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	0016649	A. BUILDING: _____ B. WING _____	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTING FOR MORE LOVE	6 MCKINLEY AVENUE RACINE, WI 53404

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M 000	INITIAL COMMENTS On 12/28/2023, with information gathered through 03/05/2024, Surveyor conducted a standard survey and compliant investigation at Hunting For More Love. As a result, 4 deficiencies were identified. One compliant was unsubstantiated. Census: 2	M 000		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a service agreement was completed for 1 of 1 resident reviewed. Resident 1 was admitted on 05/26/2023 and did not have a service agreement signed by his/her guardian. Findings include: On 01/16/2024 at 11:25 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted on 05/26/2023. Resident 1 was placed under	M 384		

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

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M 384	Continued From page 1 protective placement on 05/26/2023 at the facility. Resident 1 had a guardian. Resident 1's service agreement indicated it was a service agreement for Licensee A's other facility s/he operated and was signed by Licensee A on 05/25/2023 and Resident 1 on 05/27/2023. The admission agreement was not signed by Resident 1's guardian. The document read, "This service agreement is between [Resident 1] and Pride and Joy Adult Family Group Home LLC and shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or that person's guardian or designated representative." On 02/29/2024, at 3:10 p.m., Surveyor interviewed Licensee A and Attorney O regarding Resident 1's service agreement. Licensee A reported when Resident 1 moved in, there was a lot of paperwork to sign between Racine County, the Managed Care Organization (MCO), and the facility. Licensee A stated, "There was a lot going on. It may have been missed."	M 384		
M 408	88.06(3)(c) ASSESSMENT IDENTIFY NEEDS & ABILITIES The assessment shall identify the person's needs and abilities in at least the areas of activities of daily living, medications, health, level of supervision required in the home and community, vocational, recreational, social and transportation.	M 408		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not assess 1 of 1 resident to identify the needs and abilities in the areas of activities of daily living and level of supervision required in the home and community. Resident 1's initial assessment did not include a description of safety or an elopement plan to address behaviors including suicidal ideation, substance abuse or elopement. Resident 1 received 1:1 staffing from his/her Managed Care Organization (MCO) from 12/06/2023 to 12/20/2023 due to a suicide attempt at the facility on 11/25/2023. There was no assessment after Resident 1 returned to the facility after the suicide attempt.

Findings include:

On 12/21/2023, the department received a complaint alleging on 12/20/2023, Resident 1 either jumped or fell out of his/her second story bedroom window. Resident 1 was transported to hospital where s/he passed away the morning of 12/21/2023 from injuries related to the incident.

On 01/16/2024 at 11:25 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted on 05/26/2023, with diagnoses including obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), anxiety, alcohol induced dementia, history of suicide ideation and alcohol abuse. Resident 1 was placed under protective placement on 05/26/2023 at the facility. Resident 1 had a guardian.

On 01/16/2024 at 12:16 p.m., Surveyor requested

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copies of Resident 1's assessments from Licensee A via telephone. Licensee A stated, "I reassessed him/her at the hospital in December. I did not believe s/he belonged here anymore."

On 01/16/2024 at 12:46 p.m., Surveyor received fax from Manager D with an hourly checklist titled, "UTHealth Houston Behavioral Science Center Campus- Precautions Checklist (To be completed by Nursing Staff)." Surveyor did not observe Resident 1's name on the document. Section 1 had the date 12/20/2023 handwritten in. There were boxes below the date to check: 1. Suicide 2. Combative/destructive, 3. Fall risk, 4. Sexually acting out and 5. Elopement. There were boxes for both direct and observational 1:1 care. None of the boxes were checked. Section 2 provided a series of numbers associated with behaviors and locations. Section 3 provided a table to fill in with time, code and initial of staff. Surveyor observed staff initials and codes indicating location of individual. No observations were recorded on behaviors. The bottom of the document provided a space for staff initials and printed names. Surveyor observed Caregiver L's, Caregiver M's, and Caregiver N's signatures.

