STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018616	A. BUILDING: _____ B. WING _____	R-C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUCE ASSISTED LIVING	405 BRUCE LAKE RD BRUCE, WI 54819

(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 11/07/2024, Surveyor conducted 2 complaint investigations and a verification visit at Bruce Assisted Living. Data was collected through 11/13/2024. Two of the 2 complaints were substantiated. Nine deficiencies were identified. Three of the 9 deficiencies were repeat deficiencies. See Statement of deficiency (SOD) YQ4612, dated 05/28/2024, and SOD T6KY12, dated 06/18/2023. Census: 4 Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.	{M 000}		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange	M 114		

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

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M 114	Continued From page 1 for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure 2 of 4 caregivers reviewed, Caregiver F and Caregiver G, had a complete caregiver background check (CBC). Findings include: A complete CBC consists of the following: - A completed Background Information Disclosure (BID) form. - A report of findings from the Department of Justice (DOJ). - Government Findings Report (GFR) from the Department of Health Services (DHS). On 11/07/2024, Surveyor emailed Administrator A and requested complete caregiver background checks on 4 employees.	M 114		

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M 114	Continued From page 2 On 11/12/2024, Surveyor reviewed the caregiver background checks. Caregiver F's date of hire was 07/20/2024. His/her BID was dated 07/20/2024. His/her DOJ and GFR reports were dated 11/07/2024, which was the same date Surveyor requested the records. Caregiver G's date of hire was 06/21/2024. His/her BID was dated 06/12/2024. His/her DOJ and GFR reports were dated 11/07/2024. On 11/13/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A. Administrator A told Surveyor Caregiver F and Caregiver G worked unsupervised after their dates of hire. Surveyor explained the requirement to have the DOJ and GFR reports prior to employees working unsupervised and no later than 60 days after their date of hire, if supervised. The licensee did not ensure Caregiver F and Caregiver G had complete CBCs.	M 114		
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	M 134		

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M 134	Continued From page 3 suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department, within 24 hours, a significant change to Resident 1 when s/he fell and was hospitalized. Findings include: On 11/06/2024, the Department received a complaint that alleged a resident fell, sustained multiple injuries, and was hospitalized. On 11/07/2024, Surveyor reviewed the Department's electronic file for Bruce Assisted living. Surveyor did not locate a report that indicated a resident fell and was hospitalized. On 11/07/2024 at approximately 5:45 a.m., Surveyor interviewed Caregiver D. Caregiver D told Surveyor Resident 1 was in the hospital as a result of a fall. Caregiver D said s/he did not know what happened. On 11/07/2024 at approximately 6:45 a.m., Surveyor interviewed Administrator A. Administrator A told Surveyor Resident 1 fell in the shower. S/he said Caregiver E was present when Resident 1 fell. S/he said s/he came in the next day with Caregiver E and decided to take Resident 1 to the emergency room. On 11/07/2024, Surveyor reviewed Resident 1's record. On 11/05/2024, Caregiver D documented: "[Resident 1] has bruised eye (purple in color)	M 134		

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M 134	Continued From page 4	M 134		

lower part of eye, staff asked if [his/her] eye hurts {[s/he] said yes} [sic] [s/he] has quarter size red mark above [his/her] eye and red mark (quarter size) on the side of [his/her] cheek bone area. [S/he] has a red nose, and [s/he] had a bloody nose when staff came in to check on [him/her] this morning, [s/he] has a bruise on [his/her] hand (upper side) ring finger is black/grey in color and swollen [sic] staff asked if this hurt {[s/he] said yes} [sic] [s/he] has a red spot {size of pencil eraser end} on the bridge of [his/her] nose from a previous incident which was reported to staff ...[Resident 1] has 4 x 4 in (inch) size Bruises [sic] on both of [his/her] knees {dark purple in color} [sic] [s/he] was breathing like is [sic] was hard for [him/her] [sic] staff asked if [s/he] was ok {[Resident 1] said yes and waved staff off} [sic] [s/he] was asked again if [s/he] wanted anything to eat and {[Resident 1] said No} [sic] {this staff member is unsure of when these bruises first occurred} [sic] ... [Resident 1's] other eye underneath [his/her] eye is bruised [sic] also starting of a bruise ... [s/he] went to the ER (emergency room) in [city] @ 11:20 am with management to be checked out."

