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	0014996	A. BUILDING: _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLOMON HILL RESIDENTIAL CARE	N5903 238TH STREET MENOMONIE, WI 54751

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M 000	INITIAL COMMENTS On 09/07/2023, Surveyor conducted a complaint investigation at Solomon Hill Residential Care. Data was collected through 09/26/2023. Three of 3 complaints were substantiated. Four deficiencies were identified. Census: 3	M 000		
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 observation, interview, and record review, the licensee permitted the existence or continuation of a condition that placed residents at risk. Home Manager (HM) A was permitted to work with residents while under investigation for abuse. Findings include: The provider is licensed to care for 4 adults in the client groups traumatic brain injury, irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and developmentally disabled. The facility has a separate staff living area that can be accessed through a door in the main entrance foyer. Based on prior survey	M 230		

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

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observations and the Department's correspondence with the provider, HM A and his/her spouse reside at the facility.

On 08/23/2023, 08/29/2023, and 08/30/2023, the Department received complaints related to resident care and treatment.

On 08/30/2023 at 2:30 PM, Surveyor interviewed adult protective services (APS) social worker, Social Worker (SW) I and criminal investigator, Investigator J. Investigator J explained s/he was investigating allegations that HM A abused Resident 1. SW I said Dunn County received a report on 08/24/2023 (Thursday) that HM A physically assaulted Resident 1 on 08/24/2023. Investigator J said the reporter recorded the incident on a cell phone. Investigator J stated the camera was placed in a pocket within a couple seconds into the recording, so it mostly captured HM A yelling at and threatening Resident 1.

On 08/25/2023 (Friday), SW I and Investigator J went to the facility and interviewed HM A and Caregiver G. Caregiver G was allegedly a witness to the recorded incident on 08/24/2023. Caregiver G denied witnessing wrongdoing but stated s/he believed the facility had hidden surveillance cameras that HM A and his/her spouse had access to. HM A denied any wrongdoing. SW I and Investigator J stated they planned to interview Caregiver G away from the facility later. SW I stated s/he recommended Resident 1, a nonverbal resident with intellectual disabilities who had been placed at the facility under a protective placement order, be emergently removed from the home to ensure his/her safety. SW I stated s/he worked with Resident 1's case manager, Case Manager (CM) K, and Resident 1's county social worker to find alternative

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placement that afternoon. SW I stated that when the alternative placement provider showed up at the facility to get Resident 1, HM A and Licensee H were on site and they stated they "refused to release custody of [Resident 1]." A deputy (Officer L) was called to the scene. Ultimately, Resident 1 remained at the facility until Monday, 08/28/2023.

SW I stated that while s/he and Investigator J were at the facility on 08/25/2023, APS received additional reports alleging HM A mistreated other residents at the facility.

Investigator J stated Licensee H and his/her spouse called the sheriff's department multiple times demanding to know the details of Investigator J's investigation. Investigator J stated they were informed each time that HM A was being investigated for assaulting Resident 1.

On 08/30/2023, Surveyor reviewed an email, dated 08/25/2023, from Officer L to SW I and Investigator J that read, "I was asked to stand by as another group home took custody of the resident from the allegations of the case you are working. While I was there, [Licensee H] arrived and was talking about suing the sheriff's office and DHS (Department of Health Services) for whatever happened today as [s/he] has an attorney... we could not get a hold of the [managed care organization] social worker that made the request [Resident 1] be moved, so Solomon Hills and the other group home agreed for the individual to stay at the group home until Monday [sic] when things could get figured out."

On 09/07/2023 at 8:45 AM, Surveyor arrived at the facility. HM A stated s/he was the only employee on site with 3 residents.

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At 9:02 AM, Licensee H arrived. Surveyor interviewed Licensee H. Licensee H stated s/he received a call from HM A at 3:00 PM on 08/25/2023 that Dunn County Sheriff and APS were at the facility. Licensee H stated HM A was upset and stated they were telling him/her s/he needed a vacation. Licensee H stated s/he called dispatch to try to gather information and was informed that SW I and Investigator J were gone for the day. Licensee H said s/he received a call about 45 minutes later from HM A stating an officer was back on site and trying- to take Resident 1 away. Licensee H stated, "I knew there were allegations toward [HM A], but I didn't know what they were... I'm assuming the allegations were serious because the police were involved." Licensee H stated s/he removed HM A from the floor and s/he had no contact with residents until Monday. Licensee H stated s/he spoke with Resident 1's county social worker (SW M) on Tuesday 08/29/2023, who informed Licensee H that there were concerns that HM A was physically violent. Licensee H stated, "I'm frustrated because if that's case, I need to look at removing [HM A] from the property." Licensee H said s/he spoke with Investigator J and SW I on Wednesday, 08/30/2023, and was informed that they were investigating allegations of abuse. Licensee H stated s/he believed after speaking with Investigator J and SW I that HM A was "cleared" of these physical abuse allegations but Licensee H also acknowledged the investigation was ongoing. Licensee H stated s/he was still unsure what happened on 08/24/2023 but s/he had heard staff reported the situation to police and recorded something on their cell phones. Surveyor asked if Licensee H talked to staff in attempt to gather more information and Licensee H stated, "No because I didn't believe it." Surveyor asked how Licensee H determined it

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was ok to allow HM A to return to work status; Licensee H stated, "Because [Investigator J] and [SW I] said there was no physical abuse."

