STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020150	A. BUILDING: _____ B. WING _____	C 01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUCKAROOS AFH 3B	1318 WAKOKA ST WATERTOWN, WI 53094

(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 10/30/2024, with information gathered through 01/06/2025, Surveyor conducted a complaint investigation at Buckaroos AFH 3B. Twelve (12) cites were identified. The complaint was substantiated. Census: 2	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 report a significant change in 2 of 2 resident's condition resulting in emergency room (ER) treatment and/or hospitalization. The provider did not report to the Department within 24 hours after Resident 1 required hospital treatment after ingesting batteries on 09/13/2024, 09/22/2024 and 10/23/2024. The provider did not report to the Department within 24 hours after Resident 2 required hospital treatment on 05/11/2024 after ingesting an	M 134		

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

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excessive amount of medications; 05/19/2024 after ingesting batteries; 06/20/2024 due to suicidal ideation and wrapping a cord around his/her neck in his/her room; 09/05/2024 after ingesting batteries; and 09/13/2024 after s/he cut his/her wrist and then tried to strangle him/herself with a seatbelt.

Findings include:

On 10/30/2024, Surveyor conducted a complaint investigation. The provider is licensed as a non-ambulatory adult family home (AFH) able to serve up to 4 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, and physically disabled.

At approximately 10:00 a.m., Surveyor asked Licensee A if Resident 1 had ever ingested non-edible food items. Licensee A stated, yes, Resident 1 started to do it for attention after s/he saw Resident 2 was doing it. Surveyor asked how many times Resident 1 and Resident 2 had ingested batteries. Licensee A stated s/he did not know. Surveyor asked Licensee A if s/he ever reported the incidents to the Department if they required a medical procedure or hospitalization to remove the batteries. Licensee A stated s/he did not know and would have to look back in his/her records.

Example 1 - Resident 1
Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 03/13/2024 with diagnoses affective disorder, impulse disorder, borderline personality disorder, suicidal ideation, and intellectual disability.

On 10/30/2024, at 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 1's record,

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including progress notes. The progress notes document:
09/17/2024 - "...[s/he was very agitated due to hearing voice in [his/her] head but wanted to go for a walk to help with [his/her] agitation and voices."
09/18/2024 - "...[Resident 1] got back [s/he] asked if [s/he] could call the crisis line due to [him/her] having self-harming thought and hearing voices in [his/her] head [s/he] wanted to go to the hospital so [s/he] could get sent to a mental hospital. Staff let [him/her] call crisis. [S/he] talked to crisis [Resident 1] didn't like what they told [him/her] so [s/he] hung up on them..."
09/22/2024 - "swollen[sic] batteries"
10/02/2024 - "[Resident 1] returned from hospital stay on 10-2-24"

On 11/19/2024, at 6:33 a.m., Surveyor obtained and reviewed Resident 1's hospital record. The hospital documented Resident 1 presented at the ER and required the following treatment:

09/13/2024 - "...psychogenic nonepileptic seizure history who comes in with group home caregiver for the evaluation of suicide ideation and after attempting to hurt [him/herself] by ingesting 2 AAA batteries earlier today. Patient reports [s/he] feels fine in regards to not having any chest pain, shortness of break no abdominal pain no nausea vomiting. However [s/he] reports ongoing suicide ideation and depression. [S/he] reports [s/he] ingested these to try to hurt [him/herself]. Has previously done this a few years ago." Resident 1 required an emergency endoscopy by a general surgeon to remove the batteries.

9/22/2024-09/24/2024 - "Concern for ingestion of batteries. Patient states that [s/he] hears voices that tell [him/her] things. Patient states that [s/he]

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took the batteries other[sic] remote control at [his/her] group living home and swallow[sic] them. Patient denies any further ingestion or any other attempt to harm [him/herself]. Patient has a history of this type of behavior. Patient denies any symptoms of illness such as fever, chills, chest pain, shortness of break, abdominal pain, nausea, vomiting or diarrhea. Ingestion occurred approximately 1-1/2 hour prior to arrival. Patient had eaten a meal just prior to that." Resident 1 stated s/he ingested the batteries in an attempt to kill him/herself. Resident 1 required an esophagogastroduodenoscopy for the removal of the ingested batteries.

10/23/2024 - "Patient swallowed 2 AAA batteries approximately half an hour prior to arrival. [S/he] is hearing voices telling [him/her] to do this, as [s/he] is schizophrenic. [S/he] has been having [his/her] medications adjusted recently [s/he] has a history of swallowing objects from least the time when [s/he] was 18 years old. [S/he] tells me [s/he] swallows screws as well as landscaping rocks. [S/he] has also had some reason[sic] history of swallowing batteries from TV remote controls. Denies any pain nausea vomiting or diarrhea." Resident 1 required an esophagogastroduodenoscopy with endoscopic evaluation for the removal of the ingested batteries.

Example 2 - Resident 2
Surveyor reviewed the closed record of Resident 2. Resident 2 was admitted to the provider on 04/01/2024 with diagnoses including anxiety, depression and autism.

On 10/30/2024, at 10:34 a.m. HR Assistant B emailed Surveyor parts of Resident 2's record, including progress notes. The progress notes

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document:
06/20/2024 - "[Resident 2] was taken to the ed [sic] after seeing [his/her] primary."
06/20/2024 - "[Resident 2] was picked up and brought back to [facility] last night."
06/21/2024 - "[Resident 2] was admitted to [mental health institution]"
09/05/2024 - "[Resident 2] swallowed batteries and [s/he] was brought to the hospital to make sure everything was okay and if [s/he] needed something to pass them the hospital kept [him/her] for surgery to get the batteries out."
09/12/2024 - "[Resident 2] was picked up around 9 am by [staff] and [staff] from [mental health institution]."
09/14/2024 - "[Resident 2] was taken to [emergency department] and they took [him/her] to [mental health institution] for suicide attempts."

On 11/19/2024, at 6:33 a.m., Surveyor obtained and reviewed Resident 2's hospital record. The hospital documented Resident 2 presented at the ER and required the following treatment:

05/11/2024 - "...reported ingestion of 5 days worth of [his/her] usual medications as a suicide attempt. No cardiopulmonary or neurologic abnormalities on initial evaluation. Laboratory studies without clinically significant abnormality. Per Poison control, should be observed for 12 hours for any signs of deterioration. In the process of arranging admission to [hospital], patient divulged reported sexual assault 2 days ago, requesting SANE exam. Arrangements made for SANE exam at [hospital] with subsequent admission from hospitalist there. Jefferson County Human Services aware of patient, will need to be notified for psychiatric disposition once medically cleared at [hospital]."

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M 134	Continued From page 5 05/19/2024 - "...ingested in a suicide to[sic] about 2-2.5 hours ago after eating dinner at the group home which [s/he] lives. One of the batteries is AAA battery and the other 1 is an LED button battery. [S/he] states [s/he] took the batteries because [s/he] is suicidal and depressed. [S/he] says [s/he] was raped [orifice] at the group home in which [s/he] lives by a [gender] that also lives in the facility. Patient says [s/he] told the group home staff that [s/he] was raped last night but that they did not believe [him/her]. [S/he] has a history of PTSD, bipolar illness, personality disorder, autism, anxiety and depression. [S/he] has not vomited and [s/he] denies chest pain or trouble breathing. [S/he] has some right flank pain. [...] Patient also admits to eating small screws and an earring a couple weeks ago and [s/he] told the group home staff that [s/he] ingested those items. [S/he] has not ingested any screws or earrings recently. Last week the patient was very depressed and then [s/he] took an overdose and was seen here in the ER. [S/he] also stated at that time that [s/he] was raped in the group home. [S/he] was sent to [hospital] for a sane exam, medical observation for the overdose and eventually psychiatric consultation. The patient says that the psychiatrist told [him/her] [s/he] could go back to the same group home even though [s/he] does not want to be there anymore." Resident 2 underwent upper endoscopy, specifically esophagogastroduodenoscopy to remove the batteries. 06/20/2024 - "...long history of mental health disorders who lives in a group home who comes in with complaints of suicidal ideation that has been ongoing and now had an attempt by wrapping cord around [his/her] neck in [his/her] room. Police were called to the group home and	M 134		

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bring[sic] [him/her] to the ER. Patient denies any other complaint. No chest pain or shortness of breath, no nausea vomiting or diarrhea. After further discussion with patient [s/he] states that the individual grabbed [his/her] breast and then walked away. Police are at bedside along with [county] social worker. Patient has been emergency detention."

09/05/2024-09/07/2024 - "...past medical history of autism, ADHD, PTSD, Bipolar Disorder, depression, anxiety, asthma who presents with suicide attempt. Suicide attempt, ingestion of batteries: Present on admission. X-rays show 2 cylindrical batteries within the stomach.
-status post EGD with successful removal. No ulcerations noted.
-patient has sitter at bedside
-awaiting county for suicide clearance
...'I swallowed batteries to try to kill myself.' Pt states [s/he] swallowed 2 AAA batteries at approximately 2115. [S/he] states [s/he] has been struggling at [his/her] group home Buckaroos for a 'couple weeks'. [S/he] states [s/he] hasn't been getting along with the other residents that live there. Upon admission patient stated that [s/he] still has thoughts of harming [his/herself]. Sitter in room with patient, and any additional tubes/wires removed from room."

09/12/2024 - "Brought by police to emergency department for medical clearance status post trying to cut [his/her] wrist with disassembled razor and then trying to strangulate [him/herself] with a seatbelt in the police car. Patient states that [s/he] wants to die and refuses to talk more about it. Denies any physical complaints."

No further information was received from Licensee A.

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M 134	Continued From page 7 On 11/19/2024, at approximately 10:00 a.m., Surveyor reviewed the provider's electronic facility file. None of the above listed changes in Resident 1 and Resident 2's condition or hospital treatments were reported to the Department.	M 134		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observation, record review and interview, Licensee A did not ensure that the home and its operation comply with chapter 88 and all other laws governing the home and its operation. Findings include. On 10/30/2024, Surveyor conducted a complaint investigation. The provider is licensed as a non-ambulatory adult family home (AFH) able to serve up to 4 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, and physically disabled. As a result of the surveys, the complaint was substantiated. The provider was issued a total of 12 new deficiencies: 88.03(5)(e)1 Significant Change to the Resident 88.04(2)(a) Responsibilities 88.04(2)(c) Change in Type of Individual Served 88.06(1)(e) Information to Determine Services 88.06(3)(b) Persons Involved with Isp &	M 216		

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M 216	Continued From page 8 Assessments 88.06(3)(c) Assessment Identify Needs and Abilities 88.06(3)(d) Individual Service Plan 88.06(3)(d)2 Level of Supervision 88.07(1)(a) Resident Care - General Requirements 88.07(2)(b)4 Record of Medical Visits and Reports 88.07(2)(b)5 Health Monitoring 88.07(2)(b)6 Notification of Changes At approximately 11:00 a.m., when Surveyor asked about Resident 2, Licensee A stated that Resident 2 was very, "sneaky and quick." S/he stated that Resident 2 was getting, "naughtier and naughtier meaning an increase in [his/her] behaviors...[S/he] has what I call 'spoiled brat syndrome' if [s/he] doesn't get [his/her] way." Surveyor asked Licensee A about the overall lack of documentation in Resident 1 and Resident 2's paper file and electronic file. Licensee A stated some of it is on him/her and some of it s/he will have to look for when s/he has more time. Licensee A stated that s/he only works part time and likes to do the "fun" stuff. S/he then stated s/he had to leave and asked Surveyor to provide Service Coordinator G and HR Assistant B with a list of what information Surveyor will still need to complete the survey. Surveyor worked with Licensee A from 10/30/2024 to 12/20/2024 to obtain documentation to show that Licensee A had maintained records, monitored residents health, reported reportable incidents to the appropriate party and provided adequate care for residents, however, no further information was received.	M 216		

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M 220	Continued From page 9	M 220		
M 220	88.04(2)(c) CHANGE IN TYPE OF INDIVIDUAL SERVED The licensee shall report in writing to the licensing agency any change in the type of individual served at least 30 days before the change. A 30 day written notice of any change in type of individual served shall also be provided to each resident and each resident's guardian, designated representative, service coordinator, placing agency and third party payee. This Rule is not met as evidenced by: Based on record review, interview, and observation, the licensee did not submit revisions in the program statement to the licensing agency for approval 30 days prior to implementing the change. During the survey, the facility had 2 residents (Resident 1 and Resident 2) who did not have a diagnoses of: irreversible dementia/Alzheimer's, traumatic brain injury, or physically disabled, as currently identified by license and program statement. Findings Include: On 10/30/2024, Surveyor conducted a complaint investigation. The provider was licensed on 04/18/2024, as an adult family home (AFH) able to serve up to 4 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, and physically disabled. Example 1 - Resident 1 At approximately 9:30, Surveyor observed Resident 1 with Caregiver E and Caregiver F. Surveyor asked the caregivers why Resident 1	M 220		

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needed 2:1 staffing pattern. Caregiver F stated s/he has always had a 2:1 staff since Resident 1 has come to the facility. Caregiver F stated that Resident 1 has been having seizures, which are not known to be real or not, and will swallow batteries and do other attention seeking behaviors.

Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 03/13/2024 with diagnoses affective disorder, impulse disorder, borderline personality disorder, suicidal ideation, and intellectual disability.

Example 2 - Resident 2

Surveyor reviewed the closed record of Resident 2. Resident 2 was admitted to the provider on 04/01/2024 with diagnoses including anxiety, depression and autism.

At approximately 11:00 a.m., Surveyor asked Licensee A if Resident 1 and Resident 2 were both 2:1 staffing. Licensee A stated yes, and that Resident 2 was very, "sneaky and quick." S/he stated that Resident 2 was getting, "naughtier and naughtier meaning an increase in [his/her] behaviors...[S/he] has what I call 'spoiled brat syndrome' if [s/he] doesn't get [his/her] way."