On 11/12/2024, Surveyor reviewed the incident report that was emailed to surveyor by Administrator A.
The incident summary read: "Shower was off. We were getting ready to exit shower. I turned to grab some towels and when I turned back [Resident 1] was mid fall. [S/he] had fallen into [sic] the shower chair pretty hard. I attempted to grab [him/her], but [s/he] was wet and slipped out of my hands. [S/he] proceded [sic] to fall on the ground face first. I then helped [him/her] up and helped [him/her] sit on the toilet. I got [him/her] dressed and to the common area where I assesed [sic] [his/her] injuries. [S/he] had some

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M 134	Continued From page 5 scrapes on [his/her] face & nose." This report was signed as completed by Caregiver E on 11/4/2024. On 11/12/2024, Surveyor reviewed Resident 1's medical records. The note from the emergency department, dated 11/05/2024, indicated Resident 1 presented for an evaluation of a fall that occurred on 11/04/2024. Resident 1 was found to have multiple rib fractures, with a pneumothorax (collapsed lung) that required a chest tube to be placed, fractures of the L1 and L2 vertebral bodies, nasal bone fracture, fracture to left second toe and right fourth finger. Resident 1 had a chest tube placed and was diverted to a hospital that could provide a higher level of care. On 11/13/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A. Administrator A said s/he just emailed the Department with a report of the fall with hospitalization. S/he said Licensee C reminded him/her that a report was required. The provider did not report to the Department, within 24 hours, Resident 1's fall with multiple fractures and hospitalization.	M 134		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure the home	M 216		

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M 216	Continued From page 6 and its operation complied with this Wis. Admin. Code ch. 88 and all other laws governing the home and its operations. The licensee did not follow Special Orders, which resulted from previous statement of deficiency (SOD) YQ4612, dated 05/28/2024. The licensee has shown a pattern of non-compliance since being issued a license on 07/14/2022. Findings include: The provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, advanced age, terminally ill, alcohol/drug dependent, traumatic brain injury, physically disabled, and developmentally disabled. On 06/27/2024, SOD YQ4612 and a Notice and Order letter were issued to Licensee A via email with the following: NOTICE OF VIOLATION, ORDER TO COMPLY WITH REQUIREMENTS, NOTICE OF SPECIAL ORDERS, and NOTICE OF REVISIT FEE. The SPECIAL ORDERS read: "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Bruce Assisted Living: 1. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., the licensee shall develop and implement corrective measures to ensure all service providers protect and promote each resident's right to live in a home that is safe, clean, and well-maintained.	M 216		

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M 216	Continued From page 7 WITHIN 45 DAYS of receipt of this notice, the licensee will provide training to all service providers on the corrective actions taken to resolve each environmental deficiency identified in Statement of Deficiency YQ4612. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training." On 11/07/2024, with information gathered through 11/13/2024, Surveyor conducted a verification visit and 2 complaint investigations at Bruce Assisted Living. As a result of the survey, 2 of the 2 complaints were substantiated and the provider was issued 9 deficiencies. Three of the 9 deficiencies were repeat deficiencies, including resident right to live in a home that is safe, clean, and well-maintained. Surveyor reviewed training records of 4 of 4 employees, including Administrator A. The training records did not contain evidence that they received training according to the Special Orders. The following deficiencies were identified during this survey: M0114 DHS 88.03 (3)(b) Criminal Records Check M0134 DHS 88.03(5)(e)1. Significant Change To The Resident M026 DHS 88.04(2)(a) Responsibilities M0218 DHS 88.04(2)(b) Awake Staff For Continuous Care M0230 DHS 88.04(2)(f) Condition Which Represents Risk Or Harm M0276 DHS 88.05(3)(a) Home Environment M0334 DHS 88.05(4)(b)1 Fire Safety - Smoke Detectors M0580 DHS 88.10(3)(p) Prompt And Adequate Treatment Z022 Wis. Stat. 55.065(3)(b) Complete	M 216		

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M 216	Continued From page 8 Background Check Process On 11/13/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A. Administrator A told Surveyor s/he did not remember seeing the Special Orders that were issued with SOD YQ4612. S/he said s/he had a meeting with staff after s/he received SOD YQ4612 and reviewed the deficiencies but did not have staff sign that they attended the meeting. Administrator A told Surveyor it was Licensee B and Licensee C's responsibility to monitor the home and keep it maintained. S/he said Licensee C had a list of things s/he was repairing in the home. On 07/14/2022, the provider was issued a license to operate a 4-bed adult family home. Since being licensed for approximately 2 years and 4 months, the Department has issued 5 SODs with enforcement and substantiated 7 complaints. The provider has shown a pattern of non-compliance with Wis. Admin. Code ch. 88 and all other laws governing the home and its operations.	M 216		
M 218	88.04(2)(b) AWAKE STAFF FOR CONTINUOUS CARE The licensee shall ensure that he or she or a service provider is present and awake at all times if any resident is in need of continuous care. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure staff was present and awake at all times with residents that required continuous care.	M 218		

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M 218	Continued From page 9 Findings include: This provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, advanced age, terminally ill, alcohol/drug dependent, traumatic brain injury, physically disabled, and developmentally disabled. On 11/06/2024, the Department received a complaint that alleged staff would leave the facility before the next shift arrived. On 11/07/2024 at approximately 6:00 a.m., Surveyor interviewed Caregiver D. Caregiver D told Surveyor s/he arrived at work on 11/05/2024 at 5:55 a.m., and there were no other caregivers present. Caregiver D told Surveyor the schedule indicated Caregiver F was working the night shift but s/he was not present when Caregiver D arrived. Caregiver D said Resident 4 was outside smoking when Caregiver D arrived at work. Caregiver D told Surveyor that Resident 4 said, "I can babysit them." Caregiver D explained Resident 4 was referring to the other 3 residents with no staff present. Surveyor asked Caregiver D how many times s/he arrived to work and there were no staff present. Caregiver D replied, "Guessing 3 (times)." Caregiver D told Surveyor s/he did not have exact dates. Caregiver D said s/he would either text the group chat or text Administrator A individually. Caregiver D said that on 11/05/2024, s/he did not text anyone to notify that there was no staff present when s/he arrived. On 11/07/2024 at approximately 6:45 a.m., Surveyor interviewed Administrator A. Administrator A told Surveyor s/he was unaware	M 218		

