care Manager (CM) S. Surveyor asked	M 438		

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how staff communicated with Resident 2. CM S stated, "I really do not know."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Surveyor asked how staff communicated with Resident 2. Manager N stated, "There is obviously an English barrier. Was told by [Co-Owner B] and [Licensee A] [Resident 2] was talking jibberish, but I think [s/he] has [his/her] version of [his/her] native language."

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L Surveyor asked how staff communicated with Resident 2. Caregiver L stated, "[Resident 2] is difficult to interact with because [s/he] doesn't speak English. I tried to use a translator app myself. I don't know what other staff try to do."

On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. Surveyor asked how staff communicated with Resident 2. Caregiver O stated, "[Resident 2] doesn't speak English and doesn't comprehend us. [S/he] doesn't understand us. We need a translator. Try to do hand signals/sign language."

On 03/02/2024, at approximately 11:10 AM, Surveyor interviewed Caregiver U Surveyor asked how staff communicated with Resident 2. Caregiver U stated, "[Resident 2] is hard to communicate with. I think [s/he] is starting to understand us."

On 03/08/2024, at approximately 10:50 AM, Surveyor interviewed Caregiver V. Surveyor asked how staff communicated with Resident 2. Caregiver V stated, "We aren't provided with a translator. You don't know what is [s/he] saying!"

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M 438	Continued From page 85 On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Surveyor asked how staff communicated with Resident 2. Caregiver Z stated, "[Resident 2] doesn't speak the language. No wonder [s/he] displays behaviors. I am sure [s/he] is frustrated. How does [s/he] protect [him/herself]." On 04/09/2024, Surveyor reviewed Resident 2's record. Resident 2 moved into the home, 06/07/2023, with diagnosis of cognitive impairment. Resident 2's "Annual Assessment: ISP (individual service plan)," dated 12/18/2023, documented: "Communication Skills: (blank)" On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Surveyor asked how staff were to communicate with Resident 2. Co-Owner B stated, "[Resident 2] really doesn't have a language, so a language app will not be beneficial. [S/he] speaks 'jibberish.' [His/her] own family doesn't understand [him/her]." Surveyor asked what interventions have been put in place to assist staff with communicating with him/her. Co-Owner B stated, "[Resident 2] has moved out so that is something we can focus on if we are put into a similar situation."	M 438		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in	M 448		

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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 monitor 1 of 1 resident's health by observing and documenting changes in each resident's physical health.

Resident 1 experienced injuries of unknown origin and his/her change-of-condition in skin was not documented.

Findings include:

On 02/02/2024, the Department received a concern alleging a resident sustained bruising to his/her arms on two different occasions.

On 02/14/2024, at approximately 12:00 PM, Surveyor and Detective Y interviewed Licensee A and Co-Owner B. Surveyor asked if Resident 1 had sustained injuries of unknown origins. Co-Owner B stated, "There is estrangement with [Resident 1's] family due to concerns with how [Resident 1] received unexplained bruising. I spoke with [Resident 1] and [s/he] stated the caregiver with the red dreadlocks hurt [him/her]. I assumed [s/he] meant [Caregiver U]. Then [Resident 1] changed [his/her] mind. I looked at the bruises to determine if they looked like fingerprints but [Resident 1] had been placed on blood thinners, so [s/he] bruised easily." Surveyor asked if there was documentation that identified when the bruising occurred and how the bruising was monitored. Co-Owner B stated there were no incident reports on file regarding Resident 1's bruising. Surveyor asked if staff

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were responsible for documenting a change of condition a resident experienced in his/her record. Licensee A stated, "Of course."

On 02/15/2024, Licensee A provided Surveyor with a typed-up account of the provider's investigation of Resident 1's bruising. The report documented:
"Date of report: 01/23/2024"
"On Monday, 01/08/2024, [Caregiver J] reported that there were bruises on [Resident 1's] arms. From the investigation, logic dictated that the bruises likely came from someone getting [Resident 1] up by grasping or pulling [his/her] arms. [Resident 1] is a very heavy sleeper and [s/he] is often a challenge to be awoken up but [s/he] is required to be toileted every 2 to 3 hours to alleviate bed wetting. On Sunday 01/21/2024 bruises appeared on the inside of [his/her] upper left arm. [Resident 1] said that staff was rough when grasping [his/her] arm to get [him/her] up the night before."

On 02/19/2024, at approximately 7:50 AM, Surveyor interviewed Manager E. Surveyor asked if s/he had observed Resident 1's bruising and if so, where did s/he report/document this observation. Manager E stated, "I did observe additional bruising on [Resident 1's] arms, 01/21/2024. I was concerned and took pictures of the bruises since there was already a concern of bruising noted on 01/08/2024. I informed [his/her] family and management. I was told by management (Co-Owner B and Licensee A) an incident report did not need to be typed up." Surveyor asked how staff were to document resident observations as they were monitoring their health. Manager E stated, "I tell staff they were to document all observations that they considered concerning, including skin concerns.

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I have had discussions/arguments with [Licensee A] and [Co-Owner B] about the importance of this. I know health monitoring is not documented appropriately."

On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Surveyor asked if s/he had observed Resident 1's bruising and if so, where did s/he report/document this observation. Caregiver H stated, "[Resident 1's] bruising was probably from staff who do not know how to properly wake [him/her] up. To wake [him/her] up you should tickle [his/her] toes or open up a window. Do not pull on [his/her] arms. I would think staff are to document these concerns in the resident's progress notes but that doesn't mean the comment will remain in the progress notes. Management deletes comments that might alert state."

On 02/21/2024, at approximately 4:30 PM, Surveyor interviewed Resident 1's Family Member (FM) D. FM D stated s/he had been contacted by a caregiver regarding Resident 1's bruising; said it looked like hand marks. I contacted [Licensee A] and [Co-Owner B]. They were unable to tell me when the bruising occurred. It took a while for the bruising to go away, especially since there were two instances."

On 02/24/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Surveyor asked if s/he had observed Resident 1's bruising and if so, where did s/he report/document this observation. Caregiver J stated s/he was the one that reported Resident 1's bruising to management on 01/08/2024. Caregiver J stated, "[Resident 1] said it happened over the weekend. I took pictures of the bruises with [Resident 1's] permission and made a note in

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M 448	Continued From page 89 [Resident 1's] record." On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Surveyor asked if s/he had observed Resident 1's bruising and if so, where did s/he report/document this observation. Caregiver I stated, "I know I put two write ups in the progress notes and [Caregiver J] did a note about the bruising, plus an incident report." On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver T. Surveyor asked if s/he had observed Resident 1's bruising and if so, where did s/he report/document this observation. Caregiver T stated, "[Caregiver F] said the bruises were from people shaking [him/her] to wake [him/her] up and [s/he] is on blood thinners. I have never had to wake [him/her] up. [Resident 1] is so sweet." Caregiver T stated, "I do not think I documented anything about [his/her] skin, since everybody knew about it. But everyone knows, management will change your comments if they don't want it in the record." Surveyor asked how residents are monitored when there is no documentation to show change of conditions. Caregiver T stated, "Usually, you just tell management, and they determine what should be documented." On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked if s/he had observed Resident 1's bruising and if so, where did s/he report/document this observation. Caregiver M stated, "I saw bruises. I would just tell management; they were to document." On 03/02/2024, at approximately 11:10 AM,	M 448		

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M 448	Continued From page 90 Surveyor interviewed Caregiver U. Surveyor asked if s/he had observed Resident 1's bruising and if so, where did s/he report/document this observation. Caregiver U stated, "I heard about the bruises, but I don't know what came of that." (Caregiver U was documented as being questioned by Licensee A regarding the bruises.) On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Surveyor asked if s/he had observed Resident 1's bruising and if so, where did s/he report/document this observation. Caregiver W stated, "I did not work with [Resident 1] when the bruising was identified, but staff can type up incident reports, but they are going to be deleted by management. There is no specific form we are supposed to fill out regarding skin observations, say like what we observe when assisting with showers." On 03/06/2024, at approximately 4:45 PM, Surveyor interviewed Resident 1. Resident 1 stated [s/he] had bruises from staff members pulling on him/her to wake him/her up. Resident 1 demonstrated on Surveyor's arms how staff would grab his/her arms, hands on top of forearm with thumbs on the inside. First occasion of bruising was in the morning getting him/her up for a bathroom break, staff put their hands over his/her upper arms, trying to sit him/her up to scoot him/her over to the side of the bed. Resident 1 stated, "The staff said 'Oh my this [boy/girl] is heavy.' 'Yeah, yeah!' They were frustrated with me. They said, '[S/he] won't wake up.' [S/he] is getting angry, [s/he] threw me back into bed. Never did get to the bathroom. They went and got [Co-Owner B]. The second occurrence was mid-day, about two weeks later. I was in front of the big TV in the common area, the TV was too loud, I tried to turn it down.	M 448		

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[Manager E] noticed that I had bruises. [S/he] asked me to go to my room so [s/he] could look at them. [S/he] took pictures and sent them to [FM D]." Surveyor asked if Resident 1's sustained bruises were painful. Resident 1 stated, "Yeah, they were there for a while."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F/ (Caregiver F). Surveyor discussed the lack of documentation to show that Resident 1's change in skin condition was being monitored. Surveyor stated that during the survey process, requests had been made for documentation showing how a resident's skin is monitored and once a skin concern is identified, how is the concern monitored. Surveyor had not received any documentation. AED F stated s/he had increased his/her documenting in resident observation notes. Licensee A stated processes would be put into place to assist with monitoring resident concerns.

