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| M 000 | INITIAL COMMENTS<br><br>On 01/21/2025 with additional information gathered through 02/03/2025, Surveyor conducted a standard survey and complaint investigation. As a result two deficiencies were issued. The complaint was substantiated.<br><br>Census: 3 | M 000 | | |
| M 380 | 88.06(2)(a) ADMISSION-HEALTH EXAM<br><br>Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the provider did not ensure two (Residents 1 and 3) of two residents reviewed were screened for communicable disease, including tuberculosis.<br><br>Findings include:<br><br>The facility has been licensed by the department since 04/11/2018 as an AFH (Adult Family Home) serving a maximum of 4 residents who are developmentally disabled, or emotionally disturbed/mental illness. At the time of the visit | M 380 | | |

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

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| M 380 | Continued From page 1<br>the facility was home to 3 residents.<br><br>On 01/21/2025, Surveyor conducted a standard licensing survey at the home. During a review of the AFH records Surveyor noted the following:<br><br>*Resident 1 was admitted to the facility on 09/08/2022.<br>*Resident 3 was admitted to the facility on 01/18/2024.<br><br>The records for Residents 1 and 3 did not include documentation having received screening for communicable disease, including tuberculosis.<br><br>On 01/21/2025 at approximately 1 PM, Surveyor interviewed Staff C regarding the above missing documentation. Staff C indicated s/he could not locate the documentation to confirm Resident 1 and 3 were screened for communicable disease, including tuberculosis, but would continue to look and inform Licensee B of the missing information.<br><br>On 01/29/2025 at approximately 1:15 PM, Surveyor interviewed Licensee B. Licensee B indicated s/he would look for the required documentation and send it to Surveyor by 01/31/2025. On 02/03/2025 at 9:02 AM, Licensee B verified s/he could not find documentation Residents 1 and 3 were screened for communicable disease, including tuberculosis. | M 380 | | |
| M 424 | 88.06(3)(f) REVIEW OF ISP<br><br>The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated | M 424 | | |

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| M 424 | Continued From page 2 | M 424 | | |

representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian.

This Rule is not met as evidenced by:
Based on record review and interviews, the licensee did not review and update a resident's ISP (Individual Service Plan) following behaviors that were known to be harmful to Resident 1, other residents and staff.

Resident 1 displayed physical aggression towards others, property damage, and self-injurious behaviors, prompting staff to call for police intervention multiple times from 08/2024 through 12/2024. Resident 1's behaviors were not assessed related to what might have caused the behaviors, how staff were to meet the resident's needs to prevent the behaviors, or how staff were to protect themselves, other residents and Resident 1 from being injured. Additionally, the facility did not review and revise Resident 1's ISP related to the increased behaviors or identify additional care plan interventions (other than medication changes) for these behaviors.

Findings include:

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| M 424 | Continued From page 3<br><br>The facility has been licensed by the department since 04/11/2018 as an AFH (Adult Family Home) serving a maximum of 4 residents who are developmentally disabled, or emotionally disturbed/mental illness. At the time of the visit the facility was home to 3 residents.<br><br>The facility's policy and procedure titled "Behavior Assessment, Monitoring, and Response," dated 2018, indicated, "The Licensee or designee will assess all residents for behavior symptoms, develop an ISP incorporating resident supervision needs, and provide on-going health monitoring to ensure that behavior changes in the resident are identified and that prompt and adequate treatment is provided when changes occur. Procedure: 1. The Licensee or designee will conduct a comprehensive pre-admission assessment for each resident that includes assessment of behaviors: a. History of behaviors. b. Triggers for behaviors. c. Prevention strategies that have worked. d. Non-pharmacological interventions effectively used to prevent behaviors from escalating. e. Any medication used to address behaviors. 2. The Licensee or designee will review and revise the behavior assessment annually, with ongoing health monitoring, after behavior changes and after any change of condition. 3. The Licensee or designee will ensure that the ISP is developed to include a supportive behavior plan for each resident with a history of behaviors. The plan will include: a. Description of behaviors. b. Triggers and how to prevent behaviors. c. Supervision and monitoring to be done to promote resident safety. d. Specific non-pharmacological interventions to keep behaviors from escalating...9. The Licensee or designee will review and revise the resident assessment with any change of behavior identified. 10. The Licensee or designee will | M 424 | | |

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review the resident's ISP to change or add interventions for the resident experiencing behaviors. 11. The Licensee or designee will update the resident, resident's legal representative, and referring agency about any changes to the ISP. 12. The Licensee or designee will notify service provider of any changes to the residents ISP..."

