STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 04/17/2024 and 04/18/2024, The Bureau of Assisted Living, Southern Regional Office conducted a self-report review at Mystic Acres LLC, an AFH in Viola, WI. As a result of this survey, 4 violations of Chapter DHS 88 were issued. Census: 4	M 000		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 3 of 3 staff were screened for illness detrimental to residents including for tuberculosis within 90 days before the start of providing services. Findings include: This is a recite from SOD # SKJG11 dated 06/22/2021, and SOD # SKJG12 dated 09/15/2021.	M 232		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 232	Continued From page 1 On 04/17/2024 at approximately 11:25 AM, Surveyors reviewed the following staff files: Caregiver C had a date of hire of 01/11/2024. Caregiver C received a one-step tuberculosis test on 01/22/2024. The provider did not have documentation of a two-step tuberculosis test. The provider documented the tuberculosis test 11 days after hire. Caregiver D has a date of hire of 11/13/2023. Caregiver D received a one-step tuberculosis test on 11/15/2023. The provider did not have documentation of a two-step tuberculosis test. The provider documented the tuberculosis test 2 days after hire. Caregiver E has a date of hire of 12/07/2020. The provider did not have documentation of a two-step tuberculosis test. The provider did not have documentation of a tuberculosis test for Caregiver E. On 04/17/2024 at approximately 12:44 PM, Licensee A stated s/he was not aware staff had to have a two-step tuberculosis test and was not aware that the test had to be completed prior to hire and working in the facility.	M 232		
M 548	88.10(3)(a) Fair Treatment Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality. This Rule is not met as evidenced by:	M 548		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 548	Continued From page 2 Based on observation, interview and record review, the provider did not treat Resident 1 with courtesy respect and full recognition of the resident's dignity and individuality. On 04/17/2024 at 9:00 AM, Surveyor witnessed Caregiver C remove a granola bar from Resident 1's hand. Resident 1 told Caregiver C s/he had missed breakfast and wanted to eat the granola bar. Caregiver C told Resident 1 s/he could not eat food in his/her room. Caregiver C told Resident 1 s/he would need to eat the granola bar in the lower level dining room. Surveyor's witnessed Resident 1 request use of the facility phone from Manager B. Manager B did not provide Resident 1 with a phone at the time request. Resident 1 reported to Surveyors s/he felt disrespected by staff and life at facility was more restrictive than his/her recent inpatient stay at a state institution. FINDINGS INCLUDE: On 04/17/2024, Surveyor arrived at facility for a self-report review. OBSERVATION & INTERVIEWS: On 04/17/2024 at 9:00 AM, Surveyor approached Caregiver C. Caregiver C stated s/he was Resident 1's one-to-one staff and s/he was to always keep their eyes on Resident 1. Caregiver C told Surveyor s/he could stand outside Resident 1's room with the door closed during Surveyor's interview of Resident 1. Caregiver C stated Resident 1 had been admitted to the facility yesterday and came with orders for one-to-one staff as a preventative measure for self-injurious behavior. Resident 1 gave Surveyors verbal permission to enter his/her	M 548		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 548	Continued From page 3	M 548		

