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	0017303	A. BUILDING: _____ B. WING _____	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST PLACE TO BE INC	3940 MAPLE DR PLOVER, WI 54467

(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 08/06/2025, Surveyor conducted an abbreviated survey at Best Place to Be INC. Additional information was gathered through 08/11/2025. As a result of the survey, three (3) new deficiencies were identified. Census: 3	M 000		
M 218	88.04(2)(b) AWAKE STAFF FOR CONTINUOUS CARE The licensee shall ensure that he or she or a service provider is present and awake at all times if any resident is in need of continuous care. This Rule is not met as evidenced by: Based on interviews, observation, and record review, the licensee did not ensure that a service provider was present and awake at all times if any resident is in need of continuous care. Resident 1 had diagnoses to include Autism, depression, anxiety, suicidal ideations and a history of suicide attempts. Caregiver B was the primary live-in caregiver and slept during the overnight hours. On 08/01/2025, during the overnight hours, Resident 1 attempted suicide. Caregiver B and Owner A were not aware of the incident until the following morning. The provider did not make changes to the staffing pattern to ensure a caregiver was awake during the overnight hours to monitor Resident 1 for suicidal ideation. On 08/06/2025, Surveyor conducted a facility visit at 8:55 AM and observed Resident 1 was home alone with another resident and 3 children of the live in caregiver; no adults or staff were present.	M 218		

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

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M 218	Continued From page 1 Continuous care is defined as 88.02(9) "Continuous care" means the need for supervision, intervention or services on a 24-hour basis to prevent, control and ameliorate a constant or intermittent mental or physical condition which may break out or become critical during any time of the day or night. Note: Examples of persons who need continuous care are wanderers, persons with irreversible dementia, persons who are self abusive or who become agitated or emotionally upset and persons whose changing or unstable health condition requires monitoring." Findings include: The provider is licensed to care for up to 4 residents who may have a physical disability, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness and/or of advanced age. On 08/06/2025 at 8:55 AM, Surveyor arrived at the facility and was approached by 2 minor children in the driveway. Surveyor asked if an adult was home and the children said their older sibling was inside with 2 residents and the parent/caregiver was driving to Wausau (approximately 45 minutes away from the facility) and had left earlier that morning. One of the children asked Surveyor if s/he was from "the State." Surveyor entered the facility and observed another child in his/her early teens and 2 residents (later identified as Resident 1 and Resident 2). At 9:23 AM, Surveyor called Owner A who stated s/he was already informed Surveyor was there and s/he was on his/her way. Owner A acknowledged there was not a caregiver at the	M 218		

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facility and the live-in caregiver "had to run someone up to Wausau."

At 9:38 AM, Owner A arrived at the facility and at 10:11 AM, Caregiver B arrived.

On 08/06/2025 at 1:21 PM, Surveyor reviewed Resident 1's facility record including his/her pre-admission assessment, observation notes, and individual service plan (ISP). Resident 1 was admitted on 05/18/2023. S/he had diagnoses to include Autism, depression, anxiety, suicidal ideations and a history of suicide attempts. Resident 1's pre-admission assessment dated 05/04/2023 read in part, " ...suicidal-very dep [sic] .... would let someone know ...can be left alone for a little while ..."

Surveyor reviewed observation notes from March 2025 to August 2025 and noted the following;

March 2025:

-- 18th: "suicidal dark thoughts ..."
-- 28th : "had lots of dark thoughts: hurting self, cutting [his/her] throat or drinking bleach. Wanting to punch people. ER TRIP ..."

April 2025:

-- 13th labeled as "Red/Red" and read, "very agitated- called crisis because of suicidal thoughts and attempts-[S/he] cut [his/her] arm multiple times w/scissors, tried cutting [his/her] neck"
-- 23rd: " ...expressed paranoid thoughts ..."

May 2025:

-- 31st: labeled as "Red" and read, "Breakfast

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fine/Lunch fine around 3pm c/o [sic] feeling of hurting him/herself and had evidence that [s/he] tried. Red marks on [his/her] arms. Stated [s/he] poked [him/herself] in the stomach ..."

