STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017172	A. BUILDING: _____ B. WING _____	C 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS ADULT FAMILY HOME	**218 NICHOLAS ST TOMAH, WI 54660**

(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 02/06/2026, Surveyor conducted two complaints investigation at Genesis Adult Family Home. Data collection continued through 02/25/2026. Two of 2 complaints were substantiated. Six deficiencies were identified. Census: 4	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 to the department within 24 hours, a significant change in Resident 2's condition which resulted in Resident 2 being hospitalized multiple times. Findings include: On 10/15/2025, the department received a complaint related to resident services.	M 134		

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

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M 134	Continued From page 1 The provider is licensed to care for 4 residents in the client groups of: developmentally disabled, physically disabled, traumatic brain injury, alcohol/drug dependent and emotionally disturbed/mental illness. On 02/06/2026 at approximately 10:40 AM, Surveyor interviewed Registered Nurse (RN) B. RN B stated Resident 2 had been in and out of the hospital multiple times during his/her admission. On 02/06/2026 at approximately 12:00 PM, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 07/03/2025 and discharged on 09/18/2025. Resident 2 was his/her own decision maker. Resident 2 had diagnoses that included manic depression, depression, borderline personality disorder, bipolar disorder, anxiety disorder, autistic disorder, development disorder of scholastic skills, and self-injurious behaviors. Surveyor reviewed the staff observation notes dated 07/04/2025 to 09/09/2025. The following notes were documented: -On 08/21/2025, Resident 2 broke a glass jar and cut a two-inch-long laceration into his/her right arm. Resident 2 received 7 stitches to his/her right arm in the Emergency Room (ER). The laceration was to stay covered for 24 hours and then left open to air. Staff were to offer Resident 2 pain medication as needed, push fluid intake, watch for signs of infection and support Resident 2 with cleansing and caring for the wound. -On 08/22/2025, Resident 2 was admitted to the inpatient behavior health hospital due to him/her feeling like s/he wanted to harm his/herself. -On 08/25/2025, Resident 2 returned home from the inpatient behavior health hospital.	M 134		

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M 134	Continued From page 2	M 134		

-On 09/03/2025, Resident 2 was taken to the ER due to self-harm cutting his/her wrist.
-On 09/06/2025, Resident 2 returned home from the hospital.

A managed care organization (MCO) document titled "Member Absence Notification Form," confirmed Resident 2 was admitted to inpatient behavioral health on 08/22/2025 to 08/25/2025.

An email from Licensee A to the MCO dated 09/04/2025 at 4:27 PM, indicated Resident 2 was admitted to inpatient behavioral health.

On 02/06/2026 at approximately 12:00 PM, Surveyor interviewed Licensee A. Licensee A stated Resident 2 frequently caused self-harm by cutting him/herself multiple times per week. Licensee A stated Resident 2 was at a hospital for a 72-hour hold in August 2025 and left against medical advice. Licensee A stated s/he ended up at a nearby ER the next day and then took a taxicab back to his/her parents for one night before returning to the facility.

On 02/12/2026 at 3:06 PM, Surveyor received an email from Licensee A. Surveyor had asked Licensee A, "Which, if any, of [Resident 2's] injuries with ER/Hospitalization treatment [sic] reported to the Department?" Licensee A responded that s/he attached the one self-report s/he reported to the Department, and the other incidents were reported to the MCO only. The attached self-report indicated it was for an incident on 09/09/2025, where Resident 2 had been hospitalized after cutting his/herself and ingesting a whole bottle of pills. Resident 2 did not return to the facility after this incident.

Surveyor reviewed the facility e-file and found

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M 134	Continued From page 3 only 1 self-report for 2025 reported to the Department related to the incident on 09/09/2025. The provider did not report to the department, within 24 hours, a significant change in Resident 2's condition for an ER visit on 08/21/2025 that resulted in stitches and two inpatient behavior health hospitalizations from 08/22/2025 to 08/25/2025 and 09/03/2025 to 09/06/2025. Cross Reference M0384 DHS 88.06(2)(b) Service Agreement Except Respite M0414 DHS 88.06(3)(d)2 Level Of Supervision M0436 DHS 88.07(2)(a) Services	M 134		
M 352	88.05(4)(f) RESIDENT INCAPABLE OF SELF EVACUATION resident incapable of self evacuation. If a resident who is incapable of self-evacuation in an emergency is present in the home, the licensee or service provider shall be in the home. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there was adequate staff to evacuate Resident 1. Findings include: On 12/27/2025, the Department received a complaint related to resident services. The provider is licensed to care for 4 residents in the client groups of: developmentally disabled, physically disabled, traumatic brain injury, alcohol/drug dependent and emotionally	M 352		

