STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 04/23/2025, Surveyors conducted a 4 complaint investigation and verification visit at The Homeplace. Data collection continued through 05/14/2025. One of the 4 complaints were substantiated. Three deficiencies were identified. One of the 3 deficiencies was a repeat violation. See Statement of Deficiency (SOD) S75L13, dated 05/10/2022; SOD DTGP12, dated 02/06/2024; and SOD DTGP13, dated 10/25/2024. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 19	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar	N 158		

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

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N 158	Continued From page 1 days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report neglect to the Department within 7 calendar days from the date the CBRF (community based residential facility) knew or should have known about the neglect. Findings include: On 04/11/2025, the Department received a complaint alleging a resident was discharged in restraints. The provider is licensed to care for 33 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. Per Chapter 46.90(1)(f),"'Neglect' means the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual's physical or mental health." On 04/23/2025 at 10:16 AM, Surveyor reviewed an internal investigation for Resident 1's discharge on 03/28/2025. The internal investigation summary read, in part, " ...Team members were not a part of the restraining of [Resident 1], though were witness to it and in some cases, they expected the transport to be	N 158		

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N 158	Continued From page 2 with restraints as it was relayed to be a "secured wheelchair transport service" ...Most of The Homeplace team did see [Resident 1] with a gait belt around [his/her] waist and chair though did not see/recall seeing any other gait belts in place when [s/he] got onto the elevator to leave ...One [Provider] team member remembers hearing transporters discuss putting a 'belt around [his/her] legs for safety' and did see one around [his/her] legs and w/c (wheelchair) once [s/he] was wheeled out of [his/her] room." A document titled, "What did we do post discharge" read, in part, "[Community Director (CD) B] discipline, not advocating more for [Resident 1]. Not clarifying what the expectation was for transfer." The abuse and neglect policy and procedure read, in part, "If investigation confirms abuse, work with the Chief Operating Officer to ensure the following is completed: -Contact the local Ombudsman office to report the alleged abuse. -Complete the State form (see additional information) to report to the State. -Notify the local law enforcement agency if crime has occurred." On 04/30/2025 at 2:17 PM, Surveyor received an email from Chief Operating Officer (COO) A. The email read, in part, "I did not do a report about this. I looked over the reporting requirements. It outlines if there was a serious injury requiring hospitalization or ER (emergency room) treatment, [sic] there was not. It also said if there is misconduct or abuse and in our investigation there was no abuse or misconduct as our staff did not apply the seat belt. When I investigated I was told [s/he] was not in distress or pain when [s/he] left, [sic] law enforcement was not involved in the discharge."	N 158		

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N 158	Continued From page 3 On 05/06/2025 at 2:00 PM, Surveyor interviewed COO A. COO A confirmed his/her investigation results concluded staff did not place the restraints on Resident 1, but saw it occur and did not stop it. COO A stated staff were uncomfortable with the situation but no one advocated for Resident 1. COO A stated staff were not neglectful, but unknowledgeable of how to handle the situation. COO A stated this incident was not reported to the Office of Caregiver Quality (OCQ) because staff were not found to be abusive or neglectful. The provider did not report to the Department, neglect of Resident 1, when staff witnessed Resident 1 leave the provider in a restraint.	N 158		
N 351	83.32(3)(g) Rights of Residents: Physical restraints In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from physical restraints. Be free from physical restraints except upon prior review and approval by the department upon written authorization from the resident ' s primary physician or advanced practice nurse prescriber as defined in s. N 8.02(2). The department may place conditions on the use of a restraint to protect the health, safety, welfare and rights of the resident. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1 was free from	N 351		

