STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018212	A. BUILDING: _____ B. WING _____	R-C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME INSPIRED SENIOR LIVING	1201 VILLAGE CENTRE DRIVE KENOSHA, WI 53144

(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
{N 000}	Initial Comments On 05/01/2025, Surveyor completed a verification visit and complaint investigation at Home Inspired Senior Living. As a result, 3 of the previous deficiencies were corrected, and 3 new deficiencies were identified. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 26	{N 000}		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on interview and record review, the provider did not notify the Department of a change in Administrator. Findings include: On 04/30/2025, at 11:55 AM, Surveyor interviewed Executive Director B. Executive Director B reported Former Executive Director A left employment, and s/he had just finished the administrator course. Executive Director B reported while s/he was in class Owner E would have been the administrator. Executive Director B reported s/he was unaware if Owner E notified the Department of the change in administrator. On 04/30/2025, at 4:30 PM, Surveyor reviewed Department records and found no evidence the provider submitted notification to the Department of the change in administrator.	N 200		

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

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N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) had the right to self-determination and make decisions related to activities, and other aspects of life which enhanced the resident's self-reliance and support the resident's autonomy and decision making. Resident 1 was denied the ability to visit with Private Caregiver G. Findings include: On 03/24/2025, the department received a complaint alleging concerns with visitation in the facility. Record Review On 04/30/2025, at 10:45 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 02/24/2025 with diagnoses including Alzheimer's, anxiety, arthritis and asthma. Resident 1's individual service plan (ISP), undated, indicated Resident 1 capacity for self-direction was able to make own decisions, communicate needs, ideas and wishes independently. Surveyor reviewed Resident 1's observation	N 355		

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N 355	Continued From page 2 notes and identified the following: 03/08/2025 at 6:45 PM, Executive Director B documented, "Writer and [Marketing I] requested a meeting with resident power of attorney (POA) and [POA spouse] on this day due to facility having concerns [sic] Writer called the meeting to order and spoke about caregiver [Private Caregiver G] that was hired by POA to assist with resident [activities of daily living] (ADLs). Caregiver [Private Caregiver G] was present every day since resident arrived at facility which was confusing resident on who will assist [her/him] with [her/his] daily ADLs but also was asking care team about a lot of POA questions which made caregivers uncomfortable to perform their daily cares with resident due to HIPPA [regulations]. Writer did get consent from POA in writing for [Private Caregiver G] to be asking Questions [sic] about Daily [sic] ADLs and behaviors resident was having [sic] Resident will not let care staff assist [her/him] until caregiver arrived on shift. 'Resident Stating [sic] get [Private Caregiver G] I'll pay [her/him] [s/he] knows what to do [sic]' care [sic] staff tried [sic] redirect resident multiple times but was unsuccessful due to resident screaming out for [Private Caregiver G]. [Marketing I] and writer requested for personal caregiver to not be present for a couple days so resident can get use to [her/him] ADLs with our care staff. Writer reassured family that resident will be cared for in their absence due to POA living in Minnestoa [sic] Family was hesitant but sort of agreed but stated not for too long [sic] ..." 03/20/2025 at 3:00 PM, Executive Director B documented, "Care staff member [Caregiver H] contacted writer due to [Private Caregiver G] family hired caregiver offering [her/him] a position to work for [Resident 1] while [s/he] was at the	N 355		

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N 355	Continued From page 3	N 355		

facility visiting resident [sic] [Private Caregiver G] stated to caregiver they are paying very well [s/he] also stated resident will be on hospice for home care, so hours will be flexible. Caregiver left the room very uncomfortable with the whole conversation."

03/21/2025 at 2:00 PM, Executive Director B documented, "[Caregiver H] stated [Private Caregiver G] is texting [her/his] phone at 8:35a stating if [Caregiver H] can talk. Caregiver stated it's [her/his] day off and [s/he] don't want to discuss working matters. Caregiver stated [s/he] is very uncomfortable with [Private Caregiver G] calling [her/him] after [Private Caregiver G] [sic] conversation yesterday."