At approximately 10:45 AM, Surveyor interviewed HM A. HM A described the 08/24/2023 incident that was being investigated by Dunn County. Surveyor asked if s/he shared any of these details with Licensee H. HM A stated, "No... Not yet. [S/he] has a lot going on." Surveyor asked who worked Friday, 08/25/2023, through Monday 08/28/2023. HM A stated Caregiver D and Caregiver G worked.

According to the staff schedule provided by HM A on 09/07/2023, HM A worked at the facility daily from 08/27/2023 (the Sunday prior to Resident 1 being removed from the home) to 09/07/2023.

On 09/18/2023 at 2:15 PM, Surveyor interviewed Licensee H. Licensee H stated HM A was placed on leave the afternoon of 09/07/2023 and had not had contact with residents since. Surveyor discussed the results of the survey. Licensee H discussed his/her plans to remove HM A and acknowledged Licensee H should have responded to the situation differently. Licensee H stated s/he learned a lot through this investigation and s/he could have done more to protect the residents.

On 09/20/2023 at 9:22 AM, Surveyor interviewed Resident 1's managed care case manager (CM), CM K. CM K stated s/he spoke with SW I on 08/25/2023 and, per SW I's recommendation, CM K found alternative placement for Resident 1 the same day. CM K stated s/he supported the move. CM K stated Resident 1's placing county gave the verbal OK to move Resident 1 immediately but Licensee H did not like that the amended

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M 230	Continued From page 5 protective placement order had not been signed by the judge. CM K stated it was typical to get verbal approval in these cases. CM K stated, "[Licensee H] understood [HM A] could be rough but [Licensee H] claimed the allegations were false and unsubstantiated... [Licensee H] put the blame on staff." On 09/25/2023, Surveyor received an email from SW I that read, in part, "I am Substantiating [HM A] for Emotional Abuse to [Resident 1]." SW I stated APS had open investigations for 3 other residents at the facility. Cross references: M0556 DHS 88.10(3)(e) Self-Direction M0572 DHS 88.10(3)(m) Freedom From Abuse	M 230		
M 512	88.09(1)(e) RESIDENT'S RECORD RETENTION The licensee shall retain a resident's record for at least 7 years after the resident's discharge. The record shall be kept in a secure, dry place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not retain Resident 1's record for at least 7 years after discharge. Findings include: On 09/07/2023, Surveyor requested Resident 1's record for review. House Manager (HM) A provided Resident 1's face sheet and record. Surveyor reviewed the record and did not find Resident 1's June and August medication administration record (MAR) or his/her individual	M 512		

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M 512	Continued From page 6 service plan (ISP). At 11:35 AM, Surveyor asked HM A if Resident 1's records were stored elsewhere. HM A stated Resident 1 was emergently discharged on 08/28/2023 and HM A sent Resident 1's ISP and MARs with Resident 1.	M 512		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure the resident right to self-direction was respected or promoted for 4 of 4 residents in the home. Restrictions were placed on residents for when they could eat, rest, or watch TV. Residents' access to the bathroom and their bedrooms was limited due to staff locking the doors. Findings include: The provider is licensed to care for 4 adults in the client groups traumatic brain injury, irreversible	M 556		

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dementia/Alzheimer's disease, advanced aged, physically disabled, and developmentally disabled.

On 08/23/2023, 08/29/2023, and 08/30/2023, the Department received complaints related to resident care and treatment.

On 08/29/2023, Surveyor reviewed a police report dated 08/29/2023. The report read, in part: "On August 24th, 2023 I was contacted by [Caregiver C] who wished to report abuse toward a resident...[Caregiver C] said [Resident 1] has a usual routine of wanting to go to the bathroom 3 or more times after lunch because [s/he] thinks [s/he] wet [him/herself]... [Caregiver C] and other staff are familiar with this routine and [Caregiver C] said [s/he] usually just wipes [Resident 1] up, tells [him/her] [s/he] is all clean and [s/he] leaves the bathroom. This process usually repeats several times each day after lunch.

[Caregiver C] said today after lunch, [Resident 1] went to the bathroom as was usual and then wanted to go to the bathroom again. [House Manager (HM) A] was present and became upset with [Resident 1] and told staff to lock the bathroom door and told [Resident 1] [s/he] could not go back to the bathroom for 2 hours. [Resident 1] got upset in response and [HM A] took [Resident 1's] blanket (which I understood was a consequence [HM A] used before). [Resident 1] became more upset and was trying to get the blanket back from [HM A] and [Caregiver B] stepped between them. During this, [Resident 1] bit [Caregiver B]."

