STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018403	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING 2 A TOUCH OF HOME	612 E 25TH ST MARSHFIELD, WI 54449

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N 000	Initial Comments On 01/06/2025, Surveyor conducted a complaint investigation at Serenity Living 2 A Touch of Home. Additional information was gathered through 01/16/2025. As a result of the visit, two (2) new deficiencies were identified and the complaint was substantiated. Census: 8	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, after receiving an allegation of abuse, the provider did not take steps to immediately protect the safety of all residents or conduct a thorough investigation	N 158		

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

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N 158	Continued From page 1 into the allegations to determine if misconduct occurred that required reporting to the Department's Office of Caregiver Quality (OCQ) within 7 days. On 10/07/2025, the provider received a written allegation from Power of Attorney (POA - legal decision maker for health care) B for Resident 1, reporting Caregiver A physically and verbally abused Resident 1 by yelling at, hitting and pulling his/her hair. The provider did not conduct an investigation and Caregiver A continued to work with residents. The provider did not initiate an investigation or suspend Caregiver A until 3 months later on 01/06/2025 (after Surveyor's onsite visit.) The investigation did not include interviews with Resident 1 or POA B about the specific allegations of abuse. The provider subsequently terminated Caregiver A due to "verbal aggression" but did not report the incident to the OCQ. Findings include: The provider is licensed to care for up to 8 residents who may be advanced aged, terminally ill, emotionally disturbed/mental illness, physically disabled, irreversible dementia/Alzheimer's and/or developmentally disabled. On 09/11/2024, the Department received a complaint alleging caregiver abuse to residents. On 01/06/2025, Surveyor interviewed Caregiver E. S/he stated " ...[Caregiver A] is really mean. [S/he] has that tone in [his/her] voice ...[s/he] is nice during shift change, but then ...they say that [Caregiver A] was yelling and being mean." Caregiver E said Resident 1 told him/her " ... [Caregiver A] was screaming at [him/her] at the	N 158		

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top of [his/her] lungs and hit [him/her] ..." Caregiver E said s/he notified Manager C about Resident 1's reports of abuse and Manager C was dismissive and said Resident 1 has dementia.

On 01/06/2025 at 12:22 PM, Surveyor interviewed Manager C. S/he stated, "We have had some issues with [Caregiver A] before ...complaints ...voice being more mean or rough." Manager C stated s/he spoke with Caregiver A and told him/her to "make sure you are being pleasant and kind." Manager C said s/he had been notified of Caregiver A being, "mean to [residents]" and stated "It is messy." Manager C said Resident 2 also reported concerns about Caregiver A's "tone" in November 2024. Manager C stated, "[Caregiver A] is on the radar with [Owner D]." Manager stated there was a period of time where Caregiver A was not scheduled due to his/her choice to not "take hours," but otherwise was regularly scheduled to work and was never terminated previously. Surveyor requested documentation of aforementioned grievances/complaints and asked if the allegations were investigated. Manager C said, "Not officially ...I just report it to [Owner D]. I guess to your answer, no ...we handle how it goes."

On 01/06/2025 at 1:20 PM, Surveyor interviewed Resident 1. S/he stated Caregiver A "pushes me into the wall" while s/he is receiving incontinence cares in the bed. S/he has told Caregiver A that s/he is "hurting me." Resident 1 stated Caregiver A responded with, "Deal with it." S/he described one incident where Caregiver A said to Resident 1, "You are nothing but a son of a [explicit]." Resident 1 stated it "made me feel like I am not wanted." Resident 1 stated, "I hate to see

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[him/her] come," and that s/he feels "disappointed" when Caregiver A is working. Resident 1 told Surveyor, "Get [Caregiver A] out of here."

On 01/06/2025 at 1:30 PM, Surveyor interviewed POA B for Resident 1. S/h]e recalled Resident 1 reported Caregiver A abused him/her and s/he sent an email informing Manager C.

On 01/07/2025, POA B provided the email s/he sent to Manager C on 10/07/2024. POA B noted s/he never received confirmation an investigation occurred or any actions the provider took to ensure Resident 1's safety.

