STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019039	A. BUILDING: _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISION HOME	2020 ELINOR LANE HOLMEN, WI 54636

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M 000	INITIAL COMMENTS On 07/24/2024, Surveyor conducted a complaint investigation at Vision Home. Data collection continued through 08/06/2024. The complaint was substantiated. Three deficiencies were identified. Census: 2	M 000		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 had a signed service agreement prior to admission. Findings include: On 07/24/2024, Surveyor reviewed Resident 1's records. Resident 1 was admitted on 01/03/2024 and discharged on 06/11/2024.	M 384		

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

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M 384	Continued From page 1 On 07/31/2024 at 3:55 PM, Surveyor received an email from Operations Manager (OM) C. When asked to provide Resident 1's service agreement, OM C stated they completed a service agreement with Resident 1's long term care agency. When asked to provide a copy of that agreement, OM C stated in the email, "Per [Licensee A], There is an authorization put in for us to bill off of and the service authorization for the month is the agreement. We do not have a copy of it." At 4:00 PM, Surveyor interviewed Long Term Care Agent (LTCA) D. When asked about any service agreements between the long term care agency and the provider, LTCA D stated the only thing being funded by the long term care agency was Resident 1's room rate. LTCA D stated they utilized a substitute care tool which was more of a financial requirement given by the provider. The provider went through what they needed in terms of funding to maintain the home and meet Resident 1's needs. LTCA D stated there was not a signed agreement between agencies and s/he did not believe Guardian B signed any agreements with the provider. On 08/06/2024, at 11:00 AM, Surveyor interviewed Licensee A and OM C. When asked about Resident 1's service agreement, Licensee A stated it was his/her understanding the authorization with the long-term care agency was the agreement. Licensee A stated the provider was figuring things out and learning.	M 384		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a	M 404		

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M 404	Continued From page 2 written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete an individual service plan (ISP) for Resident 1 within 30 days after Resident 1's date of admission. Findings Include: The provider is licensed to care for 4 residents in the client groups of developmentally disabled and emotionally disturbed/mental illness. On 07/24/2024, Surveyor reviewed Resident 1's records. Resident 1 was admitted on 01/03/2024 and discharged on 06/11/2024. The record did not contain an ISP which included at least the following: 1. A description of the services the licensee will provide to meet assessed need. 2. Identification of the level of supervision required in the home and community. 3. Descriptions of services provided by outside agencies. 4. Identification of who will monitor the plan. 5. A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. A document titled, "Individual Portfolio," was	M 404		

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M 404	Continued From page 3 included. The document was not signed or dated. On 07/31/2024, at 8:07 AM, Surveyor received an email from Operations Manager (OM) C, with the following information regarding the Individual Portfolio: "The Individual Portfolio serves as our initial admission paperwork. This includes detailed information regarding the participant. We do not have a signed PBSP (Positive Behavior Support Plan) or ISP, however, the PBSP was distributed to the team in December 2023. The team continued communication through emails, meetings, phone calls before, during, and after the transition with information pertaining to these documents. We met at least once a month via Zoom, then started meeting face-to-face for two months due to technology concerns and wanting to be more personable to discuss the information being addressed. Information was ongoing and changing as were nearing a six-month review. Discharge occurred before this meeting could occur." When asked for clarification if the portfolio was considered a pre-admission assessment, OM C stated in the email, "Yes, we consider that as part of the preadmission process. The final draft was sent in December 2023." That draft was finalized before Resident 1 moved to the provider's home. When asked if an ISP was developed separately from that assessment, OM C stated in the email, "We chose to meet monthly for the first six months to help organize and modify [his/her] needs and supports during the transition. We were consistently working towards goals and developing future goals as [s/he] became more comfortable at the home. Any changes or modifications to daily programming or goals were discussed through the team (social worker, parents, and [Provider]). We had not developed	M 404		

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M 404	Continued From page 4 an ISP outside of the information in the portfolio at the time of discharge." At 4:00 PM, Surveyor interviewed Long Term Care Agent (LTCA) D. LTCA D stated traditionally, if everything was working, there would be a plan in place indicating what the provider would be doing and how they would meet Resident 1's needs. LTCA D stated they did not receive a copy of any plans from the provider. LTCA D stated there was a lot discussed and s/he had encouraged the provider to add more to Resident 1's care plans. LTCA D stated there was a lot of back and forth with the provider and after meetings, LTCA D would utilize emails to identify what the provider and agency responsibilities were. On 08/06/2024, at 11:00 AM, Surveyor interviewed OM C and Licensee A. Surveyor discussed findings related to the provider's lack of development of an ISP within 30 days of Resident 1's admission. Licensee A stated that piece was not formally structured by the provider. Licensee A stated it was their first state licensed facility and they had not received guidance from the long-term care agency with developing an ISP.	M 404		
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 medical condition, including any life-threatening, disabling or serious illness, any illness lasting more than 3 days, an injury sustained by the	M 450		

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M 450	Continued From page 5 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 notify Resident 1's guardian or placing agency in a timely manner when staff observed Resident 1 bite his/herself during a behavioral episode, causing injury. The guardian learned of the incident and injuries when s/he attended an online video session with Resident 1 and observed the injuries. Findings Include: On 06/13/2024, the department received a complaint regarding resident care. On 06/18/2024, at 10:11 AM, Surveyor interviewed Guardian B. Guardian B stated concerns surrounding an incident that took place in the home on 05/02/2024. Guardian B stated Resident 1 experienced self-inflicted injuries and Guardian B was not notified of the injuries. Guardian B stated s/he had an online video session with Resident 1 on the evening of 05/02/2024 and noticed Resident 1 had two open wounds on his/her hands and wrists. When Guardian B asked the staff working that evening about the wounds, the staff member could not offer clarifying information regarding the injuries. Guardian B stated the staff told him/her it was company policy staff were not supposed to tell Guardian B anything. Guardian B stated it was his/her understanding s/he would be informed by	M 450		

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M 450	Continued From page 6	M 450		

the provider if Resident 1 experienced any injuries. Guardian B stated s/he called Operations Manager (OM) C with concerns s/he was not notified of the injuries. Guardian B stated OM C had not heard anything about the injuries and no reports had been filed regarding the injuries.