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M 352	Continued From page 4 disturbed/mental illness. On 02/06/2026 at 10:30 AM, Surveyor interviewed Caregiver C. Caregiver C stated each 12-hour shift was always staffed with 2 staff per shift. Caregiver C stated Resident 3 had one-to-one staff to help him/her with activities and that was included in the 2 staff per shift. On 02/06/2026 at 10:40 AM, Surveyor interviewed Registered Nurse (RN) B. RN B stated Resident 1 was not admitted with a Hoyer lift or wheelchair. RN B stated they currently were using a gurney sheet with 4 staff to transfer Resident 1 to a cot or to the facility's wheelchair for appointments and fire drills. RN B stated they were able to transfer Resident 1 with only 3 staff the day before but preferred 4 staff for Resident 1's comfort. RN B stated if Resident 1 needed to be transferred in an emergency s/he was always available and/or there was an extra float staff that could come help. On 02/06/2026 at approximately 12:00 PM, Surveyor requested Resident 1's record and staff schedule for December 2025 to present to review. Resident 1 was admitted on 12/22/2025 and was diagnosed with closed displaced fracture of the 6th cervical vertebra with spinal cord injury status post an open reduction and internal fixation surgery, spastic diplegic cerebral palsy with intellectual disability, and nonverbal. Resident 1 had a guardian. A pre-admission assessment completed by Licensee A on 12/15/2025, indicated Resident 1 used a mechanical lift and Broda chair for complete assistance with transfers. The assessment had a note written by Licensee A which stated Resident 1 required	M 352		

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M 352	Continued From page 5	M 352		

compete care and needed 2 staff assistance with everything. Resident 1's individual service plan (ISP) indicated Resident 1 required full assistance with transfers but did not specify what a full assistance transfer looked like for Resident 1. The ISP read in part, "[Resident 1] is now unable to move [his/her] lower extremities and has little, but limited motion with [his/her] arms ...We are unaware how much [s/he] is able to assist with turning [his/herself] in bed at this time ...Due to residents inability to move extremities or reposition [his/herself], staff will toilet and reposition every two hours." The ISP indicated Resident 1 required complete assistance to evacuate the facility. A Resident Evacuation Assessment dated 12/22/2025, read in part, " ...Needs full assistance from two staff means the resident requires assistance from two persons during most of the evacuation ...[Resident 1] requires one staff to push [him/her] out of the house in [his/her] wheelchair. [S/he] would need two staff to transfer [him/her] if [s/he] was not in [his/her] wheelchair." A hospital discharge summary dated 12/22/2025, indicated Resident 1 required 2 staff assistance with a Hoyer lift for activity assistance.

The staff schedule for December 2025 to present indicated only one member of staff was scheduled on a whole or part of a shift for the following dates:
-12/24/2025
-12/27/2025
-12/28/2025
-12/29/2025
-12/30/2025
-01/02/2026
-01/09/2026
-01/12/2026
-01/17/2026

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M 352	Continued From page 6 -01/21/2026 -01/22/2026 -01/30/2026 -02/01/2026 On 02/06/2026 at approximately 12:00 PM, Surveyor interviewed Licensee A. Licensee A stated Resident 3 had one-to-one staff for 6 to 8 hours during the day shift. Licensee A stated 2 staff could transfer Resident 1, but they preferred 4 staff to assist for safety. Licensee A stated they had practiced transferring Resident 1 with 2 staff for a fire drill. Licensee A stated they were working on getting a Hoyer lift and wheelchair ordered for Resident 1. The provider did not have adequate staff to ensure Resident 1 could be transferred or evacuated from the facility. Cross Reference M0384 DHS 88.06(2)(b) Service Agreement Except Respite M0412 DHS 88.06(3)(d)1 Description Of Services M0436 DHS 88.07(2)(a) Services	M 352		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the	M 384		

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M 384	Continued From page 7 persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents sampled (Resident 1 and Resident 2) had signed service agreements. Findings include: On 10/15/2025 and 12/27/2025, the department received complaints related to resident services. The provider is licensed to care for 4 residents in the client groups of: developmentally disabled, physically disabled, traumatic brain injury, alcohol/drug dependent and emotionally disturbed/mental illness. On 02/06/2026 at approximately 12:00 PM, Surveyor requested Resident 1's and Resident 2's records to review, including the service agreements, from Licensee A. Resident 1 was admitted to the facility on 12/22/2025. Resident 2 was admitted to the facility on 07/03/2025 and discharged on 09/18/2025. Surveyor was not provided a documented service agreement for Resident 1 or Resident 2. On 02/06/2026 at approximately 12:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he started to not do service agreements with residents and/or their legal representatives if they were funded by a managed care organization (MCO) about one year ago. Licensee A stated s/he used the MCO's contract instead.	M 384		

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M 384	Continued From page 8 The provider did not have a service agreement signed by Resident 1's legal representative and Resident 2 at admission. Cross reference: M0134 DHS 88.03(5)(e)1 Significant Change To The Resident M0352 DHS 88.05(4)(f) Resident Incapable of Self Evacuation M0412 DHS 88.06(3)(d)1 Description Of Services M0414 DHS 88.06(3)(d)2 Level Of Supervision M0436 DHS 88.07(2)(a)Services	M 384		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's Individual Service Plan (ISP) contained a description of services the licensee would provide for 1 of 1 resident reviewed. Resident 1 required 2 staff assistance with a Hoyer lift for transfers and had surgery post-op orders and incision care not identified in the ISP. Findings include: On 12/27/2025, the department received complaints related to resident services.	M 412		

