STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013779	A. BUILDING: _____ B. WING _____	C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADWOOD HOUSE	**2252 BRADWOOD AVE ALTOONA, WI 54720**

(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 09/07/2023, Surveyor conducted a complaint investigation at Bradwood House. Data collection continued through 09/15/2023. The complaint was substantiated. Three deficiencies were identified. One of 3 deficiencies was a repeat deficiency. See Statement of Deficiency (SOD) GDUH11, dated 02/10/2023. Census: 3	M 000		
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 notify the department within 24 hours when Resident 1 eloped from the facility and his/her whereabouts were unknown. Findings include: On 06/05/2023, the Department received a	M 134		

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

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M 134	Continued From page 1	M 134		

complaint regarding police intervention at the facility address in response to elopements.

On 09/08/2023 at approximately 9:45 AM, Surveyor interviewed Caregiver B and asked about Resident 1. Caregiver B informed Surveyor Resident 1 was no longer residing in the facility and was given an emergency discharge because of his/her drinking problem. Caregiver B reported that while Caregiver B was assisting with another resident, Resident 1 would walk off the property to find alcohol. Caregiver B stated they were aware of Resident 1's alcohol dependence upon admission but did not identify him/her as an elopement risk. Surveyor asked Caregiver B how many times non-emergency police were contacted in response to Resident 1 leaving the facility. Caregiver B stated they called "almost every other day."

Caregiver B stated police were contacted on a regular basis to assist with behaviors or elopements. Caregiver B informed Surveyor that Resident 1 eloped frequently but no longer resided in the facility. Caregiver B stated s/he was aware Resident 1 had an alcohol dependence but was not made aware s/he was an elopement risk.

Surveyor requested all incident reports on file for Resident 1 from Operations Director (OD) A. The following incident reports for Resident 1 were provided:

-05/20/2023: 12:00 PM, Resident refused medications and verbal redirection. Eloped from the home. After searching for [Resident 1], local police department (PD) located [Resident 1] at Kwik Trip and brought back around 3:45 PM.

-05/21/2023: 9:30 AM, [Resident 1] eloped from

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M 134	Continued From page 2 the home. PD found and brought [him/her] back around 9:45 AM. -05/21/2023: 1:30 PM, [Resident 1] eloped, and PD were notified. No one was able to locate [him/her] until 10:30 PM. When PD found [him/her], [s/he] requested to be taken to hospital for detox. Was admitted with a BAC (blood alcohol level) of 0.33. Spent the night for observation and discharged back to AFH (adult family home) at 6:00 AM 05/22/2023. -05/22/2023: 1:20 PM, [Resident 1] eloped, and PD were notified. Director and two other staff located [Resident 1] walking to Kwik Trip. [Resident 1] got in the van and was taken back to AFH. Upon being dropped off s/he immediately began walking again in the direction of Kwik Trip. An officer and director were there to redirect and walk [Resident 1] back to the home. PD reports they can't continue to assist in these elopements unless [Resident 1] is a physical danger to [him/herself] or others, despite the protective placement order. -05/23/2023: 8:45 AM, [Resident 1] eloped and staff located [him/her] three blocks away. They were able to walk [him/her] back to the house without issue. -05/23/2023: 11:30 AM, [Resident 1] eloped, and staff located [him/her] seven blocks away. Again, walked [him/her] back to the house without issue. -05/23/2023: 2:23 PM, [Resident 1] eloped and staff followed with a vehicle but [Resident 1] was unwilling to return with staff. PD notified and assisted. [Resident 1] got into the squad car unassisted and was dropped off at AFH.	M 134		

