STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018318	A. BUILDING: _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELENS HOUSE GRAND CHUTE BLUE	4210 N SHADY WOOD CT APPLETON, WI 54913

(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 01/10/2025, with information gathered through 01/29/2025, Surveyor conducted a standard licensure survey and a complaint investigation at Helens House Grand Chute Blue. Four deficiencies were identified. Complaint was substantiated. Census: 4	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 prevent conditions that put the safety of residents at risk. An allegation of verbal abuse was filed regarding Caregiver C and s/he remained on the schedule when an internal investigation had not been completed. Findings include: On 12/06/2024, the Department received a complaint alleging staff members were verbally abusive towards residents. On 01/10/2025, at approximately 1:00 PM, Surveyor interviewed Program Manager (PM) B. PM B stated a concern had been filed with the	M 230		

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

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M 230	Continued From page 1	M 230		

provider stating that Caregiver C had been verbally abusive towards Resident 1. PM B stated, "[Caregiver C] continued to work after the allegation, since Resident 1 was hospitalized and not in the home. [Licensee A] had monitored [Caregiver C] in the work environment and did not have any concerns."

On 01/10/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home on 09/29/2023.

Resident 1's "Individual Service Plan," dated 12/19/2024, documented:
"General Comments: May have increased confusion. Have patience and redirect and answer question as needed. Reassure [him/her] that [s/he] is safe and you are here to take care of [him/her]. When speaking with [Resident 1] get down to [his/her] level and speak facing [him/her]."
"Behavioral Intervention Comments: Treat with respect and dignity do not talk to or treat like a child. Use a gentle tone and approach. Remember this is [his/her] home and you are here to take care of [him/her]. May ask 'what do we do now.' Redirect with walking the house, activity, paint."

On 01/10/2025, Surveyor requested Resident 1's managed care organization (MCO) documentation from the MCO provider.

On 01/15/2025, Surveyor reviewed Resident 1's MCO documentation which stated:
09/12/2024 - Spoke with [Licensee A] this day regarding Member (Resident 1) and [POA D] issues with [Caregiver C]. [Licensee A] updated that management has been stopping in more and

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M 230	Continued From page 2	M 230		

checking in on shifts [Caregiver C] is working and from what is being observed, [Caregiver C] is doing [her/his] job appropriately. [Licensee A] shared that a meeting with [POA D] and staff is taking place tomorrow to discuss the situation with [POA D] and [Caregiver C].
09/17/2024 - CM (Care Manager H) updated of communication with [POA D] this day to update of meeting with [PM B] to discuss issues with [Caregiver C], and that another staff will provide further training to [Caregiver C], and that [Caregiver C] would be on probation period to see how things go.
10/14/2024 - [POA D] updated that [s/he] overheard [Caregiver C] tell another staff that [s/he] told Member to, "sit on [his/her] ass" and another resident there complained of being woken up by staff [Caregiver C's] yelling. [POA D] also updated that when [s/he] arrived to AFH (providers adult family home), Member was in a soaking wet Depend and [s/he] told [Caregiver C] [s/he] needed to change Member. [POA D] updated that [s/he] was going to be addressing this situation with [PM B] and [Licensee A]. ... Called and spoke with [POA D] again this day and requested update on Member. [POA D] updated that [s/he] was able to meet with [Licensee A] this day at AFH to discuss [his/her] concerns with [Caregiver C] and showed [Licensee A] Members bruising and gash on leg. [POA D] updated that [Licensee A] is not able to prove that staff [Caregiver C] did anything to Member. [POA D] updated that [Licensee A] was going to however remove [Caregiver C] from the schedule at Members AFH so [Caregiver C] was no longer working with Member.
10/16/2024 - CM asked Member if [s/he] was ever scared of any staff at the AFH. Member did express feeling scared of people at the AFH sometimes but unable to elaborate any further on