The 10/07/2024 email read in part, " ...I hate to be the one to complain about [Caregiver A], but I just got here to visit ...and [Resident 1] immediately broke down crying saying that over the weekend [Caregiver A] had yelled at [him/her], hit [him/her] on [his/her] legs and back and pulled [his/her] hair. I'm not happy at all to hear this ...Especially after having issues with [Caregiver A] in the past... I understand that you may be short staffed but something needs to be done about this ... [sic-all]"

On 10/08/2024, Manager C sent an email response to POA B which read, " ...Thank you for reporting to us. We cannot fix things if we don't know ...I don't have an immediate response but want you to know that we are reviewing things and investigating things. And will get back to you ...[sic-all]"

On 01/15/2025, Surveyor reviewed Resident 1's facility record including his/her individual service plan updated 05/30/2024. Resident 1 was elderly and admitted on 01/14/2022. S/he had diagnoses

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to include dementia, anxiety, and recurrent depressive disorders. Resident 1 was bedbound and required staff assistance with all positioning needs. Resident 1 did not use the toilet and needed incontinence checks/care every 2 hours and assistance with activities of daily living. Resident 1 was receiving hospice services since at least May of 2024.

On 01/15/2025, Surveyor reviewed staff schedules provided by Manager C on 01/07/2025 and 01/14/2025 from October, November, and December 2024. Surveyor noted Caregiver A was regularly scheduled to work both before and after the allegations of abuse:

October 2024:
-- 19 shifts including the 3 days immediately preceding Resident 1's allegations of abuse
-- 10/5/2024 7:00pm - 7:00am
-- 10/06/2024 9:00pm-6:30am
-- 10/07/2024 11:30pm-7:00am

November 2024:
-- 21 shifts

December 2024:
-- 25 shifts

On 01/06/2025, Surveyor sent an email to Manager C and Owner D requesting documentation of disciplinary actions and grievances regarding Caregiver A. On 01/08/2025, Manager C responded, " ... [Caregiver A] has had several complaints against him/her from staff and residents. Most of which were small complaints of being short, snippy, rude, and tired. All concerns were addressed and brought to us. When they came up, we would discuss with [him/her] verbally the importance of

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residents to feel safe, respected and loved. And we were there to take care of them in their home. We have explained that no matter how [s/he] feels should could not come across gruff and snippy or short. (We unfortunately sadly, have no documentation of these verbal conversations) ...Due to [him/her] having several verbal conversations and warnings, [s/he] been on [Owner D's] radar and keeping close wraps on [him/her] as a disciplinary action ...Upon learning of the several more complaints against [Caregiver A], an investigation was started as of Monday Afternoon. Interviews with residents in the home as well as staff were conducted into yesterday. The results of our interviews lead us to the decision to permanently relieve [Caregiver A] of his/her position ...[sic-all]."

On 01/09/2025, Manager C sent an email to Surveyor which read in part, " ...To just make this clear, we opened this investigation by the OVERALL GENERAL feeling of the home after you left the facility on 1/6/25 ...I am gonna be honest with you, I am beyond sickened by this investigation, but I am happy it is dealt with and we are moving forward ..." The email contained documents titled, "[Caregiver A] 1.6.25" and "[Caregiver A] termination letter 1.8.25" which read in part,

"Complaint: After State was present in the building on 1/6/25 ...OVERALL IN GENERAL there was staff and residents that were upset about [Caregiver A] ...started complaining of not wanting [his/her] back to work there anymore ... [Caregiver A] is being rude and verbally not nice to residents and staff ...Residents are very stressed about ...[Caregiver A] coming into work ...

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N 158	Continued From page 6 Immediate Actions Taken: On Afternoon of 1/6/25 [Manager C] alerted [Owner D] of the OVERALL complaints of [Caregiver A] being rude and verbally not nice to staff and residents ...[Manager C] removed [Caregiver A] from the schedule moving forward until further direction from the owner ... INVESTIGATION Resident Interviews: [Resident 3] - "there is a staff member there that is mean ...I don't like it when [Caregiver A] works" [Resident 2] -"[s/he] is always cranky and rude and don't like me" ... [Resident 4] - " ...There is a staff here that I don't like ...[s/he] is always cranky and running around rushing" ... [Resident 1] ...No questions asked to [him/her] as [s/he] is hospice and hallucinates ... Staff Interviews: [Caregiver F] - " ...[s/he] was rude ...all of the residents have complained to me abt [sic] [Caregiver A] numerous times." [Caregiver E] - "Very rude to residents and staff Yells [sic] at residents Swears a lot Verbally aggressive towards staff & residents" [Caregiver G] - " ...they said [s/he] was mean to them" Decision of Complaint - "The owner decided ...in order to provide a safe environment and protect	N 158		

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the rights of residents ...terminating [Caregiver A] ...effective immediately 1/8/25."