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N 351	Continued From page 4 physical restraint. Resident 1 was discharged on 03/28/2025 from the provider with a restraint. Findings include: On 04/11/2025, the Department received a complaint alleging a resident was discharged in restraints. The provider is licensed to care for 33 residents in the client groups irreversible dementia/Alzheimer's disease, and advanced aged. Per DHS 83.02 (39), "Physical restraint means any manual method, article, device, or garment interfering with the free movement of the resident or the normal functioning of a portion of the resident's body or normal access to a portion of the resident's body, and which the resident is unable to remove easily, or confinement of a resident in a locked room." On 04/23/2025 at 10:16 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/06/2024 and discharged on 03/28/2025. Resident 1 had a guardian and diagnoses that included dementia, depression, and insomnia. Resident 1's individual service plan (ISP), dated 07/12/2024, indicated Resident 1 had a significant psychiatric history that included behaviors of agitation, tearfulness, and raising his/her voice. The ISP indicated Resident 1 may occasionally resist cares or become mildly combative. The ISP indicated that if Resident 1 were to become agitated, combative, or anxious, staff were to attempt de-escalation with 1:1 time, distraction, and or allowing alone time.	N 351		

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N 351	Continued From page 5 On 04/23/2025 at 10:16 AM, Surveyor reviewed an internal investigation for Resident 1's discharge on 03/28/2025. The internal investigation summary read, in part, " ...Team members were not a part of the restraining of [Resident 1], though were witness to it and in some cases, they expected the transport to be with restraints as it was relayed to be a "secured wheelchair transport service" ...Most of The Homeplace team did see [Resident 1] with a gait belt around [his/her] waist and chair though did not see/recall seeing any other gait belts in place when [s/he] got onto the elevator to leave ...One [Provider] team member remembers hearing transporters discuss putting a 'belt around [his/her] legs for safety' and did see one around [his/her] legs and w/c (wheelchair) once [s/he] was wheeled out of [his/her] room." A document titled, "What did we do post discharge:" read in part, "[Community Director (CD) B] discipline, not advocating more for [Resident 1]. Not clarifying what the expectation was for transfer." A Team Member Discipline Form for CD B read, in part, "[CD B] was assisting with a discharge of [Resident 1] during that transfer the transport assistants placed a restraint on [Resident 1] and [CD B] did not step in to protect [Resident 1] ... [CD B], was you stated in the investigation, that you were 'uncomfortable' during the transfer of a resident on 04/03/2025, though you did not step in and advocate for this resident. As a Community Director you understand resident rights and know that your position is primarily focused on resident safety and advocacy." On 04/23/2025 at approximately 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A stated s/he had not been aware	N 351		

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of Resident 1's discharge incident until the Monday after on 03/31/2025. COO A stated Resident 1 had received a 30-day notice and had a history of behaviors with moving.

On 04/23/2025 at approximately 3:30 PM, Surveyor interviewed Caregiver J. Caregiver J confirmed s/he worked the day of Resident 1's discharge on the second floor. Caregiver J confirmed s/he observed a gait belt around his/her waist or legs. Caregiver J stated Resident 1 was in tears.

On 04/24/2025 at 3:04 PM, Surveyor interviewed Guardian G. Guardian G stated Resident 1 was protectively placed and had a history of assaulting a police officer and being chaptered with his/her previous discharge.

On 04/24/2025 at 3:30 PM, Surveyor interviewed Case Manager (CM) C. CM C stated the other provider attempted to transport Resident 1 at an earlier date to their facility but Resident 1 became combative. The other provider requested the managed care organization (MCO) arrange transportation for the next discharge attempt. On 03/27/2025, the discharge was canceled due to an issue with transportation. On 03/28/2025, CM C stated s/he set up a "secured transport" for Resident 1 and reviewed transfer strategies with them and the provider. CM C stated s/he visited Resident 1 at the other provider and picked up 3 gait belts labeled with the provider's name.

On 04/25/2025 at 1:34 PM, Surveyor interviewed Transportation Company Owner (TCO) N. TCO N stated that when they arrived at Resident 1's room and moved him/her into his/her wheelchair, Resident 1 started getting combative, swinging arms and legs. TCO N stated s/he did not see a

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seat belt with Resident 1's wheelchair and used a gait belt to secure Resident 1 into his/her wheelchair. TCO N confirmed s/he had a gait belt around Resident 1's waist and the back of his/her wheelchair and another gait belt around his/her legs and wheelchair while in his/her room prior to leaving the facility. TCO N confirmed only the 2 gait belts were placed on Resident 1 prior to leaving the facility. TCO N stated that while they were placing the gait belts on Resident 1, there was at least 1 staff in the adjacent room packing belongings and 1 staff watching from the side. TCO N confirmed the gait belt remained in place around Resident 1's waist and legs for the 45 minute ride to the other provider.