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M 230	Continued From page 3 this. 11/06/2024 - [POA D] updated [Caregiver C] was leaving and would not be working at the home any longer after 1-1 1/2 weeks. 11/22/2024 - [POA D] also updated that [s/he] went through video footage of night of Member's fall (11/20/2024) and [Caregiver C] was working. [POA D] shared that at 8:33 p.m. on night of fall, [Caregiver C] went into Members room and raised [his/her] voice for Member to get out in the living room and when Member went out in the living room, [Caregiver C] continued to talk in a rude tone to Member and [POA D] felt Member became flustered with [Caregiver C] and shortly after, Member had [his/her] fall. [POA D] updated that [s/he] shared video with AFH staff (PM B and Licensee A) and [Caregiver C] no longer at AFH. 11/27/2024 - CM received videos from [POA D] that [s/he] had went through/viewed on night of Member's fall and a few other days that [Caregiver C] had been working with Member. ... CM left message with [Adult Protective Service (APS) F]. [County] APS regarding videos [POA D] shared with CM and also provided update to [APS F] regarding Member's recent fall and [Caregiver C] working on shift day Member had [his/her] fall. CM had sent [APS F] videos shared. Called and spoke with [Caregiver G] at AFH to get input on Member's return to AFH and [Caregiver C]. [Caregiver G] updated that it is [his/her] understanding that Member can return to AFH if a one assist. CM requested input on [Caregiver C] and if other residents had input on [Caregiver C] that [s/he] is aware of. [Caregiver G] shared that the residents do not like [Caregiver C]. When [Caregiver C] is working some residents will stay in their rooms and not want to come out because they are scared of [Caregiver C]. ... CM inquired if [Caregiver C] still with AFH. [Caregiver G] shared that [s/he] believed [s/he] was and	M 230		

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M 230	Continued From page 4	M 230		

assigned to the AFH next door. [Caregiver G] updated that since Member is not currently at the AFH, [s/he] thought [Caregiver C] may be scheduled for some shifts at the AFH while Member not there. [Caregiver G] shared that another resident ([Resident 2]) told [him/her] that [Caregiver C] had Member standing outside in the cold, no jacket, in [his/her] pajamas, and Member waving at cars. [Caregiver C] then came inside and watched Member from the window. [Caregiver G] updated that [s/he] didn't know how true this was but this is what [Resident 2] told [him/her] and that [Caregiver C] told [Resident 2] not to tell anyone but [Resident 2] told [Caregiver G]. [Caregiver G] updated that [s/he] shared this with [POA D] yesterday as well. [Caregiver G] also updated that resident [Resident 3] will make comments to [Caregiver C] on how [s/he] treats Member/others. CM left message with [APS F] again this day regarding communication from [Caregiver G] this day regarding [Caregiver C] and Member being outside per another resident. Called and spoke with [POA D] regarding CM communication with [Caregiver G] this day. [POA D] shared [s/he] was informed of Member potentially being outside in [his/her] pajamas and in the cold by [Caregiver C]. Discussed reliability of resident telling this to [Caregiver G] and uncertainty. CM inquired if [POA D] aware if [Caregiver C] no longer with AFH or working for a different AFH with the company. [POA D] updated that [s/he] received communication from [PM B] at AFH telling [him/her] that [Caregiver C] was no longer at AFH. Discussed that this may need to be clarified further due to [Caregiver G] telling CM [s/he] felt [Caregiver C] was still with AFH just at a different AFH with potential to be scheduled at Members. AFH while Member away. [POA D] updated that [s/he] was going to verify this and would let CM know if any new info had. CM

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M 230	Continued From page 5 updated [POA D] that CM did update APS again regarding Member situation/videos and [POA D] verbalized [s/he] was fine with this and willing to speak with APS if contacted. 12/02/2024 - CM updated of communication from [POA D] regarding videos family viewed night of Member's fall and other days when [Caregiver C] had been working with Member. CM updated [PM B] was also made aware. CM updated that message was left with [APS] regarding video information [POA D] shared with CM, that [Caregiver C] was working with Member day of fall and of concerns related to [Caregiver C] reported by [POA D]. CM updated of communication with [Caregiver G] at AFH regarding plan for Member's return to AFH and about concerns related to [Caregiver C]. ... Update from CM regarding communication with [APS F] this day regarding concerns with [Caregiver C]. CM updated [APS F] planned to start another investigation to gather more information. CM updated of communication with [POA D] for update on Member, and of report that Member discharged to [skilled nursing facility (SNF)] 11/29/2024. CM updated [POA D] reported Member was doing well, was working with therapy, and participating in some activities as tolerates. CM updated concerns related to [Caregiver C] were discussed as well as APS involvement, and that [POA D] reported the videos were shown to [Licensee A] by [POA D]. CM updated [APS F] was made aware of Member's current location, and that [Licensee A] was shown the videos by [POA D]. ... Discussed [Caregiver C]. [POA D] updated CM that [s/he] had gone to the AFH to obtain some of Members clothing to bring to SNF and [Caregiver C] was working when [s/he] arrived. [POA D] updated that [s/he] was not pleased to see [Caregiver C]. Discussed that APS is updated on situation.	M 230		