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M 412	Continued From page 9 The provider is licensed to care for 4 residents in the client groups of: developmentally disabled, physically disabled, traumatic brain injury, alcohol/drug dependent and emotionally disturbed/mental illness. On 02/06/2026 at 10:40 AM, Surveyor interviewed Registered Nurse (RN) B. RN B stated Resident 1 was not admitted with a Hoyer lift or wheelchair. RN B stated they currently were using a gurney sheet with 4 staff to transfer Resident 1 to a cot or to the facility's wheelchair for appointments and fire drills. RN B stated they were able to transfer Resident 1 with only 3 staff the day before but preferred 4 staff for Resident 1's comfort. On 02/06/2026 at approximately 12:00 PM, Surveyor requested Resident 1's record to review. Resident 1 was admitted on 12/22/2026 and was diagnosed with closed displaced fracture of the 6th cervical vertebra with spinal cord injury status post an open reduction and internal fixation surgery, spastic diplegic cerebral palsy with intellectual disability, and nonverbal. Resident 1 had a guardian. A pre-admission assessment completed by Licensee A on 12/15/2025, indicated Resident used a mechanical lift and Broda chair for complete assistance with transfers. The assessment had a note written by Licensee A which stated Resident 1 required compete care and needed 2 staff assistance with everything. A hospital discharge summary dated 12/22/2025, indicated Resident 1 required 2 staff assistance	M 412		

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with a Hoyer lift for activity. The discharge summary indicated Resident 1 had post-op restrictions for spine surgery with a duration of 12 weeks that included:
-10 pounds lifting, pushing, or pulling
-okay to resist body weight, but no trapeze,
-no repetitive bending or twisting outside of grooming/bathing

The discharge summary had incision care instructions that included:
-wash twice daily with mild soap and water
-keep incision clean and dry
-cover if there is drainage
-shower daily

A Resident Evacuation Assessment dated 12/22/2025, read in part, "...Needs full assistance from two staff means the resident requires assistance from two persons during most of the evacuation ...[Resident 1] requires one staff to push [him/her] out of the house in [his/her] wheelchair. [S/he] would need two staff to transfer [him/her] if [s/he] was not in [his/her] wheelchair."

Resident 1's undated individual service plan (ISP) did not indicate Resident 1 had post-op restrictions for spine surgery, the duration of restrictions, and what care staff were to provide. The ISP did not indicate Resident 1 had an incisional wound or specify how staff were to care for the incision. The ISP indicated Resident 1 required assistance with a full bed bath several times per week or as needed. The ISP indicated Resident 1 required full assistance with transfers but did not specify what a full assistance transfer looked like for Resident 1. The ISP read in part, "[Resident 1] is now unable to move [his/her] lower extremities and has little, but limited motion

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M 412	Continued From page 11 with [his/her] arms ...We are unaware how much [s/he] is able to assist with turning [his/herself] in bed at this time ...Due to residents inability to move extremities or reposition [his/herself], staff will toilet and reposition every two hours." The ISP indicated Resident 1 required complete assistance to evacuate the facility. On 02/06/2026 at approximately 12:00 PM, Surveyor interviewed Licensee A. Licensee A stated 2 staff could transfer Resident 1, but they preferred 4 staff to assist for safety. Licensee A stated they had practiced transferring Resident 1 with 2 staff for a fire drill. Licensee A stated they were working on getting a Hoyer lift and wheelchair ordered for Resident 1. Resident 1's ISP did not indicate post-op restrictions for spine surgery, incision wound care, or how Resident 1 should be transferred by staff. Cross Reference M0352 DHS 88.05(4)(f) Resident Incapable of Self Evacuation M0384 DHS 88.06(2)(b) Service Agreement Except Respite M0436 DHS 88.07(2)(a) Services	M 412		
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, the	M 414		

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M 414	Continued From page 12	M 414		

provider did not ensure 1 of 1 resident's individual service plan (ISPs) identified the level of supervision in the home and community.

Resident 2 had increased behaviors including multiple incidents of self-harm by cutting him/herself and was able to leave the facility whenever s/he wanted to. Resident 2's ISP did not identify a Behavioral Support Plan (BSP) to support caregivers with managing Resident 2's behaviors and did not specify Resident 2's level of supervision in the home and community.

Findings include:

On 10/15/2025, the department received a complaint related to resident services.

The provider is licensed to care for 4 residents in the client groups of: developmentally disabled, physically disabled, traumatic brain injury, alcohol/drug dependent and emotionally disturbed/mental illness.

On 02/06/2026 at approximately 10:40 AM, Surveyor interviewed Registered Nurse (RN) B. RN B stated Resident 2 had been in and out of the hospital multiple times during his/her admission, would constantly call 911, and would leave with his/her whereabouts unknown.