On 01/28/2025, Surveyor reviewed the City of Hartford Police report dated 12/22/2024 and noted the following: "On 12/22/2024, at 10:50 AM, the Hartford Police Department was contacted by [Staff A] advising [Resident 1], who is non-verbal autistic member of the group home, was currently attacking [her/him] at the AFH...Once on scene, I made contact with [Resident 1], who was currently sitting in the living room of the AFH... [Staff A] was in the kitchen of the home and was very worked up. I asked [her/him] what happened on today's date. [Staff A] advised me [Resident 1] was trying to show [him/her] something on [his/her] iPad as this is [his/her] only way of communication...I was then advised after [Resident 1] kept showing [Staff A] this, [Resident 1] would not back off and when [Resident 1] was not getting something [s/he] wanted [s/he] then began to attack [Staff A]. [Staff A] stated [Resident 1] would hit [her/his] with [his/her] fists...While explaining, [Staff A] began crying as [s/he] was very frustrated with the situation. [Staff A] advised me [Licensee B], would not assist them very well. [Staff A] advised me that in the past, [Licensee B] has told staff [s/he] cannot handle [Resident 1] and they have to care for [him/her], so [s/he] does not have too. [Staff A] also said multiple staff members have stated to [Licensee B] they do not feel they can handle [Resident 1] and asked for [him/her] to be removed...[Staff A] stated [Licensee B's] answer

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| M 424 | Continued From page 5<br>to this was telling staff [Licensee B] would have to lower their pay if [Resident 1] is taken away as they will not have as many residents. [Staff A] then called [Licensee B] to advise [him/her] of the situation. During that conversation, I spoke with [Licensee B] about this ongoing problem with [Resident 1]. I advised [Licensee B] of the different solutions we were looking into as we have been coming to this residence numerous times over the past four months with no change in behavior...When reviewing calls for service with [Resident 1] striking staff members or residents at this residence, I found the Hartford Police Department has responded eleven times since August for calls regarding [Resident 1]. Those calls for service (date, report number, cause for call) are listed below and are as follows:<br>1. 08-08-2024 - 24-009941- [Resident 1] struck the caller and was throwing items in the house.<br>2. 09-30-2024 - 24-012461 - [Resident 1] struck the caller and hit a hole in the wall.<br>3. 10-16-2024 - 24-013140 - [Resident 1] striking another resident of the group home.<br>4. 10-18-2024 - 24-013244 - [Resident 1] attacked other members of a different group home [Licensee B] operates.<br>5. 10-31-2024 - 24-013909 - [Resident 1] was out of control and threw a rock through a window of the group home.<br>6. 10-31-2024 - 24-013912 - [Resident 1] was out of control and was attacking a worker of the group home. When this officer was arriving on scene, the officer observed [Resident 1] chasing a staff member down the street as [s/he] was running away over fears of being injured.<br>7. 11-01-2024 - 24-013956 - [Resident 1] was getting angry and tried to hit staff.<br>8. 11-27-2024 - 24-015031 - [Resident 1] was out of control and attacked other residents of group home. | M 424 | | |

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| M 424 | Continued From page 6<br>9. 12-12-2024 - 24-015669 - [Resident 1] out of control and attempted to attack staff. Staff locked themselves in a bathroom and residents locked themselves in their room for protection.<br>10. 12-19-2024 - 24-015945 - [Resident 1] became angry, began hitting [her/himself], and when staff tried to stop this, [s/he] began attacking staff.<br>11. 12-22-2024 - 24-016105 - Incident documented in this report. -hit staff."<br><br>On 01/21/2025, Surveyor reviewed Resident 1's record and noted the resident was admitted to the facility on 09/18/2022 with diagnosis to include, developmental delay, impulse control disorder and autism.<br><br>Resident 1's ISP dated 07/18/2024, and signed by Licensee B and Resident 1's guardian on 07/19/2024 indicated, "[Resident 1] requires 24-hour supervision in the community and at the home. Mobility: Independent, Communication: Sign Language ...Behavioral Challenges: Anxiety, Impulse Behavior, Property damage, harm to [him/herself] and others. Support Interventions: Verbal redirection, police if necessary." No additional ISP was provided or located for Resident 1. On 01/21/2025 at 1:00 PM, Staff C verified the 07/18/2024 ISP for Resident 1 was the most current ISP. Staff C also confirmed no changes were implemented to the 07/19/2024 plan of care.<br><br>On 01/28/2025, Surveyor reviewed Resident 1's Incident logs from 08/01/2024 through 01/21/2025 and the following was noted:<br><br>*08/08/2024 at 2:00 PM- "[Resident 1] became angry when [s/he] wanted to be tall. I asked [Resident 1] to put [his/her] iPad away and [s/he] | M 424 | | |