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M 230	Continued From page 6 Updated [APS F] regarding follow-up communication from [POA D] [Caregiver C] still being at Members AFH per observation from [POA D] and updated [APS F] regarding Member's current location and that videos had been shown to [Licensee A] by [POA D]. 12/03/2024 - ABUSE/TRAUMA Member feels safe at this time but would express at times not feeling safe when at AFH. Family has a camera in [Resident 1's] room and reviewed footage. Family found that [Resident 1] was being mistreated by staff at AFH and reported this. Is currently served by Elder Abuse & Neglect agency or Adult Protective Services: CM had contacted APS for a second time due to concerns with staff [Caregiver C] and how [s/he] is treating [Resident 1]. APS has completed an investigation and spoke with AFH owner and staff [Program Manager B] regarding situation and concerns had. Per APS, this staff will be terminated and reported to DQA (Division of Quality Assurance) for improper caregiving. Family and other residents had noted that this particular staff would yell, swear and be very unpleasant towards him/her. History of verbal abuse by an AFH caregiver; History of involvement of Adult Protective Services or Elder Abuse and Neglect agency: CM had contacted APS due to concerns family had with a particular staff working with [Resident 1] at AFH and their treatment towards [Resident 1]. APS did make a visit to the AFH as well as CM. APS has been contacted twice now and completed investigation due to AFH staff not treating [Resident 1] and others correctly. 12/04/2024 - CM received communication from [APS F] updating that [s/he] met with [PM B] and also spoke with two of the 3 other residents at the AFH on 12/03/2024. [APS F] updated that [PM B] initially reported they do not plan to fire [Caregiver C] and felt the problem would be solved by	M 230		

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M 230	Continued From page 7 moving [Caregiver C] to another house so [s/he] did not take care of Member. [APS F] updated that [his/her] supervisor then spoke with the owner who was initially reluctant to do so but commit to firing [Caregiver C] and letting APS know when this is complete. [APS F] updated that one of the other residents [s/he] spoke with talked very openly about staying in [his/her] room when [Caregiver C] is working to avoid [him/her] because [s/he] is, "mean, yells, and swears". [APS F] updated that this resident felt [Caregiver C] was especially mean to Member. [APS F] updated that [s/he] would be filing a complaint with DQA's caregiver program about [Caregiver C]. 12/09/2024 - Received communication from [APS F] updating that [Licensee A] reported that [Caregiver C] last day of employment with AFH was on 12/04/2024. 12/23/2024 - ABUSE/TRAUMA Member feels safe at this time but would express at times not feeling safe when at AFH. Family has a camera in [Resident 1's] room and reviewed footage. Family found that [Resident 1] was being mistreated by staff at AFH and reported this. This staff no longer with AFH. Is not currently served by Elder Abuse & Neglect agency or Adult Protective Services: CM had contacted APS for a second time due to concerns with [Caregiver C] and how [s/he] is treating [Resident 1]. APS has completed an investigation and spoke with AFH owner and [PM B] regarding situation and concerns had. Per APS, this staff will be terminated and reported to DQA for improper caregiving. Family and other residents had noted that this particular staff would yell, swear and be very unpleasant towards [him/her]. History of verbal abuse by an AFH caregiver; History of involvement of Adult Protective Services or Elder Abuse and Neglect agency: CM had contacted APS due to concerns	M 230		

