STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013853	A. BUILDING: _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN ASSISTED LIVING INC	2 HERITAGE LANE BELLEVILLE, WI 53508

(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 07/19/2023, Surveyor conducted a complaint investigation at Hometown Assisted Living Inc, a CBRF in Belleville. Three deficiencies were identified. Two deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) TXSE12, dated 08/16/2022 and TXSE14, dated 03/01/2023. The complaint was substantiated. Census: 3	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure residents were safeguarded from environmental hazards. The facility's front door did not latch upon closure, leaving the door alarm disengaged. Findings include: On 07/19/2023, Surveyor conducted a complaint investigation alleging that a resident had eloped from the facility on 06/23/2023. The facility is	N 358		

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

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N 358	Continued From page 1	N 358		

licensed to serve up to 8 residents with diagnoses including traumatic brain injury, physically disabled, terminally ill, advanced age and irreversible dementia/Alzheimer's.

On 07/19/2023 at approximately 11:50 a.m., Surveyor interviewed Caregiver B. Caregiver B stated Resident 1 had eloped within the past few weeks. Caregiver B stated s/he was not working when Resident 1 eloped but received the phone call from law enforcement that Resident 1 had been found shortly after his/her arrival to work on 06/23/2023. Surveyor asked if the facility's doors were alarmed. Caregiver B explained both facility exits were alarmed, but the alarms sound for a short period of time and then turn off without any intervention. Caregiver B added that the front door didn't always latch on it's own upon closure and when the door wasn't latched, the alarm didn't sound. Surveyor then observed the front door had not self-latched when s/he entered the facility. Caregiver B was unsure how long the front door had been broken.

On 07/19/2023 at approximately 12:15 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 05/05/2023 with diagnosis of dementia. Resident 1 was identified as a high elopement risk. Resident 1's signed "Guest Handbook House Rules," dated 04/05/2023, stated all exit door were alarmed. Resident 1's record included an incident report, dated 06/23/2023, that stated "Police called building around 6 a.m. [Resident 1] was across the street and had fallen. Police called ambulance. [Resident 1] had abrasions on [his/her] face from the fall. Bed check at 4:00 a.m. [s/he] was sleeping. Shortly after [Administrator A] was toileting another resident and this must have been when [Resident 1] left. I

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N 358	Continued From page 2	N 358		

did not hear [him/her] leave. This is the first time [s/he] has left the property." A hospital record, dated 06/23/2023, stated Resident 1 walked out of the assisted living at some point without letting anyone know and was found in a cornfield by a bystander, who called 911. The hospital report documented that Resident 1 had an abrasion over his/her nasal bridge.

On 07/19/2023 at approximately 12:30 p.m., Surveyor reviewed a police report, dated 06/23/2023, that stated police were dispatched to a "check person" of an elderly man/woman who had laid down in the ditch line on a street near the facility. The man/woman was confused and unable to tell law enforcement where s/he came from or what his/her address was. The man/woman's face was bloody. The man/woman was taken to the hospital.

On 07/19/2023 at approximately 12:50 p.m., Surveyor interviewed Administrator A. Administrator A stated s/he worked the night Resident 1 eloped. Administrator A stated s/he believed Resident 1 left the building when s/he was assisting another resident at approximately 4:30 a.m. Surveyor asked which door Resident 1 exited. Administrator A stated the facility's front door is the only door s/he believed Resident 1 knew about since s/he went out on the patio frequently during the day. Surveyor shared observation that the door did not always latch to engage the alarm. Administrator A acknowledged the front door did not self-latch and needed repairs. Administrator A stated s/he was unsure how long the door had been broken, but that s/he had reached out to numerous companies to repair the door and hadn't had any luck finding a company to repair the door. Administrator A stated s/he believed the door alarmed when

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N 358	Continued From page 3 Resident 1 eloped because staff are "vigilant" about latching the door but was unable to confirm that the door alarmed. Administrator A stated neither s/he, nor his/her family member, Family Member C, who had come to work with Administrator A that evening heard the alarm. On 07/19/2023 at approximately 1:45 p.m., Surveyor exited the facility out the front door. Surveyor observed that in order for the front door to latch upon exit, s/he needed to push the door shut behind him/her. Surveyor did not observe signage instructing employees, residents or guests to ensure the door was secured shut. The facility's front door did not consistently latch, leaving the door alarm disengaged.	N 358		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the	N 389		

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N 389	Continued From page 4	N 389		

provider did not ensure Resident 1's individual service plan (ISP) was updated when there was a change in needs. Resident 1's ISP was updated to include line of sight or 15-minute checks while s/he was out on the facility's front porch.

This is a repeat deficiency. See Statement of Deficiency (SOD) TXSE14, dated 03/01/2023.

Findings include:

On 07/19/2023, Surveyor conducted a complaint investigation alleging that a resident had eloped from the facility on 06/23/2023.

On 07/19/2023 at approximately 11:50 a.m., Surveyor interviewed Caregiver B. Caregiver B stated Resident 1 had eloped within the past few weeks and was found by a bystander. Caregiver B stated Resident 1 had no further elopements. Surveyor, who had previously observed Resident 1 out on the facility front porch, asked if Resident 1 still went outside the facility on his/her own. Caregiver B stated Resident 1 was now required to be in "line of sight" when out on the facility's front porch.