The police report included details of a second incident that occurred on 08/24/2023, after Caregiver C left the facility. The second incident

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involved HM A and Resident 1 and was recorded on Caregiver B's cell phone.

On 08/30/2023, Surveyor reviewed the recording. The video was 2 minutes and 26 seconds, but according to Caregiver B, it was concealed in Caregiver B's pocket at 3 seconds. At 7 seconds a voice stated, "You are not going to the bathroom. Lock the bathroom door." A second voice replied, "It is locked." Surveyor recognized the first voice as HM A.

On 09/07/2023 at approximately 10:45 AM, Surveyor interviewed HM A. HM A stated Resident 1 would go to the bathroom and destroy his/her clothes just to get new clothes. Surveyor asked if the bathroom door was locked to prohibit Resident 1 from entering. HM A stated s/he had locked the bathroom in the past to prevent Resident 1 from going in it. HM A said the door was only locked during Resident 1's "tick times." HM A denied ever directing staff to lock the bathroom door. HM A said that when the door was locked, other residents did not have access to a bathroom; residents would need to get staff to unlock the door so they could use the bathroom. HM A said s/he also locked Resident 1's and Resident 4's bedroom doors. HM A said that if s/he did not lock Resident 1's bedroom door, Resident 1 would destroy his/her room by pulling things out of his/her dresser. HM A acknowledged that by locking the bathroom door and Resident 1's bedroom, s/he was restricting Resident 1's access to these areas of his/her home.

HM A stated residents were allowed to rest and nap any time of the day.

HM A said mealtime was the house's "family

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time," and even if residents chose not to eat, they were required to come to the table to sit with their family. HM A stated residents were able to get food whenever they wanted.

At 12:22 PM, Surveyor interviewed Caregiver D. Surveyor asked if residents were prohibited or restricted from doing anything at the facility. Caregiver D also discussed witnessing 3 newer staff at different times telling Resident 1 that s/he could not eat if s/he was not willing to come to the table at mealtime. Caregiver D recalled Caregiver B was one of the staff, but s/he could not recall the names of the other 2. Caregiver D said s/he did not tolerate these things and s/he corrected staff whenever s/he witnessed something like this.

On 09/18/2023 at 9:54 AM, Surveyor interviewed Caregiver B. According to the employee roster provided on 09/07/2023, Caregiver B was employed at the facility from 07/30/2023 to 08/28/2023. Caregiver B stated s/he was relatively new to the caregiving field and s/he quit shortly after the incident on 08/24/2023. Caregiver B said s/he worked at the facility 6 days per week, typically alongside HM A or Caregiver C.

Caregiver B stated HM A told Caregiver B that if residents did not come to the table for a meal, they did not get to eat. Caregiver B said s/he was unaware of this rule in the beginning so one day when Resident 1 refused to eat with the rest of the household, Caregiver B made Resident 1 a sandwich after lunch was done. HM A saw this and took the sandwich away from Resident 1 as Resident 1 was eating. Caregiver B said this was when HM A told Caregiver B about the rule. Caregiver B said Resident 1 did not get lunch on

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that day.

Surveyor asked if there were other rules that restricted resident's ability to make decisions about their daily activity. Caregiver B stated, "[HM A] said to lock [Resident 1's] and [Resident 4's] rooms daily." Caregiver B said Resident 4's room needed to be locked because s/he was a fall risk and if his/her door was locked, s/he would not go to his/her room to nap during the day. Caregiver B said s/he was unsure why Resident 1's room needed to be locked during the day but s/he assumed it had something to do with Resident 1 wanting to change his/her clothes throughout the day. Caregiver B said Resident 1 was also not allowed to nap during the day because if s/he did, s/he would not sleep at night.

Surveyor asked Caregiver B about the video s/he recorded on 08/24/2023. Caregiver B stated Resident 1 was on the front porch when HM A directed Caregiver B to lock the bathroom door. Caregiver B said s/he was unsure why HM A directed Caregiver B to do this because Resident 1 was nowhere near the bathroom and was making no attempt to go toward it. Caregiver B questioned if HM A said this to upset Resident 1. Caregiver B said Resident 1 got upset when the bathroom door was locked.

On 09/18/2023 at 10:15 AM, Surveyor interviewed Caregiver C (employed at the facility from 08/08/2023 to 08/29/2023). Caregiver C stated s/he worked fulltime at the facility, typically during the morning shift. Caregiver C said s/he was an experienced caregiver and s/he quit shortly after the incident on 08/24/2023. Caregiver C discussed concerns s/he witnessed during his/her employment. Caregiver C stated Resident 1 had a comfort blanket that s/he

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carried with him/her all day. If Resident 1 started to have behaviors, HM A would take the blanket away from Resident 1 until Resident 1 stopped. Caregiver C stated this agitated Resident 1 more. Caregiver C discussed concern that Resident 1 was restricted from the bathroom or changing his/her clothes. Caregiver C said Resident 1 did not enjoy being wet or dirty; if s/he got drool on his/her shirt, s/he wanted to change it immediately. If his/her underwear was slightly wet, s/he became fixated on getting a new pair. Caregiver C stated that if Resident 1 was unable to change his/her clothes, s/he started to have behaviors. Caregiver C stated s/he found that if s/he addressed Resident 1's concern by drying the wet spot on his/her clothing with a hair dryer, Resident 1 remained calm.