On 01/16/2024 at 1:21 p.m., Surveyor reviewed the providers 'one on one' observation policy. The policy was in Caregiver N's and Caregiver K's files. The caregiver's names were written on top of the policy. Surveyor did not observe the facility name, a resident name, or a date on the documents. The policy read:

"Purpose: the purpose of this document is to [sic] 1. Clarify the booking and approval process for 1:1 care both in core working hours and outside core hours for those patients who require an increased level of supervision which cannot be

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provided by daily nursing establishments.
2. To clarify, the cohort of patients deemed appropriate for this increased level of supervision.
3. To clarify the risk assessment process for this group of patients.
4. To ensure that the following controls and safety measures have been considered and/or in place before and during 1:1 care.
5. Ensure that the patient's surroundings are safe.
6. Develop an appropriate care plan-which is regularly reviewed.

Roles and responsibilities:
1. Engaging and interacting with the patient whenever the opportunity arises [sic]
2. monitoring [sic] and reporting any changes in behavior or condition to management [sic]
3. Recording and reporting of vital signs [sic]
4. Ensuring the patient has adequate nutrition and hydration [sic]
5. Providing assistance with personal care [sic]
6. Any other appropriate care or assistance as needed [sic]"

On 01/23/2024 at 4:15 p.m., Surveyor reviewed Resident 1's pre-admission assessment, dated 05/19/2023.

Resident 1's pre-admission assessment dated 05/19/2023, did not address all required areas: level of supervision in the home and transportation. Resident 1's pre-admission assessment was divided into 0-3 ratings, in the following areas:
1. Sleep. This section was rated 3 and read, "Dependent on sleep aid or staff interaction."
2. Speech. Ability to communicate. This section was rated 0 and read, "Clear." Handwritten next to the rating was, "Communicates effectively."

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3. Emotional Behavior. This section was rated 1 and read, "Depression, withdrawn".
4. Socialization-Activities. This section was rated 2 and read, "Requires supervision."
5. Safety. This section was rated 3 and read, "High Risk". Handwritten next to the rating was, "30 min [sic] checks."
6. Health Monitoring. This section was rated 2 and read, "Daily Monitoring."
7. Dressing. This section was rated 0 and read, "Independent". Handwritten next to the rating was, "Independent."
8. Hygiene. This section was rated 0 and read, "Independent". Handwritten next to the rating was, "Able to make needs known."
9. Medication Management. This section was rated 0 and read, "Independent". Handwritten next to the rating was, "Independent."
10. Mobility/Transportation. This section was rated 0 and read, "Independent". Handwritten next to the rating was, "Independent."

Resident 1's pre-admission assessment did not identify plans to address behaviors including safety, suicidal ideation, substance abuse or elopement.

On 01/23/2024 at 4:20 p.m., Surveyor reviewed Resident 1's behavior risk evaluation assessment, dated 05/19/2023, which did not identify Resident 1 needed a safety or an elopement plan to address behaviors including suicidal ideation, substance abuse, or elopement. Surveyor observed box checked next to 'constant supervision required' with a handwritten note, "Every 30-minute checks."

On 01/31/2024 at 1:30 p.m., Surveyor reviewed Resident 1's facility medication and treatment incident report, dated 11/25/2023, read, " I went to

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M 408	Continued From page 6 [Resident 1's] room and asked if s/he was hungry or wanted his/her meds [sic] S/He said no [sic] I went to the kitchen to make the other residents food [sic] about ten minutes later I heard a bang [sic] I went to go see what it was [sic] I found [Resident 1] laying on the floor with a cut on his/her wrist [sic] I called the police around 3:30 PM [sic]" On 02/16/2024 at 9:30 a.m., Surveyor reviewed Resident 1's MCO placement summary, dated 05/09/2023. The following was identified: "- Behavior Issues: Property Destruction. Physically Aggressive. - Examples/Description of Behaviors: Kicked in door when intoxicated and couldn't figure out how to get it open, swung at staff while intoxicated. - Elopement Concerns: Yes. - Please Describe Elopement Risks: [Resident 1] has left the home to walk to local gas stations to obtain alcohol either by stealing or with funds s/he obtains from family, friends etc. - Other known Risks: Extensive history of substance use. Possible stealing and sexual activity to obtain alcohol. - Level of Required Supervision: Staff on premises. - Additional Comments related to Supervision: 15-minute checks related to suicidality and substance use. - Other Information/Comments or Pertinent Information Related to Member Placement. S/He is currently hospitalized due to a recent suicide attempt. - *Note* it is the responsibility of all providers to properly assess the member referred. Determination of appropriateness of the home/facility and provider capabilities should be considered. The care team will provide some information; however, the provider may identify	M 408		