On 12/01/2024, Surveyor reviewed the facility file. The facility's program statement states, "Per DHS 88.03(2)(b)2, Buckaroos AFH 3B will be willing to accept and serve clients who are Physically Disabled, have suffered a Traumatic Brain Injury or have been diagnosed with Irreversible Dementia/Alzheimer ' s." As of 12/01/2024, the department did not have written notice the facility was changing the program statement and/or client group served at the facility.

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M 378	88.06(1)(e) INFORMATION TO DETERMINE SERVICES The licensee shall obtain information from a prospective resident necessary to determine whether the person's needs can be met with the services identified in the home's program statement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain information about 2 of 2 residents reviewed to determine whether Resident 1 or Resident 2's needs could be met by the provider. Findings include: On 10/30/2024, Surveyor conducted a complaint investigation. The provider is licensed as an adult family home (AFH) able to serve up to 4 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, and physically disabled. Example 1 - Resident 1 At approximately 9:30, Surveyor observed Resident 1 with Caregiver E and Caregiver F. Surveyor asked the caregivers why Resident 1 needed 2:1 staffing pattern. Caregiver F stated s/he has always had a 2:1 staff since Resident 1 has come to the facility. Caregiver F stated that Resident 1 has been having seizures, which are not known to be real or not, and will swallow batteries and do other attention seeking behaviors. Surveyor reviewed the record of Resident 1.	M 378		

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M 378	Continued From page 12	M 378		

Resident 1 was admitted to the provider on 03/13/2024 with diagnoses affective disorder, impulse disorder, borderline personality disorder, suicidal ideation, and intellectual disability. There was no documentation of any information obtained prior to Resident 1's admission to determine whether the provider could meet Resident 1's needs.

At approximately 10:00 a.m., Surveyor asked Licensee A how s/he ensured the facility would be able to meet the needs of Resident 1 and Resident 2 prior to admission. Licensee A stated that s/he did an admission assessment at the hospital after Resident 2 had swallowed batteries at his/her previous group home and then stated s/he went to the same hospital and did the same thing for Resident 1's admission. Surveyor asked to review the admission assessment. Licensee A stated s/he did not know where it was and would have to look back in his/her records.

Example 2 - Resident 2

Surveyor reviewed the closed record of Resident 2. Resident 2 was admitted to the provider on 04/01/2024 with diagnoses including anxiety, depression and autism. There was no documentation of any information obtained prior to Resident 2's admission to determine whether the provider could meet Resident 2's needs.

At approximately 1:00 p.m., Surveyor reviewed the information that was still needed to complete the survey, including Resident 1 and Resident 2's admission assessment, with Service Coordinator G and HR Assistant B. Surveyor requested that the information be emailed or faxed by 10/31/2024 at noon.

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On 10/31/2024 at 3:07 p.m., Surveyor emailed HR Coordinator G, who had provided documentation from Resident 1 and Resident 2's record while onsite, stating that Resident 1 and Resident 2's initial assessments should have been submitted by noon but will be accepted until the end of the day.

On 11/04/2024 at 5:12 p.m., Spouse D emailed Surveyor stating, "some of the e-mail attachments I am attempting to forward to you are too large. Do you have another way of receiving large files? Thanks, [Spouse D]"

On 11/04/2024 at 7:36 p.m., HR Assistant B responded to Surveyors email from 10/31/2024 stating, "I have requested these documents. Will send them asap."

11/05/2024 at 1:22 p.m., Surveyor provided Spouse D, Licensee A, and the provider's general email address with Surveyor's fax number, which was also provided at the time of the survey. Surveyor stated to Licensee A that s/he has not received any of the required information Surveyor has requested, such as Resident 1 and 2's admission assessments.

On 11/14/2024 at 1:38 p.m., Surveyor sent Licensee A an email stating none of the required information has been received.

On 11/14/2024 at 2:51 p.m., Director C stated that Licensee A had forwarded him/her the Surveyor's last email and asked if Surveyor could tell him/her exactly what was needed, so they could provide this right away.

On 11/18/2024 at 9:07 a.m., Surveyor responded, "I have asked multiple times for assessments and

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M 378	Continued From page 14 updates to show that both [resident's] behaviors were being monitored, assessed, and care planned. Nothing has been received." 11/18/2024 at 5:18 p.m., Surveyor received a fax from the provider. It did not include an admission assessment for Resident 1 or Resident 2.	M 378		
M 406	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This Rule is not met as evidenced by: Based on record review and interview, 2 of 2 individual service plans (ISP) were not developed with the resident and the resident's guardian, if any. Resident 1's ISP was not signed by Resident 1 or his/her legal guardian. Resident 2's ISP was not signed by Resident 2 who was his/her own decision maker. Findings include: On 10/30/2024, Surveyor conducted a complaint investigation.	M 406		

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M 406	Continued From page 15 Example 1 - Resident 1 Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 03/13/2024 with diagnoses affective disorder, impulse disorder, borderline personality disorder, suicidal ideation, and intellectual disability. At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 1's record, including his/her ISP. The ISP was dated 03/15/2024 and did not include any signatures. Example 2 - Resident 2 Surveyor reviewed the closed record of Resident 2. Resident 2 was admitted to the provider on 04/01/2024 with diagnoses including anxiety, depression and autism. At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 2's record, including his/her ISP. The ISP was dated 07/03/2024 and did not include any signatures. Surveyor asked HR Assistant B if there was a copy of Resident 1 or Resident 2's ISP's that included any signatures. HR Assistant B stated that s/he did not have that but Licensee A might. At approximately 11:00 a.m., Surveyor interviewed Licensee A and asked if s/he has a copy of Resident 1 and Resident 2's ISP that were signed by Resident 1 and Resident 2 and/or his/her guardian. Licensee A stated s/he is unsure if the residents or their guardian's signed the ISP's and would have to look through his/her records. At approximately 1:00 p.m., Surveyor reviewed the information that was still needed to complete	M 406		

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M 406	Continued From page 16 the survey, including Resident 1 and Resident 2's signed ISP, with Service Coordinator G and HR Assistant B. Surveyor requested that the information be emailed or faxed by 10/31/2024 at noon. No additional information was received.	M 406		
M 408	88.06(3)(c) ASSESSMENT IDENTIFY NEEDS & ABILITIES The assessment shall identify the person's needs and abilities in at least the areas of activities of daily living, medications, health, level of supervision required in the home and community, vocational, recreational, social and transportation. This Rule is not met as evidenced by: Based on record review and interview, 2 of 2 individuals were not assessed to identify their needs and abilities. Resident 1 and Resident 2 had documentation of concerns related to physical health, level of supervision required in the home and community, and activities of daily living that were not assessed by the provider. Findings include: On 10/30/2024, Surveyor conducted a complaint investigation. The provider is licensed as a	M 408		

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non-ambulatory adult family home (AFH) able to serve up to 4 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, and physically disabled.

Example 1 - Resident 1

At approximately 9:30, Surveyor observed Resident 1 with Caregiver E and Caregiver F. Surveyor asked the caregivers why Resident 1 needed 2:1 staffing pattern. Caregiver F stated s/he has always had a 2:1 staff since Resident 1 has come to the facility. Caregiver F stated that Resident 1 has been having seizures, which are not known to be real or not, and will swallow batteries and do other attention seeking behaviors.

Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 03/13/2024 with diagnoses affective disorder, impulse disorder, borderline personality disorder, suicidal ideation, and intellectual disability.

At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 1's record.
The progress notes in Resident 1's record document:
04/16/2024, " ...[s/he] complaint of hearing voices s/he wanted [his/her] prn's ..."
04/23/2024, "[S/he] went to see [doctor] and we addressed the sores [s/he] has we are gonna[sic] keep the area cleaned and continue to do as we been[sic] doing."
04/29/2024, " ...stated [s/he] has been feeling more depressed."
05/16/2024, "When [s/he] was told its[sic] time to come back to our side and eat dinner and start to wind[sic] down for diner [s/he] then got mad and went to [his/her] room and blasted [his/her]

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music. Staff went in and [s/he] was crying and stated [s/he] feel like [s/he] is always getting punished and then said [s/he] was over it and left the house. Staff followed [him/her] and calmed [him/her] down they went for a ride and explained to [Resident 1] why it was time to come back to [his/her] side."
05/22/2024, "[Resident 1] had a good morning up till[sic] dinner time after dinner [Resident 2] and [Resident 1] had a disagreement and had words back and forth [Resident 1] tide[sic] [his/her] shoes[sic] string around [his/her] neck I was able to get it untied [s/he] then was calmed down enough to talk to me and explain [his/her] feeling I then took all [his/her] shoes out of [his/her] room the rest of the night was good ..."
05/28/2024, "[S/he] had a rough day with a few freak outs, arguing with [his/her] roommate [Resident 2]. [S/he] had a stress seizure today and after 5 minutes of quiet time and some one on one with staff, [s/he] calmed down."
05/30/2024, "[S/he] started crying after dinner because [s/he] said [s/he] was tired and seeing things. Staff gave [him/her] a prn, as [s/he] asked then [s/he] called [his/her family member] ..."
05/31/2024, "Had a good day, only had one small issue because [s/he] was tired and having[sic] voices."
06/01/2024, "[Resident 1] got upset because one of the [other residents] wanted to apologize for something. [Resident 1] took it the wrong way and freaked out. [S/he] told staff 'Don't touch me or I'll push you down'. Staff gave [him/her] some space and [s/he] apologized when [s/he] was ready to talk. [S/he] then asked for a melatonin. Another client then triggered [him/her] and [s/he] got upset and went to hang out with another staff and residents."
06/02/2024, "[S/he] struggled with being triggered by [his/her] peers and was frustrated that [his/her

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family member] hasn't called [him/her] back at all this week and hadn't been answering [his/her] calls. [S/he] asked for a PRN after other clients were acting up."
06/04/2024, "The client was not feeling well and had dizzy spells and weakness all over [his/her] body. [S/he] asked staff to go to the hospital. Staff called [his/her] Guardian and left a message because there was no answer, and took [him/her] to the ER[sic]."
06/05/2024, "[Resident 1] woke up around 8 am [s/he] ate breakfast and took [his/her] morning meds [s/he] felt weak and went to lay back down. [S/he] got u[sic] around 11 and got dressed for the day. [S/he] is having med changes so staff is keeping a close eye on [him/her]."
06/18/2024, "[Resident 1] upset because staff allowed [Resident 2] to handle to remote in the living room. [Resident 1] went to the restroom and was upset because [Resident 2] changed the channel without asked [him/her] first. After walking outside with staff and talking [Resident 1] did come back in and apologized to [Resident 2] and staff for [his/her] outburst."
07/01/2024, "[S/he] had lunch and sat in the living room to watch a moving then [s/he] heard a staff talking to another peer and [s/he] jumped into the conversation which led [him/her] to have a behavior [s/he] then stormed to [his/her] room and cried yelled [s/he] didn't want to be her[sic] anymore and that [s/he] didn't want a certain staff around [him/her]. [S/he] calmed down then came out and apologized for [his/her] behavior and we all went for a walk."
07/02/2024, "[Resident 1] is having a behavior because of the menu that was created and is approved by the state. [S/he] has stated that they should be allowed to eat what they want and when they want and shouldn't have to follow rules. [S/he] said [s/he] is tired of being treated

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like a child."
07/02/2024, "Staff encouraged [him/her] to get ready for the day. [S/he] then went for a walk since [s/he] was getting agitated. [S/he] then came home and was very emotional stating [s/he] couldn't wait to talk to [his/her] guardian and tell [him/her] that [s/he] wanted to move."
07/04/2024, "[Resident 1] upset because [s/he] was not allowed to go to the store to buy something to drink. Did talk with staff several times regarding how [s/he] feels as though [s/he] is not being treated fairly in the house."
07/04/2024, "[Resident 1] upset with staff member because [s/he] asked [him/her] not to follow staff member into [Resident 2's] room while [s/he] was having a behavior. [Resident 1] did curse and yell at staff."
07/07/2024, "[Resident 1] upset because staff went to store without asking [him/her] to go, leaving [him/her] feeling left out."
07/10/2024, "[Resident 1] had a rough night [s/he] got upset because [s/he] was told to not bring the cat into the bathroom with [him/her] and that upset [him/her] so [s/he] then started yelling at staff and other clients around."
07/25/2024, " ...[S/he] got a little upset when another resident got upset but was easily calmed down by staff."
07/28/2024, "After diner, [s/he] started to get a little agitated and had to go for a walk. [S/he] came back and went to [his/her] room to watch a movie."
08/19/2024, "[Resident 1] had a good day and night time[sic] was a little rough [s/he] had a behavior and got an abrasion on the back of [his/her] head."
08/31/2024, "[Resident 1] had a good day but at night [s/he] got upset that the staff [s/he] wanted had to be someone elses[sic] staff and said this is [expletive] and walked off so staff switched it all

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around so [s/he] could have the staff [s/he] wanted and told [him/her] that [his/her] attitude was not okay."
09/11/2024, "[Resident 1] had a 4min seizure starting at 2:21pm eating at 2:24pm [Service Coordinator G] and [Director C] were notified."
09/17/2024, "[Resident 1's] evening was stressful for [him/her] [s/he] was very agitated due to hearing voices in [his/her] head but wanted to go for a walk to help with [him/her] agitation and voices."
09/18/2024, "[Resident 1] slept from 2 pm to 5 pm staff woke [Resident 1] up for dinner [s/he] came to the table and ate dinner after dinner [s/he] asked if [s/he] could go next door to say hi to another staff after [Resident 1] got back [s/he] asked if [s/he] could call the crisis line due to [him/her] having self-harming thoughts and hearing voices in [his/her] head and [s/he] wanted to go to the hospital so [s/he] could get sent to a mental hospital. Staff let [him/her] call Crisis [s/he] talked to Crisis [Resident 1] didn't like what they told [him/her] so [s/he] hung up on them staff asked [Resident 1] if [s/he] like[sic] to go for a walk [Resident 1] told them no staff then asked [him/her] if [s/he] wanted to watch a movie and [s/he] said no to that too staffed[sic] asked [him/her] if [s/he] would like to go talk and [s/he] agreed to talk to staff. After staff talked to [him/her s/he] still wanted to go to the hospital. [Resident 1] after talking to [Licensee A] [Resident 1] was fine [s/he] took [his/her] PRN along with night meds."
09/22/2024, "swollen[sic] batteries"
10/02/2024, "[Resident 1] returned from hospital stay on 10-2-24"
10/12/2024, "[Resident 1] had a good morning we went to the movies around 3 and left the movie theater early due to her feeling as though [s/he] would have a seizure, [s/he] got in the car and we