On 04/29/2024, Surveyor received and reviewed Resident 1's progress notes which only documented Caregiver J's initial observation: "Staff noticed bruising on left and right forearms. Resident reported they were from staff whom couldn't wake [him/her] up. Resident reported complaining to the staff about the pain from the bruising. Management was notified at 9:30 PM 01/08/2024."

On 04/29/2024, Surveyor requested and reviewed Resident 1's managed care organization (MCO) documentation which stated:
"01/09/2024 [Care Manager OO] Call with member's [FM D]. [FM D] reported to CM that

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M 448	Continued From page 92 [s/he] received a message from a current AFH (adult family home) caregiver that included pictures of member's arms with what appears to be several bruises on each arm. Per [FM D], the caregiver believes the bruises are a result of the weekend, overnight staff grabbing and yanking on member to get up and go to the bathroom. [FM D] said [s/he] received a call from AFH management who shared the same information the caregiver had shared with [her/him]. The AFH is going to investigate to determine what led to the bruises as well as send information to all caregivers about what happened and how it should not be happening. Call placed to [Licensee A] and discussed member's bruised arms. [Licensee A] voiced that the bruises could be caused by caregiving staff while assisting with overnight cares. [Licensee A] reported to writer that the AFH is conducting an internal investigation to determine the cause of the bruises. [Licensee A] noted that staff will be re-educated on safe and effective strategies to assist member with overnight cares. Discussions are ongoing related to members' bruises and possible staff involvement. 01/11/2024 Writer inquired to [FM D] if [s/he] had received any updates from [provider] regarding their internal investigation related to member's bruised arms. [FM D] reported that [s/he] has not heard from the owner directly but that AFH staff told [FM D] that member will now have two staff members assist with waking [him/her] for overnight cares. 01/11/2024 Call placed to [Licensee A] and inquired about their internal investigation regarding the bruises on member's arm. [Licensee A] stated that [s/he] could not talk at that time and would call writer later. 01/12/2024 CM sent correspondence to [Licensee A] with request for update regarding	M 448		

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M 448	Continued From page 93 AFH internal investigation related to the bruises on member's arms. CM asked [Licensee A] to reach out with results of the internal investigation including plan to prevent future occurrences. 01/16/2024 Discussed circumstances related to member's recent bruised arms. Discussed member's overnight incontinence cares. FM D reported that member has been sleeping in a recliner for part of the night before staff provides toileting assist and then helps [him/her] to [his/her] bed to sleep the remainder of the night. 01/17/2024 Call place to [Licensee A] with no answer. Left voice message and requested return call. 01/18/2024 Call placed to [Licensee A] for follow upon the facilities internal investigation related to member's bruised arms. [Licensee A] reported that [s/he] talked with all staff that were on duty during the time frame when member sustained bruises but [Licensee A] was unable to determine the cause of the bruises. [Licensee A] noted that due to member's blood thinning medication [s/he] does bruise easily. [Licensee A] noted that going forward, staff are to work in teams of two while providing assist with completing overnight incontinence cares. Per [Licensee A], [s/he] provided education to staff on strategies to wake member without physically holding [his/her] arms. Strategies included removing blanket, opening window, talking to [him/her], and ticking [his/her] feet. Discussion on safe assist practices are ongoing."	M 448		
M 450	88.07(2)(b)6 NOTIFICATION OF CHANGES Notifying the placing agency, if any, the guardian, if any, of any significant changes in the resident's	M 450		

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M 450	Continued From page 94 medical condition, including any life-threatening, disabling or serious illness, any illness lasting more than 3 days, an injury sustained by the resident, medical treatment needed by the resident or the resident's absence from the home for more than 24 hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3's care team was notified when Resident 3 stated Resident 2 touched him/her inappropriately. Findings include: On 02/04/2024, the Department received a concern alleging a resident had been touched inappropriately by another resident. On 02/14/2024, at approximately 10:10 AM, Detective U and Surveyor interviewed Resident 3. Resident 3 stated s/he had been inappropriately touched by Resident 2. While Detective U and Surveyor interviewed Resident 3, contact was made with his/her Power of Attorney MM. Detective U assisted Resident 3 with filling out an official complaint/statement with the sheriff department. Prior to exiting the home, Detective U informed Licensee A that Resident 3 had filed an official complaint/statement regarding Resident 2 touching him/her inappropriately. On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 3's managed care organization (MCO) Care Manager (CM) S.	M 450		

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M 450	Continued From page 95 Surveyor asked if s/he was aware that Resident 3 had filed an official complaint/statement with the sheriff department. CM S stated, "I was not informed there was an incident of inappropriate touching by [Resident 2] until her guardian called me after they had been informed by the police. I did not hear from the provider." Surveyor stated that based on his/her interviews and documentation reviewed, this concern originally occurred back in 01/2024. On 02/29/2024, at approximately 1:35 PM, Surveyor interviewed Licensee A, Co-Owner B, Assistant Executive Director F, and Manager KK. Co-Owner B explained to Surveyor that s/he was not aware of Resident 2's sexual behaviors until the Surveyor brought it to his/her attention.	M 450		
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 record review and interview, the provider did not ensure accurate records were kept of all prescription medications administered for 1 of 1 (Resident 1) record reviewed.	M 462		

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M 462	Continued From page 96 Findings include: On 02/02/2024, the Department received a concern that residents were not administered medications at their scheduled times. On 02/21/2024, at approximately 4:30 PM, Surveyor interviewed Resident 1's Family Member (FM) D. FM D explained to Surveyor that there were always concerns with the administration of Resident 1's medications. FM D stated, "I would receive calls from [Manager F] stating they were out of a med on a regular basis. FM D stated, "I questioned why the meds were not on auto refill. Then [Manager F] would back paddle and say it is all good or we can use [his/her] 'extra' medication due to missed doses or refusals. FM D stated, "I was especially concerned with the administration of [Resident 1's] prescribed Xyosted (a testosterone medication). When [Resident 1] moved in, I was told by [Licensee A] that they would be able to administer this medication, then that all changed. So, I was coming in to administer the medication every Wednesday until they could get a staff member delegated to administer this medication, because it was administered through a shot. In December, [Resident 1's] physician changed the administration to every other week. I kept asking if they could get a staff member delegated to administer this shot as I was scheduled for knee surgery and would not be able to come in and administer the shot. [Licensee A] finally said they had delegated a staff member. Now the problem was [Resident 1's] medication administration record was not updated, so the shot was still being giving weekly versus bi-weekly." FM D continued stating, "Then, I was being contacted by staff that the medication wasn't available. So, [Licensee A] asked for it to be switched to	M 462		

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Thursday then Friday because they didn't have the medication. They did not receive a physician order to do this. What is concerning is so many med errors occurred in January and then on 01/31/2024 at 2:30 AM, I get a call that [Resident 1] was talking out of [his/her] mind, says [s/he] is having a seizure; so, I requested [Resident 1] be sent to the emergency room." FM D explained, "After that medical emergency, when it was determined that the incident was related to [Resident 1] not receiving [his/her] prescribed medications, I moved [Resident 1] out of the home. Now, all of [his/her] medications have to be restarted and we have to get [him/her] 'leveled out' again." FM D stated, "There were also concerns that [Resident 1] was prescribed psychotropics and there are concerns the medications were not given." FM D forwarded his/her daily notes and communications between him/her and staff which documented:
10/05/2023 - 10:58 AM - Received a text from [Caregiver G] 10:58 AM - [Resident 1] will be running out of pills. Pharmacy told [him/her] there were no refills. [S/he] asked for [his/her] doctor's number to call and ask for them. I asked [him/her] which pills. [S/he] stated all of them except two. I asked, "What is the medication with the lowest amount?" [S/he] replied, "All morning meds and only two bedtime meds" I asked, "Ok, but what is the lowest pill count? I have been working to get [him/her] established with a doctor here and am not able to get [him/her] in for another month. I can call [him/her] and see if [s/he] will write the scripts because I can't get the doctor in another state to write them for here. I want to know how much time we have." [S/he] did not respond.
10/05/2023 - 5:30 PM - Visited [Resident 1]. Staff stated they [s/he] had received all of [his/her] available meds.
10/05/2023 - 8:30 PM - [Licensee A] called me to