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additional needs or variables during the assessment and the placement process. Please continue to communicate with the care team, before, during and following a placement."

On 02/16/2024 at 9:45 a.m., Surveyor reviewed Resident 1's MCO document titled, Elopement/Missing Person Response Plan, dated 06/06/2023. The following was identified:

"-Staff will attempt to keep Resident 1 busy focused on activities s/he enjoys during daytime hours. Keeping Resident 1 busy may assist in decreasing incidents of elopement. Staff will encourage him/her to participate in or watch group activities (if not interested in participating), assist him/her with listening to music or watching television show of interest, talk with him/her about topics of interest, etc.

-Resident 1 needs line-of-sight supervision (able to clearly see his/her actions, with no obstructions), whenever s/he is outside in the community to ensure his/her safety.

-Staff will check on Resident 1 at least every 30 minutes day and night when s/he is inside his/her residence and there have not been any signs signals or high-risk factors for possible elopement or self-harm within the past 72 hours.
-Staff will monitor Resident 1 closely to potential risk of exiting exterior doors to residence."

The document also included a 7-step elopement response plan and a 6-step missing person's plan. The document was signed by CM F, Resident 1, Guardian C, Licensee A and Nurse Care Manager (RN CM) G.

On 02/16/2024 at 10:45 a.m., Surveyor reviewed

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Resident 1's MCO document titled, 'Safety Plan', dated 06/06/2023, which identified warning signs, internal coping strategies, people and social settings that provided distraction for Resident 1, people whom Resident 1 and staff could ask for help from including professionals, or agencies Resident 1 could contact during a crisis. The document also identified how to ensure Resident 1's environment was safe. The document was signed by Care Manager CM F, Resident 1, Guardian C, Licensee A and RN CM G.

Surveyor did not observed information from 06/06/2023 or 09/12/2023 Elopement/Missing Person Response Plan or Safety Plan in Resident 1's original assessment or ISP.

On 02/16/2024 at 11:15 a.m., Surveyor reviewed Racine Police Department Rescue Run report, dated 11/25/2023. The report read, "[Resident 1] cut his/her wrists and was found semi-conscious by group home staff, in the upstairs bathroom. It appears s/he used a nail from baseboard trim s/he ripped from the wall. Racine fire department transported him/her to the hospital."

On 02/16/2024 at 3:30 p.m., Surveyor reviewed Resident 1's MCO visit/observation notes. The following was identified:

On 06/06/2023, RN CM G wrote, "Interdisciplinary Team (IDT) met with [Resident 1], [Guardian C], [Licensee A]. Paperwork for elopement plan, safety plan, and restrictive measures regarding privacy and possessions were reviewed and signed by all parties present."

On 07/26/2023, CM F wrote, "Provided a copy of Safety Plan, Elopement Protocol, and Client Rights Limitations to [Guardian C] and [Licensee