On 07/19/2023 at approximately 12:15 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 05/05/2023 with diagnosis of dementia. Resident 1's preadmission assessments identified him/her as a high elopement risk. Resident 1's ISP, dated 05/18/2023, indicated Resident 1 had late day agitation/wandering, became confused and thought it was time to go home, but was easily redirected. The ISP was updated on 06/26/2023 changing every 2 hour safety checks to hourly safety checks. The ISP did not specify a protocol for Resident 1 sitting out on the porch by

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N 389	Continued From page 5 him/herself. On 07/19/2023 at approximately 12:40 p.m., Surveyor observed Resident 1 go outside to sit on the facility's front porch. On 07/19/2023 at approximately 12:50 p.m., Surveyor interviewed Administrator A. Administrator A confirmed Resident 1 had eloped from the facility on 06/23/2023 and was a high elopement risk. Surveyor asked what the facility's protocol was for Resident 1 sitting on the front porch. Administrator A stated, "When [s/he] is out on the front porch, we can see [him/her] through the window, so we're doing more like 15-minute checks." Surveyor asked if Resident 1's ISP was updated to include line of sight or 15-minute checks while Resident 1 was out on the facility's front porch. Administrator A replied, "No. Let me make a note to do that."	N 389		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the	N 426		

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provider did not ensure supervision appropriate to resident's needs was provided. On 06/23/2023, Resident 1 eloped from the facility.

This is a repeat deficiency. See Statement of Deficiency (SOD) TXSE12, dated 08/16/2022.

Findings include:

On 07/19/2023, Surveyor conducted a complaint investigation alleging that a resident had eloped from the facility.

On 07/19/2023 at approximately 11:50 a.m., Surveyor interviewed Caregiver B. Caregiver B stated Resident 1 had eloped within the past few weeks. Caregiver B stated s/he was not working when Resident 1 eloped, but received a phone call approximately 10 minutes after arriving to his/her shift from law enforcement. Law enforcement informed Caregiver B that Resident 1 had been found nearby. Caregiver B stated Administrator A had worked the overnight shift and was in the facility's front office when Caregiver B arrived to work. Caregiver B stated Administrator A's family member, Family Member C, was also present, but Caregiver B was unable to recall where Family Member C was at the time Caregiver B arrived to work. Caregiver B stated neither Administrator A, nor Family Member C were aware Resident 1 was missing.

On 07/19/2023 at approximately 12:15 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 05/05/2023 with diagnosis of dementia. Resident 1 was identified as a high elopement risk. Resident 1's individual service plan (ISP), dated 05/18/2023, indicated Resident 1 would occasionally get up between 3:00 a.m. and 4:00 a.m., wander the halls, but did

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not disturb anyone and would go back to bed. The ISP stated Resident 1 required every 2-hour safety checks. Resident 1's progress notes, dated 05/05/2023 to 06/23/2023, included the following:

- 05/13/2023: Wandered up and down halls during night.
- 05/14/2023: Wandered halls during night.
- 05/21/2023: Keeps asking when s/he will get out of facility.
- 05/24/2023: Asked about going home.
- 06/04/2023: Trying to hitch hike (Doesn't clarify if this was talk or action).
- 06/07/2023: Worried about getting home.

Resident 1's record included an incident report, dated 06/23/2023 at 6:00 a.m., that stated "Police called building around 6 a.m. [Resident 1] was across the street and had fallen. Police called ambulance. [Resident 1] had abrasions on [his/her] face from the fall. Bed check at 4:00 a.m. [s/he] was sleeping. Shortly after [Administrator A] was toileting another resident and this must have been when [Resident 1] left. I did not hear [him/her] leave. This is the first time [s/he] has left the property."

On 07/19/2023 at approximately 12:30 p.m., Surveyor reviewed a police report, dated 06/23/2023, that stated police were dispatched to a "check person" of an elderly man/woman at 6:03 a.m. who had laid down in the ditch line on a street near the facility. The man/woman was confused and unable to tell law enforcement where s/he came from or what his/her address was. The man/woman's face was bloody. The man/woman was taken to the hospital.

On 07/19/2023 at approximately 12:50 p.m., Surveyor interviewed Administrator A.

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N 426	Continued From page 8 Administrator A stated s/he worked the night Resident 1 eloped. Administrator A stated s/he was unaware Resident 1 had left the facility until law enforcement called. Administrator A stated Resident 1 required every 2-hour safety checks and that s/he had conducted a safety check at 4:00 a.m. and the next safety check would have been completed shortly after 6:00 a.m. when first shift arrived. Administrator A stated s/he assisted another resident with toileting at approximately 4:30 a.m. and that was when s/he believed Resident 1 eloped. Surveyor asked if anyone else was at the facility that evening. Administrator A stated Family Member C was present, but only because Administrator A hadn't been feeling well. Administrator A stated Family Member C was not an employee, did not provide resident assistance and was likely sleeping in the living room or unoccupied room the night of the elopement. Administrator A stated both s/he and Family Member C were unaware Resident 1 had left the facility. Resident 1 eloped from the facility on 06/23/2023 and was found in a ditch near the facility with abrasions to his/her nasal bridge. Facility staff were unaware Resident 1 had eloped. Duration of time Resident 1 was outside the facility is unknown, potentially 90 to 120 minutes.	N 426		