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M 134	Continued From page 3 On 09/15/2023, Surveyor requested Resident 1's discharge date via email from OD A. OD A reported Resident 1 was given an emergency discharge on 05/26/2023. OD A provided a series of email communication with Resident 1's managed care organization (MCO) team which read, in part, "[Resident 1] left the [facility name] house this morning at 5:30am. Staff contacted [local] PD. No sign of [him/her] yet but we'll keep looking...At 2:30, [local] PD found [Resident 1] and took [him/her] to Mayo ER (emergency room) for detox. It had been determined by [Resident 1]'s entire team that [s/he] was a risk to [him/herself] if [s/he] were to be discharged from the hospital." No incident report was available for the elopement which resulted in an emergency discharge on 05/26/2023. On 09/15/2023 at 12:12 PM, Surveyor emailed OD A and asked if any of the above incidents were reported to the Department. OD A stated s/he reviewed the record and did not find evidence Resident 1's elopements were reported.	M 134		
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 record review and interview, the licensee permitted the existence or continuation	M 230		

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M 230	Continued From page 4 of a condition which placed the the health, safety and welfare of Resident 1 at substantial risk of harm. Resident 1 was not adequately supervised after Resident 1 eloped from the facility multiple times requiring police intervention to locate him/her. This is a repeat deficiency. See Statement of Deficiency (SOD) GDUH11, dated 02/10/2023. Findings include: On 06/05/2023, the Department received a complaint regarding law enforcement intervention at the facility address in response to elopements. The provider is licensed to care for 4 residents from the client groups of developmentally disabled, emotionally disturbed/mental illness, traumatic brain injury and advanced aged. RECORD REVIEW On 09/08/2023, Surveyor requested Resident 1's record from Operations Director (OD) A, including the initial assessment, individual service plan (ISP), behavioral service plan (BSP), staff charting, incident reports and self-reports submitted to the Department. Resident 1 was admitted to the facility on 04/05/2023. Resident 1 had the following diagnoses: Cognitive delays, dementia, principal alcohol dependency w/intoxication, alcohol moderate or severe use disorder (dependence), failure to thrive, homeless unspecified sheltered or unsheltered, and liver alcoholic disease.	M 230		

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M 230	Continued From page 5 The document titled, "Comprehensive Admission Assessment," provided by OD A, was not signed or dated and indicated Resident 1 was: -not permitted to go for walks or leave facility on own -an alcoholic with no stated desire to quit -smokes cigarettes -can toilet and communicate on own -not easily redirectable -noted by self for elopements and inappropriate social behavior The following incident reports were provided by OD A: -05/20/2023: 12:00 PM, Resident refused medications and verbal redirection. Eloped from the home. After searching for [Resident 1], local police department (PD) located [Resident 1] at Kwik Trip and brought back around 3:45 PM. -05/21/2023: 9:30 AM, [Resident 1] eloped from the home. PD found and brought [him/her] back around 9:45 AM. 1:30 PM, [Resident 1] eloped, and PD were notified. No one was able to locate [him/her] until 10:30 PM. When PD found [him/her], [s/he] requested to be taken to hospital for detox. Was admitted with a BAC (blood alcohol level) of 0.33. Spent the night for observation and discharged back to AFH (adult family home) at 6:00 AM 05/22/2023. -05/22/2023: 1:20 PM, [Resident 1] eloped, and PD were notified. Director and two other staff located [Resident 1] walking to Kwik Trip. [Resident 1] got in the van and was taken back to AFH. Upon being dropped off s/he immediately began walking again in the direction of Kwik Trip.	M 230		