On 04/25/2025 at 1:48 PM, Surveyor interviewed Caregiver E. Caregiver E stated s/he spoke to Resident 1 for 5 minutes by the elevators prior to him/her leaving and observed a gait belt around his/her waist.

On 04/30/2025 at 3:35 PM, Surveyor interviewed Executive Director (ED) K, Community Relations Director (CRD) L, and Community Registered Nurse (CRN) M. ED K stated that when Resident 1 arrived at their facility, s/he had 2 gait belts around his/her waist and 1 gait belt around his/her legs. All 3 gait belts were tied to the back of the wheelchair where it would be impossible for Resident 1 to reach. ED K stated it took 3 staff to get Resident 1 out of the gait belts. CRN M stated Resident 1 had no marks on his/her skin when s/he consented to be showered 1 week after admission.

On 04/30/2025 at 3:56 PM, Surveyor interviewed MCO Quality Improvement (QI) O. QI O stated a "secured transport" meant the vehicle was more secure if Resident 1 were to become combative.

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It did not mean Resident 1 would be restrained during transportation. QI O stated the provider was not aware Resident 1 was going to be restrained by gait belts.`

An email from QI H to COO A, dated 04/09/2025, read, in part, "While it was noted that [the provider] staff did not take part in the placement of the gait belts, it appears that they did observe them in place as restraints and heard the comment about a belt a [sic] being placed around [Resident 1's] legs for safety."

On 04/30/2025 at 11:48 AM, Surveyor received an email response from Ex Life Enrichment Coordinator (ELEC) D, describing his/her arrival at the other provider where Resident 1 was sent. It read, in part, "Once I arrived there I could see [Resident 1] was in the building to the left of the front desk a little ways, [sic] [s/he] was speaking to someone ...[The other provider] asked me who the admin (administrator) was there and I had asked why and [s/he] explained to me that [Resident 1] had several gait belts on [his/her] wrists, waist, and legs, strapped to the wheelchair."

On 05/06/2025 at 10:15 AM, Surveyor interviewed CD B. CD B stated s/he spoke with the MCO about Resident 1's discharge and restraints were brought up. CD B stated s/he felt uncomfortable and handed the discharge planning off to COO A. CD B stated s/he did not know what a "secure transport" was. CD B stated that on the day of discharge, s/he arrived at 9:00 AM and the transportation van was already parked out front. CD B stated s/he went up to Resident 1's room and the transporters were already in the room. CD B stated s/he overheard the transporters mention a seatbelt to Resident 1

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and Resident 1 replied s/he did not wear one. The transporters asked CD B for more gait belts and CD B walked out of the room and did not get the transporters more gait belts. CD B stated s/he could not confirm if Resident 1 had a gait belt around his/her waist upon discharge. When Surveyor asked CD B about the Team Member Discipline Form, CD B stated s/he had to get written up due to him/her not stopping the situation. When Surveyor asked CD B what s/he would have done differently in the situation, CD B stated s/he would have "stopped it all and told them to go to [explicative]." CD B confirmed s/he should have spoken up in the situation.

On 05/06/2025 at 2:00 PM, Surveyor interviewed COO A. COO A stated s/he was not aware of Resident 1's discharge with restraints until 04/07/2025, and that was the same day s/he started his/her investigation. COO A confirmed his/her investigation results concluded staff did not place the restraints on Resident 1 but saw it occur. COO A stated staff were uncomfortable with the situation but no one advocated for Resident 1. COO A stated staff were not neglectful but unknowledgeable of how to handle the situation.