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pulled off and shortly after [s/he] started to have a seizure staff was in the back with [him/her] got [him/her] on [his/her] side and was able to talk [him/her] threw[sic] the seizure not long seizure about 40 seconds long."
10/18/2024, "[Resident 1] came home and went to go take a nap, [Resident 1] then told staff [s/he] was upset due to [him/her] thinking about [his/her family member] and how [s/he's] always breaking promises talked to [his/her] and [s/he] finally took [him/her] nap after [Resident 1] woke up we went to camp to watch a movie and eat dinner. During the movie [Resident 1] notices[sic] the attention wasn't on [him/her] and had pulled staff to the side to tell them [s/he] wasn't[sic] doing good and [s/he] was hearing voices and having thoughts staff talked to [him/her] and was able to calm [him/her] down. On the ride home [Resident 1] had asked the staff if [s/he] could go next door and hang out with the other house staff told [Resident 1] they would have to make sure it was okay once the staff got confirmation that [s/he] was not able too [s/he] then got upset and stormed to [him/her s/he] then came out of [his/her][sic] and told staff [s/he] was leaving and going for a walk staff followed [him/her] and got [him/her] to calm down and to come back to the house once [Resident 1] and staff got back the rest of the night went good.
10/19/2024, "On the way home [Resident 1] was in a daze and wasn't responding to staff, staff thought [Resident 1] was having a seizure [Resident 1] finally responded to staff and told staff when she's in a 'daze' like that, that's when [s/he] hears voices."

There was documentation of 2 incident reports that stated:
08/23/2024, "Another incident was going on and [Resident 1] was under stress and had a minor

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seizure."

9/22/2024, "[Resident 1] sat down on the Sofa before dinner and discovered there was a remote there, [s/he] had the batteries on [him/her] during dinner and after dinner, [s/he] sat on the sofa and went to [his/her] room walked quickly to [his/her] room and the staff noticed that was not like [him/her] staff walked into [his/her] room after [Resident 1] walked in and [Resident 1] handed [him/her] an empty remote with no batteries in it. [Resident 1] refused to go to the hospital till[sic] another staff came and spoke with [him/her] and that staff then took [him/her] to the hospital."

There were no assessments included in Resident 1's record.

Example 2 - Resident 2

Surveyor reviewed the closed record of Resident 2. Resident 2 was admitted to the provider on 04/01/2024 with diagnoses including anxiety, depression and autism.

At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 2's record.
The progress notes in Resident 2's record document:
06/15/2024, "We came home and had lunch and got an attitude because quiet time was coming along and [s/he] said [s/he] doesn't need a nap. Staff told [him/her s/he] didn't have to sleep it was just time we allow [him/her] to be alone with [his/her] staff in [his/her] room. [S/he] finally took a nap and around 330[sic] we went to the carnival in Fort Atkinson. [S/he] had fun and kept saying how much [s/he] appreciated today. After dinner, [Resident 2] was asked to take a shower and [s/he] said [s/he] didn't want to nor needed to but

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once staff said we were swimming and it should be done [s/he] went into [his/her] room, took a shower, and had a 7 pm snack [s/he] then stated [s/he] doesn't wanna[sic] b[sic] by others or have to deal with being told what to do. Staff took [him/her] to Walmart to get more candy since [s/he] felt the need to swallow things. [Resident 2] went to lie[sic] down around 930pm[sic]."
06/20/2024, "[Resident 2] was taken to the ed[sic] after seeing [his/her] primary."
06/21/2024, "Suicidal was sent to ed[sic]."
06/27/2024, "[Resident 2] was brought back last night around 8pm."
06/28/2024, "[Resident 2] did some of[sic] coloring and then went to Walmart with staff and got to pick out some kid friendly movies to watch."
07/02/2024, "[S/he] was a little agitated due to [him/her] not getting some of [his/her] items back but was able to be directed."
07/03/2024, "[Resident 2] was having thoughts of self harming[sic] [him/her] but staff talked to [him/her] and redirected [him/her]. [Resident 2] went to [his/her] room with [his/her] staff to watch movies."
07/04/2024, "[Resident 2] upset because [s/he] no longer wanted to watch Vampire Diaries on the shared tv in the living room area. [Resident 2] asked to listen to [his/her] phone and started to have feeling of being a burden, and feeling of worthlessness. After a call to [Manager] [Resident 2] went to [his/her] room with [his/her] staff to watch movies.
07/07/2024, "[Resident 2] complaining of ear pain."
07/08/2024, "[Resident 2] up, complaint of ear pain. Given Tylenol and ice pack to try to help [him/her] feel more comfortable and get back to sleep."
07/08/2024, "[Resident 2] up and down all night,

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complaining of ear pain. At abt[sic] 5:45 this morning [Resident 2] ran into bathroom, and sat down on floor near tub clenching [his/her] ear in pain. Complained of feeling nauseated in addition to the ongoing ear pain. After this, [Resident 2] went into the living room area and proceeded to try to get some more rest on the couch instead of [his/her] bed."
07/08/2024, "[Resident 2] upset with [Resident 1] and annoyed with [Resident 1's] attitude towards [him/her]."
07/10/2024, "[Resident 2] had a rough night [s/he] got upset with other clients and needed to get away."
07/15/2024, "[S/he] took a nap due to [him/her] having pain n[sic] in [his/her] ear. [S/he] attempted to call [his/her family member] a few times and when [s/he] didn't get a response [s/he] got agitated. We then went for a walk."
07/16/2024, "[S/he] attempted to call [his/her family members] when [s/he] couldn't get through to them [s/he] started to get anxious and paced the house. [His/her] staff got [him/her] to calm down and they played uno at the kitchen table."
07/26/2024, "[Resident 2] had a good day and most of the night another resident was having a rough night [s/he] became upset was easly[sic] calmed down by staff."
08/19/2024, "[Resident 2] had a good day [s/he] earned [his/her] bed frame back. [S/he] has been doing really good. [Resident 2] took a shower and laid down for bed."
08/22/2024, "[Resident 2] had a good day today. We moved [his/her] bed back to [his/her] room to[sic] [him/her] making good and positive decisions."
09/05/2024, "[Resident 2] swolled[sic] batteries and [s/he] was brought to the hospital to make sure everything was okay and if [s/he] needed something to pass them the hospital kept

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[him/her] for surgery to get the batteries out."
09/12/2024, "[Resident 2] was picked up around 9 am by [staff] and [staff] from [psychiatric hospital]."
09/14/2024, "[Resident 2] was taken to watertown ed[sic] and they took [him/her] to [psychiatric hospital] for suicide attempts."

Incident Reports
04/30/2024, "Both staff were in the bathroom while [Resident 2] was showering [s/he] got out the shower with blood slightly dripping down [his/her] arm from a piece of meatal[sic] [s/he] got[sic] hidden in a stuffed animal from the previous company [s/he] was at."

05/07/2024, "[Resident 2] refused [his/her] meds and tried to lock [him/herself] in [his/her] room. [Caregiver J] and [Caregiver K] stayed in [his/her] room with [him/her] and did not allow [him/her] to lock the door. [Resident 2] then walked out of [his/her] room and said [s/he] wanted to die. [S/he] left the house on foot in the rain. [Caregiver K] and [Caregiver J] followed [Resident 2] down the street, [s/he] walked approximately a half of mile when [s/he] stopped. [Resident 2] began screaming and saying stop! [Caregiver J] asked [Resident 2] who [s/he] was talking to. [S/he] said the voices in [his/her] head. [Resident 2] began covering [his/her] ears and slapping [his/her] head. [S/he] was kicking the puddle of water [s/he] was
standing in. [Caregiver J] hugged [Resident 2] and began rubbing [his/her] back to calm [him/her] down. [Resident 2] then hugged [Caregiver J] back and began crying and saying [s/he] was sorry. Staff got [Resident 2] back safely to the residence around 8:35 pm. [S/he] than[sic] took [his/her] meds. [Resident 2] asked staff what happened and said [s/he] did not

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remember anything that had just happened."

05/11/2024, "[Caregiver F] was making dinner, and [Resident 2] was sitting at the kitchen table with [Caregiver L]. [Resident 2] got up and quickly went to the closet where meds are kept put in the door pin and proceeded to grab all [his/her] meds and ran to the bathroom and locked the door. Both [Caregiver L], me (writer [[Caregiver J]) and [Caregiver F] chased after [him/her] and tried to get into the bathroom, but [Resident 2] had [his/her] finger on the lock. [Resident 2] then opened the door and handed staff all the empty pill wrappers. Staff immediately contacted management. [Licensee A] arrived shortly and took [Resident 2] to the emergency room. Where [s/he] was later admitted."

05/19/2024, "Around 630pm [Resident 2], peers and staff was[sic] playing board games. [Resident 2] then got up so [Caregiver K] and [Caregiver L] both of [Resident 2] staff followed [Resident 2]. [S/he] went into [his/her] room and laid on [his/her] bed with pillows on both side[sic] of [his/her] face. [Caregiver K] and [Caregiver L] sat on the floor to be in eye site[sic] and allowed [him/her] time to calm down. [S/he] then popped [his/her] head up and stated [s/he] just swallowed 3 batteries. Both staff then got up to look around [his/her] bed. Staff then called [Licensee A]. Both staff was[sic] instructed to take [Resident 2] to the ed[sic]. [Resident 2] refused medical treatment while [Caregiver K] and [Caregiver L] was[sic] the room. [Resident 2] was seen at[sic] the ed[sic] and was admitted."

There were no assessments included in Resident 2's record.

At approximately 11:00 a.m., Surveyor asked

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Licensee A for any assessments s/he had completed for Resident 1 or Resident 2. Licensee A asked for assessment of what. Surveyor asked to start with any and all assessment of their behaviors, and their level of supervision. Licensee A stated that Resident 2 was very, "sneaky and quick." S/he stated that Resident 2 was getting, "naughtier and naughtier meaning an increase in [his/her] behaviors...[S/he] has what I call 'spoiled brat syndrome' if [s/he] doesn't get [his/her] way." Surveyor asked Licensee A what interventions were assessed and put in place. Licensee A stated Resident 1 and Resident 2 both admitted as 2 staff to 1 resident staffing level. Surveyor asked Licensee A if Resident 1 or Resident 2's ability to remain safe in this settings or their level of supervision was ever assessed after each resident was able to ingest batteries on multiple occasions. Licensee A stated no, that both residents were doing better here than at either of their previous placements. Surveyor asked Licensee A if s/he ever assessed Resident 2's pattern of sexual assault allegations. Licensee A stated no, that Resident 2 accused everyone of sexual abuse and that s/he came to the home with a history of that. Licensee A stated that s/he wouldn't say Resident 2 was lying about the accusations but thinks it maybe him/her hallucinating. Licensee A stated s/he only works part time and had to leave. Licensee A asked Surveyor to provide Service Coordinator G and HR Assistant B with a list of what information Surveyor will still need to complete the survey.

At approximately 1:00 p.m., Surveyor reviewed the information that was still needed to complete the survey, including all assessments that were completed for Resident 1 and Resident 2, with Service Coordinator G and HR Assistant B. Surveyor requested that the information be

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emailed or faxed by 10/31/2024 at noon.

On 10/31/2024 at 3:07 p.m., Surveyor emailed HR Coordinator G, who had provided documentation from Resident 1 and Resident 2's record while onsite, stating that any assessments for Resident 1 and Resident 2 should have been submitted by noon but will be accepted until the end of the day.

On 11/04/2024 at 5:12 p.m., Spouse D emailed Surveyor stating, "some of the e-mail attachments I am attempting to forward to you are too large. Do you have another way of receiving large files? Thanks, [Spouse D]"

On 11/04/2024 at 7:36 p.m., HR Assistant B responded to Surveyors email from 10/31/2024 stating, "I have requested these documents. Will send them asap."

11/05/2024 at 1:22 p.m., Surveyor provided Spouse D, Licensee A, and the provider's general email address with Surveyor's fax number, which was also provided at the time of the survey. Surveyor stated to Licensee A that s/he has not received any of the required information Surveyor has requested, including any assessments for Resident 1 or Resident 2.

On 11/14/2024 at 1:38 p.m., Surveyor sent Licensee A another email stating,
"I have not received any additional files from any of the emails I have returned. As I stated in my previous emails, I do not need emails of calendar appointments or other random information, just specific information I requested from the resident's records. In reading notes:
-I see [Resident 2] that [s/he] was complaining of ear pain from 7/7-7/15. Was this ever assessed

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or treated?
-On 8/18 it says [Resident 2] earned [his/her] bed frame back and on 8/22 it states [his/her] bed was moved back to [his/her] room after making good decisions. Can you explain this?
-On 9/18 [Resident 1] reported being suicidal and wanting to the hospital, can you please let me know what interventions and supports were put in place.
-Please send all incident reports/investigations on both [residents] hospitalizations
Please send any documentation you have by the end of day today."

On 11/14/2024 at 2:51 p.m., Director C stated that Licensee A had forwarded him/her the Surveyor's last email and asked if Surveyor could tell him/her exactly what was needed, so they could provide this right away.