room. As Surveyor advanced into Resident 1's room s/he took a granola bar off the top of his/her dresser. Caregiver C approached Resident 1 and removed the granola bar from Resident 1's hand. Resident 1 verbalized to Caregiver C s/he was going to eat the granola bar because s/he had not eaten breakfast. Caregiver C reminded Resident 1 of the house rule stating residents were not to eat or drink in their rooms. Caregiver C told Resident 1 s/he could eat the granola bar in the dining room downstairs. Resident 1 stated s/he was no longer hungry. Caregiver C exited the Resident 1's room and shut the door. Resident 1 told Surveyors s/he had recently moved to the facility from an institution, and s/he found the facility to be more restrictive than the institution. Resident 1 stated at the institution s/he was allowed to eat and drink in his/her room. Resident 1 stated s/he is not allowed to eat or drink in his/her room at the facility. Resident 1 stated s/he had been asking facility staff if s/he could use a phone to call Social Worker F. Resident 1 stated the facility had cats and s/he was allergic to cats, so s/he wanted to call Social Worker F to find him/her new placement. Resident 1 stated s/he was told by facility staff s/he could not use the phone because s/he needed permission to do that. Resident 1 began to cry, his/her respirations increased above 20 respirations per minute and his/her verbal tone became increasingly labile. Resident 1 stated s/he was in the middle of the hills where s/he did not know anyone, and s/he could not even use a phone. Resident 1's gaze became fixated on his/her bedroom window facing the county highway outside of the facility. Resident 1 stated s/he was going to hurt himself/herself. Resident 1 stated s/he was going to runaway down the road. Resident 1 did not answer Surveyors attempts to identify if Resident 1 wanted to runaway down the road with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 548	Continued From page 4	M 548		

intention to hurt themselves or elope. Resident 1 asked Surveyor what would happen is s/he went down the road. Surveyor told Resident 1 the facility would need to call 911 because s/he would be in danger of physical harm from the vehicles on the road. Resident 1's verbalizations remained labile, hands remained clenched, and respirations remained uneven. Surveyor opened the door and told Caregiver C to get Manager B and/or Licensee A to Resident 1's room. Manager B came into Resident 1's room and shut the door. Resident 1 told Manager B s/he was going to hurt himself/herself. Resident 1 told Manager B s/he was going to start walking down the road and Manager B could just call the police. Manager B used therapeutic communication, breathing exercises, and re-assurance to help Resident 1 return to a euthymic state. As Resident 1's respirations began to decrease s/he told Manager B, "I just got out of the institute I'm supposed to be done with taking my pills, eating and lying in bed all day." Manager B empathized with Resident 1's concerns. Manager B told Resident 1 s/he emailed Resident 1's care team yesterday to discuss Resident 1's issues with the cats. Resident 1 asked to use a phone. Manager B told Resident 1 s/he needed Social Worker F's approval to use the phone. Surveyors exited the room.

On 04/17/2024 at 9:45 AM, Surveyor spoke with Social Worker F on the phone. Social Worker F identified himself/herself as Resident 1's social worker. Social Worker F stated s/he had received an email from the facility the day before stating Resident 1 was having issue adjusting to facility. Social Worker F stated Resident 1 required one-to-one staff supervision. Social Worker F stated Resident 1 did not have any court-ordered or medically ordered restrictions on phone usage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 548	Continued From page 5 Social Worker F stated Resident 1 did not have any medically ordered food restrictions in place. Social Worker F verified Resident 1 was admitted to the facility on 04/15/2024. On 04/17/2024 at 9:50 AM, Surveyor spoke with Manager B. Manager B stated s/he would report Caregiver C taking the granola bar from Resident 1 to Licensee A. Manager B verified per house rules residents are not to eat/drink or store food/beverages in their rooms. Manager B stated Resident 4 had a history of calling 911 with false allegations; and that was the reason facility did not have phones in resident common areas. Manager B stated staff carry the facility phone. Manager B stated residents are to request the facility phone from staff. Manager B stated if the resident states s/he is calling a guardian or legal representative s/he will have unlimited access to the phone. Manager B stated if a resident requests a personal phone call, then staff are to keep the resident restricted to 2 phone calls a week which do not exceed the 15-minute time limit. Manager B stated s/he wasn't directly involved in Resident 1's admission to the facility so s/he did not know if Resident 1 had a phone restriction. Manager B stated previously residents had been admitted to the facility with directives on phone usage. On 04/17/2024 at 10:30 AM, Surveyors discussed the above incident with Licensee A and Manager B. Manager B stated s/he gave Resident 1 the granola bar to eat in his/her room because Resident 1 had not eaten breakfast. Manager B stated Resident 1 had unlimited access to the fruit items on the dining room table; but Resident 1 did not have access to any other forms of nutrition at that time. Manager B stated Caregiver C admitted to taking the granola bar from	M 548		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 548	Continued From page 6	M 548		

