| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0012086 | A. BUILDING: _____ B. WING _____ | R-C 10/02/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAPLE RUN CBRF | N2489 WENHAM RD FORT ATKINSON, WI 53538 |

| (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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| {N 000} | Initial Comments<br><br>On 10/02/2023, Surveyor conducted a verification visit at Maple Run CBRF.<br><br>Two deficiencies were identified.<br><br>One of 2 deficiencies was a repeat violation. See statement of deficiency (SOD) IN2M11, dated 02/09/2021.<br><br>All other deficiencies from SOD 07SK11, dated 02/27/2023 were substantially corrected.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 6 | {N 000} | | |
| N 164 | 83.12(4)(b) Reporting when law enforcement is called.<br><br>A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not send a written report to the Department within 3 working days after law enforcement personnel were called to the facility as a result of an incident that jeopardizes the health, safety, or welfare of resident or | N 164 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| N 164 | Continued From page 1 | N 164 | | |

employees. Resident 1 was involved in a physical altercation with Caregiver E that resulted in law enforcement coming to the facility.

Findings include:

On 09/27/2023, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 was admitted on 11/24/2020 with diagnoses including ADHD, depressive disorder, schizoaffective disorder, and traumatic brain injury. Resident 1 had a guardian that makes decisions on his/her behalf.

Resident 1's incident report dated 07/27/2023 documented:
"Staff was serving pizza and salad (dinner) to all residents. Everyone was sitting at the table, but [Resident 1]. [Resident 1] finally came and sat at the table while cursing for absolutely no reason. (Resident 1 seemed mad and irritable). Please note that this attitude has been going on since [s/he's] no longer allowed to go to work. Staff then said "everyone, by quiet and please eat your food." [Resident 1] visible got a lot angrier, stood up from [his/her] chair, came towards staff and shouted "I can do or say whatever the [expletive] I want, son of a [expletive]." [Resident 1] proceeded and got closer tot staff bumping [his/her] chest to the one of staff while still cursing at staff. Staff proceeded by pushing [Resident 1] back while touching [Resident 1's] chest and upper shoulder. [Resident 1] became even more aggressive and pushed staff toward the nearest couch. Staff had both [his/her] hands up when this was happening and fell (on the couch). Staff pulled back and shouted (spoke loudly) toward [Resident 1] "stay away from me, you can do or say whatever you want but cannot get physical

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| N 164 | Continued From page 2 | N 164 | | |

with me." This is when other residents stated "we will get you kicked out of this house." Staff then went outside and called [Program Manager D] to have a supervisor come in."

On 09/27/2023 at 11:15 AM, Surveyor interviewed Program Manager D. Program Manager D stated an anonymous person wrote a letter regarding the above incident to Fort Police Department and they had Jefferson County Sheriff's Office respond to the facility. Program Manager D stated s/he cannot recall what date Jefferson County Sheriff's Office came to the facility, but noted s/he was at the facility and told the deputy, Resident 1 was in jail and to contact Director A.

Surveyor reviewed an email between Director A and Deputy F dated 08/15/2023-08/16/2023 documenting:

Deputy F to Director A-08/15/2023:
"Hi [Director A],
The Sheriff's Department received an anonymous call that was sent to Fort Atkinson Police Department via the mail. It stated there was a possible abuse between a worked only named as [Caregiver E] and a client identified as [Resident 1]. This happened August 1it stated. It took place at the provider's address.

I [Deputy F] stopped there and they said the employee works at a different facility and the client is not there. If this is something that needs to be investigated, please contact our department. It if has been taken care of just advise so we can close it out.
Director A to Deputy F-08/16/2023:
Hello [Deputy F],
I [Director A] missed you on a call so I [Director A] left you an at length voicemail. It seems the report

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| N 164 | Continued From page 3 | N 164 | | |

you received was quite the opposite of what occurred. [Resident 1] was put on PO hold as [s/he] was the aggressor in the situation and the staff tried to push [him/her] away after [Resident 1] got up and chest bumped [him/her]. The resident then pushed the staff onto the couch. The staff called us and requested to be removed from the home because [s/he] did not feel safe. Myself [Director A], office manager, and [Program Manager D] were all there within minutes. [Resident 1] had no marks on [him/her] at all or any redness to indicated [s/he] had been touched. We talked with the staff and other residents and they confirmed this is what occurred. There was one resident who is [Resident 1's] best friend in the home who wanted to build on the story to try to get [Resident 1] out of trouble but [Resident 1] did admit to [his/her] parole office that [s/he] aggressed towards the staff and [his/her] parole officer did decide to lock [him/her] up."

On 10/02/2023, Surveyor reviewed Department records. There were no self-reports in the Department files regarding the above incident.

On 10/02/2023 at 3:50 PM, Surveyor interviewed Director A. Director A confirmed s/he did not report the above incident to the Department. Director A stated s/he thought since Resident 1 got locked up and the police did not open an investigation everything was handled. Director A noted after reviewing the code requirement, the above incident should have been reported to the Department.