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started stomping and yelling. When staff asked [Resident 1] to stop, [s/he] started hitting staff and threw a lamp across the room." The log indicated law enforcement and Licensee B was notified. Additionally, the log documented, "Other actions taken at the time: Called 911 ...Steps taken to prevent recurrence: Police talked to [Resident 1] about not hitting and throwing things when [s/he] gets mad."

*08/10/2024 at 3:00 PM- "[Resident 1] ran away. Got violent with staff after staff went to pick [him/her] up. Staff was polite but [Resident 1] didn't care, still got violent. Punched staff about 20 times in neck and shoulders charging at staff punching them until staff ran to car." The log indicated law enforcement, Licensee B and guardian were notified. Additionally, the log documented, "Other actions taken at the time: guardian and police called ...Steps taken to prevent recurrence: Licensee B contacted psychiatric prescriber."

*09/30/2024 at 3:20 PM, "[Resident 1] lost control of [her/himself] after being told no to ice cream. Punched a hole in the wall, through the lamp in the living room, hit on window with hands and with metal pole, threw stone figures at the house, and hit staff. Police came and calmed [Resident 1] down." The log documented, "Other actions taken at the time: [No response was written]...Steps taken to prevent recurrence: [No response was written]."

*10/16/2024 at 7:30 AM, "Told [Resident 1] no school and [s/he] began hitting staff in the shoulder and threw living room lamp at ceiling. Police came and told [Resident 1] no school." The log documented, "Other actions taken at the time: [No response was written]...Steps taken to

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prevent recurrence: [No response was written]."

*10/18/2024 at 5:00 PM, "[Resident 1] asking staff to cut off [his/her] nose. [Resident 1] left home to strip mall hitting staff, cars and windows at strip mall. [Resident 1] then hitting staff and peers at apartment building. Called cops and [Resident 1] calmed down." The log documented, "Other actions taken at the time: [No response was written]...Steps taken to prevent recurrence: [Resident 1] recently started increase in medication. Hopefully it will help. Continuing to review situation with doc (sic)."

*10/31/2024 at 2:00 PM, "[Resident 1] upset staff would not cut [his/her] nose off and give [him/her] doctors phone number. [Resident 1] attempted to hit staff, hit [him/herself]. When [Resident 1] couldn't hit staff [s/he] threw the yard décor through the garage window. Police called." The log documented, "Other actions taken at the time: [No response was written]...Steps taken to prevent recurrence: [No response was written]."

*10/31/2024 at 5:00 PM, "[Resident 1] upset because staff wouldn't take [him/her] to school. Refused to calm down. Got more upset when staff could not make dinner due to [his/her] aggressive behavior. Began pounding on walls and door. Chased staff outside down the block trying to attack staff and tried breaking more off garage window. Police called." The log documented, "Other actions taken at the time: [No response was written]...Steps taken to prevent recurrence: [No response was written]."

*11/01/2024 at 1:00 PM- "[Resident 1] got upset staff asked [him/her] to put on a sweater or pants to go outside because it's cold. When [Resident 1] didn't want to put on a sweater [s/he] asked

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staff if they could cut off [his/her] arm, staff told him no. [Resident 1] tried to attack staff. Called police." The log documented, "Other actions taken at the time: [No response was written]...Steps taken to prevent recurrence: [No response was written]."

*11/27/2024 at 4:28 PM- [Resident 1] hitting [her/himself] and screaming in living room by [her/himself]. When asked what was wrong [s/he] attempted to attack staff when [s/he] was not able to [Resident 1] ran upstairs and attacked another client. Continued to hit [her/himself] and attempted to bust down doors until police came." The log documented, "Other actions taken at the time: [No response was written]...Steps taken to prevent recurrence: [No response was written]."