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M 218	Continued From page 10	M 218		

staff were leaving prior to the next shift arriving. Caregiver D was present. Caregiver D confirmed that happened. Administrator A told Surveyor s/he knew that on one occasion, Caregiver F was out in his/her vehicle and then left when Caregiver D pulled into the driveway.

On 11/07/2024, Surveyor reviewed the residents' records.

Resident 1's individual service plan (ISP), indicated that s/he was nonverbal, but could speak "yes" or "no." The ISP indicated s/he would need assistance of one in an emergency. Resident 1 required continuous care.

Resident 2's ISP, indicated s/he could move on his/her own but "MUST be directed where to go by holding [his/her] hand and taking [him/her] with you! ... Needs to be supervised while ambulating ... [Resident 2] has been very dependent on staff since [his/her] stroke. It is hard to get [him/her] to walk unless you are standing by [him/her] holding [his/her] hand ...Is up repeatedly at night to play in the bathroom, dig through cupboards, or play at the table ... [Resident 2's] stroke has prevented [him/her] from speaking. [S/he] is no longer able to make needs known or speak words that we are able to understand ... Very out of it and confused. Needs consistent supervision." Resident 2 required continuous care.

Resident 3's ISP, indicated s/he would be aware if a fire alarm was going off, but would need to be reminded of where to go for safety. Resident 3 had a diagnosis of unspecified intellectual disabilities. Resident 3 would require continuous care.

Resident 4 had a diagnosis of schizophrenia with

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M 218	Continued From page 11 a legal guardian. His/her ISP, indicated s/he would be able to respond appropriately in the event of an emergency, without assistance. On 11/12/2024, Surveyor emailed Administrator A and asked if caregivers were awake during the overnight shift. On 11/13/2024, Administrator A emailed Surveyor and replied that the overnight shift was supposed to be awake. On 11/13/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A. Administrator A told Surveyor that there was an investigation into a time when Caregiver F was not present in the facility. S/he said Caregiver F had another job and Caregiver D was late coming into work. S/he said Caregiver F was parked on the other side of the driveway and when Caregiver F saw Caregiver D pull in, Caregiver F left. Administrator A said Caregiver D probably did not see Caregiver F leave. The licensee did not ensure Caregiver F remained present in the facility when 3 of the 4 residents required continuous care.	M 218		
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 provider permitted a condition in the home that	M 230		

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M 230	Continued From page 12	M 230		

placed the safety and welfare of the residents at substantial risk of harm.

Administrator A and Caregiver E took 3 residents on a field trip to Michigan with illegal drugs and drug paraphernalia in the vehicle that was not registered, with a headlight burned out.

This is a repeat deficiency. See Statement of Deficiency T6KY12, dated 06/08/2023.

Findings include:

On 10/30/2024, the Department received a complaint with allegations that Administrator A and Caregiver E were stopped by law enforcement on the way back from a field trip to Michigan with 3 residents. The vehicle was searched, and Administrator A was found to be in possession of illegal drugs (THC) and drug paraphernalia.

On 11/07/2024, Surveyor reviewed Price County Sheriff's Office Incident Report, 24-1702. Lieutenant (Lt) H's report read, in part: "On July 27, 2024, at approximately 9:55 p.m., [Administrator A],while on US Highway 8, near Cemetery Road, in the Township of Prentice, did knowingly and intentionally possess tetrahydrocannabinols (THC) and drug paraphernalia, by having two sealed bags of marijuana which [s/he] admitted to purchasing in Michigan, and having a pipe containing THC in the bowl ... [Caregiver E] ... did knowingly and intentionally possess tetrahydrocannabinols (THC) and drug paraphernalia, by having two bags of THC Gummies in close proximity to where [s/he] was seated, along with a teal pipe containing THC in the bowl ... On July 27, 2024, I, [Lt H], was working for Price County Sheriff's

