STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTHEWS OF SAINT FRANCIS II	3620 E DENTON ST SAINT FRANCIS, WI 53235

(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
{N 000}	Initial Comments On 06/20/2024, Surveyors completed a verification visit and 4 complaint investigations at Matthews of Saint Francis II. As a result, the five previous deficiencies were corrected, and three new deficiencies were identified. Two complaints were unsubstantiated, and two complaints were substantiated. Under statutory provisions of Wis. Stat. CH. 50, a $200 revisit fee will be assessed. Census: 13	{N 000}		
N 327	83.31(4)(b) Allowable reasons for involuntary discharge. Discharge or transfer initiated by CBRF. Reasons for involuntary discharge. The CBRF may not involuntarily discharge a resident except for any of the following reasons: 1. Nonpayment of charges, following reasonable opportunity to pay. 2. Care is required that is beyond the CBRF ' s license classification. 3. Care is required that is inconsistent with the CBRF ' s program statement and beyond that which the CBRF is required to provide under the terms of the admission agreement and this chapter. 4. Medical care is required that the CBRF cannot provide. 5. There is imminent risk of serious harm to the health or safety of the resident, other residents or employees, as documented in the resident ' s record. 6. As provided under s. 50.03 (5m), Stats. 7. As otherwise permitted by law. This Rule is not met as evidenced by:	N 327		

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

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Based on record review and interview, the provider issued a 30-day discharge notice to 1 of 1 resident (Resident 8) for reasons other than nonpayment of charges, inconsistency with the provider's program statement, care concerns, as provided under s. 50.03(5)(m) or as permitted by law. On 02/16/2024, Resident 8 was not allowed to return to the facility.

Findings include:

This facility is licensed as a class CNA (non-ambulatory) CBRF able to serve up to 20 residents within client groups of advanced aged, terminally ill, developmentally disabled, irreversible dementia/Alzheimer's, physically disabled and traumatic brain injury.

On 02/19/2024, the department received 2 complaints alleging the facility would not allow Resident 8 to return from the hospital.

On 05/15/2024, at approximately 10:00 AM, Surveyors reviewed the resident roster. Resident 8's name was crossed off from the list.

On 05/15/2024, at approximately 10:15 AM, Surveyors interviewed Regional Director (RD) M. RD M confirmed Resident 8 did not reside in the facility. RD M reported Resident 8 was sent to the hospital and the facility refused to allow Resident 8 to return. RD M reported Resident 8 had threatened to break out the windows. RD M reported Resident 8 would call police multiple times a week.

On 05/21/2024, at 8:30 AM, Surveyors reviewed Resident 8's record. Resident 8 was admitted to the facility on 04/28/2023 with diagnoses including anxiety, depression, chronic pain,

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history of seizures, and hypertension. On 11/17/2023, Resident 8 received a 30-day notice which indicated Resident 8 was to be discharged in 30 days due Resident 8's risk of serious harm to the safety of herself/himself and others. The discharge notice stated, "[Resident 8's] behavior is beyond that which the [community based residential facility] is able to care for appropriately. This is demonstrated by [Resident 8's] recent episodes, staff and resident's felt threatened and unsafe. [Resident 8] has been having more episodes of this behavior. [Resident 8] is also leaving the property and staff are having to do one on one's with [her/him] and we are not able to provide that level of care."

Resident 8's individual service plan (ISP), dated 07/12/2023, stated the following:

- Lifestyle habits/activities

"Resident smokes independently in designated areas. [Resident 8] smokes occasionally and understands that [s/he] lives at a smoke free community and that [his/her] guardian does not want [her/him] smoking ..."

- Orientation/Behaviors

"Resident is oriented to person, place and/or time. [Resident 8] is fully oriented and aware of person, place, and time. [Resident 8] does have occasional confusion and may need gentle reminders from staff relating to [her/his] orientation ..."

"Resident does not wander. [Resident 8] does not currently wander. [Resident 8] has left the community without permission from [her/his] guardian once when [s/he] was angry due to staff

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not being able to find the telephone when [s/he] wanted to use it. [Resident 8] left the community and told staff s/he was going to go and find a payphone. Staff encouraged [Resident 8] to stay in the community as they were actively looking for the phone. [Resident 8] declined and left the community. The police were called and [Resident 8] was escorted back to the community ..."