On 11/18/2024 at 9:07 a.m., Surveyor responded, "I have asked multiple times for assessments and updates to show that both [resident's] behaviors were being monitored, assessed, and care planned. Nothing has been received."

11/18/2024 at 5:18 p.m., Surveyor received a fax from the provider. It did not include any assessments for Resident 1 or Resident 2.

On 11/19/2024, Surveyor received the hospital records for Resident 1 and Resident 2 documenting the reason they were seen in the emergency room and/or required hospital admission:

Resident 1 -
03/16/2024 - "Patient presents to the emergency department by EMS for seizure activity. Patient had a witnessed tonic-clonic seizure today.

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Patient was in the presence of [his/her] new group home staff noted the seizure. Patient has a history of seizures. Patient reportedly had just become a new resident at [his/her] new group home and had come from another group home and there was a question whether or not the patient is receiving [his/her] medication as it is ordered. Patient denies any recent illness or other symptoms. At time of arrival, patient is back to [his/her] normal status. Patient is no longer postictal at this time."

03/17/2024 - "Patient presents in emergency department reporting possible seizure today. Patient apparently was in a disagreement with a member of group home. Patient then was witnessed drop into the ground and having conclusive actions. Patient immediately popped of[sic] after the compulsive action. Patient does have a history of seizures as well as pseudoseizures. Patient was evaluated yesterday for seizure as well. Patient has no injury from the the seizure no pain no injury to the tongue or cheeks from biting down no loss of bowel or bladder."

06/04/2024 - "Patient presents emergency department with [his/her] group home staff member. Patient was reported to be suffering from weakness, sleepiness, drooling. Patient recently had medication in the last week. Patient denies any symptoms at this time."

08/15/2024 - "...Discharged in[sic] hour ago from the emergency department, is brought by ambulance after having another episode of shaking/pseudo seizure at the nursing home. Patient states that [s/he] felt stressed and [s/he] kept on shaking while remaining conscious and is absolutely sure [s/he] was not seizing. Staff

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however called the ambulance and upon their arrival they 'made [him/her] come here'. Patient states that [s/he] is[sic] remember shaking, denies losing consciousness, urinating on [him/herself] and states that it was 'for sure a pseudo-seizure'. Patient denies any complaints right now however states that [s/he] feels stressed by going back and forth."

09/06/2024 - "History of pseudoseizures presents from group home after a witnessed convulsive episode. There was no reported prodrome. No urinary incontinence. No postictal confusion. Patient reports that [s/he] believes [s/he] had a seizure due to social interactions with another client."

09/08/2024 - "History of anxiety depression bipolar disorder schizoaffective disorder pseudo-seizure and a seizure disorder presents from a group home stating that [s/he] witnessed a client strike a pregnant worker and then all of a sudden [s/he] thinks [s/he] blacked out maybe had a seizure had a stress reaction [s/he] has been told [his/her] pseudoseizures in the past. [S/he] was just here 2 days ago and had a workup in all that was negative but [s/he] did not have a valproic acid checked. No headache no fever no chills no vomiting no diarrhea. No trauma.

09/13/2024 - "...psychogenic nonepileptic seizure history who comes in with group home caregiver for the evaluation of suicide ideation and after attempting to hurt [him/herself] by ingesting 2 AAA batteries earlier today. Patient reports [s/he] feels fine in regards to not having any chest pain, shortness of break no abdominal pain no nausea vomiting. However [s/he] reports ongoing suicide ideation and depression. [S/he] reports [s/he]

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ingested these to try to hurt [him/herself]. Has previously done this a few years ago." Resident 1 required an emergency endoscopy by a general surgeon to remove the batteries.

9/22/2024-09/24/2024 - "Concern for ingestion of batteries. Patient states that [s/he] hears voices that tell [him/her] things. Patient states that [s/he] took the batteries other[sic] remote control at [his/her] group living home and swallow[sic] them. Patient denies any further ingestion or any other attempt to harm [him/herself]. Patient has a history of this type of behavior. Patient denies any symptoms of illness such as fever, chills, chest pain, shortness of break, abdominal pain, nausea, vomiting or diarrhea. Ingestion occurred approximately 1-1/2 hour prior to arrival. Patient had eaten a meal just prior to that." Resident 1 stated s/he ingested the batteries in an attempt to kill him/herself. Resident 1 required an esophagogastroduodenoscopy for the removal of the ingested batteries.

10/23/2024 - "Patient swallowed 2 AAA batteries approximately half an hour prior to arrival. [S/he] is hearing voices telling [him/her] to do this, as [s/he] is schizophrenic. [S/he] has been having [his/her] medications adjusted recently [s/he] has a history of swallowing objects from least the time when [s/he] was 18 years old. [S/he] tells me [s/he] swallows screws as well as landscaping rocks. [S/he] has also had some reason[sic] history of swallowing batteries from TV remote controls. Denies any pain nausea vomiting or diarrhea." Resident 1 required an esophagogastroduodenoscopy with endoscopic evaluation for the removal of the ingested batteries.

Resident 2 -

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M 408	Continued From page 34 05/11/2024 - "...reported ingestion of 5 days worth of [his/her] usual medications as a suicide attempt. No cardiopulmonary or neurologic abnormalities on initial evaluation. Laboratory studies without clinically significant abnormality. Per Poison control, should be observed for 12 hours for any signs of deterioration. In the process of arranging admission to [hospital], patient divulged reported sexual assault 2 days ago, requesting SANE exam. Arrangements made for SANE exam at [hospital] with subsequent admission from hospitalist there. Jefferson County Human Services aware of patient, will need to be notified for psychiatric disposition once medically cleared at [hospital]." 05/19/2024 - "...ingested in a suicide to[sic] about 2-2.5 hours ago after eating dinner at the group home which [s/he] lives. One of the batteries is AAA battery and the other 1 is an LED button battery. [S/he] states [s/he] took the batteries because [s/he] is suicidal and depressed. [S/he] says [s/he] was raped [orifice] at the group home in which [s/he] lives by a [gender] that also lives in the facility. Patient says [s/he] told the group home staff that [s/he] was raped last night but that they did not believe [him/her]. [S/he] has a history of PTSD, bipolar illness, personality disorder, autism, anxiety and depression. [S/he] has not vomited and [s/he] denies chest pain or trouble breathing. [S/he] has some right flank pain. [...] Patient also admits to eating small screws and an earring a couple weeks ago and [s/he] told the group home staff that [s/he] ingested those items. [S/he] has not ingested any screws or earrings recently. Last week the patient was very depressed and then [s/he] took an overdose and was seen here in the ER. [S/he] also stated at that time that [s/he] was raped in the group home. [S/he] was	M 408		

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sent to [hospital] for a sane exam, medical observation for the overdose and eventually psychiatric consultation. The patient says that the psychiatrist told [him/her] [s/he] could go back to the same group home even though [s/he] does not want to be there anymore." Resident 2 underwent upper endoscopy, specifically esophagogastroduodenoscopy to remove the batteries.

06/20/2024 - "...long history of mental health disorders who lives in a group home who comes in with complaints of suicidal ideation that has been ongoing and now had an attempt by wrapping cord around [his/her] neck in [his/her] room. Police were called to the group home and bring[sic] [him/her] to the ER. Patient denies any other complaint. No chest pain or shortness of breath, no nausea vomiting or diarrhea. After further discussion with patient [s/he] states that the individual grabbed [his/her] breast and then walked away. Police are at bedside along with [county] social worker. Patient has been emergency detention."

09/05/2024-09/07/2024 - "...past medical history of autism, ADHD, PTSD, Bipolar Disorder, depression, anxiety, asthma who presents with suicide attempt. Suicide attempt, ingestion of batteries: Present on admission. X-rays show 2 cylindrical batteries within the stomach.
-status post EGD with successful removal. No ulcerations noted.
-patient has sitter at bedside
-awaiting county for suicide clearance
...'I swallowed batteries to try to kill myself.' Pt states [s/he] swallowed 2 AAA batteries at approximately 2115. [S/he] states [s/he] has been struggling at [his/her] group home Buckaroos for a 'couple weeks'. [S/he] states [s/he] hasn't been

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M 408	Continued From page 36 getting along with the other residents that live there. Upon admission patient stated that [s/he] still has thoughts of harming [his/herself]. Sitter in room with patient, and any additional tubes/wires removed from room." 09/12/2024 - "Brought by police to emergency department for medical clearance status post trying to cut [his/her] wrist with disassembled razor and then trying to strangulate [him/herself] with a seatbelt in the police car. Patient states that [s/he] wants to die and refuses to talk more about it. Denies any physical complaints." The provider did not assess Resident 1's 2:1 staffing pattern and level of supervision, suicidal ideation, seizures, ingestion of non-edible objects, behavioral concerns, health concerns such as open sores and an incident resulting in an abrasion on the back of his/her head, or interventions appropriate to meet the needs of Resident 1. The provider did not assess Resident 2's 2:1 staffing pattern and level of supervision, suicidal ideation, suicide attempts, safety plan, behavioral interventions, restrictions,sexual abuse allegations, physical health or activities of daily living to meet the needs of Resident 2 while s/he resided in the home.	M 408		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following:	M 410		

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M 410	Continued From page 37 This Rule is not met as evidenced by: Based on record review and interview, the provider did not insure an individual service plan (ISP) was completed for Resident 2. Findings include: On 10/30/2024, Surveyor conducted a complaint investigation. The provider is licensed as an adult family home (AFH) able to serve up to 4 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, and physically disabled. Surveyor reviewed the closed record of Resident 2. Resident 2 was admitted to the provider on 04/01/2024 with diagnoses including anxiety, depression and autism. At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 2's record, including his/her ISP. The ISP was dated 07/03/2024 and did not include any information other than Resident 2's name and the date of the ISP. Surveyor asked HR Assistant B if there was a completed version of Resident 2's ISP that addresses his/her needs and abilities. HR Assistant B stated that s/he did not have one but Licensee A might. At approximately 11:00 a.m., Surveyor interviewed Licensee A and noted that per the provider's documentation, Resident 2 had a lot of concerning behavior and a 2:1 staffing pattern. Surveyor stated that s/he was provided an ISP with no information in it and if s/he had a completed ISP for Resident 2. Licensee A stated s/he is unsure and would have to look through his/her records. No additional information was received.	M 410		

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M 414	Continued From page 38	M 414		
M 414	88.06(3)(d)2 LEVEL OF SUPERVISION Identification of the level of supervision required in the home and community. This Rule is not met as evidenced by: Based on record review and interview, Resident 1's individual service plan (ISP) did not include the 2:1 level of supervision that s/he required in the home and the community. Findings include: On 10/30/2024, at approximately 9:30, Surveyor observed Resident 1 with Caregiver E and Caregiver F. Surveyor asked the caregivers why Resident 1 needed 2:1 staffing pattern. Caregiver F stated s/he has always had a 2:1 staff since Resident 1 had come to the facility. At approximately 10:00 a.m., Surveyor asked Licensee A what Resident 1's current staffing patter is. Licensee A stated that Resident 1 has 2 staff at all times. Licensee A stated that s/he assessed Resident 1 while s/he was in the hospital after a behavioral event at his/her previous group home, so s/he has required 2 staff for the entire time s/he has been with the provider. Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 03/13/2024 with diagnoses affective disorder, impulse disorder, borderline personality disorder, suicidal ideation, and intellectual disability. At 10:45 a.m., HR Assistant B emailed Surveyor	M 414		

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M 414	Continued From page 39 parts of Resident 1's record, including his/her ISP. Surveyor reviewed Resident 1's ISP, dated 03/15/2024. The ISP did not include a level of supervision or staffing pattern. Surveyor reviewed another ISP dated 07/07/2024 that stated, "enhanced supervision/line of sight". At approximately 11:00 a.m., Surveyor interviewed Licensee A and asked why Resident 1's level of supervision was not documented in Resident 1's ISP. Licensee A stated everyone knows Resident 1 is a 2:1. On 12/16/2024 at 10:42 a.m., Case Manager I confirmed that Resident 1 had been funded for 2:1 staffing patten 24/7 for the entire duration of the time Resident 1 was with the provider. On 12/18/2024, at 7:43 p.m., Case Manager I stated that after the repeated incidents of Resident 1 ingesting batteries, s/he requested the provider's schedules and to confirm the house's staffing pattern.	M 414		
M 426	88.07(1)(a) RESIDENT CARE-GENERAL REQUIREMENTS The licensee shall provide a safe, emotionally stable, homelike and humane environment for residents. This Rule is not met as evidenced by: Based on record review and interview, 2 of 2 individuals were not provided a safe and humane environment that met the supervision needs of Resident 1 and Resident 2.	M 426		

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M 426	Continued From page 40 The provider did not provide a safe and humane environment that met the supervision needs of Resident 1 on 09/13/2024, 09/22/20204, and 10/23/2024 when s/he ingested batteries with 2:1 supervision. The provider did not provide a safe and humane environment that met the supervision needs of Resident 2 on 04/30/2024, 05/11/2024, 05/19/2024, and 09/05/2024 when s/he was able to ingest batteries with 2:1 supervision, by not investigating or assessing sexual assault allegations and suicidal ideation. The licensee did not speak of Resident 2 in a respectful way when describing behavior or diagnoses and documentation shows Resident 2 had personal items taken away from him/her that s/he did not have a client rights limitation approval for and was not part of his/her care plan. On 05/11/2024 Resident 2 was able to access his/her prescription medications and reportedly ingested 5 days worth as a suicide attempt. Findings include: On 10/30/2024, Surveyor conducted a complaint investigation. The provider is licensed as a non-ambulatory adult family home (AFH) able to serve up to 4 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, and physically disabled. Example 1 - Resident 1 At approximately 9:30, Surveyor observed Resident 1 with Caregiver E and Caregiver F. Surveyor asked the caregivers why Resident 1	M 426		

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needed 2:1 staffing pattern. Caregiver F stated s/he has always had a 2:1 staff since Resident 1 has come to the facility. Caregiver F stated that Resident 1 has been having seizures, which are not known to be real or not, and will swallow batteries and do other attention seeking behaviors.

Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 03/13/2024 with diagnoses affective disorder, impulse disorder, borderline personality disorder, suicidal ideation, and intellectual disability.

At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 1's record.

A progress note dated 09/22/2024, documented, "swollen[sic] batteries"

An incident report dated 9/22/2024, documented, "[Resident 1] sat down on the Sofa before dinner and discovered there was a remote there, [s/he] had the batteries on [him/her] during dinner and after dinner, [s/he] sat on the sofa and went to [his/her] room walked quickly to [his/her] room and the staff noticed that was not like [him/her] staff walked into [his/her] room after [Resident 1] walked in and [Resident 1] handed [him/her] an empty remote with no batteries in it. [Resident 1] refused to go to the hospital till[sic] another staff came and spoke with [him/her] and that staff then took [him/her] to the hospital."

Example 2 - Resident 2

Surveyor reviewed the closed record of Resident 2. Resident 2 was admitted to the provider on 04/01/2024 with diagnoses including anxiety, depression and autism.

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M 426	Continued From page 42 At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 2's record. The progress notes in Resident 2's record document: 06/20/2024, "[Resident 2] was taken to the ed[sic] after seeing [his/her] primary." 06/21/2024, "Suicidal was sent to ed[sic]." 09/05/2024, "[Resident 2] swolled[sic] batteries and [s/he] was brought to the hospital to make sure everything was okay and if [s/he] needed something to pass them the hospital kept [him/her] for surgery to get the batteries out." 09/12/2024, "[Resident 2] was picked up around 9 am by [staff] and [staff] from [psychiatric hospital]." 09/14/2024, "[Resident 2] was taken to watertown ed[sic] and they took [him/her] to [psychiatric hospital] for suicide attempts." Incident Reports 04/30/2024, "Both staff were in the bathroom while [Resident 2] was showering [s/he] got out the shower with blood slightly dripping down [his/her] arm from a piece of meatal[sic] [s/he] got[sic] hidden in a stuffed animal from the previous company [s/he] was at." 05/11/2024, "[Caregiver F] was making dinner, and [Resident 2] was sitting at the kitchen table with [Caregiver L]. [Resident 2] got up and quickly went to the closet where meds are kept put in the door pin and proceeded to grab all [his/her] meds and ran to the bathroom and locked the door. Both [Caregiver L], me (writer [[Caregiver J]) and [Caregiver F] chased after [him/her] and tried to get into the bathroom, but [Resident 2] had [his/her] finger on the lock. [Resident 2] then opened the door and handed staff all the empty pill wrappers. Staff immediately contacted	M 426		

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management. [Licensee A] arrived shortly and took [Resident 2] to the emergency room. Where [s/he] was later admitted."

05/19/2024, "Around 630pm [Resident 2], peers and staff was[sic] playing board games. [Resident 2] then got up so [Caregiver K] and [Caregiver L] both of [Resident 2] staff followed [Resident 2]. [S/he] went into [his/her] room and laid on [his/her] bed with pillows on both side[sic] of [his/her] face. [Caregiver K] and [Caregiver L] sat on the floor to be in eye site[sic] and allowed [him/her] time to calm down. [S/he] then popped [his/her] head up and stated [s/he] just swallowed 3 batteries. Both staff then got up to look around [his/her] bed. Staff then called [Licensee A]. Both staff was[sic] instructed to take [Resident 2] to the ed[sic]. [Resident 2] refused medical treatment while [Caregiver K] and [Caregiver L] was[sic] the room. [Resident 2] was seen at[sic] the ed[sic] and was admitted."

At approximately 11:00 a.m., Surveyor asked Licensee A if Resident 1 or Resident 2's ability to remain safe in this settings or their level of supervision was ever assessed. Licensee A stated no, that both residents were doing better here than at either of their previous placements. Surveyor asked Licensee A what interventions, if any, were put in place after Resident 1 successfully ingested batteries and the same thing for Resident 2 after suicide attempts, successfully accessing the facility's medications, and the ingestion of batteries. Licensee A stated both residents are sneaky. Surveyor asked if there was any adjustments to either resident's staffing pattern or adjustment in the expectation of staff for supervision. Licensee A stated that both residents were already a 2 to 1 staff. Surveyor asked what the expectation was for

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supervision of the 2 staff for each resident. Licensee A stated to be with the resident. Surveyor clarified and asked if the supervision was 2 staff on duty, staff within line of sight, staff to be within arms reach, ect. Licensee A stated no, that there is only so much staff can do. Surveyor asked if Resident 1 had a seizure protocol. Licensee A stated s/he did not think so.

On 11/19/2024, Surveyor received the hospital records for Resident 1 and Resident 2 documenting the reason they were seen in the emergency room and/or required hospital admission:

Resident 1 -
03/16/2024 - "Patient presents to the emergency department by EMS for seizure activity. Patient had a witnessed tonic-clonic seizure today. Patient was in the presence of [his/her] new group home staff noted the seizure. Patient has a history of seizures. Patient reportedly had just become a new resident at [his/her] new group home and had come from another group home and there was a question whether or not the patient is receiving [his/her] medication as it is ordered. Patient denies any recent illness or other symptoms. At time of arrival, patient is back to [his/her] normal status. Patient is no longer postictal at this time."

03/17/2024 - "Patient presents in emergency department reporting possible seizure today. Patient apparently was in a disagreement with a member of group home. Patient then was witnessed drop into the ground and having conclusive actions. Patient immediately popped of[sic] after the compulsive action. Patient does have a history of seizures as well as pseudoseizures. Patient was evaluated yesterday

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for seizure as well. Patient has no injury from the the seizure no pain no injury to the tongue or cheeks from biting down no loss of bowel or bladder."

06/04/2024 - "Patient presents emergency department with [his/her] group home staff member. Patient was reported to be suffering from weakness, sleepiness, drooling. Patient recently had medication in the last week. Patient denies any symptoms at this time."

08/15/2024 - "...Discharged in[sic] hour ago from the emergency department, is brought by ambulance after having another episode of shaking/pseudo seizure at the nursing home. Patient states that [s/he] felt stressed and [s/he] kept on shaking while remaining conscious and is absolutely sure [s/he] was not seizing. Staff however called the ambulance and upon their arrival they 'made [him/her] come here'. Patient states that [s/he] is[sic] remember shaking, denies losing consciousness, urinating on [him/herself] and states that it was 'for sure a pseudo-seizure'. Patient denies any complaints right now however states that [s/he] feels stressed by going back and forth."

09/06/2024 - "History of pseudoseizures presents from group home after a witnessed convulsive episode. There was no reported prodrome. No urinary incontinence. No postictal confusion. Patient reports that [s/he] believes [s/he] had a seizure due to social interactions with another client."

09/08/2024 - "History of anxiety depression bipolar disorder schizoaffective disorder pseudo-seizure and a seizure disorder presents from a group home stating that [s/he] witnessed a

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client strike a pregnant worker and then all of a sudden [s/he] thinks [s/he] blacked out maybe had a seizure had a stress reaction [s/he] has been told [his/her] pseudoseizures in the past. [S/he] was just here 2 days ago and had a workup in all that was negative but [s/he] did not have a valproic acid checked. No headache no fever no chills no vomiting no diarrhea. No trauma.

09/13/2024 - "...psychogenic nonepileptic seizure history who comes in with group home caregiver for the evaluation of suicide ideation and after attempting to hurt [him/herself] by ingesting 2 AAA batteries earlier today. Patient reports [s/he] feels fine in regards to not having any chest pain, shortness of break no abdominal pain no nausea vomiting. However [s/he] reports ongoing suicide ideation and depression. [S/he] reports [s/he] ingested these to try to hurt [him/herself]. Has previously done this a few years ago." Resident 1 required an emergency endoscopy by a general surgeon to remove the batteries.

9/22/2024-09/24/2024 - "Concern for ingestion of batteries. Patient states that [s/he] hears voices that tell [him/her] things. Patient states that [s/he] took the batteries other[sic] remote control at [his/her] group living home and swallow[sic] them. Patient denies any further ingestion or any other attempt to harm [him/herself]. Patient has a history of this type of behavior. Patient denies any symptoms of illness such as fever, chills, chest pain, shortness of break, abdominal pain, nausea, vomiting or diarrhea. Ingestion occurred approximately 1-1/2 hour prior to arrival. Patient had eaten a meal just prior to that." Resident 1 stated s/he ingested the batteries in an attempt to kill him/herself. Resident 1 required an esophagogastroduodenoscopy for the removal of

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M 426	Continued From page 47 the ingested batteries. 10/23/2024 - "Patient swallowed 2 AAA batteries approximately half an hour prior to arrival. [S/he] is hearing voices telling [him/her] to do this, as [s/he] is schizophrenic. [S/he] has been having [his/her] medications adjusted recently [s/he] has a history of swallowing objects from least the time when [s/he] was 18 years old. [S/he] tells me [s/he] swallows screws as well as landscaping rocks. [S/he] has also had some reason[sic] history of swallowing batteries from TV remote controls. Denies any pain nausea vomiting or diarrhea." Resident 1 required an esophagogastroduodenoscopy with endoscopic evaluation for the removal of the ingested batteries. Resident 2 - 05/11/2024 - "...reported ingestion of 5 days worth of [his/her] usual medications as a suicide attempt. No cardiopulmonary or neurologic abnormalities on initial evaluation. Laboratory studies without clinically significant abnormality. Per Poison control, should be observed for 12 hours for any signs of deterioration. In the process of arranging admission to [hospital], patient divulged reported sexual assault 2 days ago, requesting SANE exam. Arrangements made for SANE exam at [hospital] with subsequent admission from hospitalist there. Jefferson County Human Services aware of patient, will need to be notified for psychiatric disposition once medically cleared at [hospital]." 05/19/2024 - "...ingested in a suicide to[sic] about 2-2.5 hours ago after eating dinner at the group home which [s/he] lives. One of the batteries is AAA battery and the other 1 is an LED button battery. [S/he] states [s/he] took the batteries	M 426		

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because [s/he] is suicidal and depressed. [S/he] says [s/he] was raped [orifice] at the group home in which [s/he] lives by a [gender] that also lives in the facility. Patient says [s/he] told the group home staff that [s/he] was raped last night but that they did not believe [him/her]. [S/he] has a history of PTSD, bipolar illness, personality disorder, autism, anxiety and depression. [S/he] has not vomited and [s/he] denies chest pain or trouble breathing. [S/he] has some right flank pain. [...] Patient also admits to eating small screws and an earring a couple weeks ago and [s/he] told the group home staff that [s/he] ingested those items. [S/he] has not ingested any screws or earrings recently.
Last week the patient was very depressed and then [s/he] took an overdose and was seen here in the ER. [S/he] also stated at that time that [s/he] was raped in the group home. [S/he] was sent to [hospital] for a sane exam, medical observation for the overdose and eventually psychiatric consultation. The patient says that the psychiatrist told [him/her] [s/he] could go back to the same group home even though [s/he] does not want to be there anymore." Resident 2 underwent upper endoscopy, specifically esophagogastroduodenoscopy to remove the batteries.

06/20/2024 - "...long history of mental health disorders who lives in a group home who comes in with complaints of suicidal ideation that has been ongoing and now had an attempt by wrapping cord around [his/her] neck in [his/her] room. Police were called to the group home and bring[sic] [him/her] to the ER. Patient denies any other complaint. No chest pain or shortness of breath, no nausea vomiting or diarrhea. After further discussion with patient [s/he] states that the individual grabbed [his/her] breast and then

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walked away. Police are at bedside along with [county] social worker. Patient has been emergency detention."

09/05/2024-09/07/2024 - "...past medical history of autism, ADHD, PTSD, Bipolar Disorder, depression, anxiety, asthma who presents with suicide attempt. Suicide attempt, ingestion of batteries: Present on admission. X-rays show 2 cylindrical batteries within the stomach.
-status post EGD with successful removal. No ulcerations noted.
-patient has sitter at bedside
-awaiting county for suicide clearance
...'I swallowed batteries to try to kill myself.' Pt states [s/he] swallowed 2 AAA batteries at approximately 2115. [S/he] states [s/he] has been struggling at [his/her] group home Buckaroos for a 'couple weeks'. [S/he] states [s/he] hasn't been getting along with the other residents that live there. Upon admission patient stated that [s/he] still has thoughts of harming [his/herself]. Sitter in room with patient, and any additional tubes/wires removed from room."

09/12/2024 - "Brought by police to emergency department for medical clearance status post trying to cut [his/her] wrist with disassembled razor and then trying to strangulate [him/herself] with a seatbelt in the police car. Patient states that [s/he] wants to die and refuses to talk more about it. Denies any physical complaints."

On On 12/17/2024 at 10:40 a.m., Surveyor emailed Case Manager I and asked, "...Can you tell me what was done, if anything for the expectation of [Resident 1's] 2:1 supervision after 09/13/2024 where [s/he] swallowed batteries; 09/22/2024 when [s/he] swallowed batteries and then 10/23/2024 when [s/he] swallowed batteries.

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This was information [Licensee A] and Buckaroos staff was unable to provide when I asked how staff was unable to intervene, especially once a pattern was established, 3 times if [Resident 1] was 2:1 supervision at all times."

On 11/26/2024, Surveyor emailed Case Manager I asking about Resident 1's level of supervision and expectation of that supervision with corresponding hospital dates.

On 12/18/2024, at 7:43 p.m., Case Manager I stated, "Inclusa/Humana is only aware of two occasions for [Resident 1] swallowing batteries those dates are on 09.13.2024 and 10.24.2024." Case Manager I stated that after s/he was made aware of what s/he believe to be the second incident of Resident 1 ingesting batteries, s/he asked Licensee A how they were going to mitigate this in the future and requested schedules and to confirm the house's staffing pattern matched what Resident 1 was funded for.