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(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
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Office ... I exited my squad care and made contact with the driver who was identified as [Administrator A]. The passenger of the vehicle identified [him/herself] verbally as [Caregiver E] ... There were also three adult individuals in the back seat of the vehicle. It was later determined the three individuals resided at the Northwoods [sic] Assisted Living in Bruce, Wisconsin. [Administrator A] was their caregiver. I informed [Administrator A] the reason I stopped [him/her] was because the right headlight [sic] not working, [Administrator A] indicated they were coming from Michigan after taking the three adults in the back seat on a field trip. While I spoke with [Administrator A], I detected a pungent odor coming from the vehicle. Due to my training and experience as a law enforcement officer, I knew the odor to be that of marijuana. I returned to my squad and ran the vehicle registration through E-time. I observed the vehicle registration was expired. The registration expired on May 17, 2023 ... [Administrator A] indicated the vehicle was expired for some time, and the registered owner was [Licensee C]. [Administrator A] said [Licensee C] was the owner of the vehicle and was aware of the expired registration .... I asked [Administrator A] if there would be any marijuana in the vehicle as I detected the odor of marijuana coming from inside the vehicle. [Administrator A] indicated no. I asked [Administrator A] if I could search the vehicle. [Administrator A] indicated no. I explained to [Administrator A] that due to the odor of marijuana coming from the vehicle, I had probable cause to search the vehicle ... I requested [Deputy I] and [Wisconsin State Trooper (WST) J] respond to my location due to the anticipation of searching the vehicle and [Caregiver E] having a lengthy criminal history and [him/her] being on probation ... [WST J] and I searched the vehicle. Multiple drug items were

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located inside the vehicle ... One of the adult at risk passengers who was seated in the middle of the back seat was holding onto a brown paper bag. I asked the individual what was in the bag. It appeared the individual only made sounds. I looked inside the bag and observed six individual packages that appeared to be pre-rolled joints. The name brand was Aperion THCA ... Each package was sealed and the label indicated the package contained .5 grams of THC ... We also located multiple empty containers of alcoholic beverages and two cans of Twisted Tea on the floorboard at the feet of the [fe/male] adult at risk, who was seated in the back seat on the driver's side. There was trash and items all over the floor and things pushed under both the driver and passenger seats. The back seat passengers appeared to be non verbal or spoke very little. While searching the vehicle, there was an odor of urine and odor that one of the back seat passengers had defecated themselves. I spoke with [Administrator A] about the marijuana and drug paraphernalia in the vehicle. [Administrator A] admitted to buying the two sealed bags of Candela in Michigan. I asked about the THC Gummies. [Administrator A] admitted to buying the THC Gummies in Michigan also. I asked why there were five gummies missing out of the one package. [Administrator A] indicated [s/he] did not know where the five gummies went. [Administrator A] indicated [s/he] purchased the Apeiron THCA in Ladysmith, and believed the THCA was legal to possess. I spoke at length with [Administrator A] about being a caregiver to the three at risk adults in the back seat while [s/he] drove a vehicle containing multiple items of drugs and paraphernalia. I informed [Administrator A] and [Caregiver E] that I would be referring charges to the district attorney for review ... On August 20, 2024, I contacted Price

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County Health & Human Services and Rusk County Health & Human Services in an attempt to obtain additional information on the back seat passengers of the vehicle ... [Person K] from Rusk County Health & Human Services indicated [s/he] believed the passengers may be patients through [Managed Care Organization (MCO)] ... A short while later I received a call from [Person L] from [MCO]. [Person L] confirmed the names of the patients as being [Resident 3], [Resident 1], and [Resident 2]. [Person K] indicated the patients were adults at risk and were being housed at the Northwoods [sic] Assisted Living Home in Bruce. For future safety and well-being of the individuals, I informed [Person L] of the traffic stop I conducted on the vehicle along with some details ..."

On 11/07/2024 at approximately 2:15 p.m., Surveyor interviewed Guardian M, who was Resident 1's legal guardian and parent. Surveyor asked if s/he was aware Administrator A and Caregiver E took Resident 1 on a field trip to Michigan. Guardian M said s/he was not aware and asked if something happened. Surveyor explained the above police report to Guardian M. Guardian M told Surveyor s/he did not authorize a trip to Michigan, and this was the first time s/he heard of this. Guardian M told Surveyor it was a complete surprise.

On 11/11/2024, Surveyor emailed Administrator A and asked if there was a policy on alcohol/drug use for employees. On 11/12/2024, Administrator A replied, "We do not have a pre-employment drug screen. We do have a policy that staff signs regarding drugs/alcohol." Administrator A emailed Surveyor a copy of this policy that was signed by Caregiver E. The policy read:
"Northwoods Assisted Living LLC prohibits the

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use of drugs or alcohol on its premises. We as a company want to uphold the reputation of a drug free facility. Although drug screenings are not required for pre-employment, we do reserve the right to drug test if we feel the need to for the follow reasonings: [sic]
If an accident has occurred where you or a resident of the facility have been injured (this does not include falling or self-harm of residents.)
The smell of alcohol or drugs is present
We catch you in the act of using drugs
We feel that you are acting under the influence.
If for any of the above reasons occur and you need to be tested, the manager or owner will bring you to the facility [sic] we decide to have a drug screen done. If you fail the drug screen it will result in immediate termination. By signing and dating this document it means you understand and agree to the above terms."