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M 408	Continued From page 9 A]." On 07/27/2023, CM F wrote, "Correspondence with [Guardian C] and [Licensee A], [RN CM G], Behavioral Health Specialist (BHS) J and Racine County team regarding behavioral/mental health resources for [Resident 1] including psychotherapy and Smart Recovery program." On 10/09/2023, CM F wrote, "Received update from Hunting for More Love [Licensee A] that [Resident 1] was found with alcohol in the AFH (adult family home) and is given 30-day notice." On 11/27/2023, RN CM G noted Resident 1 admitted to hospital on 11/25/2023 for suicide attempt-cut wrists. Factors possibly contributing to hospitalization: mental health. On 12/06/2023, CM F wrote, "Received an update from [Supervisor H] that Hunting for More Love AFH owner, [Licensee A] has refused to accept [Resident 1] back from hospital due to advising s/he is not able to provide the supports [Resident 1] needs to maintain his/her safety without 1:1 staffing." On 12/06/2023, Behavioral Health Consultant (BHC) P wrote, "All current plans and protocols (routine safety checks, Safety Plan, Elopement Protocol, Crisis Plan, Client Rights Limitation or Denial Document) will continue to be implemented at Hunting For More Love AFH." Interviews On 01/16/2024 at 9:50 a.m., Surveyor interviewed Resident 2 who stated s/he saw Resident 1 in the bathroom, upstairs and s/he was bleeding. S/he ran downstairs and got the staff. The police and	M 408		

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the ambulance came and took him/her away. "I think that was a couple weeks ago. It was scary."

On 01/16/2024 at 10:08 a.m., Surveyor interviewed Manager D who confirmed Resident 1 tried slitting his/her wrists on 11/25/2023. Resident 1 was hospitalized from 11/25/2023-12/06/2023. According to Manager D, Licensee A spoke to the hospital and told them the AFH was not a safe place for [Resident 1] because there was only one staff per shift. "We could check on him/her, but we couldn't follow him/her if s/he eloped." Manager D confirmed Resident 1 was assessed for elopement behaviors upon move-in and they were aware of Resident 1's elopement history. The 1:1 staffing was a result of Resident 1's suicide attempt on 11/25/2023. Manager D stated s/he did not know if Licensee A reassessed Resident 1 after the 11/25/2023 incident. Manager D recalled the only change to Resident 1's care plan was the addition of 1:1 staff. "When s/he moved, we moved. Basically, we followed him/her."

On 01/16/2024 at 10:23 a.m., Surveyor requested copy of re-assessment and updated ISP after 12/06/2023 hospitalization. Manager D stated, "I just wrote a note in the ISP, but I didn't date it. The 1:1 is not written in the ISP. The MCO never gave us a clear understanding of what we were receiving, so we did not update the plan."

On 01/16/2024 at 10:08 a.m., Surveyor interviewed Licensee A. Surveyor asked when Resident 1 was reassessed to reflect new behaviors and new caregiver interventions. Licensee A stated, "Resident 1 was reassessed on 12/04/2023. I did not feel s/he was a good fit for our home. I had to take [Resident 1] back because s/he was on protective placement."

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M 408	Continued From page 11 On 01/16/2024 at 10:55 a.m., Surveyor requested all assessments for Resident 1. On 01/17/2024 at 1:14 a.m., Surveyor received email scan from Licensee A containing Pre-Admission Assessment, dated 05/19/2023, and Behavior Risk Evaluation, dated 05/19/2023. Both documents were signed by Licensee A. No other assessments were provided. On 02/13/2024 at 8:05 a.m., Surveyor interviewed CM F, who explained the MCO had developed an elopement protocol and safety plan after resident 1's first suicide attempt at another group home. "We provided it to [Licensee A] before [Resident 1] moved in to be sure s/he could handle those behaviors. During the first visit with [Resident 1], on 06/06/2023, we reviewed everything, and it was all signed by [Licensee A]. S/He was aware of the elopement issues, the alcoholism, and suicide watch." CM F explained Resident 1 was supposed to be on 30-minute checks. When Resident 1 attempted to elope, the safety plan, developed by the MCO, indicated Resident 1 should be on 15-minute checks for 72 hours. "The 1:1 was our last resort after the rights limitations, elopement/missing person response plan and safety plan. [Licensee A] would not take [Resident 1] back without 1:1 staffing. Prior to 1:1 staffing, they didn't have the staff to do anything else but call the police when [Resident 1] eloped. So that was a part of the safety plan." RN CM G and CM F explained the routine was outlined in the safety checks by the MCO. [Licensee A] was responsible to create a plan of care for the caregivers and a tracking plan.	M 408		