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family had with a particular staff working with [Resident 1] at AFH and their treatment towards [Resident 1]. APS did make a visit to the AFH as well as CM. APS has been contacted twice now and completed investigation due to AFH staff not treating [Resident 1] and others correctly. CM had contacted APS for a second time due to concerns with [Caregiver C] and how [s/he] is treating [Resident 1]. APS has completed an investigation and spoke with AFH owner and [PM B] regarding situation and concerns had. Per APS, this staff will be terminated and reported to DQA for improper caregiving. Family and other residents had noted that this particular staff would yell, swear and be very unpleasant towards him/her. This staff no longer employed with AFH.

On 01/29/2025, at approximately 11:45 AM, Surveyor interviewed CM H and MCO Nurse I. CM H commented that communication with the provider was difficult. CM H stated, "It seemed they did not want to address the concerns that were brought forward regarding [Resident 1]." CM H explained that the provider became more responsive with APS became involved.

On 01/29/2025 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated POA D had forwarded him/her videos s/he felt were concerning regarding how Caregiver C had treated Resident 1. Licensee A admitted that sometimes s/he was unable to open the recordings, but did not follow up with POA D. Licensee A stated the recordings only capture a fraction of the time Caregiver C spent with Resident 1 and did not point out the positive interaction Caregiver C had with Resident 1. Licensee A stated s/he did not interview other residents or staff members regarding the concerns that were being brought forward.

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M 230	Continued From page 9 Cross Reference: Z0055 DHS 13.05(3)(a) Entity Allegation Reporting Requirements	M 230		
M 548	88.10(3)(a) Fair Treatment Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure residents were treated with courtesy, respect and full recognition of the resident's dignity and individuality. Resident 1 had a motion sensor installed in his/her doorway which alarmed with all movement in his/her room. Findings include: On 10/22/2024, the Department received a concern alleging staff were unplugging alarm systems in resident rooms. On 01/10/2025 at approximately 2:15 PM, Surveyor and Program Manager (PM) B observed Resident 1's room. As Surveyor walked around in the room, an alarm was sounding throughout the home. PM B stated the family requested that a motion sensor be placed in his/her room so that staff were aware if PM B was ambulating in his/her room. PM B explained, "[Resident 1] is always moving about the home, in and out of [his/her] room, so the alarm is continuously	M 548		

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alarming. It is disruptive to the other residents who become upset, especially when they are trying to sleep." PM B stated the motion sensor had not been utilized as a fall risk intervention. Surveyor requested Resident 1's record.

On 01/28/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home 09/29/2023.

Resident 1's "Individual Service Plan," dated 12/19/2024, documented:
General Comments: Pressure pad alarm for bed - 12/14/2024. Motion detector and camera in room.

Resident 1's daily notes, dated 12/18/2024 to 01/10/2025, documented:
12/18/2024 - Up 10x (times) walking around (his/her) room and to bathroom. Finally at 3:30 AM (s/he) went to sleep again up at 4:40 AM back and forth.
12/19/2024 - Restless, will not sit still, called family to come in and help with (her/him), they also cannot get (him/her) to settle down or sleep. ... Sat in (his/her) chair then roamed around in (his/her) room. Alarm bell has been going off since 7PM but has stayed in (his/her) room.
12/28/2024 - Keeps waking up due to alarm on (his/her) bed.
12/31/2024 - Has been up and down all evening, walking around the house.

On 01/29/2025 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he understood that between the bed alarm and the motion sensor, that Resident 1 did not have any privacy in his/her room.