On 11/13/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A. Surveyor asked Administrator A to explain the field trip to Michigan. Administrator A told Surveyor they took the residents to dinner and to a waterfall. Administrator A told Surveyor the guardians were not aware they were going out of state. Surveyor asked Administrator A about the THC that was found in the vehicle. Administrator A told Surveyor s/he only purchased a 1 gram bag in Michigan the other items were already in the vehicle. This contradicts the police report that indicated Administrator A admitted to purchasing 2 sealed bags of Candela and THC gummies in Michigan. Administrator A told Surveyor they left the facility in the afternoon around 3:00 - 4:00 p.m. Surveyor asked where the residents used the bathroom and where they ate. Administrator A said they stopped at gas stations to use the bathroom. S/he said Caregiver E assisted Resident 1 and

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M 230	Continued From page 17 Resident 3 and s/he assisted Resident 2. Administrator A said they got done eating supper around 8:00 p.m. - 8:30 p.m. and they assisted the residents with using the bathroom last at that time. Administrator A told Surveyor that Licensee B was "well aware" of the incident. S/he said Licensee C was also aware and Administrator A and Caregiver E received a 3 day suspension. Administrator A said Licensee C notified all of the guardians of the incident. This contradicts Surveyor's interview with Guardian M, who told Surveyor s/he was not aware of this incident. Surveyor asked Administrator A if the vehicle was registered and the if the headlight was fixed. Administrator A said s/he did register the vehicle, but the headlight is still not fixed. Surveyor asked Administrator A if s/he would do things differently. Administrator A told Surveyor, "Absolutely, I would have done things differently. I should have taken illegal substances out ... I feel terrible. I put everyone in an awkward situation. "	M 230		
{M 276}	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was safe, well-maintained, and a homelike environment. This requirement is being cited for the third time.	{M 276}		

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{M 276}	Continued From page 18 See Statement of Deficiency (SOD) T6KY12, dated 06/18/2023, and SOD YQ4612, dated 05/28/2024. Findings include: On 11/07/2024 at approximately 8:00 a.m., Surveyor toured the facility and observed the following: Resident 2's room: There was an approximate 12 inch square board 1/4 inch thick on the floor that was not fastened down. Surveyor moved the board with his/her foot, which revealed a hole in the floor where there was an uncovered vent. There was another vent on the floor that was rigid and lifted approximately 1/4 inch off the floor that could be a tripping hazard. There was no screen on the window. There was a twin size mattress lying in the yard outside of the window. The smoke detector was hanging off the ceiling by a nail. Resident 2 was observed walking throughout the facility with a shuffled gait and was barefoot. Resident 3's room: One of the 4 lights did not have a cover over the bulbs. Resident 1's room: One of the 4 lights did not work. The rigid vent on the floor was lifted up 1/4 - 1/2" on the edge, which could potentially be a tripping hazard. There was no screen on the window. Resident 4's room: One of the 4 lights did not turn on. Office: The lights were hanging by chains from the	{M 276}		

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{M 276}	Continued From page 19 ceiling. The drywall had multiple unfinished areas. Storage room: The lights had wires hanging out of them. Activity area near shower room: The flooring tiles were loose and lifting off the floor. Caregiver D told Surveyor water leaked outside of the shower room into the activity area. Shower room: There were no paper towels to dry hands after handwashing. The grab bar by the toilet was broken off the wall on one side. There was a plastic folding chair located in the shower area. The shower chair located in the activity area had only 3 legs. The stripping around the shower was coming off. Men's bathroom: There were no paper towels to dry hands after handwashing. the toilet paper holder was broken off the wall. The grab bar was rusty and had rough metal edges exposed where the bar was connected to the wall. There were wires showing from the lights. Women's bathroom: The toilet paper holder was broken off the wall. On 11/13/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A. Administrator A told Surveyor Licensee B and Licensee C were responsible for the upkeep on the home. S/he said Licensee C had a list of repairs and had installed new flooring in the activity area after Surveyor left on 11/07/2024.	{M 276}		

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{M 334}	Continued From page 20	{M 334}		
{M 334}	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not have a battery in use in a smoke detector in Resident 1's bedroom. This is a repeat deficiency. See Statement of Deficiency YQ4612, dated 05/28/2024. Findings include: On 11/07/2024 at 8:07 a.m., Surveyor observed Resident 1's room. The battery operated smoke detector was located on the ceiling. The battery compartment was open and the battery was not connected. Surveyor showed Caregiver D. Caregiver D told Surveyor they did not have any 9 volt batteries.	{M 334}		

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M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received prompt and adequate treatment. Resident 1 fell on his/her face in the shower. Staff did not document any monitoring of Resident 1. Resident 1 did not receive a medical evaluation for over 24 hours. Resident 1 sustained multiple fractures and a pneumothorax. Findings include: On 11/06/2024, the Department received a complaint that alleged a resident fell, sustained multiple injuries, and was hospitalized. On 11/07/2024 at approximately 6:00 a.m., Surveyor interviewed Caregiver D. Caregiver D told Surveyor Resident 1 was in the hospital. Surveyor asked what happened to Resident 1. Caregiver D said that as far as s/he knew, Resident 1 fell on 11/04/2024. Caregiver D told Surveyor staff did not report to him/her what happened to Resident 1 and staff did not document on Resident 1. Caregiver D told Surveyor s/he arrived at work on 11/05/2024 at 5:55 a.m. S/he said s/he did not locate another staff member when s/he arrived. Caregiver D said that around 7:30 a.m., s/he asked Resident 1 if s/he wanted breakfast. Caregiver D said Resident 1 waved Caregiver D off. Caregiver D said s/he went back into his/her room at approximately 8:30	M 580		

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a.m. with his/her morning medications and that is when s/he got a "full look at what [s/he] looked like." Caregiver D told Surveyor s/he documented it in his/her notes. Caregiver D provided Surveyor with his/her notes on Resident 1.