*12/12/2024 at 7:30 PM- [Resident 1] upset that staff cannot change [her/his] physical appearance began punching [her/himself] in the throat attempted to attack staff. Blocked staff from leaving the room so [s/he] could attack them pounding on walls and doors. Police called because staff could not calm [her/him]." The log documented, "Other actions taken at the time: [No response was written]...Steps taken to prevent recurrence: [No response was written]."

*12/19/2024 at 7:45 AM- [Resident 1] came downstairs went into the living room, without warning [Resident 1] began hitting [her/himself] and screaming. When asked what is wrong [s/he] attacked staff and had to be kept separate from the other resident downstairs. [Resident 1] continued to strike staff until police arrived." The log documented, "Other actions taken at the time: [No response was written]...Steps taken to prevent recurrence: ACS (Acute Crisis Service) Assessment was discussed. One officer declined

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stated it would be "a waste if time." Med review scheduled at 1 PM today with physician."

12/22/2024 at 10:40 AM- "[Resident 1] came after staff after refusing the answer of "No" [Licensee B] today. Started hitting [her/himself] then went up to staff and started hitting staff, then ran up to resident bedrooms to try and attack them too. Resident bedrooms were locked." The log documented, "Other actions taken at the time: [No response was written]...Steps taken to prevent recurrence: Police being called."

01/04/2025 at 7:25 PM- "[Resident 1] started jumping up and down all the while hitting [her/himself] on the arms, stomach and throat. Did this four times in the space of 20 minutes. Able to calm [him/her] with verbal prompt. 10-15 minutes of calm and [Resident 1] again started jumping up and down hitting [her/himself]. [Resident 1] then stopped and ran to the med locker and started beating on the door. Stopped beating on the door when staff approached and used verbal prompts. Moved to the kitchen and [Resident 1] was looking at [her/his] iPad. Finally let out loud grunt sound and ran upstairs. Started pounding on resident's doors while making loud grunt sounds. Staff moved in between [Resident 1] and the door [s/he] then went to the floor on [her/his] own. Once on the floor [s/he] kicked the door several times causing damage. Staff went down to the floor with [her/him] and talked to [her/him]. [Resident 1] calmed down after several minutes. [Resident 1] and staff returned to the kitchen. House manager arrived shortly after and talked to [Resident 1]. Addendum: During two of [Resident 1's] jumping up and down episodes [s/he] came at staff with [her/his] arms in a flailing motion. Staff was able to hold [her/him] at distance without stretched arms and side steps.

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[Resident 1] then calmed down after failing to strike staff." The log documented, "Other actions taken at the time: Notify home manager...Steps taken to prevent recurrence: [No response was written]."

On 01/28/2025, Surveyor reviewed Resident 1's "Progress Notes" and the following was noted:

*01/02/2025- "...Anxious start, crying and hitting [her/himself]..."

*01/04/2025- "Good day till shortly after dinner. Several anxiety attacks with hitting [her/himself], pounding on med locker door and resident door. Very aggressive and loud..."

*01/07/2025- "...Lots of crying and hitting [her/himself] because staff would not move rooms over and over again..."

*01/16/2025- "...Handful of crying/hitting [him/herself] episodes."

***Surveyor noted Resident 1's record did not contain an assessment as to how often a particular behavior was occurring, why a behavior may be occurring or identification of alternate interventions (besides medications) and results of the interventions. Additionally, there were no revisions or updates to Resident 1's ISP despite the increased behaviors and police involvement on 12 different occasions.

On 01/21/2025, at approximately 12:30 PM, Surveyor interviewed Staff C regarding Resident 1. Staff C indicated Resident 1 was independent with ADL's including ambulation, was nonverbal and communicated frequently through an iPad. Staff C stated, "[Resident 1] is very hit or miss.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017106 | A. BUILDING: _____ B. WING _____ | C 02/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JAMES COURT | 908 JAMES COURT HARTFORD, WI 53027 |