On 05/14/2025 at 9:04 PM, Surveyor received an email response from Social Worker (SW) I with Chippewa County Adult Protective Services (APS) that read, in part, "Upon meeting [Resident 1] at [his/her] new placement, the director of the new facility shared [his/her] discomfort with the details of [his/her] transfer. This was the first I, or the APS team heard of any issues with [his/her] transfer. Upon speaking with both facilities, each blamed the other for the mistake. [The provider] also felt that the fault was with [Guardian G] and the transport company." SW I stated the MCO

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N 351	Continued From page 10 would be providing further education with the provider, but s/he still felt "uncomfortable with the details of the transfer, and lack of advocation [sic] on the part of the director." SW I stated the APS team was going to look into the incident further. The provider did not ensure Resident 1 was free from physical restraint when the transportation company secured him/her to his/her wheelchair with gait belts in his/her room prior to discharging from the facility. Staff were aware of the gait belt placement but did not advocate for Resident 1. Cross References N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse Neglect N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication	N 351		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received medication as prescribed. Resident 1 received lorazepam 1 time on 03/27/2025 and 03/28/2025, in place of one of his/her morning medications without his/her knowledge.	{N 352}		

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{N 352}	Continued From page 11 This is a repeat deficiency. See Statement of Deficiency (SOD) S75L13, dated 05/10/2022, SOD DTGP12, dated 02/06/2024, and SOD DTGP13, dated 10/25/2024. Findings include: On 04/11/2025, the Department received a complaint alleging a resident did not receive medication as prescribed. The provider is licensed to care for 33 residents in the client groups irreversible dementia/Alzheimer's disease, and advanced aged. Per DHS 83.02 (27), "Involuntary administration of psychotropic medication means any one of the following: (a) Placing psychotropic medication in an individual's food or drink with knowledge that the individual protests receipt of the psychotropic medication. (b) Forcibly restraining an individual to enable administration of psychotropic medication. (c) Requiring an individual to take psychotropic medication as a condition of receiving privileges or benefits." On 04/23/2025 at 10:16 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/06/2024 and discharged on 03/28/2025. Resident 1 had a guardian and diagnoses that included dementia, depression, and insomnia. Resident's individual service plan (ISP) dated 07/12/2024, indicated staff managed his/her medications and Resident 1 would frequently	{N 352}		

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refuse medications, except his/her blood pressure medication.

Surveyor reviewed staff observation notes, dated 03/01/2025 to 03/31/2025, and found the following:

03/26/2025 9:15 PM , written by Community Director (CD) B - "MCO (managed care organization) called and stated that [s/he] had arranged secured transportation to [the other provider] for 3/27/25. A prn (as needed) was ordered from primary."

03/27/25 8:45 AM written by Chief Operating Officer (COO) A - "This am PRN lorazepam was given for anxiety related to [his/her] move (potentially) this am."

03/27/25 10:15 AM written by COO A - "Lisinopril (1 tab) was destroyed this am to give his/her PRN Lorazepam as this residents [sic] counts pills in am [sic] and will refuse to take more than "normal" [sic] [physician] is aware of exchange and destruction of 1 pill as well as [Case Manager (CM) C]."

03/27/25 12:30 PM written by Ex Life Enrichment Coordinator (ELEC) D - " ...am [sic] med (medication) this morning didn't really have much affect [sic] on [him/her] other than just slowing down [his/her] speech a bit."

The March 2025 medication administration record (MAR) indicated lorazepam 0.5 mg tablet PRN was given by COO A on 03/27/2025 at 8:45 AM, and by Caregiver E on 03/28/2025 at 8:38 AM.

An order from Resident 1's primary care provider (PCP) indicated lorazepam 0.5 mg 2 tablets was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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
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ordered on 03/26/2025. The order did not indicate this medication should be replaced with one of Resident 1's blood pressure medications.