On 11/07/2024 at approximately 6:45 a.m., Surveyor interviewed Administrator A. Administrator A told Surveyor Resident 1 fell in the shower. S/he said Caregiver E was present when Resident 1 fell. Administrator A said s/he came to the facility the next day with Caregiver E and they decided to take Resident 1 in for a medical evaluation.

On 11/07/2024, Surveyor reviewed Resident 1's notes. There were no notes documented on 11/04/2024. On 11/05/2024, Caregiver D documented the following: "[Resident 1] has bruised eye [purple in color] [sic] lower part of eye, staff asked [Resident 1] if [his/her] eye hurts {[s/he said yes} [sic] [s/he] has quarter size red mark above [his/her] eye and red mark [quarter size] [sic] on the side of [his/her] cheek bone area, [s/he] has red nose, and [s/he] had a bloody nose when staff came in to check on [him/her] this morning, [sic] [s/he] has a bruise on [his/her] hand [upper side] [sic] ring finger is black/grey in color and swollen [sic] staff asked if this hurt {[s/he] said yes} [sic] [s/he] has red spot [size of pencil eraser end] [sic] on the bridge of [his/her] nose from a previous incident which was reported to staff ... [Resident 1] has 4x4 in (inch) size Bruises [sic] on both of [his/her] knees [dark purple in color] [sic] [s/he] was breathing like is [sic] was hard for [him/her] staff asked if [s/he] was ok [[Resident 1] said yes and waved staff off] [sic] [s/he] was asked again if [s/he] wanted anything to eat and [[Resident 1] said No] [sic] [this staff member is unsure of when these

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bruises first occurred] [sic] ... [Resident 1's] other eye underneath [his/her] eye is bruised [sic] also starting of a bruise [grey in color slight purple starting] [sic] [s/he] went to the ER (emergency room) in [city] today @11:20 am with management to be checked out."

On 11/07/2024, Surveyor reviewed Resident 1's binder. Resident 1 was admitted to the facility on 11/15/2023, with a diagnosis of Rubenstein-Taybi syndrome (genetic condition characterized by moderate to severe intellectual disability). Resident 1's individual service plan (ISP), read, in part: "[Resident 1] will sometimes hang on to the wall or something close to keep [his/her] balance ... [Resident 1] can help wash some areas on [his/her] body. [S/he] needs full assist of 1 to complete bath ... [Resident 1] is nonverbal. [S/he] can say a few words and knows some sign language ..."

On 11/07/2024, Surveyor reviewed the shower sheets. Resident 1's last documented shower was 10/31/2024.

On 11/07/2024, Surveyor reviewed the employee schedule and the employee's handwritten timesheets. On 11/04/2024, the schedule indicated Caregiver E worked from 6:00 a.m. - 2:00 p.m., Caregiver N worked from 2:00 p.m. - 10:00 p.m., and Caregiver F worked from 10:00 p.m. - 6:00 a.m. Caregiver E's timesheet for 11/04/2024 was scribbled out and Caregiver F's timesheet indicated s/he worked from 10:00 p.m. on 11/03/2024 - 2:00 p.m. on 11/04/2024. Caregiver D told Surveyor there was no staff present when s/he arrived to work on 11/05/2024 at 5:55 a.m.

On 11/07/2024 at approximately 8:00 a.m.,

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M 580	Continued From page 24 Surveyor observed the shower room. There was a plastic folding chair in the walk in shower. The shower chair was sitting out in the activity area and had only 3 legs. There was also a banquet style dining chair in the activity area that was soaked. Caregiver D told Surveyor that when s/he returned to work on 11/05/2024, the shower chair was broken, and they were using the other chairs for a shower chair. On 11/07/2024, Surveyor emailed Administrator A and requested Resident 1's notes from July to current. On 11/11/2024, Administrator A emailed Surveyor Resident 1's notes. The notes only went through 11/01/2024. Administrator A did send the incident report on Resident 1's fall. The incident report summary, signed by Caregiver E on dated 11/04/2024, read, in part: "Shower was off. We were getting ready to exit shower. I turned to grab some towels and when I turned back [Resident 1] was mid fall [S/he] had fallen into the shower chair pretty hard. I attempted to grab [him/her], but [s/he] was wet and slipped out of my hands. [S/he] proceded [sic] to fall on the ground face first. I then helped [him/her] up and helped [him/her] sit on the toilet. I got [him/her] dressed and to the common area where I assesed [sic] [his/her] injuries. [S/he] had some scrapes on [his/her] face & nose." The immediate actions were: "I immediately did an assessment on [him/her]. I called [Administrator A] to inform of the fall. I got [him/her] dressed and brought [him/her] to the main living area ..." On 11/12/2024, Surveyor reviewed the provider's fall policy and procedure. The policy and procedure read, in part: "3. When staff become aware that a resident has fallen, staff will respond immediately to provide assistance to the resident.	M 580		

