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PROMISING PALS AFH	4020/4022 LONDON ROAD EAU CLAIRE, WI 54701

(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 06/20/2025, Surveyor conducted a complaint investigation and licensure survey at Promising Pals AFH. Data collection continued through 06/25/2025. The complaint was substantiated. Four deficiencies were identified. Census: 4	M 000		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or activities of the adult family home,	M 114		

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

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M 114	Continued From page 1 the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Caregiver D had a complete caregiver background check upon hire. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete caregiver background check (CBC), at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A Government Findings Report (GFR) from the Department of Health Services. On 06/20/2025 at 11:00 AM, Surveyor reviewed Caregiver D's record. Caregiver D had a hire date of 03/16/2025. Surveyor did not find a BID, DOJ, or GFR in Caregiver D's record. On 06/20/2025 at 11:05 AM, Surveyor interviewed Program Manager (PM) B and asked PM B to	M 114		

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M 114	Continued From page 2 review Caregiver D's record to find the background check documents. PM B was also unable to find background check documents in Caregiver D's record. PM B stated Licensee A may have the documents and s/he would reach out to him/her for them. On 06/23/2025 at 3:40 PM, Surveyor received an email from Licensee A. The email read, in part, "[PM B] could not find the original background check which [s/he] had done. Here is one done today." Attached to the email was a completed DOJ and GFR, dated 06/23/2025 for Caregiver D. Surveyor did not receive a completed BID for Caregiver D.	M 114		
M 218	88.04(2)(b) AWAKE STAFF FOR CONTINUOUS CARE The licensee shall ensure that he or she or a service provider is present and awake at all times if any resident is in need of continuous care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a service provider was present and awake at all times when a resident was in need of continuous care. Findings include: On 04/21/2025, the Department received a complaint alleging a resident was left unsupervised by staff. Per DHS 88, "Continuous Care" is defined as the need for supervision, intervention, or services on	M 218		

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a 24-hour basis to prevent, control and ameliorate a constant or intermittent mental or physical condition which may break out or become critical during any time of the day or night.

The provider is licensed to care for up to 4 residents in the client group of developmentally disabled.

On 06/20/2025 at 9:00 AM, Surveyor interviewed Caregiver C. When asked if any of the residents required continuous care, Caregiver C stated all the residents in the home required continuous care and 24/7 supervision. Caregiver C stated no residents were able to self-supervise. Caregiver C stated staffing was typically 1 staff on day and overnight shifts. Caregiver C stated that on the evening shift, there would be 1 to 2 staff when all the residents were home. Surveyor inquired if there had been any incidents when residents had been left at the home without staff present. Caregiver C stated an incident occurred not long ago where Resident 1 was brought back to the home and left by the transportation company without staff present. Caregiver C stated Resident 1 was nonverbal, had a feeding tube, needed staff to push his/her wheelchair, and needed staff assistance with transfers and toileting.

On 06/20/2025 at 9:40 AM, Surveyor interviewed Program Manager (PM) B. PM B stated s/he started as the PM in April 2025 but had worked at the home for approximately 3 years as a caregiver prior. Surveyor inquired about the incident that occurred with Resident 1. PM B stated the incident with Resident 1 occurred on 04/03/2025, when the transportation company dropped off Resident 1 and no staff were present in the home. PM B stated it was the transportation company's responsibility to make

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sure staff were present prior to leaving a resident at the home.

On 06/20/2025 at 11:40 AM, Surveyor reviewed Resident 1's record. Resident 1 had a guardian and the "About Me" summary read, in part, "Developmentally disabled from birth, jaw deformity and teeth loss due to being hit in the mouth at a younger age. [Resident 1] also takes medications for arthritis and osteoporosis pains. Arms are limited in movement. Non-verbal but communicates [his/her] needs." Resident 1's admission agreement indicated they would provide the following service: "Twenty four [sic] hour per day supervision by awake staff. Assistance leaving the building in the event of an emergency." The individual service plan, last reviewed on 04/02/2025, indicated Resident 1 required 24-hour supervision and was unable to make his/her needs known. The ISP indicated Resident 1 was a total assist by staff for activities of daily living (ADLs) and had a feeding tube for his/her main nutrition. Resident 1's record indicated s/he was on aspiration precautions. The ISP indicated Resident 1 needed 2 staff with a gait belt to pivot transfer and needed a Hoyer lift for transfers if only 1 staff was present.