"Non complaint/refusals. [Resident 8] frequently refuses cares, medications and help from staff. [Resident 8] is educated on the risks/benefits of refusing cares, medications and/or help from staff. Staff are to document appropriate when [Resident 8] refuses cares, medications or help from staff. Staff are to update all parties regarding [her/his] refusals as necessary. [Resident 8's] guardian is very involved and has been trying to assist staff in finding new ways to encourage [Resident 8] to participate in [her/his] cares and accept [her/his] medications and help from staff. [Resident 8's] guardian recently came up with the idea to give [her/him] incentives that s/he provides. The method of providing incentives has worked on occasion. Staff are to not to do this unless they speak with [Guardian Q] first ..."

"Agitation: anxious; fluctuates emotionally. [Resident 8] frequently gets angry with the staff and yells at the staff when they try and discourage/educate on behaviors that are either potentially harmful to [Resident 8] or that violate the community guidelines. When [Resident 8] is angry, it is best to give [her/him] some space. Providing [Resident 8] with a distraction may also help take [her/his] mind off of the subject that is making [her/his] [sic] upset. Should [Resident 8] be unable to calm down, staff can call [her/his] guardian [Guardian Q] as [s/he] is also [her/his] [sibling] call the Admin [sic] or call the police

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N 327	Continued From page 4 should the situation escalate. [Resident 8's] goal is to be provided a calm and safe place to calm down when [s/he] is agitated ..." Resident 8's behavior monitoring log reported the following: January 2024 - 01/01/2024 Day shift - Resident 1 experienced "elopement" behavior, due to a possible trigger from a cigarette lighter. Staff intervention was talking with [her/him]. The length of the behavior was less than 15 minutes. 01/02/2024 PM shift - Resident 1 experienced "elopement" behavior, due to a possible trigger from a cigarette lighter. Staff intervention was talking with [her/him]. The length of the behavior was 30-45 minutes. 01/03/2024 PM shift - Resident 1 experienced "swinging/pushing" behaviors, due to a possible trigger from a cigarette lighter. Staff intervention was talking with [her/him]. The length of the behavior was not documented. February 2024 02/06/2024 Day shift - Resident 1 experienced "cursing and yelling" behaviors, due to a possible trigger from a cigarette lighter. Staff intervention was talking with [her/him]. The length of the behavior was unable to be identified. 02/07/2024 Swing shift - Resident 1 experienced "cursing, yelling and being very disresful [sic]". The trigger was not documented. The length of the behaviors lasted less than 15 minutes. Surveyor reviewed 6 police call reports from St.	N 327		

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Francis Police Department regarding Resident 8 during the timeframe of 11/01/2023-02/16/2024 and identified the following:

11/09/2023 - Resident 8 called police due to concerns of theft.

11/14/2023 - Caregiver S called police due to Resident 8 became disruptive. "Resident is not being physical at the time but is being verbally aggressive towards staff and other residents. Officer T made contact with [Resident 8] and situation was mediated. Officer cleared."

11/19/2023 - Resident 8 called police due to complaint regarding company policy regarding cigarettes.

12/26/2023 - "Citizen reports elderly [fe/male] in a wheelchair stating the staff will not let [her/him] in ....[Officer U] reports they would let [Resident 8] in, but not into [her/his] room because [s/he] kept locking it. [Resident 8] was advised that only two staff members were working and they could not unlock [her/his] door when ever [sic] [s/he] needed ..."

01/13/2024 - Resident 8 reported theft, " ...was smoking outside and the plow guy took [her/his] cigarette out of [her/his] mouth and threw it ..."

02/16/2024 - Resident 8 called the police twice due to staff refused to give Resident 8 her/his cigarettes due to Resident 8 refused her/his medications. An ambulance was called, and Resident 8 was removed for the day.

On 06/20/2024, at 2:30 PM, Surveyors interviewed Regional Director M. Regional Director M acknowledged Surveyors concerns in

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N 327	Continued From page 6 regarding appropriate reasons for involuntary discharges. Regional Director M did not offer additional information regarding Resident 8's discharge. Regional Director M did not know why staff did not follow the behavior interventions in Resident 8's ISP.	N 327		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident's (Resident 8) individual service plan (ISP) was updated with changes. Resident 8's ISP did not reflect all of Resident 8's behaviors. Findings include: On 05/21/2024, at 8:30 AM, Surveyors reviewed Resident 8's record. Resident 8 was admitted to the facility on 04/28/2023 with diagnoses including anxiety, depression, chronic pain,	N 389		

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history of seizures and hypertension. On 11/17/2023, Resident 8 received a 30-day notice which indicated Resident 8 was to be discharged in 30 days due Resident 8's risk of serious harm to the safety of herself/himself and others. The discharge notice stated, "[Resident 8's] behavior is beyond that which the [community based residential facility] is able to care for appropriately. This is demonstrated by [Resident 8's] recent episodes, staff and resident's felt threatened and unsafe. [Resident 8] has been having more episodes of this behavior. [Resident 8] is also leaving the property and staff are having to do one on one's with [her/him] and we are not able to provide that level of care."