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4. Staff will:
a. Determine the resident's level of consciousness.
b. Evaluate the resident's ability to move extremities.
c. Question the resident about pain ...
d. Determine if the resident has wounds and or bruises (note location, size and appearance).
5. Staff will provide first aid as needed ...
6. Staff will check the resident's vital signs if the resident is able to cooperate and activity is not hampered by any injuries the resident may have incurred.
7. Staff will encourage the resident to arise with assist from staff only if the resident is able to actively participate, does not report pain and does not have apparent injury ...
14. Staff will monitor the resident and document the resident's condition no less than every shift for 48 hours after the fall to ensure the resident's condition is stable and to address any further change of condition if noted."

Resident 1's notes did not include documentation of vital signs, ability to move extremities, or pain assessment.

On 11/12/2024, Surveyor reviewed Resident 1's medical records. The provider notes from the emergency department, dated 11/05/2024 at 12:26 p.m., read, in part:
"Chief Complaint
Fell yesterday @0930 (9:30 a.m.) in the bathroom; facial bruising, bruised finger, several injured toes; no LOC (loss of consciousness)
History of Present Illness
[age] [fe/male] presents [sic] emergency department for evaluation regarding ground-level fall. Original fall happened yesterday at 9:30 AM. Patient has a medical history including cognitive

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disorder, developmental disorder, esophageal stricture, history of bleeding ulcers, major depression, obesity, type 2 diabetes. Patient currently lives at an assisted living facility and staff was assisting the patient in the bathroom for [his/her] morning shower yesterday. Patient had a fall in the shower, patient has a walk-in shower at the assisted living facility, unfortunately [s/he] had tripped on the lip of the shower entry, where the patient had a semi-witnessed fall. Per staff, staff was reaching for a towel when the patient had fallen. The patient had reportedly fallen into a shower chair and landed on a tile surface with [his/her] face. They did give some Tylenol through the night, [s/he] had a dose of Tylenol earlier this morning. Staff was concerned about the face as it started to have some bruising around [his/her] nose, and but [sic] otherwise due to the patient's baseline they were hard to get a true history on what had happened and/or if the patient is having any other symptomatology as the patient does answer yes/no questions occasionally. Patient arrives via caregivers vitally intact and getting information from staff. [Guardian] has been contacted and was told to bring patient in for further exam. Here now for further eval (evaluation) ...
Medical Decision /Making ...
On exam patient has significant subcutaneous emphysema (air under the skin) in [his/her] right neck, right chest, right flank extending into the left as well. Multiple areas of bruising on the nose, right fourth finger, left second toe. As well as various bruising on [his/her] right knee. Elect to pan scan (whole body scan) the patient ..."

Resident 1's CT scans and x-rays revealed Resident 1 sustained a pneumothorax (collapsed lung) from a chest wall injury, lung contusion possible; multiple bilateral, anterior, lateral, and

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posterior rib fractures; transverse process fractures of the L1 and L2 vertebral bodies; extensive subcutaneous emphysema involving the chest, back, and upper abdomen; nasal bone fracture, fracture of 2nd toe on left side; right 4th finger fracture.
Resident 1 had a chest tube placed for the pneumothorax and was transferred to a level 2 trauma hospital.

On 11/05/2024, a trauma consult note documented, in part: "Per report, injuries secondary to multiple falls. Patient noted to have bruises of different ages throughout body. Given injury pattern and bruises of different ages, social work up consulted to assess need for APS (adult protective services) evaluation. Admit to SICU (surgical intensive care unit) overnight for pulmonary hygiene and pain control."

On 11/06/2024, hospital social services documented the following: "Social work received a consult for suspected abuse. Chart reviewed. This service met with the patient at bedside. With the assistance of the RN (registered nurse), all bruising visualized and pictures taken. Call placed to Rusk County APS. Discussed case. APS case opened at this time. Records sent. APS worker shared triggers for the patient that can cause [him/her] to become violent, such as touching [his/her] feet, big dogs, and violent TV or games. It was also shared that the patient has not had a violent outburst since 2020. Discussed with the RN. This service to follow."

On 11/12/2024, Surveyor emailed Administrator A and requested any documentation on Resident 1 after his/her fall and how often staff checked on Resident 1.