On 06/20/2025 at 12:08 PM, Surveyor interviewed PM B again about the incident with Resident 1 on 04/03/2025. PM B stated s/he was working the day shift on 04/03/2025. PM B stated Resident 1 had left for his/her job earlier in the morning via a transportation company at approximately 9:00 AM. PM B stated s/he had taken Caregiver E and Resident 3 to his/her appointment at 11:30 AM. PM B stated Caregiver E could not drive him/herself and Resident 3 needed staff with him/her at appointments. PM B stated after s/he dropped them off s/he had to run

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to a few banks for the resident's petty cash funds. PM B stated Resident 1 typically got back to the home from work between 12:30 PM and 1:00 PM. PM B stated s/he was late getting back to the home due to traffic. PM B stated s/he received a text message from Caregiver F indicating Caregiver F had arrived for training at 1:00 PM, but Caregiver F's message did not indicate Resident 1 was at the home. PM B stated s/he let Caregiver F know s/he was running late and would be at the home shortly. PM B stated s/he had arrived at the facility at approximately 1:03 PM. When s/he arrived, Resident 1 was still sitting inside the home by the entrance and Caregiver F was in the kitchenette folding laundry. PM B stated s/he asked Resident 1 if s/he needed to use the bathroom and looked him/her over. PM B stated Resident 1 indicated s/he did not need anything. PM B stated s/he proceeded to show Caregiver F how to load Resident 1 into the van and together they went to pick up Resident 3 and Caregiver E. PM B stated s/he did not fill out an incident report and did not notify Resident 1's care team about the incident. PM B stated s/he discussed the incident with Licensee A and did not investigate any further.

On 06/23/2025 at 3:52 PM, Surveyor received an email from Licensee A describing his/her knowledge of the incident on 04/03/2025, that read, in part, "I was notified by almost my whole staff the next day. I did an investigation and discovered as you have, that [Resident 1] was dropped off by [transportation company] without checking to see if staff were present. After the investigation, it became clear that [Resident 1] was not left alone by my staff. After interviewing the manager, I was assured that no one on our staff would leave [Resident 1] alone. Since I felt [transportation company] was at fault, no one was

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notified. To prevent this from happening again, we are posting our number on the door and we have doubled checked to see that [transportation company] has a good phone number for us."

On 06/25/2025 at 10:15 AM, Surveyor interviewed Caregiver F. Caregiver F stated that on 04/03/2025 at 1:00 PM, s/he was to meet PM B at the home for training. Caregiver F stated that when s/he arrived at the home, Resident 1 was sitting inside the home by the front door with his/her coat on and no staff were present. Caregiver F stated s/he texted PM B and PM B replied back that s/he forgot about Caregiver F coming in for training. Caregiver F stated s/he was still in training and not fully working on his/her own yet. Caregiver F stated s/he did not know what to do with Resident 1, so s/he started on laundry. Caregiver F stated PM B arrived at approximately 1:30 PM and right away started to show him/her how to load Resident 1 into the van to pick up Caregiver E and Resident 3. Caregiver F stated s/he informed Licensee A about the incident and was not questioned further about it. Caregiver F stated s/he no longer worked at the home.

On 06/25/2025 at 10:44 AM, Surveyor interviewed Human Resource (HR) G from the transportation company. HR G stated that per their records, Resident 1 was dropped off at the home at 12:15 PM on 04/03/2025. HR G stated it was the provider's responsibility to inform them if a resident needed continuous supervision. HR G stated Resident 1 did not have this noted, so the driver did not know to make sure staff were present at the home when Resident 1 was dropped off. HR G stated there was no incident reports or notes indicating the provider contacted them about the incident.