Resident 1's hands. Manager B stated Caregiver C believed s/he had to enforce the house rule. Manager B and Licensee A acknowledged Caregiver C did not treat Resident 1 with courtesy or respect when s/he took a food item out of Resident 1's hands. Manager B and Licensee A acknowledged Resident 1 was still adjusting to the facility, Resident 1 was on medications which may cause stomach upset if taken without food, and agitation is a common symptom of hunger. Manager B and Licensee A acknowledged adequate access to nutrition is imperative to resident wellbeing. Licensee A stated Resident 1 was admitted to the facility on 04/15/2024; and the facility was still creating a care plan/facesheet for Resident 1.

RECORD REVIEW:

On 04/17/2024, Surveyor reviewed Resident 1's comprehensive admission assessment completed by Licensee A on 11/20/2023. Licensee A listed Resident 1's primary diagnoses as but not limited to: schizoaffective disorder and post-traumatic stress disorder. Licensee A documented Resident 1 had access to a working phone and had a history of calling 911. No, dietary restrictions were documented in the comprehensive admission assessment.

On 04/17/2024, Surveyor reviewed Resident 1's physician orders as of 04/08/2024. No, physician orders related to dietary restrictions were listed.

On 04/17/2024, Surveyor reviewed facility program statement. The following is documented, "Family Contacts [Facility Name] will encourage each client to have family contact. [Facility Name] will provide 2 calls every week for 15-minutes each call...Meals/Food [Facility Name] will serve

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 548	Continued From page 7 all meals in the dining room area, all food and drinks will stay in the dining room and will not be taken to the client's room." On 04/17/2024, Surveyor reviewed a document titled, "Rules of Mystic Acres,". The following is documented, "No, cellphones allowed in the homes, if any residents come with phones with must turn them in, they will receive them back upon discharge. Unless there is a specific plan in place." On 04/19/2024 at 11:09 AM, Licensee A sent Surveyor an email. Attached to the email was documentation related to the above incident. "Regarding incident that took place on April 17th, 2024, a staff member was working with [Resident 1], [Resident 1] requested something to eat as [s/he] didn't eat breakfast, [Manager B] took a granola bar to [his/her] room, [his/her] one on one staff [Caregiver C] had taken that away due to following the house rules of no eating in their rooms at that time, [Manager B] talked to [Caregiver C] to explain that [s/he] was allowed to have the bar to eat in [his/her] room, this situation was resolved. [Resident 1] was asking to use the phone, [Manager B] told [Resident 1] that [s/he] needed to wait to use the phone as [Manager B] didn't have [his/her] number at that time and was unsure who [s/he] could call and not call due to [Resident 1] just moving in on Monday April 15th, 2024, and [Manager B] was able to redirect [Resident 1] at that time. [Licensee A]." CROSS REFERENCE M0586 DHS Chapter 88.10(3)(s) Telephone Calls	M 548		
M 570	88.10(3)(l) Safe Physical Environment	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 570	Continued From page 8 Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure a safe environment for 4 of 4 residents residing at the facility. Findings include: On 04/17/2024 at approximately 8:32 AM, Surveyors toured the facility and observed the following: 1.) The cabinet above the toilet was pulling out of the wall. The top of the cabinet was no longer secured to the wall. 2.) There were trim pieces in the dining room that had nails sticking out of the trim. 3.) There were wires sticking out of the kitchen wall in 4 separate locations. One set of wires had bare wires exposed. 4.) There were flammables within 3 feet of the furnace which included cardboard boxes and pails.	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 570	Continued From page 9 On 04/17/2024 at approximately 12:50 PM, Surveyors interviewed Manager B. Manager B stated the facility started remodeling about two weeks ago. Manager B stated the construction was supposed to take a week and was not sure when it would be completed. Manager B agreed there were hazards left around the house and stated s/he had just gotten back from vacation and had not had time to address the hazards yet.	M 570		
M 586	88.10(3)(s) Telephone Calls Telephone calls. To make and receive a reasonable number of telephone calls of reasonable duration and in privacy. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure residents were able to make and record a reasonable number of telephone calls for reasonable duration and in privacy. On 04/17/2024 at 9:00 AM, Surveyor's witnessed Resident 1 request use of the facility phone from Manager B. Manager B did not provide Resident 1 with a phone at the time request. On 04/17/2024 at 9:50 AM, Manager B stated provider did not have any phones available in resident common areas. Manager B stated residents are to request use of the phone from staff. Manager B stated residents have unlimited access legal calls but are limited to 2 fifteen-minute personal calls per week. Manager B denied residents having access to a telephone without staff assistance.	M 586		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 586	Continued From page 10 On 04/17/2024, Surveyor reviewed provider's program statement which stated residents are provided 2 personal fifteen-minute phone calls each week. On 04/17/2024, Surveyor reviewed provider's house rules which state all residents are to turn in personal cellular phones upon admission to be secured by staff and will be returned to the resident upon discharge. FINDINGS INCLUDE: On 04/17/2024, Surveyor arrived at facility for a self-report review. OBSERVATION & INTERVIEWS: On 04/17/2024 at 9:00 AM, Surveyors interviewed Resident 1 in his/her room. Resident 1 told Surveyors s/he had recently moved to the facility from an institution, and s/he found the facility to be more restrictive than the institution. Resident 1 stated s/he had been asking facility staff if s/he could use a phone to call Social Worker F. Resident 1 stated the facility had cats and s/he was allergic to cats, so s/he wanted to call Social Worker F to find him/her new placement. Resident 1 stated s/he was told by facility staff s/he could not use the phone because s/he needed permission to do that. Resident 1 began to cry, his/her respirations increased above 20 respirations per minute and his/her verbal tone became increasingly labile. Resident 1 stated s/he was in the middle of the hills where s/he did not know anyone, and s/he could not even use a phone. Resident 1's gaze became fixated on his/her bedroom window facing the county highway outside of the facility. Resident 1 stated	M 586		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 586	Continued From page 11	M 586		

