Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013672	A. BUILDING: ______ B. WING ______	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE AND BEYOND ADULT FAMILY HOME	**5404 WRIGHT AVENUE** **RACINE, WI 53406**

(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 11/28/2023, Surveyor conducted an abbreviated survey and 1 complaint investigation. One deficiency was identified. One complaint substantiated. Census: 3	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all incidents requiring Department notification were reported to the Department for 3 of 3 incidents. Twice on 11/17/2023 and once on 11/19/2023, Resident 1 had a significant change in condition requiring police intervention due to elopements from the facility. Findings include: On 11/22/2023, the Department received a complaint alleging police had been repeatedly called to the facility due to staff failure to effectively manage Resident 1's elopement	M 134		

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

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M 134	Continued From page 1 behavior. On 11/28/2023 at approximately 1:00 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 11/17/2023, with a diagnosis of unspecified dementia. Incident report, dated 11/17/2023, at 4:41 PM, stated, "Client [Resident 1] kept leaving home, fell on the rocks at the church. [Resident 1] said their back hurt. Ambulance and police were called. Ambulance took [Resident 1] to the hospital." Incident report, dated 11/17/2023, at 7:30 PM, stated, "[Resident 1] went outside and walked across the street to the church and fell. [Resident 1] had to go to the hospital because [s/he] said their back and arm were hurting." Incident report, dated 11/19/2023, at 2:52 PM, stated, "[Resident 1] left again for the third time. Non-emergency [phone number] was called early and was able to bring them back." On 11/28/2023, Surveyor reviewed department records and identified there were no self-reports submitted by the provider related to these incidents. On 11/28/2023, at 1:45 PM, Surveyor interviewed Administrator B. Administrator B confirmed they did not report Resident 1 elopements to the Department. They stated they had overlooked this requirement. Surveyor provided information to Administrator B regarding the department Publication-02007 Reporting Requirements for Assisted Living Facilities.	M 134		