Caregiver C stated that if residents did not eat with everyone else during a mealtime, they had to wait until the next meal to eat. Caregiver C stated, "This was [HM A's] rule."

On 09/18/2023 at 12:40 PM, Surveyor interviewed Caregiver G (hired on 08/22/2023). Caregiver G stated s/he worked for HM A in the past. Surveyor asked if s/he was aware of a household mealtime rule. Caregiver C stated, "I think I recall [HM A] say things like if they refuse, you don't give it to them." Caregiver C stated s/he never had anyone completely refuse to eat with the group. Caregiver C said Resident 1 would occasionally refuse at the first attempt but Caregiver C would reapproach until Resident 1 agreed to eat with the group. Caregiver C stated s/he never was directed to lock the bathroom or resident bedroom doors; however, after Surveyor was onsite, HM A told Caregiver C that they could not lock the doors anymore. Caregiver C stated, "I was confused why they were [locked] before."

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M 556	Continued From page 12 RECORD REVIEW: On 09/07/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 07/21/2021 and discharged on 08/25/2023. A progress note dated 05/05/2023 read, "[Resident 1] asking for new undies 1:45-6PM wanted to change clothes - kept [his/her] door locked until bed time [sic]." On 04/30/2023, staff wrote, "...started changing clothes door locked no other issues." On 04/29/2023, staff wrote, "[Resident 1] had shower and laundry. In good spirits until 4pm, started with changing clothes, undies kick, to avoid behaviors I did lock [his/her] bedroom door after [s/he] changed twice... [Resident 1] slamming silverware, [his/her] spoon on [his/her] bowl and table; attention seeking behaviors and I was able to redirect [him/her] 3-4xs just to eat." At approximately noon, Caregiver D provided Surveyor Resident 1's undated individual service plan (ISP). Caregiver D stated s/he did not know when the ISP was updated and s/he was unsure if the version s/he provided was the most recent copy. The ISP did not include reference to behavioral interventions that could explain why staff were restricting Resident 1's access to the bathroom and bedroom, preventing him/her from eating outside the scheduled meal, or taking his/her comfort object away. Resident 1's behavioral interventions included distraction, exercise, re-orientation, talking, and time alone. On 09/20/2023, Surveyor reviewed Resident 1's member center care report (MCCP) provided by Resident 1's managed care organization (MCO). The MCCP, dated 11/29/2022-05/31/2023, indicated Resident 1 was diagnosed with cerebral	M 556		

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palsy, pervasive developmental disorder, personality disorder, generalized anxiety disorder, gait instability/impaired mobility, and unspecified urinary incontinence. Resident 1 required full assistance with activities of daily living (ADLs) and occasionally required standby assistance with ambulation and transfers. According to the MCCP, Resident 1 exhibited challenging behaviors that required intervention 5+ times per day. His/her behaviors included self-injurious behaviors (biting, pulling hair, slapping/hitting self, hitting his/her head), physical aggression (biting, scratching, hitting, pulling hair), masturbating in public areas, attempting to take other's belongings, smearing feces on the wall, refusing to eat, and fixating on using the bathroom.

The MCCP read:
"Long Term Care Outcome ... [Resident 1] to reside in a least restrictive setting, that provides structure to maximize [his/her] independence and manage [his/her] behavioral needs ...

[Resident 1] is able to communicate [his/her] basic needs on an inconsistent basis. [S/he] has a difficult time communicating [his/her] needs and desires effectively. Often times, due to difficulty understanding [his/her] feelings, thoughts and needs, [s/he] utilizes challenging behavior as a means of communication ...

[Resident 1] continues to focus on using the bathroom and will often state 'I'm wet.' This appears to be attention seeking in nature ... persanstant [sic] asking to use the bathroom may be due to boredom. If [Resident 1] is offered participation in an activity this will typically extinguish this behavior."