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M 408	Continued From page 12 On 02/13/2024 at 8:40 a.m., Surveyor interviewed Care Manager Supervisor (CMS) H, who stated after [Resident 1's] suicide attempt in November [Licensee A] did not want to take him/her back. [Licensee A] did not seem to understand what the court order and chaptering meant. The MCO team had to re-explain to [Licensee A] since [Resident 1] was court-ordered to live at [Licensee A]'s facility, the MCO could not just move him/her without legal approval. On 02/29/2024, at 3:12 p.m., Surveyor interviewed Licensee A and Attorney O regarding Resident 1's assessments. Licensee A confirmed pre-admission assessment dated 05/19/2023. Licensee A confirmed the only place s/he recorded information and documentation for residents were in his/her assessments. S/He then converted the information into the residents ISP. Licensee A reported when Resident 1 tried slitting his/her wrists on 11/25/2023, Resident 1 was hospitalized from 11/25/2023- 12/06/2023. Licensee A explained to re-admit Resident 1 after the 12/6/2023 hospitalization, s/he needed to implement 1:1 staffing. Licensee A stated s/he put a 1:1 policy in place and had the staff always stay with Resident 1. Licensee A stated, "I would not take [Resident 1] back unless s/he had 1:1 staffing." Licensee A further explained CM F left a message for him/her that the 1:1 staffing was approved to start 12/06/2023. However, Licensee A did not know what the parameters of the care and timespan were to entail. Licensee A explained before Resident 1 returned with 1:1 care, his/her staff was required to review the 1:1 policy. Licensee A stated, "This is what I required my staff to do with [Resident 1]. S/He was court ordered. S/He was on protective placement. S/He	M 408		

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	0016649	A. BUILDING: _____ B. WING _____	03/05/2024

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M 408	Continued From page 13 was not to leave." If Resident 1 left the facility, Licensee A explained his/her staff would follow him/her, call 911, and encourage Resident 1 to return to the facility. Licensee A explained Resident 1 had issues with mental health and they "just could not provide the proper care for him/her." Licensee A described the assessment process on 12/06/2023 for Resident 1 which consisted of a conversation with a care manager and a nurse from the hospital and a conversation with Resident 1. Licensee A stated, "[Resident 1] was discharged on 12/06/2023 and s/he died on 12/20/2023. His/her ISP was not due yet. I had 30 days to revise the ISP with the changes. There was no updated ISP. I had 30 days to update it." Cross Reference: N0424 DHS 88.06(3)(d) Individualized Service Plan	M 408		
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	M 424		

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M 424	Continued From page 14 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 each resident's Individual Service Plan (ISP) was updated at least every 6 months and with changes for 1 of 1 resident. Resident 1's ISP was due for review and/or update by 11/28/2023 and was not updated/reviewed. Resident 1's ISP did not include a description of a safety plan or an elopement plan to address behaviors including suicidal ideation, substance abuse, or elopement. There were no interventions listed for staff to implement when Resident 1 had behaviors. Resident 1 had a change in condition after a psychiatric crisis and was discharged from the hospital on 12/06/2023. Resident 1 received 1:1 staffing from his/her Managed Care Organization (MCO) from 12/06/2023 to 12/20/2023 due to a suicide attempt at the facility on 11/25/2023. Resident 1's ISP was not updated to reflect Resident 1's updated supervision needs. Findings include: On 12/21/2023, the department received a complaint alleging on 12/20/2023, Resident 1 either jumped or fell out of his/her second story bedroom window. Resident 1 was transported to hospital where s/he passed away the morning of 12/21/2023. On 01/16/2024 at 11:25 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted on	M 424		

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05/26/2023 with diagnoses including obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), anxiety, alcohol induced dementia and history of suicide ideation and alcohol abuse. Resident 1 was placed under protective placement on 05/26/2023 at facility. Resident 1 had a guardian.

On 01/23/2024 at 4:15 p.m., Surveyor reviewed Resident 1's pre-admission assessment, dated 05/19/2023, which did not identify Resident 1 needed a safety or an elopement plan to address behaviors including suicidal ideation, substance abuse, or elopement.