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share that they have allowed [Resident 1's] meds to completely lapse and [s/he] wouldn't receive any meds that night. [S/he] also shared that their physician with [physician office] hasn't seen [Resident 1] to write new prescriptions for [him/her] as I was told would happen repeatedly since [s/he] moved in. They shared that they did not have any further medications and needed new prescriptions. I had to find a physician that would write the prescriptions the next day.
10/19/2023 - 12:25 PM - I sent [Manager F] a text asking if [s/he] received [Resident 1's] meds so that I could stop by and give [him/her] [his/her] testosterone shot since they didn't have it yesterday. [S/He] wrote back that they had not received them but were told it would be there today. 4:03 PM, I texted [Manager F] that I was concerned that I hadn't heard from [him/her] about the medications and asked if I needed to call the pharmacy. [S/He] said [s/he] had to wait until the driver brings it. [S/He] told me to call them. I called [pharmacy] and was told I could pick it up because their driver wasn't going to be able to get it there. 6:02 PM, I arrived at [provider's] with the missing medications. 6:17 PM, I texted [Manager F] to come downstairs and observe [Resident 1's] behaviors (being delusional and hallucinating). I wanted [him/her] to see this behavior because it was due to [him/her] not receiving [his/her] medications as they were ordered.
11/08/2023 - I stopped by [provider] to give [Resident 1] [his/her] shot and notified [Manager F] that they need to order another box of [his/her] testosterone since that was shot #4. [S/he] shared that [s/he] called it in yesterday and changed the prescriber.
11/15/2023 - 10:53 AM texted [Manager F] that I would be stopping in today to give [Resident 1] [his/her] shot in the afternoon. 11:03 AM

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M 462	Continued From page 99 [Manager F] texts me back, "Hey, That injection was out when I called it in last week. It should be delivered today I will check in it now." I found it odd that it would take a week to get the meds if [Manager F] had placed the order with the pharmacy. I called the pharmacy and learned that they never received the new prescription from the doctor. I called [doctor's office] and they never sent the new prescription to the pharmacy. At 11:34 AM I texted [Manager F] that I made some calls to the pharmacy and they had not received the refill from [doctor]. [Pharmacy] isn't able to get the injection until tomorrow. 11/16/2023 - 8:47 AM texted [Manager F] if [s/he] had received any updates from [pharmacy] for the ETA (estimated time of arrival) of the testosterone. 9:07 AM [s/he] texts that the meds will be there at 1pm unless I can pick it up. I shared that I was unable to make a trip down to [city] again, but I would be there soon after 1pm to give [Resident 1] [his/her] injection. 1:20pm texted [Manager F] that I could be there in 20 mins. [S/He] texted back that it wasn't there yet and [s/he] would call again. 3:44pm texted [Manager F], " Any word yet?" 4:11pm [s/he] texted, "I reached out again. They claim it should be here shortly." 6:47pm I texted [him/her], "Any update? I am very concerned. If they said 1pm and it's not there yet, I am very worried." 6:49pm [s/he] texts, "They said it will be here today. I will text u (you) when it come in tonight." 7:15pm [s/he] texts, "[His/her] injection stuff is here now" 7:16pm I texted that I was on the way. 11/28/2023 - [Resident 1] had an appointment with [endocrinologist], medication changes were made to [Resident 1's] Desmopressin. 11/28/2023 - Upon returning [Resident 1] to [provider], I notified the staff of the changes that were being made to [his/her] medications with the pharmacy. I spoke to, [Caregiver M], who stated	M 462		

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that the change were going to confuse the other caregivers. [s/he] was very concerned about it. I specifically spoke with [Licensee A] at 5:11pm via phone and shared the changes with her.
12/01/2023 - 1:03pm Spoke with [Licensee A] about Desmopressin medication changes to verify if they have been implemented. [s/he] shared that they had not received the new meds from the pharmacy yet.
12/04/2023 - 3:01pm message from [Licensee A] that new Desmopressin changes implemented at [provider] and medications onsite.
12/05/2023 - I stopped by [provider] to check on the medication changes with the Desmopressin. Talked to [Caregiver M] and [s/he] shared [his/her] concerns about how the pharmacy packaged the meds in two different strips and packaged various pills with the new dosing. [s/he] expressed [his/her] concerns that staff would not notice that there was a second strip and would only give [Resident 1] the one pack on one strip and not check to make sure that it matches the MAR (medication administration record). [s/he] shared that [s/he] talked to management and ownership about [his/her] concerns.
12/06/2023 - I stopped by [provider] to administer [Resident 1's] Testosterone shot and see how the new medication changes were going well with the staff. I saw the same caregiver from last week was on shift again, [Caregiver M]. [S/he] was very quick to tell me that [s/he] was right the day before and that the caregiver on staff that night did not give [Resident 1] [his/her] medications as they were prescribed. [S/he] was very upset about this and expressed how hard [s/he] tried to make sure they didn't miss the second strip of meds, but they simply gave [Resident 1] the one pill pack from the bigger strip. [S/he] showed me the missed meds in their pill pack. I asked [him/her] to grab whoever was the manager and

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we needed to talk. [Licensee A] and [Manager N] came downstairs and I spoke with them about how this cannot be happening and stressed the importance of this medication.
01/03/2024 - Talked to [Licensee A] about [Resident 1's] testosterone injection and whether it had been given. [s/he] had no idea and mentioned that [Manager N] was no longer with them and they needed to figure that out. I asked [him/her] when the last time was that [s/he] received [his/her] shot. [s/he] said [s/he] didn't know. I emailed [Resident 1's manager care organization (MCO) Care Manager OO] about Medication mismanagement with [Resident 1] and shared my concerns. [s/he] shared that they would look into it and stop in to investigate.
01/04/2024 - At 12:22am, received a text from [Caregiver J], "[Resident 1] didn't get [his/her] shot this morning. I was just about to leave 11pm and [Lead Caregiver P] asked [Resident 1] (who had gotten up and was eating in the kitchen, if got [his/her] shot. [S/He] said no..." "So for the next 40 minutes me and [Lead Caregiver P] investigated what happened. If it was true, look logs etc" "F! Short story, we discovered the box the shot comes in, has different directions that is in the computer and so the worker had no like direction in the med chart to give it to [him/her] today which means they had been changed Recently" Since manager denies changing it, says it was always such a way since [s/he] started, [s/he] never changed it. Which leaves [Licensee A]. The box says every Wednesday at 8am. The report shows every 14 days and also weekly. Just so you know. [Lead Caregiver P] gave the shot tonight when I left." (Surveyor is unsure if Lead Caregiver P had received RN delegation.)
01/27/2024 - 11:29am Received a call and voicemail from [Licensee A] stating, "We are RN

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(registered nurse), delegate staff to do the injection for you, and the one that is delegated is no longer with us so yesterday we were waiting to be delegated anything happen Pharmacy said we can do it today but them we have to change every 14 days to be Saturday. However, my RN has not called me back yet so I do need you to. If you have somebody that can come in to do the injection Call me back please [number]."
01/27/2024 - 11:35am received text from [Manager E] stating: "I am contacting you about the injection for [Resident 1] I was informed by [Licensee A] to contact you because the nurse they have is not available to delegate anyone to the injection so [s/he] stated to call you because you know some nurses." at 1:14pm, I responds, "Omg! (oh my goodness) This is unbelievable. So, [s/he] hasn't had it yet? I am about to lose my mind!!" At 1:22pm, [Manager E] responds, " I informed [Licensee A] on Wednesday that I needed to be delegated on Wednesday so it could be done on Friday." At 1:48pm, responds, "I believe you!! It's just ridiculous that this continues to be an issue!!!" At 4:25pm, received a call from [Licensee A] that they didn't have anyone available to give [Resident 1] [his/her] injection. I asked why [s/he] was calling me on a Saturday when [his/her] injection is supposed to be administered bi-weekly on Wednesdays. [s/he] stated that they talked to the Pharmacy to change it to Saturday. I asked how they were able to make that change when it is ordered on Wednesdays. [s/he] said it was due on Fridays and the pharmacist said it was ok to move it a day. I corrected [him/her] to say, it isn't a one day change from Wednesday. [s/he] was trying to say it was ok by the pharmacist. I stated the doctor's orders are for every other Wednesday and there are dangers to changing the date without the doctor's orders because if [s/he] were to ever

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have to go to the hospital, the orders would be for the shot to be administered on a Wednesday. If they changed this and [s/he] ended up getting a shot on a Saturday and then on a Wednesday, you would be over medicating [him/her]. This is a controlled substance that needs to be administered according to doctor's orders. Changing the date to cover your medication mismanagement so you are not given a violation from the State for not administering medications is not acceptable. [s/he] apologized and said that [s/he] was the one who made the changes with the pharmacy. [Co-Owner B] was also on this call and said nothing to acknowledge their errors. They then asked me if I would come down and give [Resident 1] [his/her] shot. They said they would bring [him/her] to my house to give [him/her] the shot. I told them that I would be reaching out to [Resident 1's] endocrinologist about this situation and ask [him/her] how we should proceed with the medication schedule either so that we would have a consistent and correct date for the injection. I told them [s/he] will probably want to order labs. I told them I would let them know what [doctor] says. At 5:20 PM [Co-Owner B] texted me to say that [Licensee A] and [Manager E] were in the process of getting delegated to administer [Resident 1's] shot. At 6:25pm, [Co-Owner B] sent me the following text, "I have been in the wings, hearing the details in the last few hours. We should have had a better method of not letting this slip by. When someone knew this was not going to happen on the correct day, alarms and bells should have clanged until a way was found to give the injection. As many layers of "redundancy to remind" is welcome. 1.final layer could be you reminding myself (or a group text to [Licensee A], Manager, and myself) a day or few before. No that this would be the only reminder, just a layer to add to our ECP

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(electronic computer program) reminder, and our personal scheduling apps. These kind of things are so bad AND should be SO avoidable."
01/28/2024 - At 11:46am, [Co-Owner B] texts: "Good morning. Yesterdays med item was something we are still examining to create a more failsafe system. ... Also, last evening was short a caregiver for [provider] but all seemingly went ok as the home had 3 total caregivers in the 3 homes which allowed safety for all."