Resident 1's MCO's Positive Behavior Support

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M 556	Continued From page 14 Plan, dated December 2022 read: "Interventions for Challenging Behavior: 1. If [Resident 1] begins to shut down, not establishing eye contact, not responding verbally, holding [his/her] clenched hands close to [his/her] face, body becoming rigid or [s/he] is pacing around the room try to determine what is upsetting [him/her]...Remember to make sure you have established eye contact so [s/he] understands what you are asking... Encourage [him/her] to tell you what is upsetting [him/her]. 2. If [Resident 1] continues to exhibit agitation try another sensory activity ... 3. If [s/he] refuses and remains agitated use short one to four word directives. Staff should be direct and use a firm, but respectful tone of voice. If [s/he] is near others then [s/he] should be redirected away from any of her peers when agitated ... 4... encourage [Resident 1] to go with them to a "safe area" ... Due to reports that [s/he] becomes highly agitated when left alone or isolated in [his/her] room, staff should remain with [Resident 1] until [s/he] is able to calm... 5. If this in ineffective and if [s/he] continues to engage in challenging behavior or if it appears that [s/he] is receiving too much attention and this is escalating [his/her] behavior, staff need to escort [him/her] to [his/her] room ... 6. Staff need to check on [Resident 1] frequently as [s/he] has a history of self-injury ... if at any time [s/he] is at risk of harming [him/herself] or others, notify Nursing to assess for PRN (as needed) medication. 7. Once [Resident 1] has calmed, encourage [him/her] to rejoin [his/her] peers ... When [Resident 1] is agitated [s/he] may request to use the bathroom numerous times within a very short period of time. As soon as staff assist	M 556		

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M 556	Continued From page 15 [him/her] from the bathroom [s/he] will state [s/he] needs to go again. If this occurs try to figure out what [s/he] may be anxious about. Reassure [him/her] that [s/he] is ok and that [s/he] just went to the bathroom. Remind [him/her] that [s/he] can go again in a few minutes. Then try to switch the discussion to another topic." On 09/07/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 08/14/2023 and did not have a ISP developed. Resident 4's MCCP, dated 02/10/2023 through 08/31/2023, indicated Resident 4 was able to ambulate through the house by using furniture, walls, or standby assist with his/her walker. Resident 4 was designated as a high fall risk; interventions included, "staff are using safe transfer methods." Resident 4's MCCP did not indicate a need to lock Resident 4's bedroom door.	M 556		
M 572	88.10(3)(m) Freedom from Abuse Freedom from abuse. To be free from physical, sexual or mental abuse, neglect, and financial exploitation or misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 4 residents were free from abuse. House Manager (HM) A yelled and threatened to physically harm Resident 1 on 08/24/2023. HM A threatened Resident 1 with sleeping in the barn as a consequence to his/her behavior. HM A threatened to manipulate Resident 2's body to prevent him/her from urinating. Findings include:	M 572		

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The provider is licensed to care for 4 adults in the client groups traumatic brain injury, irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and developmentally disabled.

The property has multiple outbuildings, including a large barn. The facility has a separate staff living area that can be accessed through a door in the main entrance foyer. Based on prior survey observations and the Department's correspondence with the provider, HM A and his/her spouse reside at the facility.

On 08/23/2023, 08/29/2023, and 08/30/2023, the Department received complaints related to resident care and treatment.

On 08/30/2023 at 2:30 PM, Surveyor interviewed adult protective services (APS) social worker, Social Worker (SW) I and criminal investigator, Investigator J. Investigator J explained s/he was investigating allegations that HM A abused Resident 1. SW I said Dunn County received a report on 08/24/2023 (Thursday) that HM A physically assaulted Resident 1 on 08/24/2023. Investigator J said the reporter recorded the incident on a cell phone. Investigator J stated the camera was placed in a pocket within a couple seconds into the recording, so it mostly captured HM A yelling at and threatening Resident 1.

On 08/25/2023 (Friday), SW I and Investigator J went to the facility and interviewed HM A and Caregiver G. Caregiver G was allegedly a witness to the recorded incident on 08/24/2023. Caregiver G denied witnessing wrongdoing but stated s/he believed the facility had hidden surveillance cameras that HM A and his/her spouse had

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access to. HM A denied any wrongdoing. SW I and Investigator J stated they planned to interview Caregiver G away from the facility later. SW I stated s/he recommended Resident 1, a nonverbal resident with intellectual disabilities who had been placed at the facility under a protective placement order, be emergently removed from the home to ensure his/her safety. SW I stated s/he worked with Resident 1's case manager, Case Manager (CM) K, and Resident 1's county social worker to find alternative placement that afternoon. SW I stated that when the alternative placement provider showed up at the facility to get Resident 1, HM A and Licensee H were on site and they stated they "refused to release custody of [Resident 1]." A deputy (Officer L) was called to the scene. Ultimately, Resident 1 remained at the facility until Monday 08/28/2023.

SW I stated that while s/he and Investigator J were at the facility on 08/25/2023, APS received additional reports alleging HM A mistreated other residents at the facility.

On 08/29/2023, Surveyor reviewed a police report dated 08/29/2023. The report read, in part:
"On August 24th, 2023 I was contacted by [Caregiver C] who wished to report abuse toward a resident at the Solomon Hill Estates group home. I spoke with [Caregiver C] by phone who said [s/he] and [Caregiver B] were at [his/her] residence and available to speak with me.