On 12/19/2024, at 11:25 a.m., Case Manager I confirmed s/he was not made aware of the incident on 09/22/2024, which s/he stated was frustrating.

On 01/06/2025, at 6:34 p.m., when asked if there was concerns about Resident 2's supervision within the home, Case Manager H responded, "We were concerned we were not getting accurate accounts on staffing patterns and were following up with the provider on concerns, especially staffing."

The provider did not provide a safe and humane environment that met the supervision needs of Resident 1 on 09/13/2024, 09/22/20204, and 10/23/2024.

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M 426	Continued From page 51 The provider did not provide a safe and humane environment that met the supervision needs of Resident 2 on 04/30/2024, 05/11/2024, 05/19/2024, and 09/05/2024. Example 3 - Resident 2 At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 2's record. Progress notes documented: 06/28/2024, "[Resident 2] did some of[sic] coloring and then went to Walmart with staff and got to pick out some kid friendly movies to watch." 07/02/2024, "[S/he] was a little agitated due to [him/her] not getting some of [his/her] items back but was able to be directed." 08/19/2024, "[Resident 2] had a good day [s/he] earned [his/her] bed frame back. [S/he] has been doing really good. [Resident 2] took a shower and laid down for bed." 08/22/2024, "[Resident 2] had a good day today. We moved [his/her] bed back to [his/her] room to[sic] [him/her] making good and positive decisions." At approximately 11:00 a.m., Surveyor asked Licensee A for any assessments for Resident 2. Licensee A asked for assessment of what. Surveyor asked to start with any and all assessment of their behaviors, and their level of supervision. Licensee A stated that Resident 2 was very, "sneaky and quick." S/he stated that Resident 2 was getting, "naughtier and naughtier meaning and increase in [his/her] behaviors... [S/he] has what I call 'spoiled brat syndrome' if [s/he] doesn't get [his/her] way." S/he continued to say Resident 2 is the reason Resident 1 was	M 426		

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swallowing batteries.

On 11/14/2024, Surveyor emailed Licensee A and asked, " 'On 8/18 it says [Resident 2] earned [his/her] bed frame back and on 8/22 it states [his/her] bed was moved back to [his/her] room after making good decisions'. Can you explain this?"

As of 12/17/2024, Licensee A has not responded to why Resident 2's bed and bed frame were removed.

On 12/17/2024 at 2:45 p.m., Surveyor asked Case Manager H, "On 8/18 a progress note states [Resident 2] earned [his/her] bed frame back and on 8/22 it states [his/her] bed was moved back to [his/her] room after making good decisions. Are you aware of restriction or client right limitations being in place for [him/her] while [s/he] was there? Based on the documentation the provider had, there was nothing."

On 01/06/2024 at 6:34 p.m., Case Manager H stated, "I was not aware they removed [his/her] bed frame."

Example 4 - Resident 2

At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 2's record.

Surveyor reviewed an incident report dated 05/11/2024, documents, "[Caregiver F] was making dinner, and [Resident 2] was sitting at the kitchen table with [Caregiver L]. [Resident 2] got up and quickly went to the closet where meds are kept put in the door pin and proceeded to grab all [his/her] meds and ran to the bathroom and locked the door. Both [Caregiver L], me (writer

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[Caregiver J]) and [Caregiver F] chased after [him/her] and tried to get into the bathroom, but [Resident 2] had [his/her] finger on the lock. [Resident 2] then opened the door and handed staff all the empty pill wrappers. Staff immediately contacted management. [Licensee A] arrived shortly and took [Resident 2] to the emergency room. Where [s/he] was later admitted."how did resident 2 access the door pin? What a pin key?

At approximately 11:00 a.m., Surveyor asked Licensee A how Resident 2 was able to access the medications if they were securely stored and Resident 2 had 2:1 staff. (how do you know this?) Licensee A stated that Resident 2 was very, "sneaky and quick." Surveyor asked if there was any other documentation regarding this incident. Licensee A stated the staff filled out the incident report.

On 11/19/2024, Surveyor received the hospital record for Resident 2, via record request through the hospital. The hospital record documents: 05/11/2024 - "...reported ingestion of 5 days worth of [his/her] usual medications as a suicide attempt. No cardiopulmonary or neurologic abnormalities on initial evaluation. Laboratory studies without clinically significant abnormality. Per Poison control, should be observed for 12 hours for any signs of deterioration. In the process of arranging admission to [hospital], patient divulged reported sexual assault 2 days ago, requesting SANE exam. Arrangements made for SANE exam at [hospital] with subsequent admission from hospitalist there. Jefferson County Human Services aware of patient, will need to be notified for psychiatric disposition once medically cleared at [hospital]."

According to the hospital discharge summary,

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M 426	Continued From page 54 Resident 2 gained access to the medication room and ingested a quantity of various medications, all of which were prescribed to him/her, approximately: Lamotrigine - total 1000 mg Melatonin - total 15 mg Oxybutynin - total 25 mg Prazosin - total 25 mg Trazadone - total 500 mg Buspirone - total 100 mg Metformin - total 4000 mg Fluoxetine - total 24 mg Omeprazole - total 80 mg The provider did not provider a safe and emotionally stable environment by not providing the supervision necessary for Resident 2, resulting in him/her accessing an excess of medications and consuming them in a suicide attempt.	M 426		
M 446	88.07(2)(b)4 RECORD OF MEDICAL VISITS AND REPORTS Keeping a current record of all medical visits, reports and recommendations for a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not keep a current record of all medical visits for 2 of 2 residents reviewed. Findings include: On 10/30/2024, Surveyor conducted a complaint investigation. The provider is licensed as a non-ambulatory adult family home (AFH) able to serve up to 4 residents within the client groups of	M 446		

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irreversible dementia/Alzheimer's, traumatic brain injury, and physically disabled.

Example 1 - Resident 1

Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 03/13/2024 with diagnoses affective disorder, impulse disorder, borderline personality disorder, suicidal ideation, and intellectual disability.

At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 1's record.
The progress notes in Resident 1's record document:
04/16/2024, " ...[s/he] complaint of hearing voices s/he wanted [his/her] prn's ..."
04/23/2024, "[S/he] went to see [doctor] and we addressed the sores [s/he] has we are gonna[sic] keep the area cleaned and continue to do as we been[sic] doing."
04/29/2024, " ...stated [s/he] has been feeling more depressed."
06/04/2024, "The client was not feeling well and had dizzy spells and weakness all over [his/her] body. [S/he] asked staff to go to the hospital. Staff called [his/her] Guardian and left a message because there was no answer, and took [him/her] to the ER[sic]."
08/19/2024, "[Resident 1] had a good day and night time[sic] was a little rough [s/he] had a behavior and got an abrasion on the back of [his/her] head."
09/11/2024, "[Resident 1] had a 4min seizure starting at 2:21pm eating at 2:24pm [Service Coordinator G] and [Director C] were notified."
09/17/2024, "[Resident 1's] evening was stressful for [him/her] [s/he] was very agitated due to hearing voices in [his/her] head but wanted to go for a walk to help with [him/her] agitation and

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voices."
09/18/2024, "[Resident 1] slept from 2 pm to 5 pm staff woke [Resident 1] up for dinner [s/he] came to the table and ate dinner after dinner [s/he] asked if [s/he] could go next door to say hi to another staff after [Resident 1] got back [s/he] asked if [s/he] could call the crisis line due to [him/her] having self-harming thoughts and hearing voices in [his/her] head and [s/he] wanted to go to the hospital so [s/he] could get sent to a mental hospital. Staff let [him/her] call Crisis [s/he] talked to Crisis [Resident 1] didn't like what they told [him/her] so [s/he] hung up on them staff asked [Resident 1] if [s/he] like[sic] to go for a walk [Resident 1] told them no staff then asked [him/her] if [s/he] wanted to watch a movie and [s/he] said no to that too staffed[sic] asked [him/her] if [s/he] would like to go talk and [s/he] agreed to talk to staff. After staff talked to [him/her s/he] still wanted to go to the hospital. [Resident 1] after talking to [Licensee A] [Resident 1] was fine [s/he] took [his/her] PRN along with night meds."
09/22/2024, "swollen[sic] batteries"
10/02/2024, "[Resident 1] returned from hospital stay on 10-2-24"
10/12/2024, "[Resident 1] had a good morning we went to the movies around 3 and left the movie theater early due to her feeling as though [s/he] would have a seizure, [s/he] got in the car and we pulled off and shortly after [s/he] started to have a seizure staff was in the back with [him/her] got [him/her] on [his/her] side and was able to talk [him/her] threw[sic] the seizure not long seizure about 40 seconds long."
10/19/2024, "On the way home [Resident 1] was in a daze and wasn't responding to staff, staff thought [Resident 1] was having a seizure [Resident 1] finally responded to staff and told staff when she's in a 'daze' like that, that's when

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M 446	Continued From page 57 [s/he] hears voices." There was documentation of 2 incident reports that stated: 08/23/2024, "Another incident was going on and [Resident 1] was under stress and had a minor seizure." 9/22/2024, "[Resident 1] sat down on the Sofa before dinner and discovered there was a remote there, [s/he] had the batteries on [him/her] during dinner and after dinner, [s/he] sat on the sofa and went to [his/her] room walked quickly to [his/her] room and the staff noticed that was not like [him/her] staff walked into [his/her] room after [Resident 1] walked in and [Resident 1] handed [him/her] an empty remote with no batteries in it. [Resident 1] refused to go to the hospital till[sic] another staff came and spoke with [him/her] and that staff then took [him/her] to the hospital." Resident 1's paper record at the home as well as the documentation that HR Assistant B emailed to Surveyor did not include documentation of any medical visits, reports or recommendations. Example 2 - Resident 2 Surveyor reviewed the closed record of Resident 2. Resident 2 was admitted to the provider on 04/01/2024 with diagnoses including anxiety, depression and autism. At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 2's record. The progress notes in Resident 2's record document: 06/20/2024, "[Resident 2] was taken to the ed[sic] after seeing [his/her] primary." 06/21/2024, "Suicidal was sent to ed[sic]."	M 446		

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M 446	Continued From page 58 06/27/2024, "[Resident 2] was brought back last night around 8pm." 07/03/2024, "[Resident 2] was having thoughts of self harming[sic] [him/her] but staff talked to [him/her] and redirected [him/her]. [Resident 2] went to [his/her] room with [his/her] staff to watch movies." 07/07/2024, "[Resident 2] complaining of ear pain." 07/08/2024, "[Resident 2] up, complaint of ear pain. Given Tylenol and ice pack to try to help [him/her] feel more comfortable and get back to sleep." 07/08/2024, "[Resident 2] up and down all night, complaining of ear pain. At abt[sic] 5:45 this morning [Resident 2] ran into bathroom, and sat down on floor near tub clenching [his/her] ear in pain. Complained of feeling nauseated in addition to the ongoing ear pain. After this, [Resident 2] went into the living room area and proceeded to try to get some more rest on the couch instead of [his/her] bed." 07/15/2024, "[S/he] took a nap due to [him/her] having pain n[sic] in [his/her] ear. [S/he] attempted to call [his/her family member] a few times and when [s/he] didn't get a response [s/he] got agitated. We then went for a walk." 09/05/2024, "[Resident 2] swolled[sic] batteries and [s/he] was brought to the hospital to make sure everything was okay and if [s/he] needed something to pass them the hospital kept [him/her] for surgery to get the batteries out." 09/12/2024, "[Resident 2] was picked up around 9 am by [staff] and [staff] from [psychiatric hospital]." 09/14/2024, "[Resident 2] was taken to watertown ed[sic] and they took [him/her] to [psychiatric hospital] for suicide attempts." Incident Reports	M 446		

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M 446	Continued From page 59 04/30/2024, "Both staff were in the bathroom while [Resident 2] was showering [s/he] got out the shower with blood slightly dripping down [his/her] arm from a piece of meatal[sic] [s/he] got[sic] hidden in a stuffed animal from the previous company [s/he] was at." 05/11/2024, "[Caregiver F] was making dinner, and [Resident 2] was sitting at the kitchen table with [Caregiver L]. [Resident 2] got up and quickly went to the closet where meds are kept put in the door pin and proceeded to grab all [his/her] meds and ran to the bathroom and locked the door. Both [Caregiver L], me (writer [[Caregiver J]) and [Caregiver F] chased after [him/her] and tried to get into the bathroom, but [Resident 2] had [his/her] finger on the lock. [Resident 2] then opened the door and handed staff all the empty pill wrappers. Staff immediately contacted management. [Licensee A] arrived shortly and took [Resident 2] to the emergency room. Where [s/he] was later admitted." 05/19/2024, "Around 630pm [Resident 2], peers and staff was[sic] playing board games. [Resident 2] then got up so [Caregiver K] and [Caregiver L] both of [Resident 2] staff followed [Resident 2]. [S/he] went into [his/her] room and laid on [his/her] bed with pillows on both side[sic] of [his/her] face. [Caregiver K] and [Caregiver L] sat on the floor to be in eye site[sic] and allowed [him/her] time to calm down. [S/he] then popped [his/her] head up and stated [s/he] just swallowed 3 batteries. Both staff then got up to look around [his/her] bed. Staff then called [Licensee A]. Both staff was[sic] instructed to take [Resident 2] to the ed[sic]. [Resident 2] refused medical treatment while [Caregiver K] and [Caregiver L] was[sic] the room. [Resident 2] was seen at[sic] the ed[sic] and was admitted."	M 446		

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Resident 2's paper record at the home as well as the documentation that HR Assistant B emailed to Surveyor did not include documentation of any medical visits, reports or recommendations.

At approximately 11:00 a.m., Surveyor asked Licensee A for Resident 1 and Resident 2's medical disharge summaries from their hospital visits. Licensee A stated they are not always given those. Surveyor noted that it is required to be part of the resident's record. Licensee A stated s/he could look through his/her records to see what s/he has.

