STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010619	A. BUILDING: _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITE ABILITY INC II	**W9141 THUNDERBIRD ROAD PORTAGE, WI 53901**

(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 10/30/2024, with information obtained through 10/31/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Infinite Ability Inc II, an adult family home (AFH) located in Portage, WI. As a result of the survey, 3 deficiencies were identified. The complaint was substantiated. Census: 3	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 ensure that 1 of 2 occasions in which Resident 1 was missing from the home was reported to the licensing agency. Findings include: On 10/30/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider	M 134		

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

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on 06/14/2024 with diagnoses including diffuse traumatic brain injury (TBI). Resident 1 was documented as having a legal guardian. Resident 1's record included an incident report dated 10/25/2024, which detailed an incident when Resident 1 left the home that same day. The following was documented:

"Resident wanted to take a walk up and down the driveway...At approximately 11:30 caregiver took [him/her] for a walk up and down the driveway, after several rounds [s/he] told [Resident 1] that they needed to go back as [s/he] had food in the oven that needed to be attended to. [Resident 1] refused to go back inside and as soon as the caregiver went inside the house, [s/he] started walking off the property. The caregiver immediately called [Operations Manager A] (operations manager) who promptly started heading to the facility and found [Resident 1] walking towards [local restaurant] again..."

At approximately 12:31 p.m., Surveyor interviewed Operations Manager A about the above incident. Operations Manager A reported that when s/he found Resident 1 after being called by staff, s/he was in an area where the road off of the provider's drive met the next intersection. Operations Manager A pointed in an westward direction when indicating the direction of the intersection's location. Operations Manager A confirmed that typically only 1 caregiver worked per shift and so if a resident was discovered missing, or was leaving the premises, s/he was expected to be contacted.

From geographical map information reviewed by Surveyor, the provider's home is located at the end of an approximate 230-foot driveway off the road. The next intersection west (the direction

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M 134	Continued From page 2 Operations Manager A indicated having found Resident 1 that day) is approximately 0.5 miles away. On 10/30/2024, Surveyor reviewed the Department's records for the provider. There was no evidence of a self-report having been submitted for the above incident. At approximately 1:35 p.m., Surveyor interviewed Operations Manager A and Chief Executive Officer B. Chief Executive Officer B confirmed that the provider did not send a report to the Department for the above incident. Chief Executive Officer B reported s/he did not think the above incident was reportable. Both Operations Manager A and Chief Operating Officer B confirmed Surveyor's concern that while the caregiver working that day went back inside the house (as documented in the incident report), there was a period of time where Resident 1's whereabouts were unknown until s/he was found by Operations Manager A down the road.	M 134		
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 permitted the existence of a condition which placed Resident 1's safety and welfare at substantial risk of harm.	M 230		

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Resident 1 left the home on 2 occasions, 09/27/2024 and approximately mid-morning on 09/30/2024, which warranted outside staff to come onsite and retrieve him/her. Despite this, there was no evidence of the provider having established clearly defined supervision parameters or a visual check schedule for him/her. Later during the late afternoon/early evening of 09/30/2024, Resident 1 eloped with having last been documented as seen by Caregiver C at approximately 4:30 p.m. Resident 1 was picked up by law enforcement approximately 2.8 miles away, approximately 38 minutes after Caregiver D discovered him/her missing. Resident 1 walked with a walker, was known to have unsteady gait, and was identified as a fall risk. The pathway s/he took consisted of rural roads and a county highway - none of which contained paved shoulder areas or sufficient shoulder space to support safe walking.

Findings include:

On 10/30/2024, Surveyor conducted a complaint investigation into concerns of staffs' supervision of residents secondary to elopement.

On 10/30/2024, at approximately 9:30 a.m., Surveyor interviewed Caregiver E. Caregiver E reported it was only his/her second day working with the home's residents, but s/he wasn't sure if there was a specific frequency with which s/he was expected to supervise / visually check on residents.

On 10/30/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/14/2024 with diagnoses including diffuse traumatic brain injury (TBI). Resident 1 was

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documented as having a legal guardian. Resident 1's face sheet identified him/her as a fall risk. Surveyor reviewed Resident 1's individual service plans (ISPs), which included a current one last signed as reviewed on 10/11/2024, and a previous one dated 09/11/2024. Both identified that Resident 1 required "24-hour supervision" and required a walker for all ambulation as well as staff cuing to utilize the walker. Resident 1's ISP from 10/11/2024 identified him/her as an elopement risk with the following documented: "Resident has been identified as an elopement risk. Resident had an elopement incident on 09/30/2024...Staff will provide redirections/interventions to prevent elopement episodes. If interventions/redirections fail, staff will contact 911 and/or local crisis team."