August 2025:

-- 1st : labeled as "Red/yellow" and read, "Had suicide attempt @ [sic] 2am. Drank eye glass cleaner. Tried to strangle herself w/ [sic] a belt."

Resident 1's ISP dated "7/2025" identified "depressive + suicidal thoughts" and self-abuse behavior to include "hitting self, cutting, pulling hair, suicidal ideations." The ISP noted Resident 1 could be left alone for "1-2 hours" and needed "some supervision" and "monitoring numerous times a day."

The ISP did not identify the actual suicide attempt on 03/28/2025 resulting in emergency room treatment or the attempt on 08/01/2025 during the overnight hours. The ISP was not updated based on assessment with interventions to assist Resident when s/he was having suicidal thoughts and was not updated with specificity regarding the level of supervision needed to monitor, prevent and respond to suicide attempts.

On 08/06/2025 at 12:00 PM, Surveyor interviewed Owner A and Caregiver B. Owner A recalled Resident 1's suicide attempt on August 1st. S/he said that on Friday morning Resident 1 "sent me a text message of [his/her] thoughts. I have told [him/her] numerous times that text message do not wake someone up." S/he stated, "Caregiver B will say [s/he] was cutting [him/herself] or say that [s/he] was drinking something ...[s/he] does not actually cut [him/herself]and draw blood but there is a red

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mark." Owner A stated s/he contacted Caregiver B in the morning after reading the text messages and Resident 1 was sent to the emergency room which, "snapped [him/her] out of it and everything was great ..."

Following Surveyors request, Owner A provided a series of text messages that Resident 1 sent to him/her on 08/01/2025 from 12:13 AM to 2:30 AM. The text messages read in part, " ...I'm terrified I bought an energy drink ...I started getting warm and sweaty my heart started beating fast I [sic] started getting a headache and dizzy and breathing started getting heavy and my body stiffened ...my whole body started shaking bad ...I'm tired scared idk what to do I don't feel good at all ...I don't know why I ...live here if no one helps me when I've experienced the worst pain and tremors ...in my entire life ...I still feel like if I fall asleep I won't wake up ...I'm in the red ...I tried reaching out but got no where [sic] ...I tried killing myself with eyeglass cleaner and a belt and I kept hurting myself physically with my hands but it doesn't seem like you or anyone cares ...everything in my body is telling me to end it ..."

At 7:31 AM on 08/01/2025, Owner A responded to Resident 1's text message which read, "[Resident 1]. If you need help, a text message does not wake me up. Did you try to wake up [Caregiver B]?"

On 08/08/2025, following Surveyors request for a staff schedule, Owner A sent an email which read in part, " ...[Caregiver B] is the Live-in Caregiver ..."

On 08/11/2025 at 3:00 PM, Surveyor interviewed Owner A and Owner C. Owner A acknowledged Resident 1's suicidal ideation and history of

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M 218	Continued From page 5 attempts as recent as 08/01/2025. S/he acknowledged after the 08/01/2025 suicide attempt, they did not make changes to the staffing pattern to ensure caregivers were awake during the overnight hours to supervise and monitor Resident 1. Cross Reference M0276 88.05(3)(a) Homelike Environment	M 218		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was safe, clean and well-maintained. Findings include: The provider is licensed to care for up to 4 residents who may have a physical disability, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness and/or of advanced age. On 08/06/2025 from approximately 10:22 AM to 11:30 AM, Surveyor observed the following while on tour with Caregiver B:	M 276		