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M 580	Continued From page 28 On 11/13/202, Administrator A replied, in part: "[S/he] was checked every couple hours until bedtime. I arrived in the morning and that's when I took him to the ER. I attached the vitals that [Caregiver E] took and sent me as I requested them." The attached vitals were on a scratch sheet of paper and indicated at 10:15 (a.m. or p.m. not documented) blood pressure was 133/66, oxygen was 95%. At 10:45 (a.m. or p.m. not documented) blood pressure was 132/70 and 95 was written. It did not indicate if the 95 was pulse rate or oxygen saturation. At 1:30 (a.m. or p.m. not documented), a blood pressure of 122/65 was written. This was the only documentation Administrator A provided for monitoring Resident 1 after s/he sustained a fall onto his/her face. On 11/13/2024, Surveyor attempted to call Caregiver E, Caregiver F, and Caregiver N for interview regarding Resident 1's condition after his/her fall. None of the caregivers returned Surveyor's call. On 11/13/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A. Surveyor explained the discrepancy in the employee schedule and Caregiver E and Caregiver F's timesheets. Administrator A told Surveyor s/he would have to call Caregiver E and ask. Surveyor explained observations of the plastic folding chair in the shower and the wet banquet dining chair. Administrator A said that when Resident 1 fell onto the shower chair, the leg broke off the shower chair. Administrator A said Caregiver E told him/her that Resident 1 was seated on the shower chair and Resident 1 stood up on his/her own when s/he fell. Surveyor asked how staff were to know when they should call for emergency services after a resident falls and hits	M 580		

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M 580	Continued From page 29 their head. Administrator A said it would be when the resident loses consciousness or has swelling or bruising. Administrator A said Caregiver E did not report any swelling or bruising. Surveyor asked why there was no documentation in Resident 1's notes related to his/her fall. Administrator A said there was no documentation because Caregiver E completed an incident report. Surveyor explained concerns that when Caregiver D reported to work on the morning of 11/05/2024, no staff were present and s/he was not aware Resident 1 had a fall, as there were no notes. Administrator A said s/he would look into that. Administrator A said Caregiver D "probably didn't see" Caregiver F as one time Caregiver F waited in his/her vehicle until Caregiver D pulled in. Surveyor asked if Resident 1 had any other falls. Administrator A said s/he had a fall last December when s/he missed the recliner and fell onto the floor. The provider did not ensure Resident 1 received prompt and adequate treatment following a fall onto his/her face. Staff did not document their observations and vital signs of Resident 1 at least every shift (per the provider's policy). Resident 1 did not receive a medical evaluation until over 24 hours after the fall. Resident 1 sustained multiple fractures and a pneumothorax that required a chest tube placement.	M 580		
Z 022	50.065(3)(b) COMPLETE BACKGROUND CHECK PROCESS Every 4 years or at any other time within that period that an entity considers appropriate, the entity shall request the information specified in sub. (2) (b) 1. to 5. for all caregivers of the entity.	Z 022		

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This Rule is not met as evidenced by:
Based on record review and interview, the licensee did not ensure that a complete caregiver background check (CBC) was completed every 4 years for Administrator A and Caregiver E.

Findings include:

On 10/30/2024, the Department received a complaint with allegations of inappropriate conduct and supervision by caregivers.

A complete CBC consists of the following:

- A completed Background Information Disclosure (BID) form.
- A report of findings from the Department of Justice (DOJ).
- Government Findings Report (GFR) from the Department of Health Services (DHS).

On 11/12/2024, Surveyor reviewed Administrator A and Caregiver E's CBCs.

Administrator A's date of hire was 07/14/2022.
His/her BID was dated 07/14/2022.
His/her DOJ criminal records report was dated 10/03/2019. This was greater than 4 years ago.
His/her GFR was dated 04/20/2022.

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Caregiver E's date of hire was 01/30/2023.
His/her BID was dated 01/30/2023.
His/her DOJ report was dated 11/04/2020.
His/her GFR report was dated 11/04/2020.
Caregiver E's DOJ and GFR reports were greater than 4 years old.

On 11/13/2024, Surveyor reviewed Price County Sheriff's Office Incident Report, 24-1702. The report indicated on 07/27/2024 at approximately 9:55 p.m., Lieutenant (Lt.) H conducted a traffic stop and found Administrator A and Caregiver E to be in possession of THC (tetrahydrocannabinol) and drug paraphernalia. Lt H's report read, in part: "I detected a pungent odor coming from the vehicle ... I knew the odor to be that of marijuana ... I requested [Deputy I] and [Wisconsin State Trooper J] respond to my location due to the anticipation of searching the vehicle and [Caregiver E] having a lengthy criminal history and [him/her] being on probation." The report indicated Resident 1, Resident 2, and Resident 3 were present in the vehicle during this traffic stop.

On 11/13/2024, Surveyor reviewed the Wisconsin Circuit Court Access web site. Caregiver E had 12 open cases, including multiple felony charges for bail jumping and a disorderly conduct charge.

On 11/13/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A. Administrator A told Surveyor Licensee B and Licensee C were aware of Administrator A and Caregiver E being pulled over and found to be in possession of drugs and drug paraphernalia with 3 residents. Administrator A told Surveyor s/he was not aware the caregiver background checks were required every 4 years.

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Z 022	Continued From page 32 The licensee did not ensure a caregiver background check was completed every 4 years for Administrator A and Caregiver E.	Z 022		