On 02/06/2026 at 11:02 AM, Surveyor interviewed Caregiver C. Caregiver C stated staff needed to make sure medications, sharps, and anything Resident 2 could use for self-harm was secured. Caregiver C stated Resident 2 had cut his/her wrist 1 month after admission and after that incident staff were to check on Resident 2 when s/he was downstairs in his/her room every hour. Caregiver C stated Resident 2 could come and

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M 414	Continued From page 13 go from the facility as s/he wanted. On 02/06/2026 at approximately 12:00 PM, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 07/03/2025 and discharged on 09/18/2025. Resident 2 was his/her own decision maker. Resident 2 had diagnoses that included manic depression, depression, borderline personality disorder, bipolar disorder, anxiety disorder, autistic disorder, development disorder of scholastic skills, and self-injurious behaviors. The Managed Care Organization (MCO) report dated 05/15/2025, indicated Resident 2 required overnight monitoring for self-injurious behaviors. The report indicated self-injurious behaviors would require intensive one-on-one interventions more than twice each day. A pre-admission assessment dated 07/03/2025, indicated Resident 2 lived independently with supportive care. The assessment indicated Resident 2 required minimal supervision and could be left alone for 1 to 3 hours. The assessment indicated Resident 2 was self-abusive and behaviors occurred weekly and required intervention from others for safety of persons or others. The ISP dated 07/20/2025, indicated Resident 2 needed some supervision. The ISP read in part, "[Resident 2] does not have a guardian (yet), and [s/he] can determine [his/her] day as [s/he] pleases. If [s/he] wants to go on a walkabout, or meet up with someone, [s/he] has every right to ...I do want staff to ask, can you share with me what time you expect to be back? I would need to know when to be concerned that you have arrived ...and then maybe try to find out (nicely) where	M 414		

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[s/he] is going etc. Staff should also evaluate how [s/he] is when [s/he] returns, pupils pinpoint? Dilated? Do you smell MJ (marijuana) or alcohol? Etc. Do not confront [him/her] about it, but do document this event. Should [s/he] not be back within the times [s/he] set - allow for another 10 minutes, call [his/her] phone and/or text [him/her]. If no answer - please let admin know right away ...CALL AND TEXT ADMIN [Licensee A] AND THE NURSE RIGHT AWAY ...To receive full supervision and redirection from staff to avoid and prevent wandering episodes." The ISP indicated Resident 2 required supervision and monitoring at all times to prevent and stop destructive and self-abusive behavior. The ISP indicated Resident 2 had a behavioral safety plan, but the provider did not have it at this time. The ISP indicated Resident 2 had coping skills and the provider would get them to staff in a Safe Behavior Plan. The ISP indicated Resident 2 needed assistance with shopping needs.

Surveyor reviewed the staff observation notes dated 07/04/2025 to 09/09/2025. The notes indicated Resident 2 had multiple incidents of self-harm by cutting in his/her room, suicidal ideation, agitation/aggression, intercepting online orders, and leaving the facility unsupervised. The notes indicated Resident 2 had multiple emergency room (ER) visits and hospitalizations, including 2 inpatient behavior health hospitalizations during his/her stay. On 09/09/2025, Resident 2 intercepted an online delivered order outside the facility and took it down to his/her room. Resident 2 took a whole bottle of 100 Benadryl pills and self-harmed by cutting his/her wrist. Resident 2 was hospitalized and did not return to the facility.

Surveyor reviewed emails between Licensee A

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M 414	Continued From page 15 and the Managed Care Organization (MCO) and found the following: An email from Licensee A to Case Manager (CM) E dated 08/27/2025 at 9:11 AM, indicated Resident 2 left the home a couple times for 20 minutes and came back on his/her own. The email read in part, "I do not know where [s/he] went or if [s/he] just wanted to take a walk or what. I do know as [s/he] has told me, [s/he] has a ...friend that does show up and take [him/her] for a drive whereby [s/he] smokes pot with [him/her]." Licensee went on to state this would happen about once per week. An email from CM E to Licensee A dated 08/27/2025 at 11:00 AM, indicated Resident 2 did not have a plan in place to support him/her having independent time in the community. An email from Licensee A to Case Manger (CM) E dated 09/02/2025 at 2:34 PM read in part, "With the intensity of [Resident 2's] behaviors, we need to have a BSP developed or if there is one, modified ...Without a BSP, it is likely that all staff are not supporting [Resident 2] within [his/her] needs and understanding." Licensee A responded in part, "At this time, [his/her] needs are not defined [S/he] is in a 4-bed home with one resident requiring one on one during the day, so [s/he] is in essence getting higher supervision with a 1:3 ratio ...I have told [Resident 2] that if [s/he] needs a higher supervision need that will have to come from [the managed care organization (MCO)] and not from me." Licensee A went on to state, "Keeping sharps away is almost impossible, as [s/he] is very creative and sneaky." An email from CM E to Licensee A dated	M 414		