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M 276	Continued From page 6 Shared Bathroom Lower Level: -- Surveyor did not observe a means to dry hands or a fixture to hang towels on. Caregiver acknowledged Surveyor's observation and stated residents bring in their own towels when utilizing the bathroom. Resident 3's Bedroom: -- A white heating register that spanned the length of one wall. There was an exposed section, approximately 7 feet long, that was missing the cover, exposing the heating coils -- A broken laundry bin containing Resident 2's clothes -- A closet which did not contain closet doors. Kitchen: -- From approximately 8:55 AM to 11:20 AM, Surveyor observed a white plastic bin on the kitchen counter which contained, an "asthma check" devise, an inhaler containing Ventolin HFA medication canister, and a tube of Clotrimazole Cream 1%. The Clotrimazole cream displayed a red warming label on the side which read, "keep this and all medications out of the reach of children." -- A large chip in the kitchen counter to the left of the stove exposing the wood countertop. Surveyor was able to lift a section of the laminate countertop which was approximately 1.5 inches wide and 12 inches long exposing a wood surface. Surveyor observed dirt like substance under the laminate. -- A section behind the sink which contained a buildup of what appeared to be dirt or mildew. On 08/06/2025 at 3:00 PM, Surveyor interviewed	M 276		

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M 276	Continued From page 7 Resident 1 and asked how s/he dries his/her hands in the bathroom. Resident 1 stated, "nothing really there ...sometimes I am lazy and air dry." On 08/11/2025 at 3:30 PM, Surveyor interviewed Owner A and Owner C and shared the observations made while one tour of the facility with Caregiver B. Owner A acknowledged Surveyor's observations. Cross Reference M0218 88.04(2)(b) Awake Staff For Continuous Care	M 276		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility did not ensure Resident 1 received services as specified per the Individual Service Plan (ISP) that are the licensee's responsibility. On 08/06/2025, while reviewing while on tour of the facility, Surveyor observed expired medications in Resident 1's storage bin labeled "PRN (as needed)". Findings include:	M 436		

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M 436	Continued From page 8 The provider is licensed to care for up to 4 residents who may have a physical disability, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness and/or of advanced age. On 08/06/2025 at 11:00 AM, while on tour of the facility with Caregiver B, Surveyor asked to see Resident 1's current medications. Caregiver B placed a small black storage bin on the kitchen counter which was labeled, "[Resident 1] PRN." The bin contained the following expired medications: -- Epinephrine 0.3 MG pen with expiration date of "June 2024" -- Diclofenac Sodium Topical 1% Gel with Discard date of "05/18/24" -- A box of Ventolin HFA containing an inhaler and canister with a discard date of "02/14/24" -- One (1) Ventolin HFA inhaler and canister with an expiration date of "July 2025" -- One (1) box of Ventolin HFA with a discard date of "10/18/24". The box did not contain an inhaler and canister. On 08/06/2025 at 11:10 AM, Surveyor interviewed Caregiver B. S/he said there was a "huge mix-up" with Resident 1's inhaler. S/he picked up a box containing a Ventolin HFA inhaler and canister and stated that "this is [his/her] next one." Surveyor asked when the medication expired that Caregiver B was holding. Caregiver B looked at the medication and acknowledged it expired in "2024." Caregiver B also acknowledged that Resident 1's only epinephrine pen utilized in emergencies for anaphylaxis expired in "June 2024" and there was no other epinephrine pens available for Resident 1 at this time.	M 436		

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M 436	Continued From page 9 On 08/06/2025 at approximately 2:30 PM, Surveyor showed Owner A the expired medications located in the black bin labeled, "[Resident 1] PRN." Owner A acknowledged the expiration dates and stated, "I am wondering if theses came from [Resident 1's] parents house." On 08/06/2025 at 1:30 PM, Surveyor reviewed Resident 1's current individualized service plan (ISP) dated "7/2025" which indicated Resident 1's need for medications to be administered by AFH (Adult Family Home) staff. Following Surveyors request, on 08/08/2025, Owner A provided Resident 1's current medication orders which read in part: "EPINEPHRINE 0.3 MG INJECTABLE KIT ...PRN for anaphylaxis ...VENTOLIN HFA 90 MCG/INH INHALATION AEROSOL ...PRN as needed for wheezing ...DICLOFENAC 1% TPOICAL GEL ...PRN as needed for knee and ankle pain ..." On 08/11/2025 at 3:00 PM, Surveyor interviewed Owner A and Owner C. Owner A confirmed that the facility is in charge of managing Resident 1's medications including ensuring medications are available for the Resident. S/he stated that they recently hired a registered nurse to assist with medication management at all their facilities.	M 436		