Contact with [Caregiver C]: ...
[Caregiver C] had been working a day shift at the home on August 24th and reported that after lunch was served, [Resident 1] went to the bathroom. [Caregiver C] said [Resident 1] has a usual routine of wanting to go to the bathroom 3 or more times after lunch because [s/he] thinks

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M 572	Continued From page 18 [s/he] wet [him/herself] but does not wet [him/herself] ... [Caregiver C] said today after lunch, [Resident 1] went to the bathroom as was usual and then wanted to go to the bathroom again. [HM A] was present and became upset with [Resident 1] ... [Resident 1] then got upset in response and [HM A] took [Resident 1]'s blanket (which I understood was a consequence [HM A] used before). [Resident 1] became more upset and was trying to get the blanket back from [HM A] and [Caregiver B] stepped between them. During this, [Resident 1] bit [Caregiver B]. [Caregiver B] got [Resident 1] to sit back down and [HM A] told [Caregiver B] to get [Resident 1] [his/her] PRN (as needed medication to help [him/her] calm down). [Caregiver C]'s shift ended and [s/he] said [Resident 1] was sitting in the recliner calmly when [s/he] left. [Caregiver C] told me a bit later, [Caregiver B] called [him/her] and told [him/her] that [HM A] had become physical with [Resident 1] and [Caregiver B] was upset. [Caregiver C] told [Caregiver B] [s/he] would come back to the home and ultimately made an excuse for [Caregiver B] to leave for the day (so they could meet with a deputy)... [Caregiver C] said [HM A] can be quite stern/firm with residents. Contact with [Caregiver B]: ... I asked [Caregiver B] about what had happened earlier in the day and [s/he] told me about [Resident 1]'s usual after lunch habits with wanting to use the restroom multiple times. Shortly before 1400 hrs, [HM A] got involved and told [Resident 1] [s/he] couldn't use the bathroom	M 572		

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anymore and took [his/her] blanket. [Resident 1] got upset and started biting [him/herself] (which is not uncommon when [s/he] gets upset). [Caregiver B] told me [Resident 1] was trying to get [his/her] blanket back from [HM A] and [Caregiver B] got between them during which [Resident 1] bit [him/her].

I asked [Caregiver B] about the bite and [s/he] showed me a red mark on [his/her] right arm with no pronounced teeth marks. [Caregiver B] said [s/he] was not upset about the bite and knew it sometimes came with the territory when caring for people with special needs. [Caregiver B] got [Resident 1] settled down in [his/her] chair and gave [him/her] a PRN and everything was fine for a while.

A little bit later, [Resident 1] got out of the chair and walked out to the porch area. [Caregiver B] followed [him/her] and as [Resident 1] approached the exterior door to [HM A]'s house, [Caregiver B] told [Resident 1] to stop. [Resident 1] opened the door and stepped into the house. [Caregiver B] said [s/he] could see [HM A] in the kitchen and [HM A] picked up a yard stick, walked toward the door and then dropped the yard stick. [Caregiver B] told me [HM A] grabbed [Resident 1] by [his/her] arms and pushed [him/her], causing [Resident 1] to fall to the ground. After [Resident 1] fell down, [Caregiver B] said [HM A] got inches away from [Resident 1]'s face and was yelling at [him/her].

[HM A] then picked [Resident 1] up by wrapping [his/her] arms under [Resident 1]'s armpits and interlocking [his/her] fingers behind [Resident 1]'s head (Full Nelson) and threw [him/her] out the front door and then put [him/her] on a bench outside and continued to yell at [him/her]. [HM A]

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told [Resident 1] to go sit back in [his/her] chair which [Resident 1] did. After the parties separated, [Caregiver B] called [Caregiver C] who told [HM A] there was a family problem so [Caregiver B] could leave and they called Law Enforcement."

On 08/30/2023, Surveyor reviewed the recording. The video was 2 minutes and 26 seconds, but according to Caregiver B, it was concealed in Caregiver B's pocket at 3 seconds. The video briefly showed the feet of someone standing on what appeared to be a wooden deck and the back of another person in a gray t-shirt crouching down on the deck before the video went dark. A voice that Surveyor recognized as HM A stated: "You better go sit your butt down! 'Cause as soon as that doctor calls me, I'm showing him these pictures. I'm sick of it. You understand me [Resident 1]? Sit down!

You sure [s/he] took that pill? Because it should have knocked [him/her] on [his/her] [expletive]...

Sit down! You wait til (until) [the doctor] calls me. I can't fricking wait.

[S/he] comes in my house again. I'm going to kick [his/her] [expletive]."

On 09/07/2023 at 8:45 AM, Surveyor arrived at the facility. HM A stated s/he was the only employee on site with 3 residents.

At 10:27 AM, Surveyor interviewed HM A. HM A described the 08/24/2023 incident that was being investigated by Dunn County. HM A stated the investigator asked HM A if s/he said s/he would "kick [Resident 1's] [expletive]." HM A said s/he was on his/her side of the house cooking when

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Resident 1 and Caregiver B came into HM A's house. HM A stated, "While I was walking - coming over with the chicken - I tripped over the cat." HM A stated the threat was directed at the cat.