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M 414	Continued From page 16 09/03/2025 at 10:15 AM, read in part, "The things I would like to see in the BSP include, self harm [sic], suicide ideation, definition of emergency, and elopement." An email from Licensee A to CM E dated 09/03/2025 at 1:53 PM, read in part, "Part of [his/her] behavior plan must address the impulsive decisions to change meds/reschedule appts (appointments)/make appts/ leave to go with friend and or home to [parent]. Our company policy is residents put a request on a form for overnight or day visits - also we ask for 24-48 hours of safety after hospitalizes/ER (emergency room)/UC (urgent care) visits before a resident leave the AFH (Adult Family Home)." An email from Provider Contracting Professional (PCP) F to Licensee A dated 09/17/2025 at 12:08 PM, read in part, "Additionally, our team has repeatedly requested [Resident 2's] Behavior Support Plan (BSP), which is critical to understanding what interventions have been tried and what supports may be needed moving forward. To date, we have not received this documentation. This lack of information has hindered our ability to assist in problem-solving and planning for [Resident 2's] safe return." An email from Licensee A to PCP F dated 09/17/2025 at 12:08 PM, indicated Licensee A would not be taking Resident 2 back after his/her hospitalization due to not being able to meet his/her needs. The email read in part, "Clearly, [his/her] patten of cutting and seeking admission due to 'feeling unsafe' and wanting medication changes proves that the care [s/he] was receiving was not what was needed, [s/he] has been unstable for weeks."	M 414		

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M 414	Continued From page 17 On 02/06/2026 at approximately 12:00 PM, Surveyor interviewed Licensee A. Licensee A stated Resident 2 was hard to manage and staff could not use usual interventions with him/her. Licensee A stated Resident 2 was easily triggered and spiraled quickly with his/her behaviors. Licensee A stated Resident 2 had left the inpatient behavioral hospitalization against medical advice and became a missing person through the state at one point. Licensee A stated Resident 2 needed 1:1 staff to meet his/her needs and truly was a danger to him/herself. Licensee A stated Resident 2 did not have a safety plan in place. On 02/11/2026 at 3:39 PM, Surveyor interviewed CM E. CM E stated Resident 2 would frequently elope and would come back whenever s/he wanted to. CM E stated they pleaded with Licensee A for a BSP and the BSP Licensee A sent after Resident 2's discharge did not suit his/her needs. CM E stated s/he came on Resident 2's team towards the end of his/her stay at the facility and did not get a copy of Resident 2's ISP to review prior to him/her discharging. Cross Reference M0134 DHS 88.03(5)(e)1 Significant Change To The Resident M0384 DHS 88.06(2)(b) Service Agreement Except Respite M0436 DHS 88.07(2)(a) Services	M 414		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the	M 436		

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M 436	Continued From page 18 licensee's responsibility. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the provision of individualized services for 2 of 2 residents reviewed. The provider did not have the needed durable medical equipment to meet Resident 1's needs upon admission and did not provide follow-up appointments and referrals promptly. The provider did not provide the supervision needed to meet Resident 2's needs. Findings include: On 10/15/2025 and 12/27/2025, the Department received complaints related to resident services. The provider is licensed to care for 4 residents in the client groups of: developmentally disabled, physically disabled, traumatic brain injury, alcohol/drug dependent and emotionally disturbed/mental illness. Resident 1 On 02/06/2026 at approximately 10:15 AM, Surveyor observed during a tour with Caregiver C, Resident 1 laying in a hospital bed in a double occupancy room. Caregiver C stated Resident 1 had limited mobility from the waist down and needed total care assistance from staff. Caregiver C stated they were working on getting	M 436		

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a Hoyer lift and wheelchair ordered for Resident 1.

On 02/06/2026 at 10:40 AM, Surveyor interviewed Registered Nurse (RN) B. RN B stated Resident 1 was not admitted with a Hoyer lift or wheelchair. RN B stated they currently were using a gurney sheet with 4 staff to transfer Resident 1 to a cot or to the facility's wheelchair for appointments and fire drills. RN B stated Guardian D wanted Resident 1 to have physical and occupational therapy (PT/OT). RN B stated Resident 1 had a four-hour appointment with his/her primary physician yesterday (02/05/2026) and they were working to get the equipment and PT/OT referrals s/he needed. RN B stated once they received Resident 1's equipment, they could get him/her out of the room and take him/her on community outings. RN B stated Resident 1 had 2 appointments since his/her admission, but they had to be rescheduled a couple of times.

On 02/06/2026 at approximately 12:00 PM, Surveyor requested Resident 1's record to review.

Resident 1 was admitted on 12/22/2026 and had a guardian. Resident 1 was diagnosed with closed displaced fracture of the 6th cervical vertebra with spinal cord injury status post an open reduction and internal fixation surgery, spastic diplegic cerebral palsy with intellectual disability, and nonverbal. Resident 1 had a guardian.

A pre-admission assessment completed by Licensee A on 12/15/2025, indicated Resident 1 used a mechanical lift and Broda chair for complete assistance with transfers. The assessment indicated Resident 1 would need

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numerous trips for appointments. The assessment had a note written by Licensee A which stated Resident 1 required compete care and needed 2 staff assistance with everything.

A hospital discharge summary dated 12/22/2025, indicated Resident 1 required 2 staff assistance with a Hoyer lift for activity. The discharge summary indicated Resident 1 was to have a primary care physician follow-up appointment within 2 weeks of discharge, a cervical x-ray on 01/07/2026, and neurosurgery outpatient appointment on 01/07/2026, and continue home health with physical and occupational therapy. The discharge summary indicated no durable medical equipment was needed for discharge.

