| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| M 000 | INITIAL COMMENTS<br><br>On 01/22/2025, Surveyor completed a standard survey and complaint investigation at Nurturing Hands Adult Living Home. As a result, 13 deficiencies were identified. One complaint was substantiated.<br><br>Census: 1 | M 000 | | |
| M 232 | 88.04(2)(g)1 HEALTH SCREENING FOR STAFF<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 3 of 3 caregivers (Caregiver C, Caregiver D, and Caregiver F) were screened for communicable diseases, including tuberculosis (TB), within 90 days before the start of providing cares. Caregiver C, Caregiver D, and Caregiver F were not screened for communicable diseases before providing cares.<br><br>Findings include:<br><br>On 01/15/2025, at 11:20 AM, Administrator B | M 232 | | |

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

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| M 232 | Continued From page 1 | M 232 | | |

provided Surveyor with a staff roster. The staff roster indicated Caregiver C was hired on 08/01/2023, Caregiver D was hired on 09/01/2023 and Caregiver F was hired on 08/01/2023.

Surveyor reviewed employee records and identified the following:

Caregiver C was hired on 08/01/2023. Caregiver C was screened for TB on 01/11/2023. Caregiver C's record did not evidence Caregiver C was screened for communicable diseases.

Caregiver D was hired on 09/01/2023. Caregiver D was screened for TB on 09/07/2022. Caregiver D's record contained a communicable disease screening questionnaire, dated 09/07/2022. The questionnaire did not contain a signature from a registered nurse, physician, or a physician assistant on her/his communicable disease screening. Caregiver D's record did not evidence Caregiver D was screened for communicable diseases.

Caregiver F was hired on 08/01/2023. Caregiver F was screened for TB on 07/17/2023. Caregiver F's record contained a communicable disease screening questionnaire, dated 04/29/2022. The questionnaire did not contain a signature from a registered nurse, physician, or a physician assistant on her/his communicable disease screening. Caregiver F's record did not evidence Caregiver F was screened for communicable diseases.

On 01/15/2025, at 12:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he was unaware the communicable disease forms were not signed.

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| M 240 | 88.04(4)(a) INSURANCE-VEHICLE<br><br>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 licensing agency.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not ensure every service provider transporting residents under the direction of the licensee had a valid driver's license. Caregiver E's record did not include evidence of a valid driver's license.<br><br>Findings include:<br><br>On 12/30/2024, the department received a complaint alleging concerns about caregiver's not having valid licenses.<br><br>On 01/15/2024, at 12:15 PM, Surveyor interviewed Licensee A. Licensee A reported Caregiver E was a driver. Licensee A reported Caregiver E had a license in her/his file, but the file was at another house. Licensee A reported s/he would send it to Surveyor. | M 240 | | |

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| M 240 | Continued From page 3<br><br>On 01/16/2025, at 8:55 AM, Surveyor received a scanned document from Licensee A. Caregiver E was issued a probationary driver license on 12/22/2021. The driver license expired on 10/06/2024. Surveyor did not review any documentation which indicated Caregiver E had a valid driver license. | M 240 | | |
| M 244 | 88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 3 staff received 15 hours of training related to health, safety and welfare, resident rights, first aid and fire safety, and treatment appropriate to residents prior to or within 6 months of starting to provide cares. Caregiver C did not receive any training related to health, safety and welfare, resident rights, first aid and fire safety, and treatment appropriate to residents. Caregiver F did not receive resident rights training or first aid training.<br><br>Findings include: | M 244 | | |

