STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009776	A. BUILDING: _____ B. WING _____	C 07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIL MAGELLAN HOUSE	212 S 16TH AVE WEST BEND, WI 53090

(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 From 07/17/2024 to 07/19/2024, Surveyor conducted an abbreviated survey and 2 complaint investigations at HIL Magellan House, an AFH in West Bend. One deficiency was identified. Two of 2 complaints were substantiated. 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 record review and interview, the provider did not ensure the existence of a condition in the home which placed the safety of residents at substantial risk of harm was prohibited. Caregiver D, who had previously been observed with droopy eyes, slurred speech and/or sleeping at work, overdosed while working alone and responsible for the care of 3 residents. Findings include: On 07/17/2024, Surveyor conducted a complaint investigation alleging that a caregiver overdosed while working at the provider's home. On 07/17/2024 at approximately 8:00 a.m., Surveyor reviewed a police report that stated law	M 230		

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

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enforcement was dispatched to the provider's home on 04/22/2024 for an unconscious individual, who was identified as Caregiver D. The report documented the following:

- Caregiver E reported s/he arrived to the home at 10:56 p.m. and found Caregiver D lying on his/her right side in the kitchen.
- When Service Coordinator C contacted law enforcement to report Caregiver D being unconscious, Service Coordinator C stated s/he may be diabetic or having an opiate overdose. Service Coordinator C later informed law enforcement s/he did not suspect Caregiver D of using drugs that day but mentioned s/he had suspected previous situations that Caregiver D had used drugs.
- Upon law enforcement's arrival, Caregiver D was observed with a brown substance in his/her right nostril and a greenish-blue substance in the left nostril. Caregiver D's eyes were pinpoint, indicative of drug use. Caregiver D was administered Narcan and began breathing on his/her own.
- Law enforcement observed the provider's medication cabinets were unlocked upon arrival. Service Coordinator C stated that wasn't unusual for staff to not lock the doors.
- When Direct Support Specialist A (DSS A) was asked by law enforcement about Caregiver D, DSS A stated s/he was present when Caregiver D was dropped off at the home and "For once [s/he] came in sober." DSS A stated s/he had voiced past concerns with Caregiver D coming to work with droopy eyes and slurring words.
- Caregiver F reported to law enforcement s/he arrived to the home at 3:04 p.m. on 04/22/2024 and that Caregiver D was "fine" at that time. Caregiver F reported Caregiver D met his/her significant other outside the provider's home at

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approximately 7:30 p.m. and was later observed "nodding off" and slurring words as s/he made a client's meal. Caregiver F stated the resident had to repeat his/her request several times in an effort to get Caregiver D's attention. Caregiver F reported s/he left work at approximately 9:00 p.m.
- DSS A reported s/he spoke to Caregiver D at approximately 9:20 p.m. This leaves Caregiver D's status from approximately 9:20 p.m. to 10:56 p.m. unknown.
- On 04/23/2024, law enforcement interviewed Caregiver D, who stated s/he snorted half of an illegally purchased Xanax pill brought to the home by a family member. Law enforcement informed Caregiver D the Xanax was counterfeit and contained Fentanyl. Due to Caregiver D ingesting a substance that s/he did not have a prescription for and caused him/her to become unconscious while caring for residents who relied on him/her to provide and care for their basic needs, Caregiver D was arrested for Neglect of a Patient or Resident.

On 07/17/2024 at approximately 9:10 a.m., Surveyor interviewed Caregiver B. Caregiver B stated the home required an awake caregiver to always be present due to the behaviors of residents. Caregiver B stated Resident 1 and Resident 2 had a history of verbal and physical aggression and Resident 3 had a history of eloping.

On 07/17/2024 at approximately 9:15 a.m., Surveyor interviewed DSS A, who stated the home was to be staffed with an awake caregiver 24 hours/day due to behaviors. Surveyor asked DSS A if s/he had any concerns with caregivers working impaired. DSS A stated s/he had heard "hearsay" about Caregiver D and due to the "hearsay" was more vigilant when Caregiver D

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was working in the home. DSS A did not go into further details.

On 07/17/2024 at approximately 9:30 a.m., Surveyor reviewed resident records, which documented the following:

- Resident 1 was admitted on 07/19/2021 with diagnoses including autism, intellectual disability, anxiety and mood disorder. Resident 1's individual service plan (ISP), dated 07/09/2024, stated Resident 1 had an extensive history of property destruction and being physically abusive towards others.
- Resident 2 was admitted on 12/15/2018 with diagnoses including autism, intellectual disability, attention deficit hyperactivity disorder and personality disorder. Resident's ISP, dated 02/15/2024, documented Resident 2 had a history of elopements, self-abuse, property destruction, verbal aggression and physical aggression.
- Resident 3 was admitted on 08/15/2020 with diagnoses including autism, anxiety disorder, obsessive compulsive disorder and sleep disorder. Resident 3's, ISP, dated 02/06/2024, stated s/he did not have a typical sleep pattern and would go to sleep at 9 p.m. some nights, but not until 4:00 a.m. at other times. The ISP documented that Resident 3 had a history of verbal outbursts, aggressive behaviors such as hitting/head-butting, flooding the bathroom and elopement, which had resulted in complaints from the neighbors due to disturbance and property damage to a neighbor's door.

On 07/17/2024 at approximately 10:00 a.m., Surveyor interviewed Service Coordinator C and asked about the incident on 04/22/2024. Service Coordinator C stated s/he was contacted by

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Caregiver E for the door code to enter the home because the home's doors were locked. Service Coordinator C stated s/he reported to the home and found Caregiver D on the kitchen floor. Service Coordinator C stated all residents were sleeping. Service Coordinator C stated the only previous concern s/he had with Caregiver D's performance were due to not managing his/her diabetes and 1 occurrence of sleeping while on shift at an affiliated home. Service Coordinator C denied past concerns with drug use. When Surveyor shared comments documented in the police report, such as Caregiver D working with droopy eyes and slurring words, Service Coordinator C replied, "This is the first I'm hearing of it."

On 07//17/2024 at approximately 12:00 p.m., Surveyor received Caregiver D's record for review from Regional Director G. Caregiver D was employed on 09/06/2023. Caregiver D's record included an "Employee Counseling Form," dated 04/05/2024, that sated "Final Warning - Sleeping ... On 03/20/2024 you were scheduled for 3rd shift at [affiliated home] 12a-9a. You were late to your scheduled 3rd shift arriving at 1:09a. At 7:30 a.m., management arrived at [affiliated home] and found you asleep at the desk in the office. When management initially entered the program a client greeted them by stating [you] was sleeping and [s/he] could not wake [you] up anymore. Management quickly checked on all the clients and observed another client wondering around in [his/her] underpants, carrying [his/her] pants, looking for assistance ... You will be transferred to a 2nd shift position at [provider's home]. You will need to have double coverage at all times. You will also be limited to 50 hrs/wk." Caregiver D's record included a letter, dated 04/24/2024, informing Caregiver D s/he was

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M 230	Continued From page 5 informed for "Gross Misconduct." On 07/18/2024 at approximately 12:00 p.m., Surveyor asked Regional Director G if Caregiver D had received previous warnings and why Caregiver D worked alone on 04/22/2024 after s/he had received a final warning. Regional Director G stated Caregiver D had not had previous warnings and worked alone on 04/22/2024 because s/he had switched shifts with another employee without management approval. On 04/22/2024, Caregiver D, whom the provider's staff had identified previous concerns with his/her ability to provide supervision to residents, overdosed and was not coherent to provide supervision to 3 of 3 residents that required 24 hour supervision.	M 230		