Resident 1's undated individual service plan (ISP) indicated Resident 1 required full assistance with transfers but did not specify what a full assistance transfer looked like for Resident 1. The ISP did not indicate Resident 1 had home health for PT and OT.

A Resident Record Health Care Visit dated 01/20/2026, indicated Resident 1 had his/her neurosurgery follow-up appointment and ordered x-rays. The note indicated Resident 1 was 2 months post-surgery and it was okay to advance therapy and activities.

A Resident Record Health Care Visit dated 01/20/2026, indicated Resident 1 saw a physician for a wellness visit but still needed to see his/her primary physician as soon as possible. The document indicated home health PT and OT referrals were made and assessments for a Hoyer lift and wheelchair were needed.

A Resident Record Health Care Visit dated

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M 436	Continued From page 21 02/05/2026, indicated Resident 1 saw his/her primary care physician. The document had notes which indicated PT and OT referrals were made and a Hoyer lift and a wheelchair were ordered. On 02/06/2026 at approximately 12:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he knew about Resident 1's physical condition but did not realize no equipment would come with Resident 1 at discharge. Licensee A stated they did not know Resident 1 could not sit up and hold a sitting position. Licensee A stated they could not start getting equipment or make referrals for Resident 1 without Guardian D present and explained Guardian D had left right after Resident 1's admission for a vacation. Licensee A stated they did provide out of their pocket an air mattress and nebulizer machine. Licensee A stated it was a miscommunication and misunderstanding at discharge that Resident 1 would not come with the proper equipment. On 02/25/2026 at 9:24 AM, Surveyor interviewed Guardian D. Guardian D stated s/he was upset Resident 1 did not have a Hoyer lift or wheelchair to get out of bed since his/her admission. Guardian D stated s/he was under the impression this should have been taken care of prior to Resident 1's discharge from the hospital. Guardian D also stated the provider did not take Resident 1 to his/her follow-up appointments and had to reschedule them. Guardian D stated PT and OT were not started until recently. Guardian D expressed frustration with Resident 1 not receiving services promptly. Resident 1 did not have his/her durable medical equipment for transfers upon admission. Resident 1 did not get to his/her follow-up appointments and have a referral for PT and OT	M 436		

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M 436	Continued From page 22 promptly after discharge from the hospital. Resident 2 A self-report dated 09/10/2025, indicated Resident 2 had gone for a walk and intercepted an online order delivery. The report indicated Resident 2 broke a glass jar and cut his/her wrists and took 100 pills of Benadryl. Resident 2 was transported to the hospital and admitted inpatient to behavioral health. On 02/06/2026 at approximately 10:40 AM, Surveyor interviewed Registered Nurse (RN) B. RN B stated they did not expect Resident 2 to order medications online. RN B stated Resident 2 was fixated on items s/he could use for self-harm. RN B stated Resident 2 needed to be constantly monitored. On 02/06/2026 at approximately 10:50 AM, Surveyor observed, with RN B, the facility floor plan. Upon entering the facility's front entrance, the main living area with bedrooms, dining room, and kitchen were located. To the right there was a staircase leading down to a common living area. Downstairs there was also a bedroom and second bathroom. This was where Resident 2 resided while living at the facility. On 02/06/2026 at 11:02 AM, Surveyor interviewed Caregiver C. Caregiver C stated staff needed to make sure medications, sharps, and anything Resident 2 could use for self-harm was secured. Caregiver C stated Resident 2 had cut his/her wrist 1 month after admission and after that incident staff were to check on Resident 2 when s/he was downstairs in his/her room every hour. Caregiver C stated Resident 2 could come and go from the facility as s/he wanted.	M 436		

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M 436	Continued From page 23 On 02/06/2026 at approximately 12:00 PM, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 07/03/2025 and discharged on 09/18/2025. Resident 2 was his/her own decision maker. Resident 2 had diagnoses that included manic depression, depression, borderline personality disorder, bipolar disorder, anxiety disorder, autistic disorder, development disorder of scholastic skills, and self-injurious behaviors. The Managed Care Organization (MCO) report dated 05/15/2025, indicated Resident 2 required overnight monitoring for self-injurious behaviors. The report indicated self-injurious behaviors would require intensive one-on-one interventions more than twice each day. A pre-admission assessment dated 07/03/2025, indicated Resident 2 lived independently with supportive care. The assessment indicated Resident 2 required minimal supervision and could be left alone for 1 to 3 hours. The assessment indicated Resident 2 was self-abusive and behaviors occurred weekly and required intervention from others for safety of persons or others. The ISP dated 07/20/2025, indicated Resident 2 needed some supervision. The ISP read in part, "[Resident 2] does not have a guardian (yet), and [s/he] can determine [his/her] day as [s/he] pleases. If [s/he] wants to go on a walkabout, or meet up with someone, [s/he] has every right to ...I do want staff to ask, can you share with me what time you expect to be back? I would need to know when to be concerned that you have arrived ...and then maybe try to find out (nicely) where [s/he] is going etc. Staff should also evaluate how	M 436		