HM A stated Caregiver B was blocking/holding the front door shut so Resident 1 could not go to the porch. HM A stated, "Resident 1 was in a tizzy and started putting [him/herself] on the ground ... I picked [him/her] up and put [him/her] on the bench ... I told [Resident 1], '[Resident 1] you need to calm down'...When I picked [Resident 1] up, I had bruises because [Resident 1] was so upset. I told [Resident 1], 'Honey, calm down.' ... [Resident 1] listens to me because I am firm."

HM A went on to explain that s/he planned to terminate Caregiver B because Caregiver B triggered Resident 1. HM A said s/he sent Caregiver B home on 08/24/2023 after the incident because Resident 1 was so worked up. HM A stated, "I sent [Caregiver B] home. It had to be something with [him/her]."

HM A stated s/he had counseled Caregiver B in the past about his/her interactions with residents. HM A stated, "I told [him/her] you can't do that. You can't address them [residents] like that. You can't force them to do something...I told [Caregiver B] to watch me and how I interact with the residents."

HM A stated s/he believed s/he was being "set up" by Caregiver B and Caregiver C. HM A began reading text messages from his/her phone presumably to show Surveyor how much staff drama HM A had to navigate. In one text message thread, HM A read that Caregiver C texted HM A shortly after the incident on

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08/24/2023 to say Caregiver B needed to leave for a family emergency. HM A said to Surveyor, "So, [Caregiver C] came and picked up [Caregiver B]." Surveyor questioned why HM A told Surveyor earlier that HM A sent Caregiver B home after the incident. HM A deflected the question and replied, "[S/he] went to the hospital."

Surveyor asked HM A if s/he was aware of residents being told they would need to sleep in the barn. HM A laughed and stated it was a running joke between HM A and the residents. HM A stated s/he had joked with residents for years about this. HM A said s/he would say something like, "[Resident 1], you want to go to the barn, and we can pick where you want your curtains?" According to HM A, the joke was used to break up the silence and residents would laugh.

Surveyor questioned HM A about Resident 2's incontinence and staff's response to it. HM A stated Resident 2 enjoyed watching TV. HM A said that, at times, Resident 2 will not recognize his/her need to use the bathroom. HM A stated, "I'll say to [him/her], 'Don't you wet your pants!'"

At 12:22 PM, Surveyor interviewed Caregiver D. Caregiver D stated s/he was aware the police were onsite on Friday to investigate HM A for abuse. Surveyor asked if s/he ever had concerns about HM A's interactions with residents. Caregiver D said that when s/he first started working at the facility, s/he had concerns with the way HM A interacted with a past resident, but as time went on, Caregiver D stated s/he realized the resident "was just as mouthy as [HM A]."

Surveyor asked if s/he was aware residents were told they would be sleeping in the barn. Caregiver

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D said HM A would use this as a way to redirect Resident 1's challenging behaviors. Caregiver D said, "[HM A] would grab [Resident 1's] coat and tell [him/her] we are going to the barn."

On 09/07/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 05/28/2013. Resident 2's 2023 service plan indicated s/he required assistance with all transfers in or out of his/her wheelchair and s/he required full assistance with toileting and incontinence care. The service plan read, "If there is any disruption in [his/her] routine [s/he] will get a nervous bladder and the frequency of this care will increase dramatically." Resident 2's service plan did not indicate s/he was on a toileting schedule or that there were interventions or consequences to prevent incontinence.

On 09/18/2023 at approximately 9:30 AM, Surveyor interviewed Resident 2's parent, Guardian E. Guardian E stated s/he was not at the facility often, but HM A provided regular updates. Guardian E stated, "[HM A] teases [Resident 2] a lot... [S/he] says [s/he] will do something, but I know [s/he] won't." Guardian E did not wish to provide further details or examples. Surveyor asked how Resident 2 responded to the teasing. Guardian E stated, "Even when [s/he] was little, people would tease [him/her]. [Resident 2] is used to that stuff."

On 09/18/2023 at approximately 10:00 AM, Surveyor interviewed Caregiver B. Caregiver B described the incident that occurred on 08/24/2023 as s/he reported it to the officer on 08/25/2023. Caregiver B stated Resident 1 was not agitated when s/he knocked on HM A's door; s/he was smiling and calm. Caregiver B said Resident 1 did not wait for HM A to respond

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	0014996	A. BUILDING: _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLOMON HILL RESIDENTIAL CARE	N5903 238TH STREET MENOMONIE, WI 54751

(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 572	Continued From page 24	M 572		

before Resident 1 opened the door to HM A's living quarters. Caregiver B said Resident 1 appeared scared as HM A was yelling at him/her.

Caregiver B stated HM A never asked Caregiver B to leave after the incident on 08/24/2023.

Caregiver B said HM A appeared irritable on 08/24/2023 but s/he assumed s/he was tired because s/he worked the noc (overnight) shift.