At 10:26 AM, Surveyor received an email chain forwarded from Guardian B. The email chain included an email, dated 05/03/2024 at 8:48 AM, sent from Long Term Care Agent (LTCA) D to Licensee A and OM C. The email read, in part, "I am off work today, but was setting up my automatic e-mail reply and saw an email from [Guardian B,] with this picture of [Resident 1] (below). Do either of you know how this happened? [Guardian B] saw this during the [Video Session] last night, no one had contacted [him/her] prior." An email response from OM C, dated 05/03/2024 at 11:38 AM, was sent to Licensee A, LTCA D and Guardian B. The response stated, in part, "I looked into this last night and am working with staff to complete the event report and send it out today. [Guardian B], per our conversation last night, I apologize you were not notified when it happened, you should have received communication with this type of injury/behavior. Unfortunately, the staff member who did share information with you while [Video Session Occurred] did not have the complete details and was not there when the incident occurred ...We want you to know that not knowing about an incident like this and hearing details for the first time from individuals who were not present and did not have the proper information can be scary. We are diligently working with staff to ensure proper and timely communication happens with you in the future."

The photo included in the email chain, time

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M 450	Continued From page 7	M 450		

stamped at 6:40 PM on 05/02/2024, showed Resident 1's wounds on his/her right wrist and hand. One wound was approximately 2 inches long and 1 inch wide on Resident 1's wrist. The wound appeared bright red in color. There was a small area that appeared white on the wound. Above that wound, were two smaller and darker red wounds on Resident 1's hand. The wounds were not covered with dressings.

On 07/24/2024, Surveyor reviewed Resident 1's records.

Resident 1 was admitted on 01/03/2024 and discharged on 06/11/2024. Resident 1 had a legal guardian and multiple diagnoses, including disruptive behavior disorder, developmental delay, anxiety state and at risk for self-inflicted injury.

An event report, dated 05/02/2024, indicated Resident 1 participated in self-injurious behavior in the provider's bathroom. The event started at 8:30 AM and ended at 10:15 AM. The description of events, read, in part, "[Resident 1] got out of bed and staff directed [him/her] to the bathroom to take a shower and use the bathroom. [Resident 1] sat on the toilet and [sic] about 8:30 AM told staff "no," when prompted to take a shower. Due to incontinence, staff felt a shower was important for [his/her] daily hygiene ... [Resident 1] stood up off the toilet and proceeded to sit on the bathroom floor. [Resident 1] continued to yell, while remaining seated on the floor. [Resident 1] started to become more upset and started to bite [his/her] hands and wrist causing them to bleed. A PRN (as needed) medication was given around 10:00 AM as [his/her] SIB (self-injurious behavior) was escalating. Staff attempted to block the SIB, and

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M 450	Continued From page 8 [Resident 1] started to strike and spit at staff. Staff gave space while keeping [Resident 1] in view and remained silent until [Resident 1] got up off the ground and said, "shower." Staff helped [Resident 1] into the shower and cleaned off the blood from [his/her] wounds, then helped [him/her] with the rest of [his/her] shower. Once out of the shower and dressed, staff dried the wounds and applied antibiotic ointment to the wounds to help with keeping the area clean." Under a section titled, "What were some areas to learn from," it read, "Staff should report incidents to supervisors in a timely manner in order for the appropriate people to be contacted when needed. Staff members should also have the correct information when talking to parents about incidents with their children, as to not miscommunicate inaccurate details." The event report indicated it was sent to Resident 1's guardians on 05/03/2024. On 08/06/2024 at 11:00 AM, Surveyors interviewed Licensee A and OM C. When asked about the provider's policy for reporting injuries to legal guardians, Licensee A stated the provider wanted guardians to know as much as they wanted to know but the provider did not want to overwhelm them during tough transitions. Licensee A stated anything that required medical attention would be an immediate phone call. Licensee A stated the injuries being discussed were not out of the ordinary but a little more intense than typical. Licensee A stated staff were walking on eggshells with Guardian B and would at times feel blamed for things. Licensee A stated Guardian B should not have been informed about the injuries via the online video session with Resident 1. Licensee A stated it was a good thing Guardian B called Licensee A and OM C	M 450		

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M 450	Continued From page 9 immediately to discuss his/her concerns. Licensee A stated that because of miscommunication, staff were instructed not to communicate with parents. Licensee A stated second shift staff did not communicate correctly with Guardian B, which further upset Guardian B. Licensee A stated Caregiver E should have called Guardian B about the incident and that was discussed with Caregiver E when it happened. OM C stated they wanted their staff to be able to communicate professionally with guardians. OM C stated that was not achieved during the online video session with Guardian B and the provider planned to work on that through additional training opportunities for staff.	M 450		