s/he was going to hurt himself/herself. Resident 1 stated s/he was going to runaway down the road. Resident 1 did not answer Surveyors attempts to identify if Resident 1 wanted to runaway down the road with the intention to hurt themselves or elope. Resident 1 asked Surveyor what would happen is s/he went down the road. Surveyor told Resident 1 the facility would need to call 911 because s/he would be in danger of physical harm from the vehicles on the road. Resident 1's verbalization remained labile, hands remained clenched, and respirations remained uneven. Surveyor opened the door and told Caregiver C to get Manager B and/or Licensee A to Resident 1's room. Manager B came into Resident 1's room and shut the door. Resident 1 told Manager B s/he was going to hurt himself/herself or s/he was going to start walking down the road and Manager B could just call the police. Manager B used therapeutic communication, breathing exercises, and re-assurance to help Resident 1 return to a euthymic state. As Resident 1's respiratory rate began to decrease s/he told Manager B, "I just got out of the institute I'm supposed to be done with taking my pills, eating and lying in bed all day." Manager B empathized Resident 1 was adjusting to a new home and that process can be stressful. Manager B told Resident 1 s/he emailed Resident 1's care team yesterday to discuss Resident 1's issue with the cats. Resident 1 asked to use a phone. Manager B told Resident 1 s/he needed Social Worker F's approval to use the phone. Surveyors exited the room.