Caregiver B said s/he had witnessed HM A call residents names such as pig, brat, nosey, and bag of bones. Caregiver B stated s/he heard HM A call Resident 2 stupid one time. Near the end of July or early August, Caregiver B said s/he was working with HM A and Caregiver C when s/he heard HM A tell Resident 2 that s/he would tie his/her genitals in a knot to prevent incontinence. Caregiver B stated HM A appeared agitated when s/he said this; HM A was not smiling or appear to be making an inappropriate joke. Caregiver B said Resident 2 also did not smile or laugh at the comment.

On 09/18/2023 at 10:15 AM, Surveyor interviewed Caregiver C. Caregiver C discussed concerning interactions s/he witnessed while working at the facility. Caregiver C stated that during his/her first few days, Resident 2 was having increased incontinence in the morning. One of these mornings, Caregiver C heard HM A tell Resident 2 that s/he was going to tie his/her genitals so s/he couldn't urinate. Caregiver C said Resident 2 got quiet. Caregiver C said, "[Resident 2] apologizes nonstop if [s/he]'s incontinent."

On 09/18/2023 at 12:40 PM, Surveyor interviewed Caregiver G. Caregiver G stated s/he was working with Caregiver C on 08/24/2023.

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Caregiver G discussed speaking with SW I and Investigator J on 09/12/2023 at which time s/he watched the recording referenced above. Caregiver G stated s/he originally did not recall details of the event when s/he spoke with SW I and Investigator J on 08/25/2023 because everything happened fast. Caregiver G described HM A's reaction to Resident 1 entering HM A's living quarters as "intense." Caregiver G stated s/he never witnessed HM A interact with residents inappropriately prior to 08/24/2023.

Caregiver G stated Resident 2 apologized when Caregiver G changed him/her.

Caregiver G said, "Someone said [HM A] said to tell [Resident 1] to sleep in the barn if [s/he] doesn't go to sleep at night. I would never say that to [him/her]. What the heck is that?... It might have been [HM A] that said it to me. I've heard other staff have been told that too."

On 09/25/2023, Surveyor received an email from SW I that read, in part, "I am Substantiating [HM A] for Emotional Abuse to [Resident 1]." SW I stated APS had open investigations for 3 other residents at the facility.

On 09/26/2023, Surveyor received Investigator J's report, dated 09/26/2023, which read: "On Tuesday, September 12, 2023, [Caregiver G] came to the Dunn County Sheriff's Office for a follow-up interview ...[Caregiver G] again denied observing any kind of actions by [HM A] that [s/he] would consider physical abuse. [Caregiver G] stated [s/he] did not observe [HM A] push [Resident 1] down and [s/he] believed [Resident 1] sat down on [his/her] own. [Caregiver G] again stated [HM A] is 'definitely assertive' but nothing [s/he] believes rose to the level of abuse. [S/he]

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also indicated [s/he] would have not handled the situation that way and it made [him/her] feel somewhat uncomfortable ...[S/he] also denied having heard [HM A] making any comment about 'kicking anybody's [expletive].'

I then played the audio recording that I previously received of the incident. After listening to the recording, [Caregiver G] agreed it was [HM A]'s voice; however, stated [s/he] did not recall [him/her] staying that. [Caregiver G] stated [s/he] was busy tending to the clients and other things. [Caregiver G] confirmed [s/he] previously worked for [HM A] approximately four years ago in 2019 for a duration of approximately ten months. [S/he] again stated [s/he] did not observe [HM A] be that vocal in the past and never observed anything that [s/he] would consider abuse; however, acknowledged that [s/he] personally would not handle matters in the same fashion ....

[Caregiver G] was also asked about any knowledge of comments to clients that they would have to sleep in the barn as a consequence for what is perceived as bad behavior. [Caregiver G] stated [s/he] recalled someone saying that [HM A] possibly said that. [S/he] stated that [Resident 1] would then comply and go to sleep in [his/her] room for the evening ...

Recorded Interview of [HM A]: ...
When asked if [s/he] recalled anything further about the incident in question, [s/he] stated [s/he] may have made the comment about 'kicking your [expletive]' to [his/her] pet that [s/he] almost tripped over.

[HM A] again denied physically abusing [Resident 1] or ever pushing [him/her] down. I eventually played the video/audio recording. [HM A] initially

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M 572	Continued From page 27 questioned if it was even [him/her]. [S/he] then indicated the recording could have been altered or taken out of context when [s/he] was talking to someone else. [S/he] stated [s/he] could have been saying it to 'Joe Blow' or someone else and also that [s/he] may have received a phone call. [HM A] then repeatedly stated that [s/he] did not say it directly to [Resident 1]. This conversation went on for quite some time with [HM A] trying to justify or rationalize [his/her] behavior. I advised [HM A] that it was very concerning to me that [s/he] would just not own up to what [s/he] said or done. [HM A] also continually tried to deflect [his/her] behavior and asked [SW I] and I if we had ever personally threatened to kick someone's [expletive] as well ...[HM A] eventually acknowledged [his/her] actions and made comments that [s/he] might have had a bad day and did not recall saying that. [S/he] also acknowledged that what [s/he] said was inappropriate."	M 572		