Surveyor reviewed a behavior support plan for Resident 1, dated 10/11/2024 (after the elopement incident referenced above). The plan identified that Resident 1's behaviors included wandering and elopement. The plan documented, "The resident likes to take walks up and down the driveway. On one occasion (on 9/30/24) [s/he] walked past the driveway and started walking to [local restaurant]. The facility had to call the police and report the resident missing. Resident was found a few miles away from the facility walking to the [local restaurant]...Per resident report, [s/he] was seeking [local restaurant] root beer. It is possible that the behavior was also caused by attention seeking..."

Surveyor reviewed Resident 1's medical reports, which included a medical evaluation on 09/24/2024 (prior to the 09/30/2024 elopement incident referred to above). The report documented, "...[Staff] report that [s/he] does a lot of inappropriate self-transferring and is not very

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stable..." Under the "Follow-up" section of the note, the medical provider documented, "Refer to [physical therapy]/[occupational therapy] for eval & treat for balance issues."

Resident 1's record included an incident report dated 09/30/2024, which detailed an incident when Resident 1 eloped from the facility that day, corroborating the elopement mention in his/her current ISP. The following was documented:

"At 4:30pm the resident told caregiver [Caregiver C] that [s/he] was going to go for a walk down the driveway (which is what the resident does frequently). [Caregiver C] was able to see the resident through the window and kept watching [him/her]. At approximately 5:45 pm [Caregiver C] looked out the window and noticed that [Resident 1] wasn't around. [S/he] went down the driveway to look for the resident, [s/he] looked all around the proximity of the house, called resident's name, without success. At 5:56pm caregiver [Caregiver C] called [Operations Manager A] stating that [s/he] couldn't find the resident. Operations manager immediately called the owner [Chief Executive Officer B], [s/he] advised that [Operations Manager A] call the guardian right away and that the owner would call non-emergency police. Operations Manager called guardian right away letting [him/her] know what was going on. The police arrived at the location within 15 minutes. Police ended up locating [Resident 1] and brought [him/her] to the house. When the police asked [Resident 1] where [s/he] was going [s/he] stated that [s/he] wanted to go to [local restaurant] to get a root beer. Operations manager called [Former Guardian D] at 6:39pm stating that [s/he] was located safe and free of injuries..."

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Surveyor reviewed Resident 1's observation/progress notes from 08/01/2024 - 10/30/2024, which included the following related to his/her elopement risks and behaviors:

- Note dated 09/27/2024 (3 days prior to the elopement incident on 09/30/2024): "[Resident 1] wanted to go for a walk. I asked [him/her] to go to mailbox + back he left + wandered away[.] staff called [operations manager] to retrieve [Resident 1] and bring [him/her] back home..."

- Note dated 09/30/2024: "...Eloped today [operations manager] came back to get [him/her] [illegible]..."

- Second note dated 09/30/2024: "Staff observed client go outside @ 4:30pm while preping [sic] dinner. There was another client on the front porch. Staff thought nothing about it. Dinner was served and waiting for clients when staff could not find [him/her]. Management notified and staff searched down by the river. Police found [him/her] walking by sharp curve down highway [local highway]. Client said [s/he] was going to get root beer...They brought [him/her] back to house..."

Surveyor reviewed the staff schedule on 09/30/2024, which identified 1 staff, Caregiver C, as having worked the evening shift that day from 3:00 p.m. - 11:00 p.m.

On 10/30/2024, at approximately 11:38 a.m., Surveyor observed Resident 1 walking around the home using a 4-wheeled walker. Resident 1 was physically assisted by 2 staff, Operations Manager A and Caregiver E, to step onto the scale and get weighed. After this observation, Surveyor interviewed Operations Manager A.

