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	0017984	A. BUILDING: _____ B. WING _____	C 08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMITLESS POSSIBILITIES 221 BITTERS AVE	221 BITTERS AVENUE OCONTO, WI 54153

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M 000	INITIAL COMMENTS On 08/05/2025, Surveyor conducted a complaint investigation at Limitless Possibilities 221 Bitters Ave. Additional information was collected through 08/08/2025. The complaint was substantiated, and 1 deficient practice was identified. Census: 3	M 000		
M 614	88.11(3) INVESTIGATION OF ABUSE OR NEGLECT As soon as possible after being contacted under sub. (1) the licensing agency shall undertake an investigation of the reported abuse or neglect. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure an investigation into potential abuse met all requirements. The investigation conducted did not safeguard the residents from the accused caregivers, did not document all evidence gathered, did not report the allegations or findings to Department of Health Services (DHS,) and dismissed some of their own findings. The provider terminated one caregiver (Former Manager C) while choosing to maintain employment for another caregiver (Caregiver D) who, per their own investigation, had a greater amount of supporting evidence against him/her. Findings include:	M 614		

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

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M 614	Continued From page 1 The provider is licensed to care for up to 4 residents who may have diagnoses including developmental disability, emotionally disturbed /mental illness, and/or traumatic brain injury. On 07/18/2025, the Department received a complaint alleging residents were being abused. https://www.dhs.wisconsin.gov/publications/p00976.pdf Misconduct Definitions (Retrieval date 08/13/2025) "'Abuse' is defined as: 1. An act or repeated acts by a caregiver or non-client resident, including but not limited to restraint, isolation, or confinement that, when contrary to the entity's policies and procedures, not a part of the client's treatment plan and done intentionally to cause harm, does any of the following: ... b. Substantially disregards a client's rights under Wis. Stat. chs. 50 or 51, or a caregiver's duties and obligations to a client. c. Causes or could reasonably be expected to cause mental or emotional damage to a client, including harm to the client's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, or a fear of harm or death, or a combination of these behaviors. ... 4. A course of conduct or repeated acts by a caregiver which serve no legitimate purpose and which, when done with intent to harass, intimidate, humiliate, threaten, or frighten a client, causes or could be reasonably expected to cause the client to be harassed, intimidated, humiliated, threatened, or frightened Examples of abuse include, but are not limited to: ... Verbal Abuse - Threats of harm, saying things to intentionally frighten a client	M 614		

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M 614	Continued From page 2 Mental Abuse - Humiliation, harassment, and intimidation with threats of punishment ..." On 08/05/2025 at 9:30 AM, Surveyor interviewed Regional Manager E and asked for resident records including any investigation reports. Regional Manager E stated the previous facility manager (Former Manager C) was recently terminated from employment after an investigation was completed due to "the way (s/he) was speaking about the residents." Regional Manager E stated the provider had been conducting an investigation because a former caregiver (Former Caregiver F) reported caregiver misconduct to management. Surveyor reviewed the letter that was sent to Quality Assurance Manager (QA Manager) B on 07/13/2025 from Former Caregiver F. The caregiver (who was in training) reported witnessing on 07/12/2025 and 07/13/2025, Caregiver D verbally and emotionally abuse Residents 1, 2 and 3. The report noted Caregiver G was present, participated in unprofessional behavior, and did not intervene to stop Caregiver D abusing the residents. The report included specific examples of the residents being sworn at, mocked, and threatened. The report included a summary of concerns related to "repeated acts of emotionally abusive, threatening and demeaning language toward vulnerable residents," use of "punitive confinement" and isolation, "neglect of therapeutic support and person-centered care," and a "mocking" and "hostile" environment that is "harmful to resident well-being." Surveyor was given the Investigation Report (dated 07/31/2025) written by QA Manager B as documentation of the investigation. The Investigation Report was a summary of findings	M 614		

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M 614	Continued From page 3	M 614		

that was sent to the resident's guardians and care teams. The Investigation Report did not include the timeline of the investigation, or documentation of immediate measures taken to ensure resident safety. The Investigation Report did not include how neither of the alleged caregivers involved (Caregivers D and G) were found to not be involved. The Investigation Report focused on Former Manager C being found to have unprofessional behavior, including the provider substantiating the use of derogatory labels, such as describing resident as "manipulative" and "attention-seeking", swearing within the home, speaking negatively about residents, being dismissive and disrespectful to residents while having non-therapeutic and non-engaging interactions. Regional Manager E stated due to the finding of the investigation Former Manager C had been let go from his/her employment. Surveyor asked to review the schedule as the Investigation Report noted "Initial interviews and information gathered led to an extended investigation to thoroughly verify and confirm the nature of staff behavior and misconduct alleged." Regional Manager E could not confirm when the investigation had been completed.

Surveyor interviewed QA Manager B on 08/08/2025 at 1:02 PM. QA Manager B stated the investigation began on 07/14/2025 and concluded on 07/22/2025 and noted Caregiver G's involvement had been cleared by the investigation by 07/16/2025. The schedule noted Caregiver D continued to work with the residents during the investigation on 07/15/2025, 07/16/2025, 07/17/2025, 07/20/2025, 07/21/2025, and 07/22/2025. QA Manager B stated during the investigation on 07/14/2025 it was identified that Former Manager C was also exhibiting unprofessional behavior. Per the schedule,

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M 614	Continued From page 4	M 614		

Former Manager C was allowed to continue to work during the investigation on 07/15/2025, 07/16/2025, 07/17/2025,07/18/2025, 07/21/2025, 07/22/2025 and after the investigation concluded on 07/24/2025, after it had been determined his/her actions merited termination. Surveyor reviewed the schedule with QA Manager B who confirmed while the investigation was occurring both Caregiver D and Former Manager B were allowed to continue to work with the residents. QA Manager B was unable to state how the residents had been immediately protected after the report had been made alleging the misconduct.