On 05/01/2025, at 8:58 AM, Surveyor reviewed an email from Executive Director B sent to Resident 1's POA J, dated 03/21/2025. The email stated, "Dear [Resident 1's POA], We are writing to inform you that, effective immediately, [Private Caregiver G] is no longer allowed on the property of Home Inspired Senior Living. On March 20, 2025, [Private Caregiver G] made attempts to persuade a valued employee to leave our facility and join [Resident 1's] care team. She made the caregiver feel uncomfortable by stating, "[Resident 1's] family pay's well, and [Resident 1] will be joining hospice, so hours will be flexible." This conversation was unsettling for our Caregiver, and the Caregiver reported the incident immediately to upper management. Furthermore, on March 21, 2025, the caregiver received a text message from [Private Caregiver G] at 8:11 AM, requesting a conversation. The caregiver responded, stating that it was their day off and they did not wish to discuss work matters. Despite this, The [sic] caregiver again expressed discomfort with the situation. [Private Caregiver

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N 355	Continued From page 4 G] should not be contacting our care team under any circumstances. This behavior is unprofessional and unacceptable. As a result of these actions, [Private Caregiver G] is no longer welcome at Home Inspired Senior Living. We take these matters very seriously and are committed to maintaining a professional and respectful environment for all of our staff and residents. If you have any questions or need further clarification, please do not hesitate to contact us. Thank you for your understanding. Sincerely, [Executive Director B] Interview On 04/30/2025, at 11:55 AM, Surveyor interviewed Executive Director B and Nurse F. Executive Director B reported the owner made the decision to stop Private Caregiver G from visiting Resident 1. Executive Director B reported the decision was made due to Private Caregiver G had attempted to recruit staff which made staff uncomfortable. Executive Director B reported s/he was unaware they could not ban visitors from the facility.	N 355		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with	N 386		

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N 386	Continued From page 5 specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident's (Resident 1) individual service plan (ISP) identified the resident's needs and outcomes. Resident 1's ISP did not identify Resident 1's needs for fall risk and elopement. Findings include: On 04/30/2025, at 10:45 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 02/24/2025 with diagnoses including Alzheimer's, anxiety, arthritis and asthma. Resident 1's individual service plan (ISP), undated, indicated the following: Fall Risk - High Directions: Resident is a high fall risk because of they forget their limitations, gait is unsteady, forget to let someone help transfer, medications and/or a cognitive impairment, [sic] Current Status: [Resident 1] states that sometimes [her/his] head feels like it is spinning, dizziness. Measurable goals, Outcomes and Review: A fall risk evaluation will be done with interventions to prevent falls until the next review. Resident Goal: Resident wishes to remain without falls with the teams [sic] implementation of interventions to help decrease them. Sensor Alarm	N 386		

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N 386	Continued From page 6 Directions: Resident will utilize bed alarm and chair alarm to prevent fall [sic] resident is a high fall risk due to dementia behaviors. Door Alarm Directions: Resident door alarm must be checked and on at all times to help prevent resident from living [sic] the facility unsupervised. Wandering - Independent Directions: Current Status: Resident does show wandering episodes. Measurable goals, Outcomes and Review: Resident is showing wandering episodes until next review. Resident Goal: Resident wants to have no wandering episodes. Resident 1's fall risk assessment, dated 02/27/2025 indicated Resident 1 was a high fall risk due to Resident 1 utilized a rollator walker and was unsteady on her/his feet. Resident 1 would have frequent checks by the team and private caregiver. Resident 1's wandering/elopement risk assessment, dated 03/05/2025, indicated Resident 1 was at risk for elopement. Interventions implemented personal safety alarm device and frequent monitoring. The assessment had a note which indicated, "Resident is frequently monitored every 30 [minutes] door alarm was purchased to prevent resident from leaving facility [sic] it [sic] will be delivered 3/7/25 and installed on 3/7/25." Date the interventions were implemented was 03/05/2025. Resident 1's fall reports indicated Resident 1 had the following falls:	N 386		