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M 230	Continued From page 7 Operations Manager A confirmed that Resident 1 typically used a 4-wheeled walker for ambulation and that this had been since at least his/her admission. Operations Manager A reported that Resident 1's walking ability was "not very good sometimes." Operations Manager A reported that Resident 1 was identified as a fall risk due to how s/he walked since s/he was known to be unsteady at times. Operations Manager A reported that Resident 1 could occasionally get out of breath and required a wheelchair for ambulation on these occasions. At approximately 12:05 p.m., Surveyor observed an interaction between Resident 1 and an outside vendor who was helping him/her set up a smart watch. Resident 1 reported to the vendor that s/he had partial paralysis of his/her right side since his/her history of a car accident. At approximately 12:31 p.m., Surveyor interviewed Operations Manager A again. Regarding Resident 1's earlier overheard comment about his/her partial paralysis, Operations Manager A confirmed that Resident 1's partial paralysis and impaired ambulation was from the same incident in which s/he sustained his/her TBI, which occurred in the recent past prior to his/her admission. Regarding the 09/27/2024 incident documented above, Operations Manager A reported that Resident 1 had went down the road due to wanting to go for a walk. Operations Manager A reported that s/he was visible from the house from the time s/he left the driveway to the time s/he was picked up by Operations Manager A. Regarding the 09/30/2024 second shift elopement, Operations Manager A reported that Caregiver D was making dinner when at some point s/he realized s/he could no longer see Resident 1 in the driveway.	M 230		

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When asked how Caregiver D "kept watching Resident 1" as documented in the incident report but then lost sight of him/her while making dinner, Operations Manager A replied that s/he wasn't sure and that was just the report that Caregiver D had given to him/her. When asked where Resident 1 was found, Operations Manager A reported that s/he was found on nearby County Highway U. Operations Manager A confirmed Surveyor's observation that based on the 09/30/2024 observation note and incident report that it was unclear how, between 4:30 p.m. (when Resident 1 was last seen by Caregiver D) and 5:45 p.m. (when discovered missing), Caregiver D was supervising Resident 1. Operations Manager A confirmed that there was no specific supervision / visual check frequency that was established for Resident 1. Surveyor discussed the concern that the provider's home was located in a rural area, with all surrounding roads of the area having limited shoulders for safe walking and higher vehicular speed limits, to which Operations Manager A replied that people were known to drive fast down the roads near the provider's house.

At approximately 1:35 p.m., Surveyor interviewed Operations Manager A and Chief Operating Officer B. Chief Operating Officer B acknowledged Surveyor's concern that it wasn't clear how staff were supervising Resident 1 or how this supervision had changed from his/her baseline to his/her known elopement risk starting on 09/27/2024 when s/he "wandered away" (per observation note) and had to be picked up by Operations Manager A. Chief Operating Officer B reported that they thought the 09/27/2024 incident wasn't as serious.

From approximately 2:06 p.m. - 2:09 p.m.,

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Surveyor observed the 3 roadways between the provider's location and where it was thought Resident 1 was picked up by law enforcement (Photos 1, 2, 3). This path included and ended on a county highway. None of the roads had sidewalks or paved shoulders for ease of walking. The 2 roads prior to the county highway did not have posted speed limit signs, or designated shoulder edge lines. The first and second roadways contained vegetation on either side of the roads that extended up to the road pavement. The county highway contained an approximate 1.5-2' gravel shoulder outside of the shoulder edge line.

On 11/01/2024, Surveyor reviewed an outside sheriff's office report which documented Resident 1's elopement from 09/30/2024. The report documented the following: "At approximately 6:10 p.m. I received a call from [dispatch agency]...regarding that a resident was missing. The resident was named [Resident 1] and was advised that [s/he] went missing about 30 minutes ago prior to them calling. [Resident 1] was last seen walking down the block when they lost sight of [him/her]...[S/he] was last seen heading westbound towards Portage. The caller, [Caregiver C], had stated that [s/he] was making dinner and may not have seen [him/her] turn around. [Caregiver D] stated that [s/he] usually goes towards the river at the dead-end road of Thunderbird [road the provider's drive is located off of]...At approximately 6:14 p.m., I advised [dispatch] that I would be enroute. While enroute, on Highway U, just off of Highway 33, about a mile to a mile and a half down the road, I observed an elderly [person] walking westbound on the shoulder...the identity was confirmed to be [Resident 1]. When asked how far [s/he] had been walking, [s/he] didn't know exactly how far

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[s/he] had walked...

"[Caregiver C] stated that [Resident 1] typically does not go for walks. If [s/he] would go for a walk, it would just be to the end of the mailbox and back or typically down to the river and back but nothing like this as [s/he] was not previously listed as a flight risk."