On 01/23/2024 at 4:20 p.m., Surveyor reviewed Resident 1's behavior risk evaluation assessment, dated 05/19/2023, which did not identify Resident 1 needed a safety or an elopement plan to address behaviors including suicidal ideation, substance abuse. or elopement. Surveyor observed box checked next to 'constant supervision required' with a handwritten note, "Every 30-minute checks."

On 01/23/2024 at 4:25 p.m., Surveyor reviewed Resident 1's ISP, dated 05/28/2023, and was unable to locate interventions or methods to reduce elopements, missing persons plan, self-harm incidents, or alcohol incidents.

On the last page of the ISP, under behavior concerns, Surveyor read, "Property destruction [sic] [Resident 1] will get physically aggressive, [Resident 1] will kick doors [sic] swing at staff when [sic] being intoxicated. [Resident 1] will sneak out the home [sic] Sneak alcohol into the home [sic] into his/her room [sic] [Resident 1] will try to use razors for suicide attempts [sic] s/he need [sic] to be monitored at all times [sic] we do

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M 424	Continued From page 16 every 15 minutes safety checks [sic]." The ISP was signed by Licensee A and Care Manager (CM) F. Resident 1's ISP was not signed by Guardian C. On 02/16/2024 at 11:15 a.m., Surveyor reviewed Racine Police Department Rescue Run report, dated 11/25/2023. The report read, "[Resident 1] cut his/her wrists and was found semi-conscious by group home staff, in the upstairs bathroom. It appears s/he used a nail from baseboard trim s/he ripped from the wall. Racine fire department transported him/her to the hospital." On 02/16/2024 at 3:30 p.m., Surveyor reviewed Resident 1's MCO visit/observation notes. The following was identified: On 11/27/2023, RN CM G noted Resident 1 admitted to hospital on 11/25/2023 for suicide attempt-cut wrists. Factors possibly contributing to hospitalization: mental health. On 12/06/2023, CM F wrote, "Received an update from [Supervisor H] that Hunting for More Love AFH (adult family home) owner, [Licensee A] has refused to accept [Resident 1] back from hospital due to advising s/he is not able to provide the supports [Resident 1] needs to maintain his/her safety without 1:1 staffing." On 12/06/2023, CM F wrote, IDT (Interdisciplinary team) is in agreement to authorize 16 hours of 1:1 staffing per day for [Resident 1] during awake hours. No behavioral or suicide concerns noted during sleeping hours." Interviews	M 424		

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M 424	Continued From page 17 On 01/16/2024 at 9:25 a.m., Surveyor interviewed Lead Caregiver (LC) K who stated Resident 1 cut his/her wrists 3 weeks before the incident on 12/20/2023. Resident 1 was not on 1:1 supervision at that point. LC K could not recall if Resident 1 was on any kind of official checks before s/he cut his/her wrists. Resident 1 was staffed for 1:1 when s/he came home. LC K recalled the Managed Care Organization (MCO) bringing him/her back to the facility. On 01/16/2024 at 10:23 a.m., Surveyor requested copy of the updated ISP after the 12/06/2023 hospitalization. Manager D stated, "I just wrote a note in the ISP, but I didn't date it. The 1:1 is not written in the ISP. The MCO never gave us a clear understanding of what we were receiving, so we did not update the plan." On 02/09/2024 at 4:11 p.m., Surveyor interviewed Guardian C, who stated Licensee A voiced s/he did not want Resident 1 to come back to his/her facility after Resident 1 tried committing suicide. S/he did not want to take Resident 1 back. Guardian C stated Licensee A agreed to take Resident 1 back to the facility because the MCO approved one-on-one care for him/her. Guardian C stated the only care document s/he recalled for Resident 1 were from the MCO and Racine County. Guardian C stated, "[Licensee A] notified me via text when [Resident 1] cut his/her wrists with a nail...I never saw an ISP or signed anything like that. In November, I don't know if there was a new ISP or service plan. The only thing done differently was the addition of the one-on-one staffing." On 02/13/2024 at 8:05 a.m., Surveyor interviewed Care Manager (CM) F, who explained Resident 1 was supposed to be on 30-minute checks. When	M 424		

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Resident 1 attempted to elope, the safety plan, developed by the MCO, indicated Resident 1 should have been on 15-minute checks for 72 hours. CM F stated, "The 1:1 was our last resort after the rights limitations, elopement/missing person response plan, and safety plan. [Licensee A] would not take [Resident 1] back without 1:1 staffing. Prior to 1:1 staffing, they didn't have the staff to do anything else but call the police when [Resident 1] eloped. So that was a part of the safety plan."