On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Surveyor asked if s/he had concerns regarding Resident 1 receiving [his/her] prescribed medications. If [Resident 1] had behaviors, it was probably due to [him/her] not receiving [his/her] meds. I had called [FM D] about [Resident 1's] meds, regarding shots. Meds were missed but then marked as refused."

On 02/29/2024, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home, 08/24/2023, with diagnoses including: bipolar disorder, diabetes, anemia, craniopharyngioma (brain tumor), adrenal insufficiency, and schizoaffective disorder.

Resident 1's October 2023 MAR documented: "Xyosted 75 MG (milligram) - Inject 0.5 ML (milliliter)/75 MG subcutaneously in the morning, once a week on Wednesday. Scheduled: PRN (as needed) on Wednesdays"
The medication was not documented as administered in October.
Communication documented that FM D administered this medication.
"Pantoprazole Sodium - Take 1 Tablet by mouth 2

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times a day. Scheduled at 8:00 AM and 8:00 PM"
Not administered 10/04/2023 and 10/05/2023 due to medication being unavailable.
"Risperidone - Take 1 tablet by mouth at bedtime."
Not administered 10/04/2023 and 10/05/2023 due to medication being unavailable.

Resident 1's November 2023 MAR documented:
"Xyosted 75 MG (milligram) - Inject 0.5 ML (milliliter)/75 MG subcutaneously in the morning, once a week on Wednesday. Scheduled: PRN on Wednesdays"
The medication was not documented as administered on 11/01/2023, 11/08/2023 and 11/15/2023.
Communication documented that FM D administered this medication but 11/15/2023 dose was administered late on 11/16/2023 due to non-availability.

Resident 1's December 2023 MAR documented:
"Xyosted 75 MG (milligram) - Inject 0.5 ML (milliliter)/75 MG subcutaneously in the morning, once a week on Wednesday. Scheduled: PRN on Wednesdays"
The medication was documented as administered on 12/06/2023.
"Xyosted 75 MG (milligram) - Inject 0.5 ML (milliliter)/75 MG subcutaneously in the morning every 14 days on Wednesday. Scheduled: PRN on Wednesdays"
The medication was documented as administered on 12/20/2023 and 12/27/2023.
Communication documented that Manager N had been delegated to administer this medication starting in December.
Desmopressin Acetate 0.1 MG - Take 1 tablet by mouth in the morning and take 2 tablets (0.2 MG) by mouth at bedtime. Start Date: 12/04/2023.

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Desmopressin Acetate 0.1 MG - Take 1 tablet by mouth 2 times a day (take with 0.1 MG) at bedtime to equal 0.2 MG total dose at bedtime. Start Date: 12/04/2023.
The 8:00 AM dose was documented as 2 tablets given on 12/05, 12/06, 12/07, 12/09, 12/10, 12/11, 12/12 and 12/13.
The 8:00 PM dose was documented as administered each day except 12/05 and 12/12 with no rationale.
Communication documented that the 12/05 dose had not been given.

Resident 1's January 2024 MAR documented: "Xyosted 75 MG (milligram) - Inject 0.5 ML (milliliter)/75 MG subcutaneously in the morning every 14 days on Wednesday. Start Date: 12/06/2023. Scheduled: 8:00 AM."
The medication was documented as administered 01/03/2024, 01/10/2024, 01/17/2024 (left blank), 01/24 (not administered - switched to Friday), 01/26/2024.
Communication documented that the medication was administered 01/27/2024, not 01/26/2024.

Surveyor noted that Manager E was documented as administering the Xyosted on 12/27/2023, 01/10/2024, and 01/25/2024 when s/he was not recorded as delegated until 01/26/2024.

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked if s/he had concerns regarding Resident 1 receiving [his/her] prescribed medications. Caregiver M stated, "Not everyone can pass meds. I would find [his/her] night meds not passed and then it would show up signed out in the MARs, but the blister packs were still in the med closet."

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M 462	Continued From page 107 On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Surveyor asked if s/he had concerns regarding Resident 1 receiving [his/her] prescribed medications. Manager N stated, "Individuals in [home] weren't giving meds the way they were supposed to, a lot of missed medications. [The home] (which is located in the lower portion of the building) would be forgotten because staff would be pulled from that home to help the staff in the other two homes. Medications were all over the place when I first started. They were making [FM D] take charge of [his/her] medications, [his/her] appointments. I became delegated to give [Resident 1's] shot so [FM D] didn't have to come out anymore. [Resident 1] missed doses of his/her shot because they didn't have someone to give it." On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if s/he had concerns regarding Resident 1 receiving [his/her] prescribed medications. Caregiver L stated, "I talk to FM D about [Resident 1's] meds. I didn't have issues with [Resident 1] taking [his/her] meds but when there were changes, it takes so long for the MAR to be updated, when a new PO (physician order) comes in, why do they not update the MAR immediately?" On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Surveyor asked if s/he had concerns regarding Resident 1 receiving [his/her] prescribed medications. Caregiver W stated, "I heard there were med errors because staff was documenting it in [software system that staff used to chat between each other.]"	M 462		

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M 462	Continued From page 108 On 03/06/2024, at approximately 5:00 PM Surveyor interviewed Resident 1. Surveyor asked if s/he had concerns regarding [his/her] prescribed medications. Resident 1 stated, "Oh yeah they would skip my meds. They would forget to pass meds in [home] or they would say [s/he] is sleeping, so they would mark that I refused my meds." On 03/08/2024, at approximately 10:50 AM, Surveyor interviewed Caregiver V. Surveyor asked if s/he had concerns regarding Resident 1 receiving [his/her] prescribed medications. Caregiver V stated, "I was the only person who could get [him/her] up and get [him/her] to take [his/her] meds. There were so many issues with [his/her] meds." On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Surveyor asked if s/he had concerns regarding Resident 1 receiving [his/her] prescribed medications. Caregiver G and Caregiver K stated, "Meds were missed on numerous times. They would just let [him/her] sleep so they let [him/her] miss meds but it would still be documented that the medications had been given." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F (Manager F). Surveyor asked for explanation on why Resident 1 was not receiving his/her medications as prescribed. Licensee A stated, "We need the MAR to show that medications are being given." AED F stated, "We have to follow the physician orders." Licensee A, Co-Owner B, Administration C, and AED F discussed what	M 462		

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M 462	Continued From page 109 practices should be followed to ensure medications are ordered timely and administered as prescribed. Cross Reference: M0218 DHS 88.04(2)(b) Awake Staff For Continuous Care	M 462		
M 480	88.08 TERMINATION OF PLACEMENT TERMINATION OF PLACEMENT. A licensee may terminate a resident's placement only after giving the resident, the resident's guardian, if any, the resident's service coordinator, the placing agency, if any and the designated representative, if any, 30 days written notice. The termination of a placement shall be consistent with the service agreement under s. HSS 88.06(2)(c)7. The 30 day notice is not required for an emergency termination necessary to prevent harm to the resident or the other household members. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident and resident's guardian were given a 30-day written notice of discharge. A 30-day written notice of involuntary discharge was issued to Resident 2, dated 02/26/2024. Findings include: On 02/29/2024, at approximately 1:35 PM, Surveyor interviewed Licensee A, Co-Owner B, Assistant Executive Director F, and Manager KK.	M 480		

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M 480	Continued From page 110 Co-Owner B was asking if the Surveyor felt that Resident 2 could be moved to one of [his/her] homes in the Milwaukee area. Co-Owner B stated s/he was still in shock that there were concerns regarding Resident 2's behaviors in [his/her] current home. Surveyor asked if Resident 2 had ever been violent towards staff that could have endangered a resident or acted inappropriately towards [fe/male] residents. Co-Owner B stated that the Surveyor had made [him/her] aware of these concerns as s/he did not realize these were concerns. Co-Owner B reiterated again that Resident 2 had not displayed behaviors since [his/her] first week of moving in but due to the concerns that the Surveyor brought forward, Resident 2, would be moved. Co-Owner B stated, "Now family members of other residents are upset that [Resident 2] will be leaving." Surveyor stated that, based on numerous interviews, [Resident 2] had displayed physical aggression on a consistent basis but the behaviors were not to be documented. Co-Owner B stated, "Thank you, we will move forward." On 02/29/2024 at 2:20 PM, Co-Owner B emailed Surveyor and stated: "After we ended our call, [Licensee A] and Managers quickly reminded that there WAS a violence confrontation with [Resident 2] and a few caregivers in the RECENT past, that was documented and investigated." On 03/01/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility, 06/07/2023, with diagnosis of cognitive impairment.	M 480		