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N 386	Continued From page 7 02/27/2025 at 7:30 AM - Resident 1 found in room next to her/his chair. 03/09/2025 at 6:19 PM - Resident stated s/he fell, hit her/his head and her/his left forearm was hurt. Sent to emergency room (ER). 03/11/2025 at 7:30 AM - During rounds found Resident 1 in front of her/his chair on her/his back. 03/12/2025 at 10:28 PM - Chair alarm was going off, Resident 1 found on bathroom floor. Sent to ER with diagnoses of non-displaced fracture of proximal end of right humerus and non-displaced fracture of acromial process of right scapula. 03/14/2025 at 7:54 PM - Chair alarm was going off; Resident 1 was found on floor outside bathroom. 03/16/2025 at 7:48 PM - Caregiver was assisting another resident, heard Resident 1 yelling help and found Resident 1 on the floor. 03/20/2025 at 5:07 AM - Resident 1's bed alarm went off; Resident 1 was on the floor by her/his bed. 04/02/2025 at 6:09 AM - During rounds Resident 1 was laying on the floor in front of her/his closet. 04/03/2025 at 7:50 AM - Resident 1 had an unwitnessed fall in her/his room. It appeared Resident 1 attempted to self-transfer from her/his wheelchair to the bed. 04/04/2025 at 7:40 PM - Resident 1's alarm was going off; Resident 1 was found on the floor next	N 386		

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N 386	Continued From page 8 to the bed. 04/06/2025 at 8:20 PM - Found resident on floor by fireplace after hearing her/his bed alarm. 04/10/2025 at 5:47 AM - Resident yelled out for help when writer walked past her/his room, the bed alarm was on the whole shift but did not go off when Resident 1 got up. Sent to ER. 04/14/2025 at 6:00 AM - Resident 1 fell near bathroom door. 04/14/2025 at 6:30 AM - Resident 1 fell in bathroom. Sent to ER with diagnoses of laceration. 04/14/2025 at 6:55 PM - Resident 1's bed alarm sounded. Resident 1 was seated on the floor with her/his back against the bed and feet bent facing the wall. Sent to ER with diagnoses of laceration. An incident report, dated 03/05/2025, indicated the following, "Writer was in room 128 giving care to resident when 106 came to find me and let me know that [Resident 1] had left out of the backdoor a few minutes prior. Writer ran outside to find resident [sic] and [s/he] was behind the facility walking on the road by the flag pole [sic] going towards the apartment complex in the rain. Writer got to resident and convinced [her/him] that I would give [her/him] a car ride and that the car was back at [Home Inspired Senior Living]. Resident resisted a few times and got agitated with writer and tried to keep walking in the other direction. Resident seemed to be a little unbalanced and kept pulling hand away from writer causing [her/him] to wobble and resident stated at the time to 'leave her the hell alone and go away', After explaining a few times that the	N 386		

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N 386	Continued From page 9 care was the other direction we walked back to the building holding hands without incident." On 04/30/2025, at 11:55 AM, Surveyor interviewed Executive Director B and Nurse F. Nurse F reported s/he just started the position earlier in the week. Nurse F reported s/he would be responsible for completing the assessments and ISPs. Executive Director B reported s/he was also assisting with the ISPs. Executive Director B reported Resident 1 utilized a chair alarm, a bed alarm, and frequent monitoring due to her/his fall risk, and door alarms were purchased after the elopement. Nurse F reported all falls and incidents should be reported in the ISPs. Executive Director B reported s/he was unsure why the falls and elopement were not identified in Resident 1's ISP. Nurse F and Executive Director B confirmed the ISP should contain all information and interventions for fall prevention and behavior management.	N 386		