STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009180	A. BUILDING: _____ B. WING _____	R-C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE HOUSE	3410 STRATFORD AVE RACINE, WI 53402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	INITIAL COMMENTS On 11/15/2024, Surveyor concluded a verification visit and 2 complaint investigations at Paradise House. As a result, 3 deficiencies were identified. One complaint was substantiated. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 1	{M 000}		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report elopements to the department for 1 of 1 resident. Resident 3 eloped from the facility 9 times in 2024 and none were reported to the department. Findings include: On 11/15/2024, Surveyor reviewed Racine Police Department Call Logs and Reports involving Resident 3 for 2024. The call logs and reports	M 134		

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

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M 134	Continued From page 1 identified the following: -02/21/2024, Resident 3 eloped from the home and no one from the facility was looking for him/her. -04/08/2024, Licensee B called the police to assist in locating Resident 3, who eloped from the home. -06/27/2024, Facility staff called the police to assist in locating Resident 3, who had eloped. -08/09/2024, "...resident left the group home/court ordered to be there...[Resident 3]." -09/10/2024, Licensee B called the police to assist in locating Resident 3, who was found blocks away from the facility unsupervised. -09/30/2024, Licensee B called the police to report Resident 3 eloped. Licensee B reported to police s/he did not have a car and was unable to look for Resident 3. Licensee B was in the bathroom when Resident 3 left. -10/08/2024, Licensee B called the police to report Resident 3 eloped. The call log stated, "Court ordered, [Resident 3]...does this regularly [sic]...unk[nown] direction of travel...left on foot." -11/01/2024, Licensee B called the police to report Resident 3 left the facility and had an unknown direction of travel. -11/09/2024, Licensee B called the police to report Resident 3 left the facility and had an unknown direction of travel. On 11/14/2024, Surveyor reviewed the departments electronic file for the facility. There were no self-reports submitted by Licensee B in 2024. On 11/14/2024, at approximately 1:45 PM, Surveyor interviewed Licensee B. Licensee B reported s/he called Resident 3's case manager and guardian to report the elopements. Licensee	M 134		

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M 134	Continued From page 2 B reported s/he was unaware s/he had to report to the department. Licensee B confirmed s/he did not send any self-reports for Resident 3's elopements.	M 134		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all residents were assessed and plans created for identified needs for 1 of 1 resident. Resident 3 eloped from the facility on 12/27/2023. Resident 3 was not assessed for elopement, and no plan was created to keep Resident 3 safe. Findings include: On 09/13/2024, the department received a complaint alleging services were not being offered in accordance with residents' needs and there was a heavy police presence at the facility. On 11/14/2024, Surveyor reviewed Resident 3's record. The following was identified:	M 408		

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M 408	Continued From page 3	M 408		

-Resident 3 was admitted on 09/26/2023 with diagnoses including schizophrenia, bipolar disorder, and anxiety.
-Resident 3's hospital discharge summary, dated 01/19/2024, identified "...was admitted on 12/27/2023, after presenting to the ED (emergency department)...pedestrian versus vehicle accident, causing traumatic brain injury and spinal fractures. [S/he] was admitted to the ICU (intensive care unit)." Resident 3 underwent surgery to repair his/her spine at T9-T11 vertebrae. These are in the middle section of the spine.
-Resident 3's record did not include an assessment for elopement.
-Resident 3 was deemed incompetent and assigned a guardian on 02/27/2024.
-Resident 3's Individual Service Plan (ISP), dated 06/13/2024, did not identify Resident 3 exhibited elopement behaviors.

On 11/15/2024, Surveyor reviewed Racine Police Department Call Logs and Reports and identified the following:

-12/27/2023, Resident 3 eloped from the facility.
-02/21/2024, Resident 3 eloped from the home and no one from the facility was looking for him/her.
-04/08/2024, Licensee B called the police to assist in locating Resident 3, who eloped from the home.
-06/27/2024, Facility staff called the police to assist in locating Resident 3, who had eloped.
-08/09/2024, "...resident left the group home/court ordered to be there...[Resident 3]."
-09/10/2024, Licensee B called the police to assist in locating Resident 3, who was found blocks away from the facility unsupervised.
-09/30/2024, Licensee B called the police to

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M 408	Continued From page 4	M 408		

report Resident 3 eloped. Licensee B reported to police s/he did not have a car and was unable to look for Resident 3. Licensee B was in the bathroom when Resident 3 left.
-10/08/2024, Licensee B called the police to report Resident 3 eloped. The call log stated, "Court ordered, [Resident 3]...does this regularily [sic]...unk[nown] direction of travel...left on foot."
-11/01/2024, Licensee B called the police to report Resident 3 left the facility and had an unknown direction of travel.
-11/09/2024, Licensee B called the police to report Resident 3 left the facility and had an unknown direction of travel.

On 11/14/2024, at approximately 2:15 PM, Surveyor interviewed Licensee B. Licensee B reported Resident 3 did not exhibit street safety skills and was hit by a car in December 2023 after eloping from the facility. Licensee B reported since living at the facility Resident 3 had eloped several times. Licensee B confirmed Resident 3 was hit by a car when s/he eloped on 12/27/2023. Licensee B confirmed Resident 3 was not assessed and did not have a written plan to address the elopement behaviors. When Resident 3 eloped, Licensee B reported s/he placed door alarms on all the doors, so s/he was able to respond and attempt to redirect Resident 3 from leaving the facility unattended. Licensee B reported Resident 3 eloped when s/he was told "no" or if s/he's having delusions. Licensee B reported the intervention worked sometimes and other times it would not. Licensee B reported s/he was the only caregiver, so s/he knew the behavior and would call the police when Resident 3 eloped or would follow him/her if there were no other residents in the facility at the time of the elopement.

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M 420	Continued From page 5	M 420		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a statement of agreement with the Individual Service Plan (ISP) was dated and signed by all persons involved in developing the plan for 1 of 1 resident. Resident 3 had a guardian and a managed care organization case management team involved in planning the services and the ISP was not signed. Findings include: On 11/14/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 09/26/2023 with diagnoses including schizophrenia, bipolar disorder, and anxiety. Resident 3 was deemed incompetent and assigned a guardian on 02/27/2024. Resident 3 had a managed care organization case management team. Resident 3's Individual Service Plan (ISP), dated 06/13/2024, was not signed by Resident 3's guardian or the managed care organization case management team. On 11/14/2024, at 1:59 PM, Surveyor interviewed Licensee B. Licensee B reported s/he ensured all guardians and case management teams participated in the reviews, but s/he did not have them sign the ISP. Licensee B reported s/he was responsible for ISP development and did not	M 420		

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M 420	Continued From page 6 know to have the case management team sign the ISPs, but s/he would start immediately. Licensee B reported it was difficult to obtain signatures from guardians but would document his/her attempts in the future if s/he could not get a signature.	M 420		