| (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 424 | Continued From page 12<br><br>One day [s/he] likes a staff and the next day [s/he] won't like the staff." Staff C verified Resident 1 has become physically aggressive and violent due to being frustrated and having a hard time communicating. Staff C stated, "If staff can't get [Resident 1] what [s/he] wants immediately or tells [Resident 1] "No" [s/he] will escalate. I've been hit by [Resident 1] and [Resident 1] has hit plenty of other staff and residents. The last couple of months [Resident 1] has been more aggressive, but it's been better the last few weeks. When [Resident 1] gets worked up I get a little nervous. [Resident 1] will hit [her/himself] and then go after anything in [his/her] way. [Resident 1] has hit [Resident 2] recently because [Resident 2's] bedroom door was open. [Resident 1] went in and hit [Resident 2] on the shoulder with a closed fist...[Resident 2] didn't need medical treatment." Staff C went on to say, "I try to get [Resident 1] to calm down and de-escalate the situation. I've seen [Resident 1] fake cry or say "Boo Who" before [his/her] behavior escalates to violence. If [Resident 1's] behaviors are bad and it's just me and [Resident 1], I will lock myself in the bathroom, otherwise I will quick run upstairs and make sure the other residents' doors are locked. [Resident 1] usually goes after staff but will go after residents if [s/he] can't get at staff. We make sure the residents lock their doors when they're in their rooms." Surveyor asked Staff C if there were any specific or specialized instructions for managing Resident 1's behaviors. Staff C stated, "When I can't get [Resident 1] to calm down, I call the police. [Licensee B] agrees with me calling the police, because "It's my right." Surveyor then asked if Resident 1's ISP gave any specific interventions and Staff C stated, "[Resident 1's] ISP just tells us to verbally redirect [him/her] or call the police, there are no other directions on how to manage | M 424 | | |

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| M 424 | Continued From page 13<br><br>[Resident 1's] behaviors." Staff C went on to say, "A few things I've noticed that have worked for me with managing [Resident 1's] behaviors are setting timers, offer meals/snacks, review [Resident 1's] notes on the iPad, look at [his/her] pictures and calendar, encourage deep breaths, journal/color, listen to music, and help [him/her] call [License B] when [s/he's] upset."<br><br>On 01/23/2025 at 5:00 PM, Surveyor interviewed Staff A regarding Resident 1. Staff A stated, "I've worked in the home for 2 years. [Resident 1] was never like/this. [Resident 1] was never attacking staff and hitting. [Resident 1] didn't have outbursts, but now [s/he's] literally attacking staff and other people often. No one wants to work in the home with [Resident 1]." Staff A went on to say, "Around 08/2024, [Resident 1's] behaviors changed drastically. I would call the police when I worked in the home because I didn't feel comfortable turning my back or even cooking a meal. [Resident 1] would hit staff, other residents and damage property. [Resident 1] has tried to bust down other residents' doors. The rule is to have the other residents' lock their doors. [Resident 1] has hit me and [Resident 2]. This past month (12/2024) I was on edge because [Resident 1's] medications were not working and [his/her] temperament was really bad." Surveyor asked Staff A if there were any specific or specialized instructions for managing Resident 1's behaviors. Staff A stated, "I wasn't instructed to do anything. We've never had training on self-defense. I was never direct to do anything when all these behaviors escalated. I'm not aware of [Resident 1's] triggers or interventions to use to manage the behaviors. I was told we had to stop calling the police and handle [Resident 1's] behaviors on our own, and if the behaviors are bad to run away or lock myself in the | M 424 | | |

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| M 424 | Continued From page 14 | M 424 | | |

bathroom...If I run away, I'm leaving two other residents in the house with [Resident 1] who is violent. The other two residents have to go to their rooms and lock their doors when [Resident 1] has an outburst and stay in their rooms until [Resident 1] calms down...That's no way to live..." Surveyor then asked if Resident 1's ISP gave any specific interventions for managing his/her behaviors. Staff A replied, "The only thing written is to redirect and call the police, there is nothing else. No behavior plan to assist staff with managing [his/her] behaviors." Staff A stated, "[Licensee B] has not implemented alterative interventions to help staff. [Licensee B] tells me this is how [Resident 1] is and it will pass."

On 01/29/2025 at approximately 1:15 PM, Surveyor interviewed Licensee B. Licensee B verified Resident 1 had property damage, self-injurious, and physical aggressive behaviors. Licensee B verified the police were called recently on multiple occasions due to Resident 1's behavior. Licensee B verified the above incidents were not reflected in a behavioral assessment or in Resident 1's ISP. Licensee B verified there were no revisions or updates to Resident 1's ISP despite the resident's increased behaviors and police involvement on 12 different occasions. Additionally, Licensee B verified Resident 1 has not seen a Behavioral Specialist and did not have a supportive behavior plan.

In summary, the facility did not assess Resident 1's behaviors when an escalation of behaviors were identified and documented. Additionally, Resident 1's ISP was not reviewed or revised after an increase in behaviors that were known to be harmful to Resident 1 and others.