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| M 244 | Continued From page 4<br><br>On 01/15/2025, at 11:25 AM Surveyor reviewed employee records and identified the following:<br><br>Caregiver C was hired on 08/01/2023. Caregiver C's record did not contain any evidence of training in health, safety and welfare, resident rights, first aid and fire safety, and treatment appropriate to residents.<br><br>Caregiver F was hired on 08/01/2023. Caregiver F received standard precautions training on 10/18/2019, fire safety training on 10/14/2019 and medication administration training on 09/19/2019. Caregiver F's record did not contain evidence of training in resident rights or first aid training.<br><br>On 01/15/2025, at 12:15 PM, Surveyor interviewed Licensee A and Administrator B. Licensee A and Administrator B confirmed staff required 15 hours of training. Licensee A reported all staff were required to take the CBRF training. Licensee A and Administrator B reported they have staff sign policies regarding the other topics. When Surveyor inquired about Caregiver C not having any training, Licensee A reported Caregiver C was scheduled to take the training this month. Licensee A confirmed with Surveyor Caregiver C had not received any training in the required topics since her/his start date. | M 244 | | |
| M 246 | 88.04(5)(b) TRAINING-8 HOURS ANNUALLY<br><br>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 | M 246 | | |

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| M 246 | Continued From page 5<br>residents every year beginning with the calendar year after the year in which the initial training is received.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure each service provider received annual training for 3 of 3 caregivers. Caregiver C, Caregiver D, and Caregiver F did not receive annual training in 2022 and 2023.<br><br>Findings include:<br><br>On 01/15/2025, at 11:25 AM Surveyor reviewed employee records and identified the following:<br><br>Caregiver C was hired on 08/01/2023. Caregiver C's record did not contain any evidence of annual training in 2024.<br><br>Caregiver D was hired on 09/01/2023. Caregiver D's record did not contain any evidence of annual training in 2024.<br><br>Caregiver F was hired on 08/01/2023. Caregiver F's record did not contain any evidence of annual training in 2024.<br><br>On 01/15/2024, at 12:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed staff were required to have 8 hours of annual training. Licensee A reported they hire an outside agency to conduct the trainings. Licensee A reported s/he was unsure of why the trainings were not completed. | M 246 | | |

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| M 276 | Continued From page 6 | M 276 | | |
| M 276 | 88.05(3)(a) HOME ENVIRONMENT<br><br>An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure the home was well-maintained, clean, and a homelike environment for 1 of 1 resident. The walls contained holes, the windows did not contain window coverings and had plexiglass covering them, and the stove was missing 2 burners.<br><br>Findings include:<br><br>On 01/15/2025, at 9:40 AM, Surveyor toured the home and observed the following:<br><br>- Resident 1's bedroom contained numerous holes in the walls, 1 hole on the southeastern wall in Resident 1's bedroom measured 9 inches by 12 inches. The second hole on the southeastern wall measured 2 inches by 5 inches. Surveyor observed areas in Resident 1's room which had sections of plywood covering the walls. Two windows in Resident 1's bedroom was covered by plexiglass. The windows did not contain any window coverings for privacy.<br><br>- An empty bedroom, which contained a large lounge type of chair, had 2 windows which were covered with plexiglass and did not contain window coverings for privacy. | M 276 | | |

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| M 276 | Continued From page 7<br><br>- The bathroom contained a window in the shower area. The window was covered in plexiglass and did not contain a window covering for privacy. The bathroom did not contain hand soap for handwashing.<br><br>- The living room windows had plexiglass on the windows. The cold air return in the living room was covered in a thick, greyish matter, similar to dust. The cold air return contained an indentation in the center, which caused the edges to not be secured to the wall. The baseboards were covered in a thick, greyish matter, similar to dust.<br><br>- The kitchen stove only contained two burners. The 2 back burners were missing.<br><br>On 01/22/2025, at 9:30 AM, Surveyor interviewed Licensee A. Licensee A reported when a hole occurs in the wall, maintenance will repair the hole with drywall. When Surveyor inquired about the pieces of plywood on the walls, Licensee A reported Resident 1's managed care organization made them put the ply wall on the walls to make it safer for Resident 1. When Surveyor inquired how the areas of plywood made it safer for Resident 1, Licensee A was unable to provide an explanation.<br><br>Cross Reference: N0298 DHS 88.05(3)(g) Windows and Ventilation | M 276 | | |
| M 298 | 88.05(3)(g) WINDOWS AND VENTILATION<br><br>The home shall have ventilation for health and comfort. There shall be at least one window which is capable of being opened to the outside in each | M 298 | | |

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| M 298 | Continued From page 8 | M 298 | | |

resident sleeping room and each common room used by residents. Windows used for ventilation shall be screened during appropriate seasons of the year.