QA Manager B sent Surveyor "Bitters Investigation Timeline" on 08/08/2025. The Timeline document noted Quality Assurance Specialist (QAS) H made observations on 07/14/2025 of Former Manager C's behavior and reported to QA Manager B. On 07/14/2025, QAS H noted an interview with Resident 1 (who was identified during the interviews with QA Manager B and Regional Director E as the only resident who is able to provide an interview.) The interview with Resident 1 noted Resident 1 reported "verbal mistreatment" but did not give specific examples and noted the resident "reports fear of retaliation."

On 08/05/2025 at approximately 11:00, Surveyor interviewed Resident 1. Resident 1 stated most of the staff were kind and respectful to him/her, but some were not. Regarding caregivers that were not respectful, Resident 1 stated "they got rid of one of them," referring to Former Manager C, "but one is still here. [Caregiver D] swears at us."

During the interview with QA Manager B on 08/05/2025, QA Manager B stated on 07/15/2025 s/he observed both Former Manager C and Caregiver D's conduct was the behavior that was

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M 614	Continued From page 5	M 614		

noted on the Investigation Report (unprofessional behavior, including the use of derogatory labels, such as describing resident as "manipulative" and "attention-seeking", swearing within the home, speaking negatively about residents, being dismissive and disrespectful to residents while having non-therapeutic and non-engaging interactions.) The Timeline written by QA Manager B noted Caregiver D, " ...downplays client concerns and describes clients as manipulative and attention seeking ..." The Timeline excluded additional evidence collected by QA Manager B during his/her interview with Caregiver D which QA Manager B recounted during the interview on 08/08/2025 with Surveyor:

QA Manager B stated when s/he interviewed Caregiver D on 07/15/2025 and asked how s/he would handle resident behaviors, Caregiver D described the use of threatening to seclude a resident to their room for their behaviors as a commonly used form of behavior management. This information was not included in the investigation documentation.

The Timeline written by QA Manager B noted an interview with Caregiver G that could provide, " ... no specific or actionable information about [Former Manager C's] behavior. [S/he] denies witnessing any inappropriate behavior from [Caregiver D] in [his/her] recent shifts." The timeline excluded additional evidence collected by QA Manager B during his/her interview with Caregiver G which QA Manager B recounted during the interview on 08/08/2025 with Surveyor:

QA Manager B stated when s/he interviewed Caregiver G on 07/15/2025, the caregiver was hesitant to speak. QA Manager B stated s/he asked Caregiver G if s/he heard the other staff,

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M 614	Continued From page 6 specifically Caregiver D, down-talking to the residents and Caregiver G's initial response was "Not this past weekend." When asked for more information, QA Manager B stated Caregiver G told him/her that s/he witnessed Caregiver D tell the residents to "shut the [explicative] up" and tell them that they were "annoying" during a previous shift (no date given.) QA Manager B stated Caregiver G told him/her that s/he told Caregiver D if s/he ever heard him/her talking to a resident like that again s/he would report Caregiver D. This information was not included in the investigation documentation. During the interview with QA Manager B on 08/08/2025 at 1:02 PM, QA Manager B stated upon initiating investigation observations it was made clear that Former Manager C's conduct was a concern. QA Manager B stated Caregiver's D's conduct matched that of Former Manager C's conduct, but the investigation team chose to focus on Former Manager C's conduct, believing it was the root cause as s/he was Caregiver D's direct supervisor. QA Manager B stated the provider held Former Manager C accountable for Caregiver D's behavior, believing it had to do with training and the example the Former Manager C had set in the facility. After a review and discussion of reporting requirements, QA Manager B acknowledged each caregiver was responsible for their own behavior, as Caregiver D had already received resident right training, and despite Former Manager C's behavior, other caregivers did not participate in the behavior, but Caregiver D chose to. Despite the additional information the provider received during their investigation about Caregiver D's actions, the provider chose to focus the investigation on Former Manager C. Two	M 614		

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M 614	Continued From page 7 caregivers reported Caregiver D as being involved in misconduct, while Resident 1 confirmed mistreatment was occurring in the home and Caregiver D him/herself confirmed abusive behavior (use of threats and seclusion) was occurring to QA Manager B during their interview on 07/15/2025. The provider dismissed its own findings against Caregiver D and did not include all evidence gathered in their investigation documentation. The provider concluded, though the actions of Former Manager C were enough to merit his/her termination, it was determined his/her actions did not meet the definition of abuse. Subsequently a report was not submitted to the Department (as is required if there is a potential any other entity could substantiate based on their investigation findings or the provider has received conflicting evidence,) or the Office of Caregiver Quality as is required for any allegation of caregiver misconduct, despite the final determination. The provider found evidence of an act or repeated acts by the caregivers, that included threats and isolation, which substantially disregarded the resident's rights, and could reasonably be expected to cause mental or emotional damage to the residents.The course of conduct or repeated acts by the caregivers served no legitimate purpose and were done with intent to humiliate, threaten, and/ or frighten the residents. The conduct caused and/or could be reasonably expected to cause the residents to be intimidated, humiliated, threatened, or frightened. This included verbal abuse by swearing at the residents and threats of isolation to intentionally frighten, mental abuse including humiliation by calling the residents annoying and attention seeking, and intimidation with threats of punishment to be secluded in their rooms.	M 614		

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