STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018319	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELENS HOUSE GRAND CHUTE	4236 N SHADY WOOD CT APPLETON, WI 54912

(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 06/05/2025, with information gathered through 06/09/2025, Surveyor conducted a standard licensure survey at Helens House Grand Chute. Three deficiencies were identified. Census: 4	M 000		
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 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 1 of 2 resident's (Resident 1) Individual Service Plans (ISP) were reviewed at least every 6 months. Findings include: On 06/05/2025, Surveyor reviewed Resident 1's	M 424		

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

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M 424	Continued From page 1 record. Resident 1 moved into the home on 10/28/2021 and was represented by Power of Attorney (POA) and managed care organization (MCO) Care Manager (CM) G. Resident 1's ISP was dated 05/29/2024. Resident 1's ISP did not contain CM G's signature. The ISP should have been reviewed in 11/2024 and 05/2025. On 06/05/2025, at approximately 12:30 PM, Surveyor interviewed Program Manager B. Program Manager B stated s/he would review the ISPs and ensure they were updated timely and the proper care team members reviewed and signed them. On 06/09/2025 at 3:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he understood the concern.	M 424		
M 440	88.07(2)(b)1 SUPERVISNG & ASSISTING WITH ADLS Supervising or assisting a resident with or teaching a resident about activities of daily living. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure all activities of daily living services (ADLs) were provided for 1 of 1 resident.	M 440		

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M 440	Continued From page 2 Resident 1 did not receive supervision with toileting cares. Findings include: The licensee is able to serve up to 4 residents within the client groups of traumatic brain injury, advanced aged, irreversible dementia/Alzheimer's, physically disabled, terminally ill, and developmentally disabled. On 06/05/2025, at approximately 10:20 AM, Surveyor interviewed Hospice Nurse C while s/he was providing cares to Resident 1. Hospice Nurse C stated s/he had been contacted that morning stating that Resident 1 was unable to bear weight onto his/her right leg and his/her knee appeared swollen. Surveyor observed Resident 1's knee which was swollen in appearance and was turning a golden color, due to bruising. Resident 1 appeared to grimace when s/he attempted to readjust him/herself in his/her recliner. Hospice Nurse C stated s/he asked Caregiver D if Resident 1 had sustained a fall. Caregiver D informed Hospice Nurse C that s/he had not been informed of any falls but would contact other staff who worked the day before. Hospice Nurse C stated Caregiver D then informed him/her that Caregiver E found Resident 1 on the ground in the bathroom, while s/he was assisting another resident. Surveyor asked Hospice Nurse C if Resident 1 was able to ambulate independently. Hospice Nurse C stated Resident 1 was a pivot transfer and ambulated solely with his/her wheelchair. Resident 1 was unable to ambulate independently with the wheelchair. Hospice Nurse C stated Resident 1 would now require a sit-to-stand lift or a Hoyer lift. On 06/05/2025, at approximately 10:50 AM,	M 440		

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M 440	Continued From page 3	M 440		

Surveyor interviewed Caregiver D. Surveyor asked Caregiver D to explain what s/he had learned about Resident 1's injury of unknown origin. Caregiver D stated s/he had contacted Caregiver E who stated s/he had assisted Resident 1 into the bathroom for toileting. Resident 2 required assistance, so Caregiver E went to assist Resident 2, whose room was attached to the shared bathroom. When Caregiver E returned to the bathroom, Resident 1 was on his/her knees on the bathroom floor.

On 06/05/2025, at approximately 11:10 AM, Surveyor observed Caregiver E speaking with Caregiver D. Caregiver E stated, "I went into the bathroom, and [s/he] was on [his/her] knees. I couldn't say it was a fall. Is [s/he] injured?" Caregiver D stated, "Yes, [his/her] knee is swollen and bruised."

On 06/05/2025, at approximately 11:18 AM, Surveyor observed Nurse H speaking with Caregiver E. Caregiver E stated, "[S/he] must have tried to stand up. I ran in by [Resident 2] for a minute and when I came back [Resident 1] was on [his/her] knees. I didn't see [him/her] fall, so I did not think I needed to fill out any incident forms."

On 06/05/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home 10/28/2021.

Resident 1's "Individualized Service Plan," dated 05/29/2024, documented:
"Always use gait belt and wheelchair when transferring. HIGH RISK FOR SELF TRANSFERS * KEEP ALARMS ON AT ALL TIMES!! ..... Full cares for ADLs"

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M 440	Continued From page 4 "Mobility - Resident needs assistance with transferring. On 06/05/2025, at approximately 12:30 PM, Surveyor interviewed Program Manager B. Surveyor explained what s/he had learned about Resident 1's injury. Program Manager B stated s/he had not been made aware of Resident 1's injury and would conduct an internal investigation. On 06/09/2025 at 3:00 PM, Surveyor interviewed Licensee A. Licensee A stated Caregiver E had been re-educated. Licensee A stated Caregiver E should not have left Resident 1 unsupervised while s/he was being toileted.	M 440		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 2 residents received prescribed medications in the proper dosage and administration times. Resident 1's Melatonin was not administered as prescribed.	M 582		

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M 582	Continued From page 5 Resident 4's Atorvastatin (cholesterol and fats medication), Balsalazide Disodium (anti-inflammatory drug), and Risperidone (psychotropic) as prescribed. Findings include: On 06/05/2025, at approximately 12:15 PM, Surveyor and Program Manager B reviewed Resident 1's and Resident 4's medications in the med closet. Surveyor observed Resident 1's 'bedtime' blister card of Melatonin which did not have his/her 06/04/2025 evening dose dispensed. Surveyor observed Resident 4's 'bedtime' blister cards of Atorvastatin, Balsalazide Disodium, and Risperidone which did not have his/her 06/04/2025 evening doses dispensed. Surveyor asked Program Manager B if staff dispensed meds out of the blister cards based on the day of the month. Program Manager B stated, "The med cycle starts on the first of the month, so staff are trained to dispense meds off of the blister card that correlate with the date of the month." On 06/05/2025, at approximately 12:20 PM, Surveyor and Program Manager B reviewed Resident 1's and Resident 4's June 2025 Medication Administration Records (MARs) which documented: Resident 1's MAR did not document that s/he had received his/her Melatonin on 06/04/2025 which was scheduled at 8:00 PM. Resident 4's MAR did not document that s/he had received his/her Balsalazide Disodium and Risperidone on 06/04/2025 which was scheduled at 8:00 PM. The MAR documented that his/her Atorvastatin was administered at 8:00 PM. Program Manager B stated s/he would be	M 582		

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M 582	Continued From page 6 reviewing the medication administration errors with the staff. Program Manager B stated, "Staff are to review the MARs, along with the blister cards of medications, during shift change, to ensure all medications were administered." On 06/09/2025 at 3:00 PM, Surveyor interviewed Licensee A. Licensee A stated all staff members that worked the evening of 06/04/2025 and the day shift of 06/05/2025 were written up for a med error. Licensee A stated, "Staff are to review the meds during shift change, which did not happen."	M 582		