This Rule is not met as evidenced by:
88.05(3)(g) Windows and Ventilation

Based on observation and interview, the provider did not ensure at least one window was capable of being opened to the outside in 4 of 4 required locations. The windows in Resident 1's bedroom, a spare room for Resident 1, the living room and kitchen were covered in sheets of plexiglass.

Findings include:

On 01/15/2025, at 9:45 AM, Surveyor toured the facility and observed the following:

- Resident 1's bedroom had 2 double-hung windows. On both windows in Resident 1's bedroom, screwed into the sash, of the top window and bottom window were sheets of hard, clear plastic, similar to plexiglass. When Surveyor attempted to open the bottom window, the plastic which was screwed into the top window, would not allow the window to be opened.

- The bathroom had a window, in the shower. The window contained hard, clear plastic, similar to plexiglass, screwed into the sash of the windows.

- The living room had 2 windows, 1 was a picture window, and the other window was a double-hung window. The double hung window, located on the southwestern wall, contained hard, clear plastic, similar to plexiglass, screwed into the sash of the windows.

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| M 298 | Continued From page 9<br><br>- The kitchen had 2 double-hung windows, one on the southwestern wall, the other on the southern wall. Both windows contained hard, clear plastic, similar to plexiglass, screwed into the sash of the windows.<br><br>On 01/15/2025, at 10:30 AM, Surveyor interviewed Licensee A. Licensee A reported Resident 1's team required the windows to be covered before Resident 1 could be admitted. Licensee A reported s/he was unaware of the code.<br><br>Cross Reference: N0276 DHS 88.05(3)(a) Home Environment | M 298 | | |
| M 336 | 88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE<br><br>The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure the facility's smoke detectors were tested monthly for 4 of 4 smoke detectors. There was no evidence the smoke detectors were tested in July through December in 2023, and for the entire year of 2024. | M 336 | | |

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| M 336 | Continued From page 10<br>Findings include:<br><br>On 01/15/2025, at, 11:40 AM, Surveyor reviewed the facility safety files. There was no evidence of smoke detector testing for July, August, September, October, November, and December of 2023. There was no evidence of smoke detector testing in 2024.<br><br>On 01/15/2025, at 12:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed s/he was aware of the code requirement to test smoke detectors monthly. Licensee A staff were responsible for ensuring monthly smoke detector test were completed. Licensee A was unsure why the smoke detector testing was incomplete. | M 336 | | |
| M 338 | 88.05(4)(c)1 EXITING FROM THE FIRST FLOOR<br><br>Exiting from the first floor. The first floor of the home shall have at least 2 means of exiting which provides unobstructed access to the outside.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the provider did not ensure the home had at least 2 means of exiting which provided unobstructed access to the outside for 1 of 2 exits. The rear emergency step was covered in ice.<br><br>Findings include:<br><br>On 01/15/2025, at 9:40 AM, Surveyor toured the facility. Surveyor observed the rear exit. From the | M 338 | | |

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| M 338 | Continued From page 11<br>rear exit, there was a step down to a concrete step, and another step to a walkway. The concrete step was covered in a thick layer of ice. Surveyor was unable to step down without stepping on the ice.<br><br>On 01/15/2025, at 9:55 AM, Surveyor reviewed a floor plan of the facility. The floor plan identified the rear exit as an emergency exit.<br><br>On 01/15/2025, at 12:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported staff were to be ensuring the exits were cleared of ice and snow. Licensee A reported s/he would ensure the ice was cleared from the step right away. | M 338 | | |
| M 346 | 88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION<br><br>Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not complete an annual evacuation assessment review for 1 of 1 resident (Resident 1) who lived in the facility beyond one year. Resident 1 did not have an evacuation assessment completed in 2023 and 2024.<br><br>Findings include: | M 346 | | |