A supplemental narrative report documented the following: "...As we were driving on [County Highway] U, we located [Resident 1]. [Resident 1] was located at approximately 6:23PM in front of [local resident address]...[Resident 1] told us that [s/he] would have left the residence around 4:00PM...[Operations Manager A] said [s/he] was driving on Thunderbird Drive and [s/he] checked the east end of the road as [Resident 1] had previously walked to the east end of that road to go down by the river. [Operations Manager A] said that [s/he] had found [Resident 1] by the river earlier in the day. [Operations Manager A] estimated this was around 11:00AM when [Resident 1] had earlier walked away from the residence..."

Surveyor observed that this first elopement incident from 09/30/2024, documented in the supplemental narrative, corroborated the first 09/30/2024 observation/progress note, detailed above, which had documented that Resident 1 eloped and required Operations Manager A to retrieve him/her.

From geographical map information reviewed by Surveyor for the area, the provider's home is located at the end of an approximate 230-foot driveway off the road. The address from where Resident 1 was found at approximately 6:23 p.m. was located 2.8 miles away from the provider's

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M 230	Continued From page 11 house. The absence of other roads in this area indicated a direct route that Resident 1 had taken, which was the same route observed by Surveyor on 10/30/2024 (described above). Surveyor observed that the time Resident 1 was identified as having been discovered by law enforcement, at approximately 6:23 p.m., was approximately 13 minutes after the notification was received from dispatch and 38 minutes after Caregiver D reportedly noticed Resident 1 missing.	M 230		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1's health was monitored to determine his/her compliance with his/her medical provider-ordered fluid restriction of 2,000 mL/day. Findings include: On 10/30/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/14/2024 with diagnoses including diffuse traumatic brain injury (TBI). Resident 1 was documented as having a legal guardian. Surveyor reviewed Resident 1's medical records, which included a medical provider evaluation note dated 09/24/2024. This note documented the following: - Under the "History of Present Illness" section:	M 448		

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"[Resident 1]...is being seen today for initial patient evaluation. History is significant for TBI ([s/he] was walking and was hit by a car), [diabetes mellitus type II], [chronic kidney disease], [congestive heart failure], and [obstructive sleep apnea]...Patient is a poor historian...Staff report that [s/he] is quite noncompliant. Is supposed to be on a 2000ml fluid restriction but [s/he] refuses to follow this..."

- Under the "Physical Examination" section: "...Extremities- 2+ edema..."

- Under the "Assessment and Plan" section: "...Continue to follow Cardiology. Monitor [vitals] and [weight] weekly. Encourage fluid restriction..."

Surveyor reviewed Resident 1's individual service plans (ISPs), which included a current one last signed as reviewed on 10/11/2024, and a previous one dated 09/11/2024. Neither contained any information about Resident 1's fluid restriction. Surveyor reviewed Resident 1's observation/progress notes since 08/01/2024, but there was no evidence that staff recorded Resident 1's fluid intake.

At approximately 12:31 p.m., Surveyor interviewed Operations Manager A. Operations Manager A confirmed that Resident 1 was currently and had been under a 2,000 mL/day fluid restriction since prior to his/her medical provider visit documented above, on 09/24/2024. Operations Manager A reported s/he thought the restriction had been in place since around November 2023, prior to Resident 1's admission to the provider, due to notes from his/her previous facility about having a fluid restriction. Surveyor requested from Operations Manager A evidence of staff recording Resident 1's fluid intake.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010619	A. BUILDING: _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITE ABILITY INC II	W9141 THUNDERBIRD ROAD PORTAGE, WI 53901

(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 448	Continued From page 13 Operations Manager A then showed Surveyor a document titled "Liquid Intake" which was identified as belonging to Resident 1 and was dated "September 2024." Surveyor reviewed the document, in which staff appeared to track Resident 1's daily fluid intake from 09/01/2024 through 09/30/2024. Operations Manager A confirmed that 09/30/2024 is when staff stopped recording Resident 1's daily fluid intake because it was thought that since there was no medical provider order for fluid intake monitoring that they could not do it. At approximately 1:35 p.m., Surveyor interviewed Operations Manager A and Chief Operating Officer B. Chief Operating Officer B confirmed that staff were not monitoring Resident 1's daily fluid intake and therefore had no information to inform Resident 1's daily compliance with his/her fluid restriction. Chief Operating Officer B reported s/he thought the regulations required a medical provider order to be in place for staff to conduct intake monitoring.	M 448		