As of 11/18/2024, no further records of medical visits, reports or recommendations were received for Resident 1 or Resident 2 from Licensee A.

On 11/19/2024, Surveyor received the hospital records, via record request through the hospital, for Resident 1 and Resident 2 documenting the reason they were seen in the emergency room and/or required hospital admission:

Resident 1 -
03/16/2024 - "Patient presents to the emergency department by EMS for seizure activity. Patient had a witnessed tonic-clonic seizure today. Patient was in the presence of [his/her] new group home staff noted the seizure. Patient has a history of seizures. Patient reportedly had just become a new resident at [his/her] new group home and had come from another group home and there was a question whether or not the patient is receiving [his/her] medication as it is ordered. Patient denies any recent illness or other symptoms. At time of arrival, patient is back to [his/her] normal status. Patient is no longer postictal at this time."

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M 446	Continued From page 61 03/17/2024 - "Patient presents in emergency department reporting possible seizure today. Patient apparently was in a disagreement with a member of group home. Patient then was witnessed drop into the ground and having conclusive actions. Patient immediately popped of[sic] after the compulsive action. Patient does have a history of seizures as well as pseudoseizures. Patient was evaluated yesterday for seizure as well. Patient has no injury from the the seizure no pain no injury to the tongue or cheeks from biting down no loss of bowel or bladder." 06/04/2024 - "Patient presents emergency department with [his/her] group home staff member. Patient was reported to be suffering from weakness, sleepiness, drooling. Patient recently had medication in the last week. Patient denies any symptoms at this time." 08/15/2024 - "...Discharged in[sic] hour ago from the emergency department, is brought by ambulance after having another episode of shaking/pseudo seizure at the nursing home. Patient states that [s/he] felt stressed and [s/he] kept on shaking while remaining conscious and is absolutely sure [s/he] was not seizing. Staff however called the ambulance and upon their arrival they 'made [him/her] come here'. Patient states that [s/he] is[sic] remember shaking, denies losing consciousness, urinating on [him/herself] and states that it was 'for sure a pseudo-seizure'. Patient denies any complaints right now however states that [s/he] feels stressed by going back and forth." 09/06/2024 - "History of pseudoseizures presents from group home after a witnessed convulsive	M 446		

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episode. There was no reported prodrome. No urinary incontinence. No postictal confusion. Patient reports that [s/he] believes [s/he] had a seizure due to social interactions with another client."

09/08/2024 - "History of anxiety depression bipolar disorder schizoaffective disorder pseudo-seizure and a seizure disorder presents from a group home stating that [s/he] witnessed a client strike a pregnant worker and then all of a sudden [s/he] thinks [s/he] blacked out maybe had a seizure had a stress reaction [s/he] has been told [his/her] pseudoseizures in the past. [S/he] was just here 2 days ago and had a workup in all that was negative but [s/he] did not have a valproic acid checked. No headache no fever no chills no vomiting no diarrhea. No trauma.

09/13/2024 - "...psychogenic nonepileptic seizure history who comes in with group home caregiver for the evaluation of suicide ideation and after attempting to hurt [him/herself] by ingesting 2 AAA batteries earlier today. Patient reports [s/he] feels fine in regards to not having any chest pain, shortness of break no abdominal pain no nausea vomiting. However [s/he] reports ongoing suicide ideation and depression. [S/he] reports [s/he] ingested these to try to hurt [him/herself]. Has previously done this a few years ago." Resident 1 required an emergency endoscopy by a general surgeon to remove the batteries.

9/22/2024-09/24/2024 - "Concern for ingestion of batteries. Patient states that [s/he] hears voices that tell [him/her] things. Patient states that [s/he] took the batteries other[sic] remote control at [his/her] group living home and swallow[sic] them. Patient denies any further ingestion or any other

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attempt to harm [him/herself]. Patient has a history of this type of behavior. Patient denies any symptoms of illness such as fever, chills, chest pain, shortness of break, abdominal pain, nausea, vomiting or diarrhea. Ingestion occurred approximately 1-1/2 hour prior to arrival. Patient had eaten a meal just prior to that." Resident 1 stated s/he ingested the batteries in an attempt to kill him/herself. Resident 1 required an esophagogastroduodenoscopy for the removal of the ingested batteries.

10/23/2024 - "Patient swallowed 2 AAA batteries approximately half an hour prior to arrival. [S/he] is hearing voices telling [him/her] to do this, as [s/he] is schizophrenic. [S/he] has been having [his/her] medications adjusted recently [s/he] has a history of swallowing objects from least the time when [s/he] was 18 years old. [S/he] tells me [s/he] swallows screws as well as landscaping rocks. [S/he] has also had some reason[sic] history of swallowing batteries from TV remote controls. Denies any pain nausea vomiting or diarrhea." Resident 1 required an esophagogastroduodenoscopy with endoscopic evaluation for the removal of the ingested batteries.

Resident 2 -
05/11/2024 - "...reported ingestion of 5 days worth of [his/her] usual medications as a suicide attempt. No cardiopulmonary or neurologic abnormalities on initial evaluation. Laboratory studies without clinically significant abnormality. Per Poison control, should be observed for 12 hours for any signs of deterioration. In the process of arranging admission to [hospital], patient divulged reported sexual assault 2 days ago, requesting SANE exam. Arrangements made for SANE exam at [hospital] with

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subsequent admission from hospitalist there. Jefferson County Human Services aware of patient, will need to be notified for psychiatric disposition once medically cleared at [hospital]."

05/19/2024 - "...ingested in a suicide to[sic] about 2-2.5 hours ago after eating dinner at the group home which [s/he] lives. One of the batteries is AAA battery and the other 1 is an LED button battery. [S/he] states [s/he] took the batteries because [s/he] is suicidal and depressed. [S/he] says [s/he] was raped [orifice] at the group home in which [s/he] lives by a [gender] that also lives in the facility. Patient says [s/he] told the group home staff that [s/he] was raped last night but that they did not believe [him/her]. [S/he] has a history of PTSD, bipolar illness, personality disorder, autism, anxiety and depression. [S/he] has not vomited and [s/he] denies chest pain or trouble breathing. [S/he] has some right flank pain. [...] Patient also admits to eating small screws and an earring a couple weeks ago and [s/he] told the group home staff that [s/he] ingested those items. [S/he] has not ingested any screws or earrings recently.
Last week the patient was very depressed and then [s/he] took an overdose and was seen here in the ER. [S/he] also stated at that time that [s/he] was raped in the group home. [S/he] was sent to [hospital] for a sane exam, medical observation for the overdose and eventually psychiatric consultation. The patient says that the psychiatrist told [him/her] [s/he] could go back to the same group home even though [s/he] does not want to be there anymore." Resident 2 underwent upper endoscopy, specifically esophagogastroduodenoscopy to remove the batteries.

06/20/2024 - "...long history of mental health

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disorders who lives in a group home who comes in with complaints of suicidal ideation that has been ongoing and now had an attempt by wrapping cord around [his/her] neck in [his/her] room. Police were called to the group home and bring[sic] [him/her] to the ER. Patient denies any other complaint. No chest pain or shortness of breath, no nausea vomiting or diarrhea. After further discussion with patient [s/he] states that the individual grabbed [his/her] breast and then walked away. Police are at bedside along with [county] social worker. Patient has been emergency detention."

09/05/2024-09/07/2024 - "...past medical history of autism, ADHD, PTSD, Bipolar Disorder, depression, anxiety, asthma who presents with suicide attempt. Suicide attempt, ingestion of batteries: Present on admission. X-rays show 2 cylindrical batteries within the stomach.
-status post EGD with successful removal. No ulcerations noted.
-patient has sitter at bedside
-awaiting county for suicide clearance
...'I swallowed batteries to try to kill myself.' Pt states [s/he] swallowed 2 AAA batteries at approximately 2115. [S/he] states [s/he] has been struggling at [his/her] group home Buckaroos for a 'couple weeks'. [S/he] states [s/he] hasn't been getting along with the other residents that live there. Upon admission patient stated that [s/he] still has thoughts of harming [his/herself]. Sitter in room with patient, and any additional tubes/wires removed from room."

09/12/2024 - "Brought by police to emergency department for medical clearance status post trying to cut [his/her] wrist with disassembled razor and then trying to strangulate [him/herself] with a seatbelt in the police car. Patient states

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M 446	Continued From page 66 that [s/he] wants to die and refuses to talk more about it. Denies any physical complaints." Cross Reference N0450 DHS 88.07(2)(b)6 Notification of Changes	M 446		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider have documentation that s/he was monitoring the health of 2 of 2 residents. Resident 1 had notes of a sores and an abrasion on his/her head with no follow-up or medical documentation or recommendation. Resident 2 had no documentation of the wound staff found blood dripping from on 04/30/2024, the changes, healing, or medical follow-up. There was no follow-up documentation or medical recommendation on of ear pain documented from 07/07/2024-07/15/2024. Findings include: On 10/30/2024, Surveyor conducted a complaint investigation. The provider is licensed as a non-ambulatory adult family home (AFH) able to serve up to 4 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, and physically disabled.	M 448		

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M 448	Continued From page 67 Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 03/13/2024 with diagnoses affective disorder, impulse disorder, borderline personality disorder, suicidal ideation, and intellectual disability. At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 1's record. The progress notes in Resident 1's record document: 04/23/2024, "[S/he] went to see [doctor] and we addressed the sores [s/he] has we are gonna[sic] keep the area cleaned and continue to do as we been[sic] doing." 08/19/2024, "[Resident 1] had a good day and night time[sic] was a little rough [s/he] had a behavior and got an abrasion on the back of [his/her] head." Resident 1's paper record at the home as well as what HR Assistant B emailed to Surveyor did not include any medical visits, reports or recommendations. Example 2 - Resident 2 Surveyor reviewed the closed record of Resident 2. Resident 2 was admitted to the provider on 04/01/2024 with diagnoses including anxiety, depression and autism. At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 2's record. The progress notes in Resident 2's record document: 07/07/2024, "[Resident 2] complaining of ear pain." 07/08/2024, "[Resident 2] up, complaint of ear pain. Given Tylenol and ice pack to try to help	M 448		

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[him/her] feel more comfortable and get back to sleep."
07/08/2024, "[Resident 2] up and down all night, complaining of ear pain. At abt[sic] 5:45 this morning [Resident 2] ran into bathroom, and sat down on floor near tub clenching [his/her] ear in pain. Complained of feeling nauseated in addition to the ongoing ear pain. After this, [Resident 2] went into the living room area and proceeded to try to get some more rest on the couch instead of [his/her] bed."
07/15/2024, "[S/he] took a nap due to [him/her] having pain n[sic] in [his/her] ear. [S/he] attempted to call [his/her family member] a few times and when [s/he] didn't get a response [s/he] got agitated. We then went for a walk."

Incident Reports
04/30/2024, "Both staff were in the bathroom while [Resident 2] was showering [s/he] got out the shower with blood slightly dripping down [his/her] arm from a piece of meatal[sic] [s/he] got[sic] hidden in a stuffed animal from the previous company [s/he] was at."

Resident 2's paper record at the home as well as what HR Assistant B emailed to Surveyor did not include any medical visits, reports or recommendations.

At approximately 11:00 a.m., Surveyor asked Licensee A for Resident 1 and Resident 2's medical discharge summaries from any medical visits. Licensee A stated they are not always given those. Surveyor noted that it is required to be part of the resident's record. Licensee A stated s/he could look through his/her records to see what s/he has. Licensee A stated s/he only works part time and had to leave. Licensee A asked Surveyor to provide Service Coordinator G and

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HR Assistant B with a list of what information Surveyor will still need to complete the survey.

At approximately 1:00 p.m., Surveyor reviewed the information that was still needed to complete the survey, including medical assessments that were completed for Resident 1 and Resident 2, with Service Coordinator G and HR Assistant B. Surveyor requested that the information be emailed or faxed by 10/31/2024 at noon.

On 10/31/2024 at 3:07 p.m., Surveyor emailed HR Coordinator G, who had provided documentation from Resident 1 and Resident 2's record while onsite, stating that any medical visits or assessments for Resident 1 and Resident 2 should have been submitted by noon but will be accepted until the end of the day.

On 11/04/2024 at 5:12 p.m., Spouse D emailed Surveyor stating, "some of the e-mail attachments I am attempting to forward to you are too large. Do you have another way of receiving large files? Thanks, [Spouse D]"

On 11/04/2024 at 7:36 p.m., HR Assistant B responded to Surveyors email from 10/31/2024 stating, "I have requested these documents. Will send them asap."

11/05/2024 at 1:22 p.m., Surveyor provided Spouse D, Licensee A, and the provider's general email address with Surveyor's fax number, which was also provided at the time of the survey. Surveyor stated to Licensee A that s/he has not received any of the required information Surveyor has requested, including any documentation from a health care provider for Resident 1 or Resident 2.