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M 480	Continued From page 111 Resident 2's 2024 "Observation" notes documented: 01/07/2024 - [Resident 2] started kicking and punching writer. [Resident 2] got upset and started slamming the door. Another staff tried to [Resident 2] from blocking the writer but [s/he] still was able to hit the staff by punching and kicking. [S/he] then went into [adjoining home] and started unplugging the lights. 01/14/2024 - [Resident 2] walked up to [Resident 3] and tried to touch [his/her] private areas. [Resident 2] touched [Caregiver LL] private area. 02/01 2024 - [Resident 2] became really aggressive slamming doors and pulling on them. Resident 2's record contained a document that stated: "02/26/2024 ... Recently, during a State inspection, a [fe/male] resident informed officials that [Resident 2] was still (repeatedly) attempting AND even touching the [fe/male] resident's private upper area. This came as a surprise to myself and is what has triggered this notice to you. Because we do not allow violently or sexually aggressive people to reside in any [provider homes], we are giving this formal 30 day notice for [Resident 2] to vacate ... This 30 day notice is the start." The notice was emailed to Resident 2's managed care organization (MCO) Care Manager II but did not include Resident 2's Guardian JJ. On 03/02/2024, at approximately 11:00 AM, Surveyor interviewed Detective Y who had been investigating an allegation of abuse by Resident 2. Detective Y stated s/he had been in contact with Resident 2's family who informed [him/her] that Resident 2 had been given a 30-day notice and the family was going to move [him/her] out	M 480		

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M 480	Continued From page 112 immediately. On 03/02/2024, Surveyor requested Resident 2's 30-day discharge notice from Licensee A and Administration C. Administration C forwarded the following documentation: On 02/26/2024 at 5:33 PM, Co-Owner B emailed Resident 2's managed care organization (MCO) Care Manager (CM) II and stated: "[Resident 2] has been a resident at our [adult family home] for the past 8 months (06/07/2023). The first weeks with a new resident are always a time of discovery and getting to know how to best care for the resident. The descriptions of [his/her] care needs and [his/her] personal information from [his/her] previous (hospital) care team did not particularly note episodes of physical or sexual aggression. Our interviewing and investigation of [Resident 2's] background from family loved-ones did not reveal these items either. Over the months, [Resident 2] Has become a mostly polite and helpful resident. [S/He] is does have a language barrier but somehow, we have "largely" overcome that issue. One issue is [his/her] insistence on not sleeping in [his/her] bedroom. Shortly after [s/he] arrived, we did have incidents of inappropriate attempts to touch [fe/males] in the home. No such incident however became anything more than 1 failed attempt and would never repeat toward any [fe/male], once the [fe/male] turned-away [his/her] first attempt. [S/he] had a handful of violent incidents but we believe we had identified and were able to handle these rare incidents with a set protocol. Recently, during a State inspection, a [fe/male] resident informed officials that [Resident 2] was still (repeatedly) attempting AND even touching the [fe/male] resident's private upper area. This came as a surprise to myself and is what has triggered this notice to you.	M 480		

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M 480	Continued From page 113 Because we do not allow violently or sexually aggressive people to reside in any [provider home], we are giving this formal 30-day notice for [Resident 2] to vacate [provider home]. In addition, I and my team would like to have a meeting with you, as soon as it can be arranged. We are surely conflicted on why these sexual items have not been known to our attention before, but we would like to have a resolution or game plan as soon as possible. This 30 day notice is the start." On 03/07/2024 at 1:26 PM, Surveyor emailed Licensee A and Administration C stating the concerns identified in Resident 2's discharge paperwork and admission agreement. Administration C requested the Chapter 88 regulation language regarding what is required in a service agreement and conditions of transfer or discharge which Surveyor provided. Administration C stated s/he would forward the information to Licensee A and Co-Owner B. On 04/09/2024, Surveyor reviewed Resident 2's "Incident Reports" which documented: 01/16/2024 - Has been hitting and assaulting multiple residents starting around 6:30 AM and going through the next shift. [Manager E] witnessed some of it. [S/he] was extremely upset and getting item to use as weapons to hit residents. Was too violent with the entire third shift hitting and kicking us.	M 480		
M 548	88.10(3)(a) Fair Treatment Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality.	M 548		

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M 548	Continued From page 114 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were treated with courtesy, respect and full recognition of the resident's dignity and individuality. Resident 1 had water sprinkled in [his/her] face as a tool to wake [him/her] up. Findings include: On 02/21/2024, at approximately 4:30 PM, Surveyor interviewed Resident 1's Family Member (FM) D. FM D informed Surveyor that staff had been trained to sprinkle water into Resident 1's face to wake [him/her] up, because s/he is a heavy sleeper. FM D stated, "That seems cruel." On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Surveyor asked if staff ever sprinkled water on [his/her] face to wake [him/her] up. Caregiver J stated, "I was told to drop water drips onto [his/her] face to wake [him/her] up, because [s/he] hates water. There was an incident when [s/he] was sleeping in [the house upstairs], think it was in January, [Licensee A], [Manager E], [Caregiver I] and some staff I didn't know. We were short staff in [the upstairs home], so staff from [surveyed home] had to come up and help. [S/he] brought [Resident 1] with [her/him]. The staff is trying to wake [him/her] up and [s/he] is like I am just going to get water and sprinkle it on [him/her]. I quickly walked over to [him/her] I picked up [his/her] hand, was holding it, and talking to [him/her]. I had [him/her] up before the staff returned."	M 548		

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M 548	Continued From page 115 On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked if staff ever sprinkled water on [his/her] face to wake [him/her] up. Caregiver M stated, "I used to just call [his/her] name, shake [him/her] a little bit. [S/he] is difficult to wake up. Can try cracking [his/her] window. [S/he] hates the cold air." On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Surveyor asked if staff ever sprinkled water on [his/her] face to wake [him/her] up. Manager N stated, "I was told to sprinkle water in [his/her] face. I didn't like this method." On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if staff ever sprinkled water on [his/her] face to wake [him/her] up. Caregiver L stated, "People say you have to pour water on [him/her]. Why? You don't need to do that. [Licensee A] said sprinkle a little water on [his/her] face. Would you want water sprinkled on your face?" On 03/02/2024, at approximately 11:10 AM, Surveyor interviewed Caregiver U. Surveyor asked if staff ever sprinkled water on [his/her] face to wake [him/her] up. Caregiver U stated, "I tried different things to wake [him/her] up. Like tickling [his/her] feet, opening the window, pull [his/her] feet off the bed. I've never done it, but I heard other caregivers sprinkle water in [his/her] face." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Surveyor asked if staff ever sprinkled water on [his/her] face to wake [him/her] up. Caregiver W stated,	M 548		

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M 548	Continued From page 116 "When I first started, they told me to sprinkle water on [his/her] face. That is wrong! [Licensee A] and [Co-Owner B] told me to do that. I will not do that! I just keep talking to [him/her]." On 03/06/2024, at approximately 4:45 PM, Surveyor interviewed Resident 1. Surveyor asked if staff ever sprinkled water on [his/her] face to wake [him/her] up. Resident 1 stated, "Oh yes, they would sprinkle water in my face. I did not like that. I prefer if people tickle my toes or my nose, open a window. You can say my name, but I think it only helps a little bit." On 03/06/2024, at approximately 4:55 PM, Surveyor interviewed Resident 1's new provider, Provider CC. Surveyor asked how s/he had been waking Resident 1 up. Provider CC stated, "I explain what I am doing and tap on [his/her] arm lightly. I have no issues. (Surveyor observed [him/her] waking [him/her] up when s/he arrived so they could talk. Approximately ten minutes later s/he came out of [his/her] room to talk. S/he was fine.) Surveyor asked if s/he had concerns, during sleeping hours, with waking Resident 1 up. Provider CC stated, "Why would I be waking [him/her] up during sleeping hours." Surveyor stated concerns had been reported to [him/her] that s/he needed to be woken during sleep hours to toilet [him/her]/her, due to significant incontinence. Provider CC stated, "Since [Resident 1] has moved in, we have focused on [him/her] receiving all [his/her] medications and on time, as I had heard that was a previous concern. Also, [Resident 1] was fitted with proper fitting Depends. I am happy to say, [Resident 1] has woken up dry the last 3 days in a row, meaning, [his/her] incontinence stayed in the Depends and [Resident 1] did not require a complete bed change." Resident 1 added, "I like	M 548		

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M 548	Continued From page 117 not getting made to get up when I am sleeping." On 03/08/2024, at approximately 10:50 AM, Surveyor interviewed Caregiver V. Surveyor asked if staff ever sprinkled water on [his/her] face to wake [him/her] up. Caregiver V stated, "I placed a cold towel over [his/her] face. Tell [him/her] [his/her] eggs are ready." On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Surveyor asked if staff ever sprinkled water on [his/her] face to wake [him/her] up. Caregiver G and Caregiver K stated, "You just need to learn how to wake [him/her] up, like we are going to do Legos, let's get up!" On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Surveyor discussed the concern of staff sprinkling water in Resident 1's face to wake [him/her] up as that is the way they were trained. Licensee A stated, "No, they should not be doing that."	M 548		
M 552	88.10(3)(c) Confidentiality Confidentiality. To have his or her records kept confidential as described in s. HSS 88.09(1)(b). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that resident information was kept confidential. Findings include:	M 552		