Cross Reference:
N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments

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|---|---|---|---|---|
| N 381 | Continued From page 4 | N 381 | | |
| N 381 | 83.35(1)(a) Pre-admission and ongoing assessments.<br><br>Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.<br><br>This Rule is not met as evidenced by:<br>Based on record review, and interview, the provider did not ensure an assessment was completed for Resident 1 when there was a change in needs.<br><br>Resident 1 was not re-assessed when s/he displayed physical aggression towards staff.<br><br>This is a repeat violation, see statement of deficiency (SOD) IN2M11, dated 02/09/2021.<br><br>Findings include:<br><br>On 09/27/2023, Surveyor completed a verification visit and reviewed Resident 1's record. The following was found:<br><br>Resident 1 was admitted on 11/24/2020 with diagnoses including ADHD, depressive disorder, schizoaffective disorder, and traumatic brain injury. Resident 1 had a guardian that makes decisions on his/her behalf. | N 381 | | |

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|---|---|---|---|---|
| N 381 | Continued From page 5<br><br>Resident 1's change in condition assessment dated 06/09/2023 documented:<br>"Interaction-Independent:<br>Current status: ....[Resident 1] also has a history of getting verbally aggressive if [s/he] does not get what [s/he] wants in the time [s/he] feels [s/he] should have it. [S/he] does not respond well to controlling like language.<br>Service Provider Responsibilities: ...Staff will attempt to talk [Resident 1] down when [s/he] is upset, if this does not work [s/he] has a PRN for anxiety and [s/he] will ask for these if [s/he] can't calm down."<br><br>Aggressive/Combative: [Resident 1] has displayed no aggressive behaviors since admission."<br><br>The record did not contain any other assessments.<br><br>Resident 1's incident report dated 07/27/2023 documented:<br>"Staff was serving pizza and salad (dinner) to all residents. Everyone was sitting at the table, but [Resident 1]. [Resident 1] finally came and sat at the table while cursing for absolutely no reason. (Resident 1 seemed mad and irritable). Please note that this attitude has been going on since [s/he's] no longer allowed to go to work. Staff then said "everyone, by quiet and please eat your food." [Resident 1] visible got a lot angrier, stood up from [his/her] chair, came towards staff and shouted "I can do or say whatever the [expletive] I want, son of a [expletive]." [Resident 1] proceeded and got closer tot staff bumping [his/her] chest to the one of staff while still cursing at staff. Staff proceeded by pushing [Resident 1] back while touching [Resident 1's] chest and | N 381 | | |

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|---|---|---|---|---|
| N 381 | Continued From page 6 | N 381 | | |

upper shoulder. [Resident 1] became even more aggressive and pushed staff toward the nearest couch. Staff had both [his/her] hands up when this was happening and fell (on the couch). Staff pulled back and shouted (spoke loudly) toward [Resident 1] "stay away from me, you can do or say whatever you want but cannot get physical with me." This is when other residents stated "we will get you kicked out of this house." Staff then went outside and called [Program Manager D] to have a supervisor come in."

Director A's administration follow up report dated 08/01/2023 documented:
"[Resident 1] and [Caregiver E] were engaging in verbal argument, [Resident 1] was upset that supper was taking too long to complete, [Resident 1] got up from table towards staff, they chest bumped, staff put hand out to stop [Resident 1] when stopping [him/her], [his/her] hands slide up on to [his/her] neck. [Resident 1] shoved staff onto couch, several clients witnessed and agreed. Staff reported that the verbal has escalated over the last couple weeks between each other. Other staff arrived 4 minutes after reporting the incident, [Resident 1] was eating in [his/her] room and staff was still cleaning up supper and passing 6pm meds. There were no markings of any kind on [Resident 1's] neck. [Director A] and [Program Manager D] reported to the house, spoke with residents, agreed verbally heated. Removal of staff from this home moving forward and immediately that night, retrain in challenging behaviors. Did only work every other weekend and picked up some Thursdays. In parole officer meeting the next Tuesday (08/01/2023), [Director A] transported resident to [his/her] meeting. This had been reported to the care team and to the parole officer prior to the meeting. At the meeting, the parole officer

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|---|---|
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|---|---|---|---|---|
| N 381 | Continued From page 7<br>decided to revoke [Resident 1] and put [him/her] in jail for a few weeks to understand [s/he] was not allowed to physically chest bump staff and go after them even if [s/he] did not like them. The parole officer discussed [Resident 1's] past fights in jail and how [s/he] antagonized and started fights out of camera site."<br><br>Resident 1's progress noted documented: "07/14/2023: [Resident 1] was insolent and disrespectful toward staff this evening. ]S/he] attempted to challenge staff as to how and when dinner is to be prepared. Staff had stated that dinner would be ready for everyone to eat by 5:30 pm, which [s/he] seemingly disagreed with. [S/he] wanted food much earlier that that (4:30pm) and became verbally abusive (cursed) when staff's remained.<br>07/22/2023: [Resident 1] was rude and disrespectful toward staff. [Resident 1] seems to constantly get heated and angry when things don't go [his/her] way. As for today, [Resident 1] was verbally abusive and aggressive when told that dinner wouldn't be ready to eat before 6 o'clock."<br><br>On 09/27/2023 at 11:15 AM, Surveyor interviewed Program Manager D regarding the above incident. Program Manager D reported s/he took over this home at the end of July and the event between Resident 1 and Caregiver E was the only incident with alleged abuse. Program Manager D noted Director A completed an investigation and found Resident 1 to be the aggressor and could not substantiate the allegations. Program Manager D did not know if an updated assessment was completed after Resident 1's physical aggression incident on 07/27/2023. | N 381 | | |

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|---|---|
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|---|---|---|---|---|
| N 381 | Continued From page 8<br><br>On 10/02/2023 at 3:50 PM, Surveyor interviewed Director A. Director A reviewed Resident 1's most recent assessment dated 06/06/2023 during the interview and confirmed it did not include information about Resident 1 becoming physical aggressive. Director A looked through Resident 1's record during the interview and confirmed the provider did not have evidence an assessment was completed after Resident 1 had a change in needs. Director A stated the house had an interim manager during Resident 1's incident and it appears s/he did not complete an assessment.<br><br>Cross Reference:<br>N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called | N 381 | | |