On 04/17/2024 at 9:45 AM, Surveyor spoke with Social Worker F on the phone. Social Worker F identified himself/herself as Resident 1's social worker. Social Worker F stated s/he had received an email from the facility the day before stating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 586	Continued From page 12 Resident 1 was having issue adjusting to facility. Social Worker F stated Resident 1 required one-to-one staff supervision. Social Worker F stated Resident 1 did not have any court-ordered or medically ordered restrictions on phone usage. On 04/17/2024 at 9:50 AM, Surveyor spoke with Manager B and Licensee A. Manager B stated facility a resident had a history of calling 911 with false allegations. Manager B told Surveyors facility did not keep a phone in any resident common areas due to Resident 4's history calling in false allegations to emergency services. Manager B stated staff keep the facility phone in the locked staff office or staff carry the facility phone on their person. Manager B stated residents are to request the facility phone from staff. Manager B stated if the resident asks staff to call a guardian or legal representative s/he will have unlimited access to the phone. Manager B stated if a resident requests a personal phone call, that staff are to keep the resident restricted to 2 personal phone calls a week which did not exceed the 15-minute time limit. Manager B stated s/he wasn't directly involved in Resident 1's admission to the facility, so s/he did not know if Resident 1 had a phone restriction. Manager B stated previously residents have been admitted to the facility with restrictions phone usage. On 04/17/2024 at 10:30 AM, Surveyors discussed the above incident with Licensee A and Manager B. Licensee A and Manager B acknowledged Resident 4 had documented restrictions to phone access. Licensee A and Manager B acknowledged Resident 1, Resident 2, and Resident 3 did not have documented restrictions to phone access. Licensee A and Manager B acknowledged Resident 1, Resident 2, and Resident 3 being forced to identify to staff who	M 586		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 586	Continued From page 13	M 586		

they are calling is not honoring their resident right to privacy. Licensee A and Manager B acknowledged residents are not permitted to keep their personal cellular phone while living at facility. Manager B and Licensee A acknowledged a time limit of 30 minutes a week for personal phone calls was not adeqaute for promoting resident independence.

RECORD REVIEW:

On 04/17/2024, Surveyor reviewed Resident 1's comprehensive admission assessment completed by Licensee A on 11/20/2023. Licensee A listed Resident 1's primary diagnosis as but not limited to schizoaffective disorder and post-traumatic stress disorder. Licensee A documented Resident 1 had access to a working phone and had a history of calling 911.

On 04/17/2024, Surveyor reviewed facility program statement. The following is documented, "Family Contacts [Facility Name] will encourage each client to have family contact. [Facility Name] will provide 2 calls every week for 15-minutes each call."

On 04/17/2024, Surveyor reviewed a document titled, "Rules of Mystic Acres,". The following is documented, "No, cellphones allowed in the homes, if any residents come with phones with must turn them in, they will receive them back upon discharge. Unless there is a specific plan in place."

On 04/18/2024, Surveyor reviewed Resident 2's individualized care plan (ISP). Resident 2 was admitted to the facility on 11/10/2021. Phone restrictions were not listed in Resident 2's ISP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009734	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC ACRES LLC	12878 CTY ROAD I VIOLA, WI 54664

(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 586	Continued From page 14 On 04/18/2024, Surveyor reviewed Resident 3's ISP. Resident 3 was admitted to the facility on 08/16/2012. Phone restrictions were not listed in Resident 3's ISP. On 04/19/2024 at 11:09 AM, Licensee A sent Surveyor an email. Attached to the email was documentation related to the above incident. "Regarding incident that took place on April 17th, 2024, a staff member was working with [Resident 1], [Resident 1] requested something to eat as [s/he] didn't eat breakfast, [Manager B] took a granola bar to [his/her] room, [his/her] one on one staff [Caregiver C] had taken that away due to following the house rules of no eating in their rooms at that time, [Manager B] talked to [Caregiver C] to explain that [s/he] was allowed to have the bar to eat in [his/her] room, this situation was resolved. [Resident 1] was asking to use the phone, [Manager B] told [Resident 1] that [s/he] needed to wait to use the phone as [Manager B] didn't have [his/her] number at that time and was unsure who [s/he] could call and not call due to [Resident 1] just moving in on Monday April 15th, 2024, and [Manager B] was able to redirect [Resident 1] at that time. [Licensee A]." CROSS REFERENCE M0548 DHS Chapter 88.10(3)(a) Fair Treatment	M 586		