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M 230	Continued From page 6 An officer and director were there to redirect and walk [Resident 1] back to the home. PD reports they can't continue to assist in these elopements unless [Resident 1] is a physical danger to [him/herself] or others, despite the protective placement order. -05/23/2023: 8:45 AM, [Resident 1] eloped and staff located [him/her] three blocks away. They were able to walk [him/her] back to the house without issue. 11:30 AM, [Resident 1] eloped, and staff located [him/her] seven blocks away. Again, walked [him/her] back to the house without issue. 2:23 PM, [Resident 1] eloped and staff followed with a vehicle but [Resident 1] was unwilling to return with staff. PD notified and assisted. [Resident 1] got into the squad car unassisted and was dropped off at AFH. The incident reports above were incomplete and the following areas for documentation and follow-up were left blank: - Person who observed the incident/injury - Explain what immediate action was taken (including persons contacted) - Follow-up treatment, if any - Action taken or planned (by whom and anticipated results) - Licensee/Supervisor comments The individual service plan (ISP), dated 04/05/2023 and signed on 04/25/2023 read, in part: -Requires assistance with [his/her] ADLs (activities of daily living). - [Resident 1] is an alcoholic with no stated Desire [sic] it [sic] quit.	M 230		

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M 230	Continued From page 7	M 230		

-[S/he] does have issues with memory and does require constant reminders.
- [Resident 1] has failure to thrive as an adult and will need to be reminded to eat all meals.
-This will be [Resident 1]'s first group home placement. Therefore, [Resident 1] will need reassurance that [s/he] can do things for [him/herself] with verbal cues.
-Repetitive prompts will be necessary often.
-[S/he] will require staff to be consistent in working with [Resident 1] to follow simple direction to complete chores and ADL's independently or with little physical assistance from staff.

The ISP did not identify the level of supervision required and was not updated after Resident 1 began eloping from the facility.

The behavioral service plan (BSP) was not dated or signed and had Resident 1's admission date of 04/05/2023 listed at the top. The BSP worksheet indicated Resident 1 was noted by others for elopement, criminal activity, and inappropriate sexual activity, per history. The BSP also indicated Resident 1 was hospitalized 03/17/2023-04/05/2023 for alcohol dependence w/intoxication and a broken clavicle. The BSP had a section for "Crisis Plan" but the area was left blank.

The protective placement document, dated 04/27/2023, identified Resident 1 had a need for protective placement as s/he was adjudicated incompetent on 04/26/2023 due to a developmental disability. The document also stated the least restrictive placement consistent with Resident 1's needs was placement in an unlocked unit and the most integrated setting for his/her needs was a non-institutional community

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M 230	Continued From page 8	M 230		

placement.

INTERVIEWS

On 09/08/2023 at approximately 9:45 AM, Surveyor interviewed Caregiver B and asked about Resident 1. Caregiver B informed Surveyor Resident 1 was no longer residing in the facility and was given an emergency discharge because of his/her drinking problem. Caregiver B reported that while Caregiver B was assisting with another resident, Resident 1 would walk off the property to find alcohol. Caregiver B stated they were aware of Resident 1's alcohol dependence upon admission but did not identify him/her as an elopement risk. Surveyor asked Caregiver B how many times non-emergency police were contacted in response to Resident 1 leaving the facility. Caregiver B stated they called "almost every other day."

On 09/08/2023 at approximately 10:30 AM, Surveyor interviewed OD A and asked about interventions after Resident 1 began eloping to seek alcohol. OD A stated they were not able to keep Resident 1 safe because they were not a secured facility and reported they would have additional staff on stand-by to search for him/her if s/he left the property. Surveyor asked OD A if additional staff were considered as an intervention to deter Resident 1 from leaving. OD A stated s/he felt two people would not deter Resident 1 from leaving or get him/her back safely. OD A further reported that Resident 1's managed care organization (MCO) team felt Resident 1 needed a secure facility.

On 09/15/2023, Surveyor requested Resident 1's discharge date from OD A. OD A reported Resident 1 was given an emergency discharge

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M 230	Continued From page 9 on 05/26/2023. OD A provided a series of email communication with Resident 1's MCO team which read, in part, "[Resident 1] left the [facility name] this morning at 5:30am. Staff contacted [local] PD. No sign of [him/her] yet but we'll keep looking...At 2:30, [local] PD found George and took [him/her] to Mayo ER for detox. It had been determined by [Resident 1]'s entire team that [s/he] was a risk to [him/herself] if [s/he] were to be discharged from the hospital." No incident report was available for the elopement which resulted in an emergency discharge on 05/26/2023. SUMMARY The licensee permitted the continuation of inadequate supervision for Resident 1 after Resident 1 repeatedly eloped from the facility to seek and consume alcohol. The provider did not have a safe environment with 1 staff for 4 residents after Resident 1 began eloping from the property. Law enforcement was called several times to assist in locating Resident 1.	M 230		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued	M 424		

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M 424	Continued From page 10	M 424		

appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was reviewed when Resident 1's need for supervision changed.