Surveyor reviewed an internal investigation of Resident 1's discharge on 03/28/2025. The internal investigation summary read, in part, " ...Wednesday 03.26.2025 - [CM C and THP team], stating ' ...I am reaching out to see how feasible it would be to ask [Resident 1's PCP] for a one-time order or medication to use on the day of [his/her] move ...[COO A] stated 'we could get an order for a low dose lorazepam to help ease [his/her] anxiety during the move' [sic] [CM C] was in agreement with this. [COO A] then discussed that we would take one of [his/her] three Lisinopril tabs [sic] and destroy [sic] then add in the PRN Lorazepam, as [s/he] counts pills' [sic] The plan was set to give the PRN thirty minutes or so prior to transport, which would be scheduled for 9:00am [sic] the following day. [PCP] advised of plan and in agreement ...Thursday 03.27.2025 - ' ...[Resident 1] took [his/her] PRN Lorazepam this am, [sic] we switched out one of [his/her] Lisinopril tabs [sic] ([s/he] still got the other two) as [s/he] counts [his/her] pills."

On 04/24/2025 at 3:04 PM, Surveyor interviewed Guardian G. Guardian G stated s/he did not initially object to the lorazepam ordered due to Resident 1's prior discharge issues. Guardian G stated s/he did not like Resident 1 not knowing what s/he received for medication and the 1 tablet of lisinopril was destroyed. Guardian G stated s/he did not think Resident 1 would have taken the lorazepam if s/he was aware of it.

04/25/2025 at 1:48 PM, Surveyor interviewed Caregiver E. Caregiver E stated the lorazepam

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{N 352}	Continued From page 14 was ordered to keep Resident 1 calm. Caregiver E stated s/he felt wrong about the situation and did not administer Resident 1's morning medications. Caregiver E stated s/he did not know why the lorazepam was charted under his/her name on 03/28/2025. On 04/30/2025 at 11:48 AM, Surveyor received an email response from ELEC D that read, in part, "[COO A] had asked me to assist in giving [Resident 1] [his/her] meds [sic] if needed, knew I had my med certificate but that [s/he'd] get them from the med passer and hand them to me but [s/he'd] be in the room. Apparently they had an order of Lorazepam that [s/he] was going to be given also ...So the day of the 27th [COO A] was up there and waited for [Caregiver E] to get the pills, and carried them to [Human Resource (HR) F] which we both walked in to the room together [sic] [s/he] handed them to me standing a few feet away from each other and I handed them to [Resident 1], [sic] [s/he] took them and didn't ask any questions [sic] [s/he] was in a pleasant mood. "On 03/27/2025 transportation had a mix up and Resident 1's discharge was rescheduled for the next day, 03/28/2025. [Caregiver E] again popped out the pills I honestly wasn't paying much attention ...[Caregiver E] handed them to [HR F] and [him/her] and I went in there approximately 0830-0839 [sic] ...[HR F] handed them to me and was standing right beside me and in front of [Resident 1], [sic] [s/he] took them." On 04/30/2025 at 2:17 PM, Surveyor received an email response from COO A related to a request for the order from the PCP to destroy the lisinopril and replace it with lorazepam, that read, in part, "We called out to [PCP] for [his/her] order as we cannot find it. I have not received it yet."	{N 352}		

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{N 352}	Continued From page 15 On 05/01/2025 at 9:55 AM, Surveyor interviewed CD B. CD B confirmed Resident 1 was not aware s/he was getting lorazepam with his/her morning medications on 03/27/2025 and 03/28/2025. On 05/01/2025 at 2:29 PM, Surveyor received an email response from ELEC D. When asked if Resident 1 knew s/he was receiving lorazepam with his/her morning medications on 03/28/2025, ELEC D responded, "[Resident 1] was not, I didn't really say anything [sic] [s/he] just took them ...I'm not sure if [s/he] would have, I know [s/he's] refused all of [his/her] meds quite often so not really sure. I was only asked to do so under the supervision of [COO A]." On 05/06/2025 at 2:00 PM, Surveyor interviewed COO A. COO A stated that on 03/27/2025, s/he prepped Resident 1's morning medications and went into Resident 1's room with ELEC D. COO A stated s/he could not remember if ELEC D explained to Resident 1 what medications s/he received. COO A stated s/he destroyed 1 tablet of Resident 1's lisinopril with Caregiver E and did not chart it in the medication destruction log. COO A confirmed they did not have a court order for administering the lorazepam without Resident 1's knowledge on 03/27/2025 and 03/28/2025.	{N 352}		