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M 448	Continued From page 70 On 11/14/2024 at 1:38 p.m., Surveyor sent Licensee A another email stating, "I have not received any additional files from any of the emails I have returned. As I stated in my previous emails, I do not need emails of calendar appointments or other random information, just specific information I requested from the resident's records. In reading notes: -I see [Resident 2] that [s/he] was complaining of ear pain from 7/7-7/15. Was this ever assessed or treated? -On 9/18 [Resident 1] reported being suicidal and wanting to the hospital, can you please let me know what interventions and supports were put in place. -Please send all incident reports/investigations on both [residents] hospitalizations Please send any documentation you have by the end of day today." 11/18/2024 at 5:18 p.m., Surveyor received a fax from the provider. It did not include any documentation to show the provider was monitoring and documenting the changes in Resident 1 or Resident 2's health in regards to skin concerns or pain.	M 448		
M 450	88.07(2)(b)6 NOTIFICATION OF CHANGES Notifying the placing agency, if any, the guardian, if any, of any significant changes in the resident's medical condition, including any life-threatening, disabling or serious illness, any illness lasting more than 3 days, an injury sustained by the resident, medical treatment needed by the resident or the resident's absence	M 450		

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M 450	Continued From page 71 from the home for more than 24 hours. This Rule is not met as evidenced by: Based on record review and interview, Resident 1's placing agency was not notified of injuries sustained by the resident or medical treatment needed by the resident. Resident 1's placing agency was not notified after a change in medical condition after Resident 1 starting having seizures as well as after s/he ingested batteries on 9/22/2024, which resulted in a medical procedure to remove the batteries and a hospital admission until 09/24/2024. Findings include: On 10/30/2024, Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 03/13/2024 with diagnoses affective disorder, impulse disorder, borderline personality disorder, suicidal ideation, and intellectual disability. At 10:45 a.m., HR Assistant B emailed Surveyor parts of Resident 1's record. The progress notes in Resident 1's record document: 04/23/2024, "[S/he] went to see [doctor] and we addressed the sores [s/he] has we are gonna[sic] keep the area cleaned and continue to do as we been[sic] doing." 05/22/2024, "[Resident 1] had a good morning up till[sic] dinner time after dinner [Resident 2] and [Resident 1] had a disagreement and had words back and forth [Resident 1] tide[sic] [his/her]	M 450		

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shoes[sic] string around [his/her] neck I was able to get it untied [s/he] then was calmed down enough to talk to me and explain [his/her] feeling I then took all [his/her] shoes out of [his/her] room the rest of the night was good ..."
05/28/2024, "[S/he] had a rough day with a few freak outs, arguing with [his/her] roommate [Resident 2]. [S/he] had a stress seizure today and after 5 minutes of quiet time and some one on one with staff, [s/he] calmed down."
06/04/2024, "The client was not feeling well and had dizzy spells and weakness all over [his/her] body. [S/he] asked staff to go to the hospital. Staff called [his/her] Guardian and left a message because there was no answer, and took [him/her] to the ER[sic]."
08/19/2024, "[Resident 1] had a good day and night time[sic] was a little rough [s/he] had a behavior and got an abrasion on the back of [his/her] head."
09/11/2024, "[Resident 1] had a 4min seizure starting at 2:21pm eating at 2:24pm [Service Coordinator G] and [Director C] were notified."
09/17/2024, "[Resident 1's] evening was stressful for [him/her] [s/he] was very agitated due to hearing voices in [his/her] head but wanted to go for a walk to help with [him/her] agitation and voices."
09/18/2024, "[Resident 1] slept from 2 pm to 5 pm staff woke [Resident 1] up for dinner [s/he] came to the table and ate dinner after dinner [s/he] asked if [s/he] could go next door to say hi to another staff after [Resident 1] got back [s/he] asked if [s/he] could call the crisis line due to [him/her] having self-harming thoughts and hearing voices in [his/her] head and [s/he] wanted to go to the hospital so [s/he] could get sent to a mental hospital. Staff let [him/her] call Crisis [s/he] talked to Crisis [Resident 1] didn't like what they told [him/her] so [s/he] hung up on them staff

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asked [Resident 1] if [s/he] like[sic] to go for a walk [Resident 1] told them no staff then asked [him/her] if [s/he] wanted to watch a movie and [s/he] said no to that too staffed[sic] asked [him/her] if [s/he] would like to go talk and [s/he] agreed to talk to staff. After staff talked to [him/her s/he] still wanted to go to the hospital. [Resident 1] after talking to [Licensee A] [Resident 1] was fine [s/he] took [his/her] PRN along with night meds."
09/22/2024, "swollen[sic] batteries"
10/02/2024, "[Resident 1] returned from hospital stay on 10-2-24"
10/12/2024, "[Resident 1] had a good morning we went to the movies around 3 and left the movie theater early due to her feeling as though [s/he] would have a seizure, [s/he] got in the car and we pulled off and shortly after [s/he] started to have a seizure staff was in the back with [him/her] got [him/her] on [his/her] side and was able to talk [him/her] threw[sic] the seizure not long seizure about 40 seconds long."
10/19/2024, "On the way home [Resident 1] was in a daze and wasn't responding to staff, staff thought [Resident 1] was having a seizure [Resident 1] finally responded to staff and told staff when she's in a 'daze' like that, that's when [s/he] hears voices."

There was documentation of 2 incident reports that stated:
08/23/2024, "Another incident was going on and [Resident 1] was under stress and had a minor seizure."

9/22/2024, "[Resident 1] sat down on the Sofa before dinner and discovered there was a remote there, [s/he] had the batteries on [him/her] during dinner and after dinner, [s/he] sat on the sofa and went to [his/her] room walked quickly to [his/her]

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room and the staff noticed that was not like [him/her] staff walked into [his/her] room after [Resident 1] walked in and [Resident 1] handed [him/her] an empty remote with no batteries in it. [Resident 1] refused to go to the hospital till[sic] another staff came and spoke with [him/her] and that staff then took [him/her] to the hospital."

At approximately 11:00 a.m., Surveyor asked Licensee A if Resident 1's placing agency was aware of all his/her hospital visit. Licensee A stated yes, that Licensee A keeps Resident 1's placing agency informed and they are happy with the care Resident 1 is receiving.

On 11/19/2024, Surveyor received the hospital records for Resident 1, documenting the reason they were seen in the emergency room and/or required hospital admission:
Resident 1 -
03/16/2024 - "Patient presents to the emergency department by EMS for seizure activity. Patient had a witnessed tonic-clonic seizure today. Patient was in the presence of [his/her] new group home staff noted the seizure. Patient has a history of seizures. Patient reportedly had just become a new resident at [his/her] new group home and had come from another group home and there was a question whether or not the patient is receiving [his/her] medication as it is ordered. Patient denies any recent illness or other symptoms. At time of arrival, patient is back to [his/her] normal status. Patient is no longer postictal at this time."

03/17/2024 - "Patient presents in emergency department reporting possible seizure today. Patient apparently was in a disagreement with a member of group home. Patient then was witnessed drop into the ground and having

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conclusive actions. Patient immediately popped of[sic] after the compulsive action. Patient does have a history of seizures as well as pseudoseizures. Patient was evaluated yesterday for seizure as well. Patient has no injury from the the seizure no pain no injury to the tongue or cheeks from biting down no loss of bowel or bladder."

06/04/2024 - "Patient presents emergency department with [his/her] group home staff member. Patient was reported to be suffering from weakness, sleepiness, drooling. Patient recently had medication in the last week. Patient denies any symptoms at this time."

08/15/2024 - "...Discharged in[sic] hour ago from the emergency department, is brought by ambulance after having another episode of shaking/pseudo seizure at the nursing home. Patient states that [s/he] felt stressed and [s/he] kept on shaking while remaining conscious and is absolutely sure [s/he] was not seizing. Staff however called the ambulance and upon their arrival they 'made [him/her] come here'. Patient states that [s/he] is[sic] remember shaking, denies losing consciousness, urinating on [him/herself] and states that it was 'for sure a pseudo-seizure'. Patient denies any complaints right now however states that [s/he] feels stressed by going back and forth."

09/06/2024 - "History of pseudoseizures presents from group home after a witnessed convulsive episode. There was no reported prodrome. No urinary incontinence. No posticta[sic] confusion. Patient reports that [s/he] believes [s/he] had a seizure due to social interactions with another client."

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M 450	Continued From page 76 09/08/2024 - "History of anxiety depression bipolar disorder schizoaffective disorder pseudo-seizure and a seizure disorder presents from a group home stating that [s/he] witnessed a client strike a pregnant worker and then all of a sudden [s/he] thinks [s/he] blacked out maybe had a seizure had a stress reaction [s/he] has been told [his/her] pseudoseizures in the past. [S/he] was just here 2 days ago and had a workup in all that was negative but [s/he] did not have a valproic acid checked. No headache no fever no chills no vomiting no diarrhea. No trauma. 09/13/2024 - "...psychogenic nonepileptic seizure history who comes in with group home caregiver for the evaluation of suicide ideation and after attempting to hurt [him/herself] by ingesting 2 AAA batteries earlier today. Patient reports [s/he] feels fine in regards to not having any chest pain, shortness of break no abdominal pain no nausea vomiting. However [s/he] reports ongoing suicide ideation and depression. [S/he] reports [s/he] ingested these to try to hurt [him/herself]. Has previously done this a few years ago." Resident 1 required an emergency endoscopy by a general surgeon to remove the batteries. 9/22/2024-09/24/2024 - "Concern for ingestion of batteries. Patient states that [s/he] hears voices that tell [him/her] things. Patient states that [s/he] took the batteries other[sic] remote control at [his/her] group living home and swallow[sic] them. Patient denies any further ingestion or any other attempt to harm [him/herself]. Patient has a history of this type of behavior. Patient denies any symptoms of illness such as fever, chills, chest pain, shortness of break, abdominal pain, nausea, vomiting or diarrhea. Ingestion occurred approximately 1-1/2 hour prior to arrival. Patient	M 450		

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had eaten a meal just prior to that." Resident 1 stated s/he ingested the batteries in an attempt to kill him/herself. Resident 1 required an esophagogastroduodenoscopy for the removal of the ingested batteries.

10/23/2024 - "Patient swallowed 2 AAA batteries approximately half an hour prior to arrival. [S/he] is hearing voices telling [him/her] to do this, as [s/he] is schizophrenic. [S/he] has been having [his/her] medications adjusted recently [s/he] has a history of swallowing objects from least the time when [s/he] was 18 years old. [S/he] tells me [s/he] swallows screws as well as landscaping rocks. [S/he] has also had some reason[sic] history of swallowing batteries from TV remote controls. Denies any pain nausea vomiting or diarrhea." Resident 1 required an esophagogastroduodenoscopy with endoscopic evaluation for the removal of the ingested batteries.

On 11/26/2024 at 9:09 a.m., Surveyor emailed Case Manager I in regards to Resident 1 and asked, "Have there been any meetings about expectations after any events/hospitalizations?"

On 12/18/2024, at 7:43 p.m., Case Manager I stated, "Inclusa/Humana is only aware of two occasions for [Resident 1] swallowing batteries those dates are on 09.13.2024 and 10.24.2024. [...] Can you please confirm if there was a third and separate incident with [Resident 1] ingesting batteries at Buckaroo's, this would be concerning on our half, that this was not reported to us."

On 12/19/2024 at 9:09 a.m., Surveyor stated, "I can confirm, via Watertown hospital records, as all the incidents were not documented by Buckaroos, the following:

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03/16/2024 - possible seizure activity, hospital.
03/17/2024 - possible seizure, hospital.
06/04/2024 - change in condition, hospital. Weakness, sleepiness, drooling.
08/15/2024 - shaking/pseudo-seizure, hospital.
09/06/2024 - pseudo-seizure, hospital.
09/08/2024 - pseudo-seizure, hospital.
09/13/2024 - swallowed batteries in an attempt to kill him/herself, hospital.
9/22/2024-09/24/2024 - swallowed batteries in an attempt to kill him/herself, hospitalized. EGD removal of batteries.
10/23/2024 - swallowed batteries, hospitalized. EGD removal of batteries.

So, if I am understanding correctly, you were not made aware of her hospitalization from 09/22/2024-09/24/2024?"

On 12/19/2024 at 10:54 a.m., Case Manager I stated, "The only dates I am aware of is the 9.13.24 and 10.23.24, I was not aware of all the hospital emergency room visits either. Inclusa was made aware of a hospitalization around 9.25.24 as [Resident 1] then was discharged to [psychiatric hospital] - willingly. I think the discharge date was on 10.02.2024. I am going to meet with my manager on this as I do believe that I will to be needing to perform some follow up and an incident report."

At 11:07 a.m., Case Manager I left Surveyor a voicemail stating, they were not aware of the hospital visit on 9/22 or that Resident 1 had ingested batteries a 3rd time and that it was very frustrating.

At 11:25 a.m., Case Manager I sent a followed-up email stating, "Apologies for not provider more clarity in my last email: The dates below is what

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Inclusa was informed about with [Resident 1's] hospitalizations. I will be completing another IR(incident report).

06.06.2024- ER Only medication side effectives - (Date could of actually been 6.04.24, but Inclusa was informed 6.6.24)

09.23.2024 - ER Only self-harm thoughts - Pending IMD Admission

09.24.2024 - IMD Admission - Inpatient Voluntarily to [psychiatric hospital].

03/16/2024 - possible seizure activity, hospital.
No Humana was not aware of this emergency room visit.
03/17/2024 - possible seizure, hospital.
No Humana was not aware of this emergency room visit.
06/04/2024 - change in condition, hospital. Weakness, sleepiness, drooling.
Yes, but Humana was informed the emergency room visit was on 06.06.2024.
08/15/2024 - shaking/pseudo-seizure, hospital.
No Humana was not aware of this emergency room visit.
09/06/2024 - pseudo-seizure, hospital.
No Humana was not aware of this emergency room visit.
09/08/2024 - pseudo-seizure, hospital.
No Humana was not aware of this emergency room visit.
09/13/2024 - swallowed batteries in an attempt to kill [him/herself], hospital.
Yes, Humana was aware, IR completed and Behavioral Health involved.
9/22/2024-09/24/2024 - swallowed batteries in an attempt to kill [him/herself], hospitalized. EGD removal of batteries.

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M 450	Continued From page 80 No Humana was not aware that [s/he] swallowed batteries again, we were informed [s/he] had suicidal statements. 10/23/2024 - swallowed batteries, hospitalized. EGD removal of batteries. Yes, Humana was aware of this emergency room visit, IR completed and Behavioral Health Involved." The provider did not ensure Resident 1's placing agency was not notified of injuries sustained by the resident or medical treatment needed by the resident, including multiple emergency room visits and a hospital admission.	M 450		