STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016897	A. BUILDING: _____ B. WING _____	C 06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AARNA FAMILY CARE LLC	**2427 RUSSET ST RACINE, WI 53405**

(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 06/28/2023, Surveyor conducted a complaint investigation and self-report review at Aarna Family Care LLC. One deficiency was identified. One complaint was substantiated. Census: 4	M 000		
M 610	88.11(1) REPORTING OF ABUSE AND NEGLECT A licensee or service provider who knows or has reasonable cause to suspect that a resident has been abused or neglected as defined in s. 46.90 or 940.285, Stats., shall immediately contact the licensing agency. Providing notice under this subsection does not relieve the licensee or other person of the obligation to report an incident to law enforcement authorities. If the licensee has reason to believe a crime has been committed, the incident shall immediately be reported to law enforcement authorities. This Rule is not met as evidenced by: Based on observation and interview, the provider did not immediately contact the licensing agency when they had reasonable cause to suspect that a resident had been abused by a caregiver for 1 of 1 resident (Resident 1) reviewed. Findings include:	M 610		

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

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M 610	Continued From page 1 On 06/27/2023, at approximately 12:00 PM, Surveyor interviewed Caregiver C and Caregiver D. Caregiver C reported being told on 06/18/2023 by Resident 1 that s/he was struck on the cheek by Caregiver B the day before, 06/17/2023. Caregiver C stated shortly after arriving at the Adult Family Home (AFH) to work on 06/18/2023, Resident 1 approached him/her to talk about the incident. Caregiver D reported Resident 1 told him/her about the incident on the next day Caregiver D worked, 06/19/2023. Both Caregiver C and Caregiver D stated all staff and residents were aware of the incident and stated it had been openly discussed at the AFH since its occurrence. Both Caregiver C and Caregiver D described Resident 1 as being agitated and upset when talking about the event. On 06/27/2023, at approximately 12:30 PM, Surveyor interviewed Resident 1. Resident 1 described Caregiver B striking his/her cheek hard enough to dislodge a hearing aid in Resident 1's ear. Resident 1 added s/he had been sitting in his/her wheelchair at the kitchen table. Caregiver B began using a broom to strike at Resident 1's feet and legs while sweeping the kitchen floor. Resident 1 stated s/he thought Caregiver B did so to force him/her to leave the kitchen. Resident 1 stated s/he told Licensee A what Caregiver B did to him/her the next Wednesday when Licensee A visited the AFH. Resident 1 added s/he did not think Licensee A did anything about it other than not having Caregiver B work at the AFH any longer. On 06/27/2023, at approximately 12:30 PM, Surveyor interviewed Licensee A. Surveyor asked if Licensee A was aware Caregiver B was alleged to have struck Resident 1 in the face with his/her hand and hit at Resident 1 with a broom on the	M 610		

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M 610	Continued From page 2	M 610		

legs. Licensee A stated s/he was aware of the incident. S/He stated Caregiver E notified Licensee A the day it happened, 06/17/2023. Caregiver E worked with Caregiver B that day, but Caregiver B's shift ended earlier than Caregiver E's. After Caregiver B left the AFH, Caregiver E sent a text message to Licensee A informing him/her about the abuse. Surveyor asked Licensee A to describe how they proceeded from there.

Licensee A stated Caregiver B's next day to work at the AFH was the following Wednesday, 06/21/2023. Licensee A went to the AFH to interview Resident 1 and Caregiver B about the allegations on 06/21/2023. Resident 1 described the incident to Licensee A. Caregiver B denied the incident occurred. Surveyor asked what Caregiver B's employment status was. Licensee A stated Caregiver B was a 'floater' assigned to different AFH's operated by Licensee A's company. Licensee A stated Caregiver B was assigned to work at a different AFH a few blocks away. Surveyor asked if Licensee A reported the incident to anyone, including the Office of Caregiver Quality (OCQ), or any other office in the department. Licensee A stated s/he had not reported the alleged abuse to anyone, including Resident 1's guardian or Case Manager.

On 06/28/2023 approximately 11:35 PM, Surveyor received an email from Licensee A. The email included an attachment which was a printout of a report made at 11:31 PM that evening to OCQ. Licensee A did not immediately contact the licensing agency when they had reasonable cause to suspect that a resident has been abused by Caregiver A.