STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019699	A. BUILDING: _____ B. WING _____	C 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVIE ADULT FAMILY HOMES LLC	517A FOXMEAD XING WATERFORD, WI 53185

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	INITIAL COMMENTS On 02/21/2025, Surveyor completed a complaint investigation at Navie Adult Family Homes LLC. As a result, 2 deficiencies were identified. One complaint was substantiated. Census: 4	M 000		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on observation, interview, and record review the provider did not ensure 1 of 1 resident (Resident 1) received the required supervision. Resident 1 required one-on-one (1:1) staffing 16 hours per day and did not have a dedicated 1:1 staff member after 11/19/2024. Findings include: On 02/11/2025, at 9:23 AM, Surveyor entered the adult family home (AFH) for a survey. Resident 2 answered the door and let Surveyor inside. Resident 1, Resident 2, Resident 3, and Resident 4 were all present throughout the survey. Caregiver C was the only staff present during the survey. At approximately 9:25 AM, Caregiver C called Owner B and requested s/he respond to the AFH. At 10:14 AM, Owner B arrived at the home.	M 436		

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

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M 436	Continued From page 1 On 02/11/2025, at 9:34 AM, Surveyor interviewed Caregiver C and the following was reported: S/He was the only staff working with all 4 residents. On 01/14/2025, Caregiver C was the only staff working at the AFH. Resident 1 became suicidal at approximately 10:30 AM. Resident 1 ran off onto the balcony and tied a shoestring around her/his neck. Resident 1 has anxiety and aggression and was triggered by issues with her/his family. Resident 1 requested to have 1:1 staffing but did not have 1:1 staffing provided. All shifts at the AFH were staffed with 1 caregiver for all 4 residents. On 02/11/2025, at 9:42 AM, Surveyor interviewed Resident 1. Resident 1 reported the following: On 01/14/2025, Resident 1 felt suicidal due to the loss of a family member. Resident 1 previously had a 1:1 staff, but due to sleeping during her/his shifts, s/he was terminated. Since the termination, s/he had not been replaced. Due to Resident 1's history of self-harm, Licensee A suggested 1:1 staffing. On 02/11/2025, at 10:14 AM, Surveyor interviewed Owner B. Owner B reported the following: On 01/14/2025, Resident 1 walked out the front door of the AFH and around to the back porch. S/He walked further down the street with a shoestring tied around her/his neck. Staff briefly followed Resident 1 but came back to the AFH to stay with the other residents in the home. Resident 1 circled back to the AFH and was outside by the back balcony. Resident 1 previously had 1:1 staffing, but they had been	M 436		

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M 436	Continued From page 2	M 436		

terminated. On 01/14/2025, Caregiver C was the only staff working at the AFH. Licensee A had been working on hiring a new 1:1 staff for Resident 1 but had been unable to find someone. Resident 1 was told to text Licensee A if s/he had a problem. Licensee A and Owner B came to the AFH throughout the week to check on Resident 1.

On 02/11/2025, at 1:34 PM, Surveyor interviewed Case Manager (CM) E and s/he reported the following:

Resident 1 explained the crisis s/he had on 01/14/2025 to CM E. S/He reported s/he self-harmed and called the police. CM E stated, "I know [s/he] is supposed to have a one-on-one." CM E reported s/he assumed the AFH was following their contract with the 1:1 staffing.

On 02/11/2025 - 02/21/2025, Surveyor reviewed Resident 1's records. The following was identified:

- Resident 1 was admitted to the AFH on 09/13/2024, with diagnoses of schizoaffective disorder, bipolar type, depression, anxiety disorder, post-traumatic stress disorder, conversion disorder with seizures or convulsions, unspecified intellectual disabilities, autistic disorder, suicidal ideations, and suicide attempt.

- Resident 1's Family Care Placement Summary, which was an attachment to her/his behavior support plan (BSP) stated, "Level of supervision required - dedicated 1:1 staff."

- Resident 1's Individual Service Plan (ISP) stated, " . . . Requires supervision and monitoring to help manage/redirect self-abusive behavior . . . Requires supervision and monitoring to help

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M 436	Continued From page 3	M 436		

prevent and re-direct suicidal thoughts and behaviors . . . "

- Resident 1's Member Centered Plan from Community Care stated, " . . . Intervention 1: Residential care; Provider: Navie Adult Family Home; Amount Authorized: 1 unit per day and 1:1 supervision 16 hours per day; Intervention Start Date: 11/01/2024; Intervention End Date: 04/30/2025 . . . "

On 02/12/2025, Surveyor interviewed Licensee A and the following was reported. Caregiver D was hired as an as needed (PRN) caregiver and worked at the AFH from 07/30/2024 - 11/19/2024. Caregiver D became Resident 1's 1:1 staff upon Resident 1's admission to the home, on 09/13/2024. Caregiver D was terminated on 11/19/2024 due to Resident 1's dissatisfaction with her/him. On 11/19/2024, Licensee A posted the 1:1 staffing position on Job Center of Wisconsin. No applications were received and the job posting expired on 12/19/2024. The job was reposted on a different platform and Licensee A asked other staff for any referrals they may have had. On Tuesdays, Wednesdays, Fridays, and Saturdays Licensee A filled in as Resident 1's 1:1, as well as every 3rd Monday. Owner B occasionally filled in as well, but Resident 1 did not want a fe/male staff. On 01/10/2025, Licensee A was sick and continued to be out sick through 01/14/2025. Licensee A was not Resident 1's 1:1 staff on 01/14/2025. Owner B was present on the morning of 01/14/2025 but Resident 1 did not attempt to speak with her/him and was not made aware of any issues with Resident 1.

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M 550	Continued From page 4	M 550		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses contraband. The resident shall be present for the search. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each resident had physical privacy in living arrangements for 4 of 4 residents residing in the home (Resident 1, Resident 2, Resident 3, and Resident 4). There was an electronic video monitoring camera mounted on the back balcony. Findings include: On 02/11/2025, at approximately 10:14 AM, Surveyor observed a camera mounted on the siding on the home next to the back balcony door. The camera was facing the balcony. The camera recorded audio and video. Surveyor observed Resident 1 go out onto the balcony to smoke and/or use her/his phone at least 2 times throughout the survey. On 02/11/2025, at 10:15 AM, Surveyor	M 550		

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M 550	Continued From page 5 interviewed Owner B. Owner B explained an incident which occurred on 01/14/2025, when Resident 1 eloped and s/he was seen on camera walking out the front door and around to the backyard. Owner B had an application (app) on her/his cellphone which allowed her/him to view the front door and balcony cameras. The cameras provided a live feed and Owner B could view the live feed anytime on her/his cellphone through the app. Owner B reported the camera mounted facing the balcony covered views of the entire balcony and a large amount of the backyard. S/He confirmed residents used the balcony to smoke, visit, and talk on their phones. Owner B was unaware the camera recording audio and video facing the balcony was a violation of the residents' privacy.	M 550		