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| M 346 | Continued From page 12<br><br>On 01/15/2025, at 10:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/04/2022 with diagnoses including intellectual disability and intermittent explosive disorder. Resident 1's record contained a Resident Evacuation Assessment, dated 09/04/2022. Resident 1's record did not contain a completed or updated evacuation evaluation in 2023 and 2024.<br><br>On 01/15/2025, at 12:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he thought they were completed annually. Licensee A looked in Resident 1's file and was unable to locate the evaluations. Licensee A reported s/he was unable to find the evaluations for 2023 and 2024. | M 346 | | |
| M 348 | 88.05(4)(d)2.c SEMI-ANNUAL FIRE DRILLS<br><br>The licensee shall conduct semi-annual fire drills with all household members with written documentation of the date and the evacuation time for each drill maintained by the home.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure the semi-annual fire drills documented the date and the evacuation time for each drill for 3 of 3 years. There was no documentation of fire drill being conducted in 2022, 2023 and 2024.<br><br>On 01/15/2025, at, 11:40 AM, Surveyor reviewed the facility safety files. There was no evidence of fire drill being conducted in 2022, 2023 and 2024. | M 348 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019058 | A. BUILDING: _____ B. WING _____ | C 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NURTURING HANDS ADULT LIVING HOME LL( | 2224 JEROME BLVD MOUNT PLEASANT, WI 53403 |

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| M 348 | Continued From page 13<br>On 01/15/2025, at 12:15 PM, Surveyor interviewed Licensee A. Licensee A reported staff complete fire drills. Licensee A reported s/he was unaware all fire drills needed to have written documentation of the date and time of the fire drills. | M 348 | | |
| M 384 | 88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE<br><br>An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any.<br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure an admission agreement was completed, dated, and signed by each resident, guardian or designated representative, and licensee, prior to admission for 1 of 1 resident. Resident 1 did not have a service agreement with the provider.<br><br>Findings include:<br><br>On 01/15/2025, at 10:30 AM, Surveyors reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/04/2022 with diagnoses including intellectual disability and intermittent | M 384 | | |

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| M 384 | Continued From page 14<br>explosive disorder. Resident 1 had a guardian. Resident 1's file contained an admission agreement signed by Resident 1 and Licensee A. Resident 1's admission agreement was not signed by Resident 1's guardian. Resident 1's file did not contain any evidence of a signed agreement between the licensee and Resident 1's guardian.<br><br>On 01/15/2025, at 12:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed s/he was aware of the requirement. Licensee A reported s/he was unsure why Resident 1's guardian did not sign the agreement. Licensee A reported there was a lot going on when Resident 1 was admitted. Licensee A did not elaborate. | M 384 | | |
| M 410 | 88.06(3)(d) INDIVIDUAL SERVICE PLAN<br><br>The individual service plan shall contain at least the following:<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review, the provider did not ensure 1 of 1 resident's (Resident 1's) individual service plan (ISP) contained all required information. Resident 1's ISP did not identify Resident 1's behaviors or interventions required.<br><br>Findings include:<br><br>On 01/15/2025, at 9:40 AM, Surveyor toured the home. Surveyor observed Resident 1's bedroom. | M 410 | | |