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M 218	Continued From page 7 On 06/25/2025 at 10:56 AM, Surveyor interviewed Case Manager (CM) H. CM H stated Resident 1 required continuous care with staff present in the home. CM H stated s/he was not aware of Resident 1's incident on 04/03/2025 and had not been contacted from the provider about it. On 06/25/2025 at 11:24 AM, Surveyor interviewed PM B. PM B stated s/he did not inform Resident 1's care team about the incident and did not follow-up with the transportation company about the incident. PM B stated s/he thought Resident 1 had only been there for 5 to 10 minutes without staff. Surveyor informed PM B that Resident 1 was dropped off at 12:15 PM per the transportation company and had been at the home by him/herself for at least 45 minutes, until Caregiver F arrived. PM B stated s/he was "beside myself" and would never intentionally leave residents alone at home. PM B stated that to prevent this from occurring again, they posted a sign on the door for the transportation company to call if staff were not present and had Caregiver E coming in at 11:30 AM on the days Resident 1 worked. On 06/25/2025 at 3:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he found out about the 04/03/2025 incident the next day. Licensee A stated s/he spoke to all employees involved and concluded the transportation company's driver was at fault. Licensee A stated this had never happened before and s/he thought Resident 1 was left by him/herself for only 10 minutes. Licensee A stated s/he did not report the incident to Resident 1's care team. On 04/03/2025, Resident 1 was dropped off at	M 218		

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M 218	Continued From page 8 the home at 12:15 PM by the transportation company and left inside the home without staff present. Resident 1 was alone in the home for at least 45 minutes until unqualified staff, Caregiver F, arrived at approximately 1:00 PM. PM B did not arrive until between 1:03 PM and 1:30 PM.	M 218		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was clean and well-maintained. Findings include: The provider is licensed to care for up to 4 residents in the client group of developmentally disabled. On 06/20/2025, from approximately 9:20 AM to 10:20 AM, Surveyor observed the following: Bathroom with walk-in shower -The sink was cracked on the outside edge. -There were multiple floor tiles along the shower and toilet that were cracked. -There was a soft spot between the shower and	M 276		

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toilet that Surveyor could press down on with his/her foot.
-The ceiling vent was dusty.

Hallway
-The carpet outside the bathroom with the walk-in shower had a frayed area stretching from one side of the wall to the other creating a potential trip hazard.

Resident 2's bedroom
-The carpet was frayed by the bedroom's door transition creating a potential trip hazard.

Deck
-The deck ramp had dried leaves piled up on it creating a potential barrier to the emergency exit.
-The railing was loose by the stairs and coming around the deck.

Kitchenette
-The cat food and water dishes were kept on the kitchen counter for the pet cats where potentially food prep would occur.

Bathroom with whirlpool tub
-The ceiling vent was dusty.

On 06/20/2025 at 12:40 PM, Surveyor interviewed Program Manager (PM) B. PM B stated the cracked floor tiles in the bathroom with the walk-in shower had been like that since s/he started over 3 years ago. PM B stated s/he had noticed the deck railing was loose and stated only Resident 1 utilized the deck behind the home. PM B stated s/he had brought up concerns with Licensee A in the past and had hoped they would be addressed.

On 06/25/2025 at 3:00 PM, Surveyor interviewed

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M 276	Continued From page 10 Licensee A. Licensee A stated part of his/her role was to complete maintenance on the home. Licensee A stated PM B was responsible to notify him/her of any maintenance concerns for the home. Licensee A stated s/he did not know about the flooring issues in the bathroom with the walk-in shower and did not know about the deck railing being loose.	M 276		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were securely stored to prevent unauthorized access. Findings include: The provider is licensed to care for up to 4 residents in the client group of developmentally disabled. On 06/20/2025 at 12:08 PM, Surveyor observed Program Manager (PM) B access the medication	M 458		

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cabinet in the kitchenette. PM B grabbed the medication cabinet key that was kept on a wall hook right under the medication cabinet for anyone to access. When Surveyor inquired with PM B about the medication cabinet key location, s/he indicated the keys were kept there so staff would not lose them and confirmed this practice was done for both medication cabinets within the home. The home had a duplex floor plan with two kitchenettes, one on each side of the home. Surveyor went over to the medication cabinet in the kitchenette on the other side of the home and observed the medication keys were kept on a wall hook right under the medication cabinet for anyone to access.

On 06/20/2025 at 12:22 PM, Surveyor observed the bathroom with the whirlpool tub had a resident's externally applied prescription medications, nystatin powder and ointment, stored unsecured in a cabinet. Surveyor asked PM B to secure the medications in the medication cabinet.

On 06/25/2025 at 3:00 PM, Surveyor interviewed Licensee A. Surveyor shared concerns related to how the keys were being stored and managed. Licensee A stated s/he understood the concern and was thinking about implementing keypads on the medication cabinets instead of using keys.

The keys to the provider's medications were accessible to anyone in the home.