Findings include:

On 06/05/2023, the Department received a complaint regarding law enforcement intervention at the facility address in response to repeated elopements.

On 09/07/2023 at approximately 9:45 AM, Surveyor requested to review resident records and asked Caregiver B if police were called to the facility or if there were any elopements.

Caregiver B stated police were contacted on a regular basis to assist with behaviors or elopements. Caregiver B informed Surveyor that Resident 1 eloped frequently but no longer resided in the facility. Caregiver B stated s/he was aware Resident 1 had an alcohol dependence but was not made aware s/he was an elopement risk.

Surveyor requested all incident reports on file for Resident 1 from Operations Director (OD) A. The following incident reports for Resident 1 were provided:

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M 424	Continued From page 11 -05/20/2023: 12:00 PM, Resident refused medications and verbal redirection. Eloped from the home. After searching for [Resident 1], local police department (PD) located [Resident 1] at Kwik Trip and brought back around 3:45 PM. -05/21/2023: 9:30 AM, [Resident 1] eloped from the home. PD found and brought [him/her] back around 9:45 AM. 1:30 PM, [Resident 1] eloped, and PD were notified. No one was able to locate [him/her] until 10:30 PM. When PD found [him/her], [s/he] requested to be taken to hospital for detox. Was admitted with a BAC (blood alcohol level) of 0.33. Spent the night for observation and discharged back to AFH (adult family home) at 6:00 AM 05/22/2023. -05/22/2023: 1:20 PM, [Resident 1] eloped, and PD were notified. Director and two other staff located [Resident 1] walking to Kwik Trip. [Resident 1] got in the van and was taken back to AFH. Upon being dropped off s/he immediately began walking again in the direction of Kwik Trip. An officer and director were there to redirect and walk [Resident 1] back to the home. PD reports they can't continue to assist in these elopements unless [Resident 1] is a physical danger to [him/herself] or others, despite the protective placement order. -05/23/2023: 8:45 AM, [Resident 1] eloped and staff located [him/her] three blocks away. They were able to walk [him/her] back to the house without issue. 11:30 AM, [Resident 1] eloped, and staff located [him/her] seven blocks away. Again, walked [him/her] back to the house without issue. 2:23 PM, [Resident 1] eloped and staff followed	M 424		

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M 424	Continued From page 12	M 424		

with a vehicle but [Resident 1] was unwilling to return with staff. PD notified and assisted. [Resident 1] got into the squad car unassisted and was dropped off at AFH.

The individual service plan (ISP), dated 04/05/2023 and signed on 04/25/2023 read, in part:

-Requires assistance with [his/her] ADLs (activities of daily living).
- [Resident 1] is an alcoholic with no stated Desire [sic] it [sic] quit.
-[S/he] does have issues with memory and does require constant reminders.
- [Resident 1] has failure to thrive as an adult and will need to be reminded to eat all meals.
-This will be [Resident 1]'s first group home placement. Therefore, [Resident 1] will need reassurance that [s/he] can do things for [him/herself] with verbal cues.
-Repetitive prompts will be necessary often.
-[S/he] will require staff to be consistent in working with [Resident 1] to follow simple direction to complete chores and ADLs independently or with little physical assistance from staff.

The ISP did not identify the level of supervision required and was not updated with interventions or a plan to prevent future occurrences after Resident 1 began eloping from the facility.