Resident 8's individual service plan (ISP), dated 07/12/2023, stated the following:

- Lifestyle habits/activities

"Resident smokes independently in designated areas. [Resident 8] smokes occasionally and understands that [s/he] lives at a smoke free community and that [his/her] guardian does not want [her/him] smoking ..."

- Orientation/Behaviors

"Resident is oriented to person, place and/or time. [Resident 8] is fully oriented and aware of person, place, and time. [Resident 8] does have occasional confusion and may need gentle reminders from staff relating to [her/his] orientation ..."

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not being able to find the telephone when [s/he] wanted to use it. [Resident 8] left the community and told staff s/he was going to go and find a payphone. Staff encouraged [Resident 8] to stay in the community as they were actively looking for the phone. [Resident 8] declined and left the community. The police were called and [Resident 8] was escorted back to the community ..."

"Non complaint/refusals. [Resident 8] frequently refuses cares, medications and help from staff. [Resident 8] is educated on the risks/benefits of refusing cares, medications and/or help from staff. Staff are to document appropriate when [Resident 8] refuses cares, medications or help from staff. Staff are to update all parties regarding [her/his] refusals as necessary. [Resident 8's] guardian is very involved and has been trying to assist staff in finding new ways to encourage [Resident 8] to participate in [her/his] cares and accept [her/his] medications and help from staff. [Resident 8's] guardian recently came up with the idea to give [her/him] incentives that s/he provides. The method of providing incentives has worked on occasion. Staff are to not to do this unless they speak with [Guardian Q] first ..."

"Agitation: anxious; fluctuates emotionally. [Resident 8] frequently gets angry with the staff and yells at the staff when they try and discourage/educate on behaviors that are either potentially harmful to [Resident 8] or that violate the community guidelines. When [Resident 8] is angry, it is best to give [her/him] some space. Providing [Resident 8] with a distraction may also help take [her/his] mind off of the subject that is making [her/his] [sic] upset. Should [Resident 8] be unable to calm down, staff can call [her/his] guardian [Guardian Q] as [s/he] is also [her/his] [sibling] call the Admin [sic] or call the police

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N 389	Continued From page 9 should the situation escalate. [Resident 8's] goal is to be provided a calm and safe place to calm down when [s/he] is agitated ..." On 06/20/2024, at 2:30 PM, Surveyors interviewed Regional Director M. Regional Director M reported the medication technicians, nurse, administrator, or s/he would assist in completing the updates for Resident ISPs. Regional Director M reported ISPs were reviewed every 6 months. Regional Director M was unsure why Resident 8's ISP did not reflect all the behaviors s/he exhibited.	N 389		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on interview and record review, the provider did not provide services to manage 1 of 1 resident's (Resident 8) verbal behavior patterns which affected the resident and other persons, frequent calls to the police, and smoking in non-designated areas. Findings include: On 05/15/2024, at approximately 10:15 AM,	N 433		

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Surveyors interviewed Regional Director (RD) M. RD M reported Resident 1 was sent out to the hospital due to her/his behaviors. RD M stated, "We refused to take [her/him] back, [s/he] was threatening to break out windows." RD M reported Resident 8 would call the police multiple times a week. RD M reported Resident 8 would smoke in her/his room. RD M reported they issued a 30-day involuntary notice.

On 05/21/2024, at 8:30 AM, Surveyors reviewed Resident 8's record. Resident 8 was admitted to the facility on 04/28/2023 with diagnoses including anxiety, depression, chronic pain, history of seizures and hypertension. Surveyor reviewed Resident 8's progress notes and identified the following:

"11/24/2023 - Resident Refused [sic] [her/his] meds [sic] I asked 3 times and [s/he] told me to go to [expletive] hope I burn cause [sic] [s/he] came back wanting [her/his] meds [sic]."

"12/17/2023 - Resident Just [sic] had a shower and a staff member ask [sic] me to wash [her/his] coat [sic] [s/he] saw me taking and [s/he] was screaming calling me a [expletive] telling me I am going to End [sic] up in The [sic] ICU if I did not gave [sic] [her/him] [her/his] coat [sic] other staff told me to give it to [him/her] [s/he] was standing straight up out of [her/his] chair throw [sic] the things that are on the table on the floor. [S/He] was chasing me around the table."

