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 10/06/2023

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 From 10/02/2023 to 10/06/2023, Surveyor conducted a complaint investigation at Concord Adult Family Home, an AFH in Madison. Three deficiencies were identified. One deficiency is a repeat deficiency - See Statement of Deficiency (SOD) 2J9L12, dated 03/07/2019. The complaint was substantiated. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report Resident 1 missing from the home to the department. Findings include: On 10/02/2023, Surveyor conducted a complaint investigation that alleged Resident 1 eloped from the provider's home on 09/08/2023.	M 134		

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

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M 134	Continued From page 1 On 10/02/2023 at approximately 8:15 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 09/07/2023 with diagnoses including paranoid schizophrenia and dementia. Resident 1 had a legal guardian. Resident 1's record included a "Pre Admission Assessment" that had vitals listed, but no additional information. Resident 1's record included a hospital discharge summary indicating s/he was hospitalized from 09/08/2023 to 09/11/2023 with diagnoses of syncope, cardiomyopathy, paranoid schizophrenia, facial abrasion and atrial fibrillation. On 10/02/2023 at approximately 8:40 a.m., Surveyor interviewed Caregiver B. Caregiver B stated Resident 1 admitted to the provider's home via taxi with his/her orders and medications. Caregiver B stated s/he was not provided documentation of Resident 1's needs, so s/he assumed Resident 1 was "pretty independent" like the other residents in the home. Caregiver B stated that on 09/08/2023, Resident 1 went outside and sought a cigarette from a neighbor after dinner at approximately 4:30 p.m. Caregiver B stated s/he thought Resident 1 would come back on his/her own since Resident 1 reported s/he was familiar with the area. Caregiver B stated s/he normally checked on residents at 9:00 p.m. and 1:00 a.m. but didn't check on Resident 1 because s/he didn't want to bother him/her. Caregiver B stated s/he realized Resident 1 was missing on 09/09/2023 at approximately 6:30 a.m., panicked, looked around the neighborhood for Resident 1 and then contacted law enforcement. Caregiver B stated Resident 1 was then located at a local hospital, where s/he was admitted after allegedly sustaining a fall. On 10/03/2023 at approximately 12:00 p.m.,	M 134		

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M 134	Continued From page 2 Surveyor reviewed a statement from Officer C. The statement indicated Resident 1 was reported missing by staff on 09/09/2023 at approximately 10:00 a.m. and a "Silver Alert" was issued. Resident 1 was located at a local hospital, where s/he had been admitted via paramedics on 09/08/2023. On 10/06/2023 at approximately 11:00 a.m., Surveyor interviewed Supervisor A. Surveyor asked Supervisor A if s/he reported Resident 1's elopement to the department. Supervisor A replied, "No. I should have. It's a hard job." Cross Reference: M0570 DHS 88.07(1)(a) Safe Physical Environment	M 134		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 had a service agreement completed by his/her legal representative prior to Resident 1's admission.	M 384		

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M 384	Continued From page 3 Findings include: On 10/02/2023 at approximately 8:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 09/07/2023. Resident 1 had a legal guardian. The service agreement in Resident 1's record was signed by Resident 1, not his/her legal guardian. On 10/02/2023 at approximately 8:40 a.m., Surveyor interviewed Supervisor A. Supervisor A stated the service agreement was not signed by Resident 1's guardian because the guardian never showed up. Surveyor inquired about Supervisor A's communications with Resident 1's legal guardian. Supervisor A replied, "I never contacted him [regarding the admission]."	M 384		
M 570	88.10(3)(l) Safe Physical Environment 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 record review and interview, the provider did not ensure a safe environment was	M 570		

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M 570	Continued From page 4	M 570		

provided for Resident 1. Caregiver B was unaware of Resident 1's elopement history and need for close supervision, resulting in Resident 1 eloping from the home.

This is a repeat deficiency - See Statement of Deficiency (SOD) 2J9L12, dated 03/07/2019.

Findings include:

On 10/02/2023, Surveyor conducted a complaint investigation that alleged Resident 1 eloped from the provider's home on 09/08/2023.

On 10/02/2023 at approximately 8:15 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 09/07/2023 with diagnoses including paranoid schizophrenia and dementia. Resident 1 had a legal guardian. Resident 1's record included a "Pre-Admission Assessment" that had vitals listed, but no additional information. Resident 1's record included a hospital discharge summary indicating s/he was hospitalized from 09/08/2023 to 09/11/2023 with diagnoses of syncope, cardiomyopathy, paranoid schizophrenia, facial abrasion and atrial fibrillation.

On 10/02/2023 at approximately 8:40 a.m., Surveyor interviewed Caregiver B, who lived at the provider's home and provided 24/7 care. Caregiver B stated Resident 1 admitted to the provider's home via taxi with his/her orders and medications. Caregiver B stated s/he was not provided documentation of Resident 1's needs, so s/he assumed Resident 1 was "pretty independent" like the other residents in the home. Caregiver B stated that on 09/08/2023, Resident 1 went outside and sought a cigarette from a neighbor after dinner at approximately 4:30 p.m.

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M 570	Continued From page 5 Caregiver B stated s/he thought Resident 1 would come back on his/her own since Resident 1 reported s/he was familiar with the area. Caregiver B stated s/he normally checked on residents at 9:00 p.m. and 1:00 a.m. but didn't check on Resident 1 because s/he didn't want to bother him/her. Caregiver B stated s/he realized Resident 1 was missing on 09/09/2023 at approximately 6:30 a.m., panicked, looked around the neighborhood for Resident 1 and then contacted law enforcement. Caregiver B stated law enforcement issued a "Silver Alert" and Resident 1 was located at a local hospital. Caregiver B stated it wasn't until after Resident 1's elopement that s/he received a "Watts Review" for Resident 1's guardianship in the mail, which 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." Caregiver B stated since Resident 1's return to the provider's home, now that Caregiver B was aware of Resident 1's behaviors, s/he increased his/her supervision of Resident 1 and alarmed all the exit doors. On 10/02/2023 at approximately 8:55 a.m., Surveyor interviewed Supervisor A. Supervisor A	M 570		

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M 570	Continued From page 6	M 570		

stated s/he completed the pre-admission assessment for Resident 1 and was aware s/he had a history of elopement but was told it was a 1 time occurrence. Surveyor shared concern that Resident 1's record did not include documentation of his/her needs. Supervisor A stated s/he had the assessment in his/her folder, not in Resident 1's record.

On 10/03/2023 at approximately 12:00 p.m., Surveyor reviewed a statement from Officer C. The statement indicated Resident 1 was reported missing by staff on 09/09/2023 at approximately 10:00 a.m. and a "Silver Alert" was issued. Resident 1 was located at a local hospital, where s/he had been admitted on 09/08/2023.

On 10/06/2023 at approximately 8:35 a.m., Surveyor interviewed Case Manager D. Case Manager D stated the managed care organization and Resident 1's previous placement staff worked with Supervisor A for Resident 1's admission to the provider's home. Case Manager D stated Supervisor A was made aware of Resident 1's behaviors and it was never an expectation for Resident 1 to go out independently or be unsupervised. Case Manager D stated Supervisor A was aware of Resident 1's supervision needs, but those needs did not appear to be relayed to Caregiver B.

Caregiver B, who was the 24/7 caregiver of the provider's home, was not made aware of Resident 1's elopement history or need for continuous supervision, resulting in inadequate supervision/care of Resident 1. Resident 1 eloped on 09/08/2023.

Cross Reference: M0134 DHS 88.03(5)(e)1. Significant Change To Resident

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