Follow-up Actions - "1/8/25 ...follow up for state visit to [Surveyor] ...to alert [Surveyor] of the OVERALL feeling/complaint since [s/he] left building ...Termination Letter sent to [Caregiver A] ...1/8/25 ...staff notified that [Caregiver A] is not allowed ...at facility and not to be in contact with them ...[sic-all]"

The document did not contain the following:

-- Documentation of interviews with Resident 1 and/or POA B about their specific allegations of verbal and physical abuse, or any written response to POA B after the 10/08/2024 written complaint/grievance was filed.
-- The time, date, and place that the interviews occurred.
-- Documentation a misconduct incident report was submitted to the OCQ.
-- Conclusion of whether or not abuse occurred.

"[Caregiver A] termination letter 1.8.25" read in part:

"Upon opening an investigation into complaints made against you, we have decided that we have no choice but to terminate your employment ...affective January 8, 2025 ...based on multiple accusations of verbal aggression, we cannot ...continue your employment ...Verbal Aggression is unfair to residents and goes against our resident rights and fair treatment policy ...[sic-all]."

On 01/16/2025, Surveyor interviewed Manager C and Owner D. Manager C acknowledged receiving an email from A-POA B in October regarding concerns of verbal and physical abuse

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N 158	Continued From page 8 by Caregiver A. Manager C stated "[Hospice H] looked into it" and that "before I could get to the complaint ...[Hospice H] had talked to [A-POA B]" but was unable to provide a specific timeframe or documentation that it had occurred. Manager C and Owner D ultimately acknowledged an investigation into allegations of abuse were not investigated or documented. SURVEYOR NOTE: According to the DHS "WISCONSIN BACKGROUND CHECK AND MISCONDUCT INVESTIGATION PROGRAM MANUAL" revised 01/2024, "All entities regulated by DQA must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include: Collecting and preserving any physical and documentary evidence...; Interviewing alleged victims and witnesses; Collecting other corroborating/disproving evidence; Involving other regulatory authorities who can assist (e.g., local law enforcement, elder abuse agency, Adult Protective Service agency, DQA, Board on Aging Ombudsmen, Client Right's Specialist, etc.); and Documenting each step taken during the internal investigation. These steps should be taken as part of the entity's initial attempt to determine what, if anything, happened and to determine the complete factual circumstances surrounding the alleged incident." https://www.dhs.wisconsin.gov/publications/p0/p00038.pdf	N 158		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b)	Z 010		

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Z 010	Continued From page 9 indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interview, the facility did not contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction, after information obtained during Caregiver A's background check revealed a conviction of Disorderly Conduct (state statute 947.01) during the previous 5 years.	Z 010		

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Z 010	Continued From page 10 Findings include: On 09/11/2024, the department received a complaint alleging caregiver abuse. Following Surveyors request, on 01/14/2025, Manager C emailed Caregiver I's employee background information disclosure form and the Department of Justice (DOJ) criminal background check. Surveyor noted the following: -- Caregiver I began employment on 10/15/2023. -- The provider obtained background check results on 10/02/2023. -- DOJ report documented a conviction for 947.01(1) on 02/03/2020. -- The date of conviction was less than 5 years from the date the provider obtained he information from the DOJ. On 01/15/2025, Surveyor emailed Manager C and Owner D requested the criminal complaint and judgement of conviction associated with Caregiver I's conviction for disorderly conduct. Manager C and Owner D did not provide the requested documentation and requested to discuss with Surveyor on 01/16/2025. On 01/16/2025 at 10:00 AM, Surveyor interviewed Manager C and Owner D. Owner D acknowledged that Caregiver I's DOJ report documented a disorderly conduct conviction within the last 5 years but stated an attempt was not made to obtain the criminal complaint and judgement of conviction. Owner D stated they will revise their current practice to include this step in the future.	Z 010		