"12/26/2023 - Resident said [s/he] locked [her/his] door because [s/he] aint [sic] want nobody [sic] stoling [sic] out [sic] [her/his] room than [sic] [s/he] went out before 8am resident mouth is really ridiculous on how [s/he] talk [sic] to other [sic]."

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N 433	Continued From page 11 "12/26/2023 - Resident started yelling at me and the med tech accusing us of stealing [her/his] key after [s/he] stated [s/he] lost [her/his] own keys. Residents [sic] wants to always lock [her/his] door and for us to unlock it everytime [sic]. Resident stated [she's/he's] going to kick [her/his] door down next tim [sic]" "12/26/2023 - Resident got mad because [s/he] keep [sic] locking [her/his] door when we have other things to do so [s/he] called me a [expletive]" "01/02/2024 - Resident was crossing the street to go and bye [sic] a lighter we had to bring [her/him] back." "01/02/2024 - Resident tried leaving the property to go purchase a lighter. I was able to convince [her/him] to come back. Few minutes later, [s/he] tried leaving again. [Nurse *] got in contact with [her/his] [Guardian Q], I told [Resident 8] that [her/his] [Guardian Q] will bring [her/him] a lighter tomorrow. I also stated to [Resident 8] that if [s/he] tries to leave again (off the property} that [her/his] case manager and [Guardian Q] told us to contact the police." "01/02/2024 - [S/He] refuse [sic] to take [her/his] med [sic] because nobody would go to the stor to got [sic] him a lighter, at 9:30 PM we heard a lot [sic] of banging and moving around in [her/his] room so we went to check up on [her/him] and [s/he] wouldnt [sic] let us in [s/he] keep [sic] saying no wouldn't let us in [her/his] room [sic] so when another carestaff [sic] came to work at 10 PM we told [her/him] we were coming in to do a check up [sic] [s/he] started yelling at us and calling us fat [expletive] and other name [sic] and	N 433		

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[s/he] almost swing [sic] at one of the care staff and keep [sic] saying get our, we tried to explain to [her/him] we check every one before we leave."

"01/02/2024 - [S/he] refuse to take [his/her] med because nobody would go to the store to got [sic] [his/her] a lighter, at 9:30 pm. We heard a lot of banging and moving around in [his/her] room so we went to check up on [his/her] and [s/he] wouldn't let us in [s/he] keep saying No [sic]. [sic] Wouldn't let us in [s/he] room so when another care staff came to warn[sic] at 10:00PM, we told she/him were coming in to do a check up [s/he] starting [sic] yelling at us and calling us fat [expletive] and other name [sic] and [s/he] almost swing [sic] at one of the care staff, and keep saying get out, we tried to explain to [her/him] we check every one before we leave."

"01/12/2024 - Resident got mad because we [sic] staff told him that [s/he] can't be smoking cigarettes, so [s/he] called us all [expletive], [expletive], Roll [sic] over and die. [S/he] was smoking in [s/he] Room [sic]. Also [sic] one of the other Resident [sic] told the officer that [s/he] [sic] very disrespectful."

"01/21/2024 - Went to Resident Room [sic] to give [him/her] [his/her] bedtime meds. [S/he] Door [sic] was locked. [S/he] said I am coming I could smell that [s/he] was smoking in There [sic]. [S/he] had The [sic] bath Room [sic] Door [sic] closed. And [sic] The [sic] Fan [sic] on. [S/he] said don't come in here. So I Just [sic] gave [her/him] [his/her] Pills [sic] From [sic] The [sic] Door [sic] Way [sic]."

"01/22/2024 - Resident is starting A [sic] Fighting [sic] with A [sic] other [sic] Resident saying [s/he]

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	0014179	A. BUILDING: _____ B. WING _____	R 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTHEWS OF SAINT FRANCIS II	3620 E DENTON ST SAINT FRANCIS, WI 53235

