STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016062	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD ADULT FAMILY HOME	1111 GAMMON LN MADISON, WI 53719

(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 04/09/2024, Surveyor conducted a complaint investigation at Concord Adult Family Home, an AFH located in Madison, WI. As a result of the investigation, 1 violation of Chapter DHS 88 was issued. The complaint was substantiated.	M 000		
M 440	88.07(2)(b)1 SUPERVISNG & ASSISTING WITH ADLS Supervising or assisting a resident with or teaching a resident about activities of daily living. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure proper supervision appropriate for Resident 1's needs resulting in Resident 1 sustaining a large bruise on his/her right thigh and a cut on his/her right lower leg. Findings include: On 04/09/2024, Surveyor conducted a complaint investigation that alleged Resident 1 sustained injuries at the facility on or around 02/15/2024. On 04/09/2024 at approximately 8:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 09/07/2023 with diagnoses including paranoid schizophrenia, Huntington's disease and dementia. Resident 1 had a legal guardian. Resident 1's record included a "Pre-Admission	M 440		

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
	0016062	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD ADULT FAMILY HOME	1111 GAMMON LN MADISON, WI 53719

(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 440	Continued From page 1	M 440		

Assessment" that had vitals listed, but no additional information.

On 04/09/2024 at approximately 8:40 AM, Surveyor interviewed Licensee A, who stated s/he took back ownership recently due to the former owner not wanting to continue. Licensee A stated s/he was not provided documentation of Resident 1's needs initially, and assumed Resident 1 was "independent" with self-cares. Licensee A stated it wasn't until after Resident 1's elopement in 09/2023 that s/he received a "Watts Review" for Resident 1's guardianship in the mail, which documented the following:

The Watts Review for Resident 1 documented the following: "To ensure [his/her] health and safety, Resident 1 continues to need continuous support and supervision. This need has only increased in the past few months. Beyond depending on assistance for many personal cares and all daily living activities, Resident 1 has compromised cognition related to [his/her] mental health challenges and dementia. S/he is also at risk for falls and elopement."
- " ...Exit seeking and elopement have been longstanding concerns for Resident 1. Continual monitoring has been and remains integral to his/her welfare."

On 04/09/2024 at 9:00 AM, Surveyor reviewed Resident 1's Individual Service Plan (ISP) dated 09/07/2023. Resident 1's ISP indicated that s/he needed 24 hour supervision due to being an elopement risk and a fall risk. ISP indicates that Resident 1 needs total assistance with bathing, needs cuing for dressing, grooming and toileting.

On 04/09/2024 at 9:30 AM, Surveyor interviewed Licensee A. Licensee A stated since Resident 1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016062	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD ADULT FAMILY HOME	1111 GAMMON LN MADISON, WI 53719

(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 440	Continued From page 2	M 440		

return to the provider's home, there were increased levels of 24 hour supervision of Resident 1 and alarmed all the exit doors.

Documentation received from outside sources dated 03/05/2024 indicate that the facility served Resident 1 a 30 day involuntary discharge notice and Resident 1 was discharged 02/15/2024. On 2/15/2024, the accepting facility found substantial bruising on Resident 1's right upper leg (see photo). The bruising nearly covered Resident 1's entire upper leg.

On 04/09/2024 at 10:00 AM, Licensee A provided a documented investigation regarding Resident 1's injury. Former Manager B stated that s/he did not know how Resident 1 sustained the injury despite the increased supervision. Former Manager B wrote that Resident 1 was diagnosed with Huntington's disease and had involuntary movements striking his/her legs. Licensee A agreed that the extent of the bruising would not be the result of involuntary movements of Resident 1's hands.

On 04/09/2024 at 10:30 AM, Surveyor interviewed Licensee A again. Licensee A acknowledged that Resident 1 was an elopement risk and a fall risk which required 24 hour supervision. Licensee A stated that Resident 1 did not have any witnessed falls during his/her stay. Licensee A acknowledged that it was possible that Resident 1 had an unwitnessed fall but did not tell anyone. Licensee A stated that Resident 1 attends a day program during the week, Monday through Friday (7:30 AM to 3 PM). Licensee contacted the day program regarding any incidents involving Resident 1. Day Program told Licensee A that there were no documented incidents involving Resident 1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016062	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD ADULT FAMILY HOME	**1111 GAMMON LN MADISON, WI 53719**

(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 440	Continued From page 3 Summary: Resident 1 sustained an injury of extensive bruising to right upper leg of unknown origin. Resident 1 required 24 hour supervision due to being an elopement risk and fall risk. Facility did not provide sufficient supervision appropriate to Resident 1's needs.	M 440		