On 02/29/2024, at 3:12 p.m., Surveyor interviewed Licensee A and Attorney O. Licensee A reported when Resident 1 tried slitting his/her wrists on 11/25/2023, Resident 1 was hospitalized from 11/25/2023 to 12/06/2023. Licensee A explained to re-admit Resident 1 after the 12/06/2023 hospitalization, s/he would need to implement 1:1 staffing. Licensee A stated s/he put a 1:1 policy in place and had the staff always stayed with Resident 1. Licensee A stated, "I would not take [Resident 1] back unless s/he had 1:1 staffing." Licensee A further explained CM F left a message for him/her that the 1:1 staffing was approved to start 12/06/2023. Licensee A stated, "[Resident 1] was discharged on 12/06/2023 and s/he died on 12/20/2023. His/her ISP was not due yet. I had 30 days to revise the ISP with the changes. There was no updated ISP. I had 30 days to update it."

Resident 1's ISP was not reviewed/updated in November 2023 for his/her 6-month review. Resident 1's ISP Was also not updated in December 2023 after 1:1 staffing was approved and implemented.

Cross Reference: N0408 DHS 88.06(3)(c) Assessment Identify Needs and Ability

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M 446	88.07(2)(b)4 RECORD OF MEDICAL VISITS AND REPORTS Keeping a current record of all medical visits, reports and recommendations for a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure they obtained a record of all medical visits and reports for 1 of 1 resident. Resident 1 was hospitalized from 11/25/2023-12/06/2023. Resident 1's file did not contain medical visits, reports, and recommendations from the 11/25/2023-12/06/2023 hospitalization.in his/her record. Findings include: On 01/16/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 05/26/2023 with diagnoses including obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), anxiety, alcohol induced dementia and history of suicide ideation and alcohol abuse. Resident 1 was placed under protective placement on 05/26/2023 at facility. Resident 1 had a guardian. Resident 1's record did not include a record of hospitalization from 11/25/2023-12/06/2023 and reports. On 01/16/2024, at approximately 10:10 a.m., Surveyor interviewed House Manager (HM) D regarding Resident 1's services. HM D reported Resident 1 tried slitting his/her wrists in November and was hospitalized for almost a week. HM D stated Resident 1's 1:1 care was triggered by the 11/25/2023-12/06/2023 hospitalization. HM D reported the facility was not	M 446		

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M 446	Continued From page 20 a safe environment for Resident 1 when there was only one staff person to monitor his/her safety. On 01/16/2024, at approximately 10:17 a.m., Surveyor requested Resident 1's hospitalization documentation from 11/25/2023-12/06/2023. HM D stated, "I'm not sure if s/he brought any paperwork back with him/her." On 01/17/2024, at 10:09 a.m., Surveyor corresponded with Licensee A via email regarding Resident 1's hospitalization documentation from 11/25/2023-12/06/2023. Licensee A responded, "I don't have that information because after the hospital stay [sic] s/he went over to an inpatient psychiatric facility where they didn't provide any discharge paperwork. I can reach out to his/her care team and ask for it." As of 02/20/2024, Surveyor did not receive any further information from Licensee A. On 02/29/2024, at 3:29 p.m., Surveyor interviewed Licensee A and Attorney O regarding Resident 1's 11/25/2023-12/06/2023 hospitalization. Licensee A confirmed Resident 1 returned to the facility on 12/06/2023. Licensee A confirmed s/he did not have medical visits, reports, and recommendations from Resident 1's 11/25/2023-12/06/2023 hospitalization.	M 446		