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M 436	Continued From page 24 [s/he] is when [s/he] returns, pupils pinpoint? Dilated? Do you smell MJ (marijuana) or alcohol? Etc. Do not confront [him/her] about it, but do document this event. Should [s/he] not be back within the times [s/he] set - allow for another 10 minutes, call [his/her] phone and/or text [him/her]. If no answer - please let admin know right away ...CALL AND TEXT ADMIN [Licensee A] AND THE NURSE RIGHT AWAY ...To receive full supervision and redirection from staff to avoid and prevent wandering episodes." The ISP indicated Resident 2 always required supervision and monitoring to prevent and stop destructive and self-abusive behavior. The ISP indicated Resident 2 had a behavioral safety plan, but the provider did not have it at this time. The ISP indicated Resident 2 had coping skills and the provider would get it to staff in a Safe Behavior Plan. The ISP indicated Resident 2 needed assistance with shopping needs. Surveyor reviewed the staff observation notes dated 07/04/2025 to 09/09/2025. The notes indicated Resident 2 had multiple incidents of self-harm by cutting in his/her room, suicidal ideation, agitation/aggression, intercepting online orders, and leaving the facility unsupervised. The notes indicated Resident 2 had multiple emergency room (ER) visits and two inpatient behavior health hospitalizations from 08/22/2025 to 08/25/2025 and 09/03/2025 to 09/06/2025. The notes indicated the following: 08/05/2025 - Resident 2 had cut both of his/her arms with a broken salsa jar and was medically evaluated. Resident 2 stated to staff about having thoughts about stealing the medication cabinet keys to access them. Resident 2 stated to staff s/he had a pill in his/her room that s/he planned to take with his/her other medications.	M 436		

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M 436	Continued From page 25 08/16/2025 - Resident 2 had cut his/herself with a broken glass jar and refused to be medically evaluated. 08/21/2025 - Resident 2 had used a broken glass jar and cut his/her arm. Resident 2 was medically evaluated and received 7 stitches. 08/26/2025 - Resident 2 ordered a cab to take him/her to a local gas station. 08/27/2025 - Resident 2 ordered a taxi to take him/her to a local gas station. 09/01/2025 - Resident 2 stated s/he had thoughts about buying medication online and ingesting them with intent of self-harm. 09/02/2025 - Resident 2 had an online order delivered to the facility which included a salsa jar. Staff confiscated the jar and put it in the refrigerator. 09/03/2025 - Resident 2 had an online order delivered to the facility which contained three 100 pill Benadryl bottles. Staff obtained the medication and secured it. Police and EMS arrived. Resident 2 ended up cutting his/her wrist with a diabetic needle and was taken in to receive medical care. 09/09/2025 - Resident 2 intercepted an online order delivered outside the facility and took it down to his/her room. Resident 2 took a whole bottle of 100 Benadryl pills and had another bottle of 100 Benadryl pills downstairs in his/her room. Resident 2 also self-harmed by cutting his/her wrist. Resident 2 was hospitalized and did not return to the facility. Surveyor reviewed emails between Licensee A and the Managed Care Organization (MCO) and found the following: An email from Licensee A to Case Manager (CM) E dated 08/27/2025 at 9:11 AM, indicated Resident 2 left the home a couple times for 20	M 436		

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	0017172	A. BUILDING: _____ B. WING _____	C 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS ADULT FAMILY HOME	218 NICHOLAS ST TOMAH, WI 54660

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minutes and came back on his/her own. The email read in part, "I do not know where [s/he] went or if [s/he] just wanted to take a walk or what. I do know as [s/he] has told me, [s/he] has a ...friend that does show up and take [him/her] for a drive whereby [s/he] smokes pot with [him/her]." Licensee went on to state this would happen about once per week.

An email from CM E to Licensee A dated 08/27/2025 at 11:00 AM, indicated Resident 2 did not have a plan in place to support him/her having independent time in the community.

An email from Licensee A to Case Manger (CM) E dated 09/02/2025 at 2:34 PM read in part, "With the intensity of [Resident 2's] behaviors, we need to have a BSP developed or if there is one, modified ...Without a BSP, it is likely that all staff are not supporting [Resident 2] within [his/her] needs and understanding." Licensee A responded in part, "At this time, [his/her] needs are not defined. She is in a 4-bed home with one resident requiring one on one during the day, so [s/he] is in essence getting higher supervision with a 1:3 ratio ...I have told [Resident 2] that if [s/he] needs a higher supervision need that will have to come from [the MCO] and not from me." Licensee A went on to state, "Keeping sharps away is almost impossible, as [s/he] is very creative and sneaky."

An email from Licensee A to CM E dated 09/02/2025 at 4:11 PM, indicated Resident 2 had his/her own debit card and would make orders online. Licensee A indicated they did not have any oversight of those things.