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| M 410 | Continued From page 15<br><br>Surveyor observed numerous holes in the walls, 1 hole on the southeastern wall in Resident 1's bedroom measured 9 inches by 12 inches. The second hole on the southeastern wall measured 2 inches by 5 inches. Surveyor observed areas in Resident 1's room which had sections of plywood covering the walls. Surveyor observed all windows in the facility to be covered by a plexiglass. The windows did not contain any window coverings for privacy. Surveyor observed Resident 1. Resident 1 showed Surveyor her/his elbow. Resident 1 had a healing cut on her/his left elbow. Resident 1's hands had red marks on her/his hands near her/his thumbs. Surveyor observed Resident 1 use her/his foot to back kick the cabinets in the kitchen and drop to the ground while yelling during the survey.<br><br>Interviews<br><br>On 01/15/2025, at 9:55 AM, Surveyor interviewed Caregiver F. Caregiver F reported Resident 1 had physical aggression which included physical aggressions, property damage and self-injurious behaviors. Caregiver F reported Resident 1 had physical aggressions with staff and peers, which was why Resident 1 resided in the home alone. Caregiver F reported Resident 1 used her/his foot to kick holes in the walls, would use her/his elbow to hit walls, or break windows, which is why the windows were covered in plexiglass. Caregiver F confirmed the plywood on the walls were covering previous holes caused from Resident 1's behaviors. Caregiver F reported Resident 1 would bite her/his hands when upset. Caregiver F reported Resident 1 liked Mickey Mouse and Elvis, which is why there were Elvis pictures on the wall, because Resident 1 would not destroy the walls if Elvis was on the walls. Caregiver F reported the house was going to be redecorated | M 410 | | |

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| M 410 | Continued From page 16 | M 410 | | |

with Elvis and Mickey Mouse to assist with Resident 1's property damage behaviors. Caregiver F reported Resident 1 also enjoyed watching television.

On 01/22/2025, at 9:30 AM, Surveyor interviewed Licensee A. Licensee A reported s/he did not know s/he had to put resident specific information into resident ISPs. Licensee A did not offer any further information.

Record Review

On 01/15/2025, at 10:30 AM, Surveyors reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/04/2022 with diagnoses including intellectual disability and intermittent explosive disorder. Surveyor reviewed an admission note from Winnebago Mental Health Institute (WMHI), dated 05/11/2022. The note indicated Resident 1's behaviors had been escalating prior to her/his admission to WMHI. A few weeks prior to WMHI admission, Resident 1 threw a chair at a staff member, which caused the staff member to sustain broken ribs. On 05/10/2022, Resident 1 punched a staff in the face, causing a black eye, then broke a fish tank and was chasing staff members with a piece of broken glass. Resident 1's ISP, dated 09/20/2024, indicated, "The patient exhibits combative behaviors, which can pose risks to themselves, staff, and others. Combative behaviors may include physical aggression, verbal aggression, or other challenging behaviors throwing objects. Mood will not escalate to combativeness. Administer [as needed] medications if interventions are ineffective." Resident 1's ISP did not identify what interventions were in place prior to using medications.

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| M 420 | 88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT<br><br>A statement of agreement with the plan, dated and signed by all persons involved in developing the plan.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure a statement of agreement with the Individual Service Plan (ISP) was dated and signed by all persons involved in developing the plan for 1 of 1 resident (Resident 1).<br><br>Findings include:<br><br>On 01/15/2025, at 10:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/04/2022 with diagnoses including intellectual disability and intermittent explosive disorder. Resident 1 had a guardian. The ISP in Resident 1's file was dated 10/22/2023. The ISP was not signed. There was no other ISPs located in Resident 1's file.<br><br>On 01/16/2025, at 8:57 AM, Licensee A sent Surveyor all ISP reviews for Resident 1. The document, which contained all ISP reviews, dated 09/17/2022, 03/18/2023, 09/19/2023, 03/20/2024, and 09/20/2024, did not contain signatures indicating agreement with the plan for Resident 1.<br><br>On 01/15/2025, at 12:15 PM, Surveyor interviewed Licensee A. Licensee A reported they review the ISPs every 6 months with the managed care organizations. Licensee A and Co-Licensee B reported they were not aware the ISPs needed to be signed by all parties until a | M 420 | | |

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| M 420 | Continued From page 18<br>previous survey. Licensee A reported s/he was working on getting the ISPs signed. | M 420 | | |