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M 552	Continued From page 118 On 02/14/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver X. Caregiver X stated Co-Owner B "gossips too much." Caregiver X explained that Co-Owner B will talk to staff, residents, family members about other residents. On 02/14/2024, at approximately 2:25 PM, Surveyor interviewed Manager E. Manager E stated Co-Owner B was always in violation of HIPAA guidelines, daily. Manager E stated, "[Co-Owner B] discussed resident information with POA's (power of attorney) of other residents." Manager E stated there are no protocols in this home. On 02/21/2024, at approximately 4:30 PM, Surveyor interviewed Resident 1's POA D. POA D stated, "[Co-Owner B] is a gossiper. [S/He] talks about all of the residents to the visitors, myself included." On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "I was taking a resident to the bathroom and [Co-Owner B] was doing a tour of the facility with a potential resident and [s/he] was naming the residents and their diagnoses to these individuals. Had the attitude of 'we can take care of you, see all these diagnoses in our homes.'" On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated Co-Owner B and Licensee A would be breaking HIPAA and s/he would have to ask them to take their phone calls outside as they were discussing resident information in front of the resident in question and other residents.	M 552		

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M 552	Continued From page 119 Manager N stated s/he would be approached by family members and asked specific questions about a resident, who was not their "loved one." Manager N stated, "I would be told [Manager F] said 'whatever' and they wanted me to provide them additional information. On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Caregiver Z stated, "[Co-Owner B], [Licensee A], and [Manager F] would violate HIPAA, because family members would ask them about other residents, they would always answer. Family should not be entitled to other resident's info just because they played games with the person." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F (Manager F). Co-Owner B stated, "We have family members who speak among themselves, but can be loud about it." Licensee A stated, "Family will ask questions about other residents, and we have to remind them that they cannot share that information with them." Surveyor reminded them that the concerns were that management, including Licensee A and Co-Owner B, were violating HIPPA. Licensee A confirmed that staff and management need to be aware of their surroundings when discussing resident concerns.	M 552		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew,	M 556		

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M 556	Continued From page 120 rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the right to freedom of choice for 1 of 1 resident in the home. The provider placed Resident 1 on a fluid restriction without a physician order and was woken up every two hours throughout the sleep hours. Findings include: On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Surveyor asked if Resident 1 was on a water restriction and have they seen a physician order regarding it. Caregiver H stated, "I don't know anything about a physician order, but we were told that we were to limit the amount of fluid [Resident 1] could have. I know staff was supposedly to try and get [him/her] up throughout the night because [s/he] always woke up soaked through." On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Surveyor asked if Resident 1 was on a water restriction and have they seen a physician order regarding it. Caregiver I stated, "I was taught that [Resident 1] was on a fluid restriction. [S/he] was	M 556		

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to have nothing after 8:00 PM. Then it was changed to nothing after 7:00 PM. Then back to nothing after 8:00 PM. [Resident 1] was on a two-hour toileting routine, 24x7 (24 hours a day, 7 days a week)."

On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Surveyor asked if Resident 1 was on a water restriction and have they seen a physician order regarding it. Caregiver J stated, "Our instructions were every two hours during sleep hours try to toilet [him/her], otherwise [s/he] will wet [him/herself]. [Licensee A] was adamant about that. No drinking after 7:00 PM. I never asked [Resident 1] if [s/he] minded. Then [Resident 1's] [Family Member (FM) D] stated [Resident 1] wasn't on any restrictions."

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked if Resident 1 was on a water restriction and have they seen a physician order regarding it. Caregiver M stated, "[Resident 1] is difficult to wake up and we are supposed to wake [him/her] up every two hours because [s/he] is a heavy wetter. When [s/he] is awake we are to toilet [him/her] every hour."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Surveyor asked if Resident 1 was on a water restriction and have they seen a physician order regarding it. Manager N stated, "[Resident 1] will sleep through anything and staff are supposed to wake [him/her] up when [s/he] is sleeping. It is very difficult to do. I often wondered if [s/he] needed different medications to help with [his/her] incontinence or if other interventions could be put into place. With that said, [Resident 1] missed a

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lot of medications, due to staff errors, so maybe that played a roll in it." Manager N stated, "I never saw a physician order regarding fluid restrictions."

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if Resident 1 was on a water restriction and have they seen a physician order regarding it. Caregiver L stated, "If a physician order did come in, management is so slow at updating the medication administration record, so we probably wouldn't know."

On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. Surveyor asked if Resident 1 was on a water restriction and have they seen a physician order regarding it. Caregiver O stated, "[Resident 1] was not to drink after 7PM and [s/he] does not follow that; they let [him/her] drink as much as [s/he] wants then [s/he] will urinate on [him/herself]; during the night and during the day. [Resident 1] always smells like pee. Has a drinking problem with juice/water."

On 03/06/2024, at approximately 4:45 PM, Surveyor interviewed Provider CC and FM D together, where Resident 1 currently resides. Surveyor asked if Resident 1 was on a fluid restriction and if s/he had concerns waking him/her throughout the sleeping hours. Provider CC stated, "I do not wake [him/her] up every 2 hours. 'Gosh no!' I do not have [him/her] on fluid restrictions. I'm excited to tell you [FM D] that [Resident 1] has not awoken up in a soaked bed for the last 3 nights. We changed the size of [his/her] depends to a smaller size and added a pad to it. We also placed a urinal on the side of the bed in case [s/he] needed it during the

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evening, but [s/he] has not needed it lately. I believe this is due to [his/her] medications being administered timely; [his/her] medications are vital to maintaining the fluids in [his/her] body. FM D stated, "That is great! I knew if [s/he] received [his/her] medications correctly, [his/her] incontinence would not be such an issue."

On 03/08/2024, at approximately 10:50 AM, Surveyor interviewed Caregiver V. Surveyor asked if Resident 1 was on a water restriction and have they seen a physician order regarding it. Caregiver V stated, "They couldn't get [him/her] up in the evening, so [s/he] would be 'soaked soaked' when I got there in the morning. We would try to limit [his/her] fluid intake."

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Surveyor asked if Resident 1 was on a water restriction and have they seen a physician order regarding it. Caregiver Z stated, "Very hard person to wake up and [s/he] wouldn't get up to go to the bathroom, especially when [s/he] was sleeping."

On 04/09/2024, Surveyor reviewed a report that Licensee A had provided regarding an incident involving Resident 1 which documented:
"Date of report: 01/23/2024"
" ... [Resident 1] is a very heavy sleeper and [s/he] is often a challenge to be awoken up but [s/he] is required to be toileted every 2 to 3 hours to alleviate bed wetting."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Surveyor asked if Resident 1 had a physician order for a

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M 556	Continued From page 124 fluid restriction order. Licensee A stated, "No, [s/he] has a pitcher, [s/he] was allowed a pitcher of fluid a day." Surveyor stated Resident 1's individual service plan did not identify that [s/he] was on a fluid restriction. Licensee A stated, "oh." Surveyor asked if [Resident 1] wanted to be woken up during sleeping hours every two hours. Licensee A stated, "[Resident 1] was very difficult to wake, so [s/he] was not woken every two hours."	M 556		
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, 2 of 2 residents did not receive prompt and adequate treatment when experiencing a medical emergency. Resident 1 stated s/he felt like s/he was having a stroke and was no longer baseline and medical attention was delayed. Resident 3 experienced COPD (chronic obstructive pulmonary disease) exacerbation and adequate treatment was not recommended prior to emergency services arrived. Resident 3 complaint of leg pain for 3 days before s/he received medical assistance where it was determined that s/he had fractured [his/her] ankle. Findings include:	M 580		

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M 580	Continued From page 125 This provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, physically disabled, emotionally disturbed/mental illness, developmentally disabled and advanced aged. Example 1: Resident 1 On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Caregiver H stated, "I am not sure I am supposed to tell you this, probably get fired, but [Co-Owner B] doesn't want staff calling the ambulance when residents need to go to the hospital. We are to call [him/her] so [s/he] can take them. For instance, [Resident 1] told me [s/he] was feeling like [s/he] was having a stroke on 01/31/2024. [S/he] told first and second shift. Nobody did anything. I saw [him/her] on third shift. [S/he] did not look right. I called [his/her] [Family Member (FM) D] and [s/he] said [s/he] wanted [him/her] sent out. I said I need to call [Co-Owner B] to get permission. [FM D] was upset. [S/he] wanted to know why [Resident 1] wasn't sent out when [s/he] was first experiencing [his/her] concerns. [FM D] called the ambulance. [Co-Owner B] was mad. I keep thinking, [Resident 1] could have died. [S/he] never came back to the facility." On 02/21/2024, at approximately 4:30 PM, Surveyor interviewed FM D regarding 01/31/2024 incident. FM D stated, "I received a call around 2:30 AM that [Resident 1] was talking out of [his/her] mind, says [s/he] is having a seizure. [Caregiver H] called me and I wanted 911 called immediately. [Caregiver H] said [s/he] couldn't do it because [s/he] would get fired, only [Co-Owner B] can call the ambulance. I called the ambulance. While at the hospital, [Co-Owner B]	M 580		

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kept trying to call and text me. I was so upset; I would not respond. How could staff and/or [Co-Owner B] not recognize that [Resident 1] was in medical distress. [S/he] was not even close to baseline!"

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated [Co-Owner B] always determines if 911 should be called or if a resident needs to seek medical attention.

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated [Licensee A] and [Co-Owner B] will argue and waste time about if a resident should be sent out and who is taking them.