An email from Licensee A to CM E dated 09/04/2025 at 1:03 PM, indicated Resident 2 had been chaptered. Licensee A indicated s/he would

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not let Resident 2 come back unless s/he had a different care plan as Licensee A felt Resident 2 required 1:1 staffing care, where s/he was unable to provide.

An email from Licensee A to CM E dated 09/05/2025 at 4:34 PM, read in part, "Letting you know that at this time, we will not be taking [Resident 2] back as [s/he] is needing a higher level of care than we can provide at this time, unless something drastically changes with [his/her] care and outcomes." Resident 2 did return to the facility.

An email from Licensee A to CM E dated 09/09/2025 at 8:42 PM, indicated Resident 2 had cut his/herself with a broken glass alfredo sauce jar and took 100 pills of Benedryl s/he got from an online order delivered to the home. Resident 2 came upstairs acting like s/he was having a panic attack and told staff what s/he did. Resident 2 was transported to the hospital for medical evaluation.

An email from Licensee A to CM E dated 09/10/2025 at 10:29 AM, read in part, "I am torn over giving a 30 day [sic] notice. We cannot keep doing this every 3-6 days of cutting, overdose, hospitalization. The high communication and conflict between staff is [sic] hard to get staff to agree to work in that home due to [his/her] unrelenting needs/requests/supervision."

An email from Licensee A to PCP F dated 09/17/2025 at 12:08 PM, indicated Licensee A would not be taking Resident 2 back after his/her hospitalization due to not being able to meet his/her needs. The email read in part, "We feel that in order to keep [Resident 2], [s/he] would require dedicated staffing. If that cannot happen,

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then we would not be able to care for [sic] safely, therefore indicating an immediate notice of discharge and we cannot take him/her back ...Clearly, [his/her] patten of cutting and seeking admission due to 'feeling unsafe' and wanting medication changes proves that the care [s/he] was receiving was not what was needed, [s/he] has been unstable for weeks."

An email from Licensee A to CME dated 09/15/2025 at 3:19 PM, read in part, "I will be giving a 30 day [sic] notice by the end of the week if we can't come up with a better rate for care and supervision for [Resident 2]. [S/He] is demanding one-on-one attention one way or another, and I guess it is up to you all to decide what level of care you are looking for [him/her]."

An email from Licensee A to CM E dated 09/16/2025 at 12:32 PM, indicated Licensee A's specific reasoning to MCO why Resident 2 needed one-to-one staffing. Licensee A stated Resident 2 had 41 appointments from 07/03/2025 to 09/12/2025 with 41 new medication prescriptions during that timeframe. Licensee A stated Resident 2 had severe impulsiveness with masking of his/her feelings from staff, planned his/her cutting events and then would self-admit for behavioral health inpatient treatment, so s/he could self-discharge. Licensee A requested from MCO 5 to 12 hours of dedicated staff time during the daytime hours.

An email from CM E to Licensee A dated 09/19/2025 at 9:15 AM, indicated the MCO accepted Licensee A's involuntary discharge notice and Resident 2 did not return to the facility.

On 02/06/2026 at approximately 12:00 PM, Surveyor interviewed Licensee A. Licensee A

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stated Resident 2 had two different teams through the MCO during his/her time at the facility, which made communication difficult. Licensee A stated typically they would remove all items that could be used for self-harm for a resident at risk but made a verbal agreement with Resident 2, due to him/her being his/her own decision maker, that s/he would not use his/her personal items for self-harm. Licensee A stated Resident 2's physician ordered for his/her blood sugar to be checked once daily, and Resident 2 would use the diabetic finger pokes to "saw" on his/her arms, hiding them from staff. Licensee A stated Resident 2 was hard to manage due to him/her being his/her own decision maker, having his/her own phone, and having access to some of his/her own finances. Licensee A stated staff could not use usual interventions with Resident 2. Licensee A stated Resident 2 was easily triggered and spiraled quickly with his/her behaviors. Licensee A stated Resident 2's goal was to get committed all the time and would cut his/herself 1 to 2 times per week. Licensee A stated Resident 2 had left the inpatient behavioral hospitalization against medical advice multiple times and became a missing person through the state at one point. Licensee A stated Resident 2 needed more support, such as 1:1 staffing. Licensee A stated s/he did an emergency discharge with Resident 2 due to Resident 2 being a danger to his/herself.

On 02/11/2026 at 3:39 PM, Surveyor interviewed CM E. CM E stated Licensee A gave an involuntary notice for Resident 2 at one point but rescinded it. CM E stated they received another involuntary discharge notice for Resident 2 after his/her last hospitalization while at the facility. CM E stated Resident 2 was challenging and would not have agreed to a limitation of sharps access

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M 436	Continued From page 30 to prevent self-harm. CM E felt the provider could not support Resident 2's behaviors or collaborate as a team. The provider did not ensure Resident 2 was provided supervision when Resident 2 was able to obtain sharps and cut his/her wrists and overdose on medication without staff supervision and knowledge. Cross Reference M0134 DHS 88.03(5)(e)1 Significant Change To The Resident M0384 DHS 88.06(2)(b) Service Agreement Except Respite M0414 DHS 88.06(3)(d)2 Level Of Supervision	M 436		