(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
N 433	Continued From page 13 is going to kick [his/her] [expletive]. [S/He] thinks [s/he] took a Heater [sic] out of [his/her] Room [sic]. [S/He] keep locking [his/her] Room [sic] and wants you to stop what you Are[sic] doing to unlock it. And if you Don't [sic] come Fast [sic] Enough [sic] [s/he] will call the cops [sic] [s/he] was yelling + [sic] swearing." "01/31/2024 - resident [sic] got made because [s/he] wanted more than one cigerette [sic] and told us [s/he] attorney [sic] going to take care of us. So [s/he] left and went to the store. "01/31/2024 - Police came And [sic] got Resident from the store. Dinner [s/he] asked me for some more cig{sic]. I told [her/him] [s/he] had all [his/her] cigs[sic] for the day [s/he] said [s/he] was going to call the cops. Tole [sic] me [she/he] was going to Put [sic] a hole in my tire. And [s/he] is going to smoke in [her/his] Room [sic].' "02/06/2024 - Resident advised staff that [s/he] is on strike and will not be taking any more medications until [s/he] gets a lighter to smoke cigarettes." "02/06/2024 - Resident is upset for not having cigarette. Resident started calling staff [expletive] [expletive] and telling us to go to hell and to shut the [expletive] up [expletive]." "02/07/2024- Resident was yelling And sic} Refusing to give me the white Lighter [sic], so we told [him/her] if I did not get it [s/he] was not get [sic] Any [sic] More [sic] cig. [sic]" "02/07/2024 - Well After [sic] all that [s/he] gave me the white lighter and Then [sic] [he/she] said [s/he] was sorry. So There [sic] is white + [sic] blue Lighter [sic] in the med cart."	N 433		

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N 433	Continued From page 14 "02/13/2024 - I asked [him/her} 3 time [sic] can I go in [his/her] room to clean it. I told [him/her] it [sic] on my tash [sic] sheet to make sure [his/her] room and bathroom is clean he resuse [sic] to let me in." "02/16/2024 - [He/She] refused [his/her] medication this morning. [She/He] continues to not return [his/her] lighter to staff and that resulted in in [him/her] not receiving a cigarette. [He/She] began to curse at staff and say [his/her] was calling [his/her] lawyer. at [sic] approx [sic] 9AM [him/her] got on the phone and called the St. Francis Police to come out to the facility while on the phone [he/she] was cursing at the operator and Staff [sic]. [He/She] for some reason was not able to get a hold of the police so [he/she] went to [he/she] room saying [he/she] will get the police here dont [sic] worry you [Expletive]." "02/16/2024 - At approx [sic] 9:20 AM [he/she] came back to the phone in the staff area and attempted to call the police again. [He/She} was not making contact for several minutes and told staff that [he/she] was going to smash the [Expletive] phone if [he/she] didn't get the police here. At approx. [sic] 9:25 AM [he/she] made contact with the police department and requested for an officer to come out." "02/16/2024 - At 8AM [he/she] Refused [sic] [he/she] medication [he/she] was very verbally aggressive @ [sic] 9:20AM [he/she] threatened to smash the house phone @ [sic] 10:30AM After [sic] police were called [he/she] again called St Francis Police Department and threatend [sic] to smash all windows out if police didn't Arrive [sic] in 30 min[sic]."	N 433		

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N 433	Continued From page 15 Resident 8's individual service plan (ISP), dated 07/12/2023, stated the following: - Lifestyle habits/activities "Resident smokes independently in designated areas. [Resident 8] smokes occasionally and understands that [s/he] lives at a smoke free community and that [his/her] guardian does not want [her/him] smoking ..." - Orientation/Behaviors "Resident is oriented to person, place and/or time. [Resident 8] is fully oriented and aware of person, place, and time. [Resident 8] does have occasional confusion and may need gentle reminders from staff relating to [her/his] orientation ..." "Resident does not wander. [Resident 8] does not currently wander. [Resident 8] has left the community without permission from [her/his] guardian once when [s/he] was angry due to staff not being able to find the telephone when [s/he] wanted to use it. [Resident 8] left the community and told staff s/he was going to go and find a payphone. Staff encouraged [Resident 8] to stay in the community as they were actively looking for the phone. [Resident 8] declined and left the community. The police were called and [Resident 8] was escorted back to the community ..." "Agitation: anxious; fluctuates emotionally. [Resident 8] frequently gets angry with the staff and yells at the staff when they try and discourage/educate on behaviors that are either potentially harmful to [Resident 8] or that violate the community guidelines. When [Resident 8] is angry, it is best to give [her/him] some space.	N 433		

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N 433	Continued From page 16 Providing [Resident 8] with a distraction may also help take [her/his] mind off of the subject that is making [her/his] [sic] upset. Should [Resident 8] be unable to calm down, staff can call [her/his] guardian [Guardian Q] as [s/he] is also [her/his] [sibling] call the Admin [sic] or call the police should the situation escalate. [Resident 8's] goal is to be provided a calm and safe place to calm down when [s/he] is agitated ..." On 06/20/2024, 2:30 PM, Surveyors interviewed Regional Director M. Regional Director M reported s/he was unsure why staff did not utilize any behavior interventions for Resident 8. Regional Director M reported Nurse V had many interventions for Resident 8 and was unsure why staff did not utilize these interventions.	N 433		