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Caregiver Z stated, "[Co-Owner B] would delay emergency services because it had to be [his/her] decision."

On 04/29/2024, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home, 08/24/2023, with diagnoses including: bipolar disorder, diabetes, anemia, craniopharyngioma (brain tumor), adrenal insufficiency, and schizoaffective disorder.

Resident 1's "Initial Assessment," dated 09/06/2023, documented:
"Mental Health - Requires staff assistance and encouragement maintaining positive/appropriate interactions with others."
"Verbal Skills - Has little to no verbal skills. Needs assistance in sounding out words or

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expressing self. Has a hard time speaking, staff needs to listen very closely."
(Surveyor interviewed Resident 1 on 03/06/2024 at 4:45 PM. Resident 1 understood and easily answered any questions related to [his/her] care.)

Resident 1's "Observation" notes, dated 01/01/2024 to 02/15/2024, did not document signs and symptoms Resident 1 stated s/he had experienced. Licensee A confirmed this on 02/14/2024 at 1:20 PM.

On 04/29/2024, Surveyor reviewed the sheriff department report regarding the 01/31/2024 incident:
"01/31/2024 2:29 AM [Resident 1] is currently upstairs in the main floor, in an altered mental state, having delusions, "don't know what [s/he's] trying to do" claiming [s/he] had a stroke, has schizo affective disorder, ... Caller doesn't know if [s/he] is attacking anyone, but [s/he] is angry because no one is believing [him/her] ... I arrived on scene and spoke with [FM D] via phone. ... [FM D] requested that [Resident 1] be transported to [hospital] where [s/he] will meet them and get [him/her] checked out."

Example 2: Resident 3 - COPD

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Surveyor asked if they had observed a resident receive delayed medical assistance based on guidance from Licensee A or Co-Owner B. Caregiver G stated, "Yes, there was a situation with [Resident 3]. I believe it was in October of last year. I started my shift and like I always do, I check on all my residents. I went to check on [Resident 3]. I knock on the door and [Resident 3] softly says come in. [S/he] looks

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gray, [Resident 3] looks at me, I immediately call 911. [Co-Owner B] was pissed that we called the rescue squad. [Manager F] said [Co-Owner B] told [him/her] that we should have gone and used [Resident 11's] oxygen to stabilize [Resident 3], since [Resident 11] was deceased and not using it. [Resident 3] has COPD and EMTs (emergency medical technician) immediately did a nebulizer treatment. EMTs would not let [Resident 3] walk, they put [him/her] in a wheelchair and carried [him/her] up the steps, because [s/he] was so weak." Caregiver G stated, "I am not losing my license because I am using someone else's oxygen on another person without a physician order." Caregiver K stated, "That was the last straw. We quit! If [Co-Owner B] couldn't 'fix it,' then [s/he] would throw the resident in the truck and take them to the hospital [him/herself]." Caregiver G stated, "I was also surprised that staff did not hear [Resident 3] struggling to breath, with [his/her] coughing."

On 04/09/2024, Surveyor reviewed Resident 3's record.

Resident 3 moved into the home, 06/06/2023, with diagnoses including COPD and memory loss.

Resident 3's "Observation" notes documented: 10/05/2023 - Resident had difficulty breathing this morning. Writer had [him/her] take a few puffs on rescue inhaler and did not help; Resident requested that [s/he] go to the hospital because [s/he] had a hard time breathing all night and was not getting better. Rescue was called and was immediately given a breathing treatment and taken to the hospital. The final diagnoses for the visit were COPD exacerbation. O2 (oxygen) level at the time the paramedics got [her/him] was only

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in the 60's."
Surveyor noted there were no documented signs/symptomss during previous shift.

On 04/09/2024, Surveyor reviewed the sheriff department report regarding the 10/05/2023 incident:
7:30 AM [Resident 3] was experiencing difficulty breathing and had a severe cough with a lot of phlegm.

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F (Manager F). Co-Owner B stated, "That didn't happen. I don't remember it. I would never think about doing that if it wasn't prescribed. I can believe saying 'wow that person looks like they need oxygen.' We have extra oxygen upstairs. We would still need to get an EMT or an order. We can't be giving people something just because we want to." Surveyor asked why there was a delay in Resident 3 receiving medical attention and there were no documented signs/symptoms prior to Caregiver G coming on shift. Surveyor did not receive a response.

Example 3: Resident 3 - Leg Injury

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Surveyor asked if they had observed a resident receive delayed medical assistance based on guidance from Licensee A or Co-Owner B. Caregiver W stated, "[Resident 3] was complaining about [his/her] leg or shin; [s/he] said [s/he] bumped it on something. Like a week ago. If you say anything to [Licensee A] or [Co-Owner B] they will just say [s/he] has dementia and doesn't

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understand time. So, I am going to [Co-Owner B] and [Licensee A] and saying this is day two of [Resident 3] complaining about [his/her] leg hurting. They don't want us to call 911. When [s/he] finally did receive medical attention, [s/he] came back wearing a boot. There is supposed to be an incident report. I made two comments about [his/her] leg hurting. Surveyor reviewed the progress notes with Caregiver W and stated there were no entries written by him/her. Caregiver W stated, "I don't understand that."

Resident 3's "Observations" documented:
"01/04/2024 12:30 AM written by Lead Caregiver P - [Resident 3] has been complaining of pain in [his/her] right leg."
"01/04/2024 6:45 AM written by Lead Caregiver P - Woke up around 4:40 AM ... stated that [s/he] thinks [his/her] leg is broken. [Resident 3] is requesting [s/he] go to urgent care to be checked out."
"01/05/2024 9:45 PM written by previous Caregiver I - Resident tried calling doctor to make an appointment for ankle, but unsuccessful."
"01/06/2024 2:00 PM written by Lead Caregiver P - [Resident 3] is currently still in pain from [his/her] ankle."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F (Manager F). Surveyor stated there are concerns that staff are stating they are documenting signs and symptoms that residents are experiencing which are not baseline, and they are not in the observation notes. Also, staff stated that medical treatment can be delayed due to discussion between Licensee A and Co-Owner B. Co-Owner B stated, "If a resident needs medical attention, I want to be contacted, so that I

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M 580	Continued From page 131 can go with them." Licensee A stated, "I don't know why the notes aren't there."	M 580		
Z 055	DHS 13.05 (3) (a) ENTITY ALLEGATION REPORTING REQUIREMENTS Entity's duty to report to the department. Except as provided under pars. (b) and (c), an entity shall report to the department any allegation of an act, omission or course of conduct described in this chapter as client abuse or neglect or misappropriation of client property committed by any person employed by or under contract with the entity if the person is under the control of the entity. The entity shall submit its report on a form provided by the department within 7 calendar days from the date the entity knew or should have known about the misconduct. The report shall contain whatever information the department requires. This Rule is not met as evidenced by: Based on record review and interview, the provider did not contact the licensing agency within 7 days when they had reasonable cause to suspect that a resident had been abused for 3 of 3 incidents. The licensee did not conduct a written investigation, as soon as possible, after being notified by staff and resident of alleged abuse and/or neglect and/or sustained injuries of unknown origin.	Z 055		

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Resident 1 alleged that s/he had sustained bruising due to caregiver misconduct.
Resident 3 stated s/he had been inappropriately touched by Resident 2.
Resident 4 had money misappropriated from [his/her] bedroom.

Findings Include:

Example 1: Resident 1

On 02/04/2024, the Department received a concern that a resident sustained bruising due to caregiver misconduct.

On 02/14/2024, at approximately 12:00 PM, Surveyor and Detective Y interviewed Licensee A and Co-Owner B. Surveyor asked if they were aware of the allegations of caregiver misconduct Regarding Resident 1 sustaining bruising during cares. Co-Owner B stated, "There is estrangement with [Resident 1's] family due to concerns with how [Resident 1] received unexplained bruising. I spoke with [Resident 1] and [s/he] stated the caregiver with the red dreadlocks hurt [him/her]. I assumed [s/he] meant [Caregiver U]. Then [Resident 1] changed [his/her] mind. I looked at the bruises to determine if they looked like fingerprints but [Resident 1] had been placed on blood thinners, so [s/he] bruised easily." Detective Y stated there were questions about trying to wake [Resident 1] up inappropriately, perhaps by pulling on [his/her] arms. Co-Owner B stated there were guidelines on how to wake Resident 1 up, s/he slept hard.

On 04/11/2024, Surveyor reviewed the Department's facility file and noted a written report had not been filed since licensure, 05/12/2020.