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Z 010	Continued From page 11	Z 010		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interview, the	Z 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018318	A. BUILDING: _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELENS HOUSE GRAND CHUTE BLUE	4210 N SHADY WOOD CT APPLETON, WI 54913

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Z 010	Continued From page 12 provider did not make every reasonable effort to obtain a copy of the criminal complaint and judgment of conviction related to Caregiver E's violation of 947.01(1) - Disorderly Conduct. Findings include: On 01/28/2025, Surveyor reviewed the record of Caregiver E who was hired on 11/2024. Caregiver E's record included a Department of Justice Criminal History Report, dated 11/06/2024, which listed a conviction of 947.01(1) - Disorderly Conduct on 08/11/2020. On 01/28/2025 at 8:40 AM, Surveyor informed Licensee A of the concern. As of 01/29/2025 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he did not understand that was a requirement but would obtain the report.	Z 010		
Z 055	DHS 13.05 (3) (a) ENTITY ALLEGATION REPORTING REQUIREMENTS Entity's duty to report to the department. Except as provided under pars. (b) and (c), an entity shall report to the department any allegation of an act, omission or course of conduct described in this chapter as client abuse or neglect or misappropriation of client property committed by any person employed by or under contract with the entity if the person is under the control of the entity. The entity shall submit its report on a form provided by the department within 7 calendar days from the date the entity knew or should have known about the misconduct. The report shall contain whatever information the department	Z 055		

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Z 055	Continued From page 13 requires. This Rule is not met as evidenced by: Based on record review and interview, the provider did not contact the licensing agency within 7 days when they had reasonable cause to suspect that Resident 1 had been verbally abused by Caregiver C. Findings include: On 12/06/2024, the Department received a concern that a resident had been verbally abused by a staff member. On 01/06/2025, at approximately 12:30 PM, Surveyor interviewed Program Manager B. Program Manager B stated s/he was aware Caregiver C had been investigated for verbal abuse against Resident 1 and had been dismissed from employment. On 01/10/2025, Surveyor requested Resident 1's managed care organization (MCO) documentation from the MCO provider. On 01/14/2025, Surveyor reviewed the supporting documentation that had been received with the concern, including 5 video recordings that documented: -10/25/2024: Caregiver C and Resident 1, who was in his/her pajamas, walked out of his/her bathroom and out of his/her room. Caregiver C stated in a stern like voice, "You should be	Z 055		

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Z 055	Continued From page 14 sleeping by now. Not getting up every 5 minutes. Now go. This is insane." Resident 1 and Caregiver C have left the room, and you can still hear a muffled sound of Caregiver C stating explicative words. -11/08/2024: Resident 1 is in his/her room, walking around, Caregiver C walked in and asked 3 times in a stern like voice "What are you Doing," while his/her hands were on his/her hips. Resident 1 proceeded to explain. Caregiver C responded, "You need to go lie down, you wanted to lie down so badly, and I let you in here and not you are not laying down." -11/08/2024: Resident 1 walked into his/her bathroom. Caregiver C entered the room and walked into the bathroom and began to swear at resident. -11/08/2024: Resident 1 was in his/her bedroom, in his/her pajamas, looking through his/her dresser. Caregiver C came in and redirected Resident 1 out of his/her room. Caregiver C can be heard saying, "Look at me, look at me. You need to start following directions. You need to stop lying, stop disobeying. Do you understand?" -11/20/2024: Caregiver C was walking out of Resident 1's bathroom. Resident 1 was in the common area. Caregiver C began to yell and ask Resident 1 what the [explicative word] s/he was doing and in a stern like voice stated a few times, "What did I tell you?" On 01/14/2025 at 9:50 AM, Surveyor emailed Licensee A and asked if s/he had filed a written report to the department or to the Office of Caregiver Quality (OCQ) regarding Caregiver C's. On 01/14/2025 at 10:45 AM, Licensee A emailed Surveyor and stated the county was going to file the concern with OCQ.	Z 055		

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Z 055	Continued From page 15 On 01/14/2025, Surveyor reviewed the Department file and the OCQ department file and did not observe a written report filed regarding the verbal abuse allegations against Resident 1. On 01/15/2025, Surveyor reviewed Resident 1's MCO documentation that stated: 12/02/2024 - [POA D] reported the videos were shown to [Licensee A]. On 01/29/2025 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated POA D had forwarded him/her videos s/he felt were concerning regarding how Caregiver C had treated Resident 1. Licensee A admitted that sometimes s/he was unable to open the recordings, but did not follow up with POA D. Licensee A stated the recordings only capture a fraction of the time Caregiver C spent with Resident 1 and did not point out the positive interaction Caregiver C had with Resident 1.	Z 055		