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Z 055	Continued From page 133 Example 2: Resident 3 On 02/04/2024, the Department received a concern that a resident had touched another resident inappropriately. On 02/14/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver X. Surveyor asked if Resident 2 had displayed inappropriate sexual behaviors. Caregiver X stated, "[Resident 2] will try to grope you, usually staff members. [S/he] acts out sexually. We report [Resident 2's] sexual actions to [Licensee A] and we are told not to worry about it. I have documented it in ECP (electronic software system)." Surveyor asked if s/he had observed Resident 3 be touched inappropriately by Resident 2. Caregiver X stated s/he had observed Resident 3 acting more aggressively towards Resident 2. Caregiver X stated that management had not provided any additional guidance when monitoring Resident 3 or Resident 2. On 02/14/2024, at approximately 10:10 AM, Detective Y and Surveyor interviewed Resident 3. Resident 3 stated s/he had been inappropriately touched by Resident 2 more than once. Resident 3 stated, "I was told by [Co-Owner B] if I slapped [Resident 2], that would be considered inappropriate behavior on my part. [Resident 2] walks up and touches my [private parts] and [s/he] pokes at them. This was done in the common area. [Resident 2] was watching TV and I was walking into the room and [s/he] got up and walked over and started touching me. I told [Co-Owner B] and [Co-Owner B] always says 'I will talk to [him/her].' Then [Resident 2] is taken out for lunch, like a reward, not a punishment." [Resident 3] stated [Resident 2] has touched	Z 055		

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other women in the building. Resident 3 stated, "I told [Co-Owner B] I wanted to call the police, but nothing was done. 'This is wrong!'. I told [Co-Owner B] either [Resident 2] moves out or I move out but why should I have to leave my home. [Co-Owner B] says we need to understand that [Resident 2] doesn't have a family. While Detective Y and Surveyor interviewed Resident 3, contact was made with [his/her] Power of Attorney MM. Detective Y assisted Resident 3 with filling out an official complaint/statement with the sheriff department. Prior to exiting the home, Detective Y informed Licensee A that Resident 3 had filed an official complaint/statement regarding Resident 2 touching [him/her] inappropriately.

On 02/14/2024, at approximately 11:20 PM, Surveyor interviewed Caregiver F. Surveyor asked if Resident 2 had displayed inappropriate sexual behaviors. Caregiver F stated, "Staff have said they have been touched inappropriately, no residents. This is not a good placement for [him/her]."

On 02/14/2024, at approximately 11:55 AM, Surveyor and Detective Y interviewed Co-Owner B. Surveyor and Detective Y discussed concerns that [Resident 3] had reported being inappropriately touched by Resident 2. [Co-Owner B] stated that "[Resident 3] has poor short-term memory. [S/he] never told [him/her]. No! No! No! No! No! [S/he] made all of this up. Just last week [s/he] was upset, crying, stating [Resident 1] died. [Resident 1] didn't die, [Resident 1] went to the hospital (Surveyor noted that [Resident 1's] family moved [him/her] out). [Co-Owner B] followed up with [Resident 1's] family which was difficult due to estrangement with the family caused by how medication was

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passed and unexplained bruising. Surveyor asked how the provider was ensuring Resident 3 was safe from Resident 2's inappropriate touching. Co-Owner B stated, "We don't take people who are violent or sexual. We were telling the family [s/he] may need to leave but we worked with [his/her] medications. We only had issues [his/her] first couple of weeks here. [His/her] behaviors quickly dissolved when the 'magic formula' was figured out with [his/her] meds. If [Resident 2] acts sexually inappropriate and that individual tells [him/her] No! [s/he] will stop and not do it again. I was not aware that [Resident 3] was upset about [Resident 2]." Surveyor asked if Resident 3 living with Resident 2 was appropriate. Co-Owner B stated, "If there is a problem we would have to determine if one of them needs to be moved." Detective Y asked if Resident 3 would have to move when s/he is the one that does not feel safe in [his/her] home. Co-Owner B did not have a response.

On 02/14/2024, at approximately 2:15 PM, Surveyor interviewed Caregiver LL. Surveyor asked if Resident 2 had displayed inappropriate sexual behaviors. Caregiver LL stated, "[Resident 2] touched [his/her] butts, same day [s/he] touched [Resident 3]. I called the cops. [Co-Owner B] did nothing about it." Surveyor reviewed the police report which reported that Co-Owner B put the blame for Resident 2's behaviors on Caregiver LL.

On 02/21/2024, at approximately 4:30 PM, Surveyor interviewed Resident 1's Family Member (FM) D. FM D stated, "[Co-Owner B] informed me when I was touring the place that I should watch out for [Resident 2], [s/he] will try to grab you in the [private areas]. I have seen [him/her] grab caregivers in the [private areas]."

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Z 055	Continued From page 136 On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Surveyor asked if Resident 2 had displayed inappropriate sexual behaviors towards any residents. Caregiver I stated, "[Resident 3] told me [Resident 2] tried grabbing [his/her] breasts. I didn't type it up because I wasn't the caregiver." On 02/24/2024 at approximately 5:15 PM, Surveyor interviewed Caregiver T. Surveyor asked if s/he had observed Resident 3 be inappropriately touched by Resident 2. Caregiver T stated, "[Resident 3] is adamant that [Resident 2] has acted inappropriately and doesn't want [Resident 2] near [him/her]. [S/he] gets nervous, upset, doesn't want to be alone with [him/her]." On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed Caregiver J. Surveyor asked if s/he had observed Resident 3 be inappropriately touched by Resident 2. Caregiver J stated, "[Resident 3] didn't like [Resident 2]. [S/he] can be 'very very' nice or 'very very' cruel. But [s/he] is not tolerant. [Resident 3] has consistently said the first time [s/he] met [Resident 2],[s/he] tried to touch [Resident 3]." On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 3's managed care organization (MCO) Care Manager (CM) S. Surveyor asked if s/he had been informed that Resident 3 had been inappropriately touched by Resident 2. CM S stated Resident 3 had informed him/her that s/he did not know "what to think of [Resident 2]." Surveyor asked if s/he was aware that Resident 3 had filed an official complaint/statement with the sheriff department. CM S stated, "I was not informed there was an	Z 055		

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incident of inappropriate touching by [Resident 2] until [his/her] guardian called me after they had been informed by the police. I did not hear from the provider." Surveyor stated that based on [his/her] interviews and documentation reviewed, this concern originally occurred back in 01/2024.

On 02/29/2024, at approximately 1:35 PM, Surveyor interviewed Licensee A, Co-Owner B, Assistant Executive Director F, and Manager KK. Co-Owner B explained to Surveyor that s/he was not aware of Resident 2's sexual behaviors until the Surveyor brought it to [his/her] attention. Co-Owner B stated that the Surveyor had made [him/her] aware of these concerns as s/he did not realize these were concerns."

On 02/29/2024 at 2:20 PM, Co-Owner B emailed Surveyor and stated:
"After we ended our call, [Licensee A] and Managers quickly reminded that there WAS a violence confrontation with [Resident 2] and a few caregivers in the RECENT past, that was documented and investigated. I stand corrected."

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Caregiver M stated Resident 3 wanted to live with the [girls/boys] upstairs.

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Surveyor asked if s/he had been informed that Resident 3 had been inappropriately touched by Resident 2. Manager N stated, "The day [Resident 2] tried to throw a lamp at me, I was trying to diffuse a situation between the two of them and I was trying to keep [Resident 2] from [Resident 3]." Manager N stated, "[Resident 3] is very with it and [s/he] will tell you everything.

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[S/he] knows what happens and [s/he] knows what is right and wrong."

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if Resident 2 had displayed inappropriate sexual behaviors towards residents. Caregiver L stated, "I saw [Resident 2] touch [Resident 3] and [Resident 10] but I wasn't sure if it would be considered sexual, but they just don't want [him/her] touching them. [S/he] touches staff inappropriately."

On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. Surveyor asked if s/he had been informed that Resident 3 had been inappropriately touched by Resident 2. Caregiver O stated, "[Resident 3] tells the truth when something happens. If [s/he] says it happened, it happened."

On 03/02/2024, Surveyor reviewed Resident 2's "Observation" notes which documented:
"01/14/2024 written by Caregiver LL - [Resident 2] touched [Caregiver LL] private area."
"02/5/2024 written by Caregiver PP - [Resident 2] was a bit touchy to the [wo/men] in [upstairs home], staff and other residents. [S/he] didn't' mean any harm but was a bit [wo/mannish]."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director F. Co-Owner B and Licensee A discussed with Surveyor when internal investigations needs to be completed.

On 04/11/2024, Surveyor reviewed the Department's facility file and noted a written report had not been filed since licensure,

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Z 055	Continued From page 139 05/12/2020. Example 3: Resident 4 On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Caregiver G stated that while they were on vacation, Resident 4 had $900 stolen out of [his/her] room. Caregiver G and Caregiver K stated an internal investigation had not been completed. Caregiver G stated, "I was informed by [Licensee A] and [Co-Owner B] that if I had concerns with it, then I would need to make contact with the police department which is what I did." On 04/10/2024, Surveyor requested and reviewed Resident 4's sheriff department incident report, dated 07/01/2023, which documented: "The victim of this theft was [Resident 4]. ... [S/he] had $900 taken from [his/her] wallet that was sitting on a nightstand in [his/her] room. This occurred sometime in June between noon on the 23rd to 9:00 PM on the 25th. I met with [him/her] in the living room in the lower level, just outside [his/her] room. [S/he] said that the case consisted of mostly $50 bills. ... [S/he] reported the missing money to [Caregiver NN]." On 04/11/2024, Surveyor reviewed the Department's facility file and noted a written report had not been filed since licensure, 05/12/2020. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director F (Caregiver F). Licensee A and Co-Owner B stated through this survey process they have a better understanding	Z 055		

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Z 055	Continued From page 140 of when a written report should be sent to the Department. Cross Reference M0450 DHS 88.07(2)(b)6. Notification of Changes	Z 055		