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	510185	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTEN HOUSE I	2573 S 7TH ST LA CROSSE, WI 54601

(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 08/01/2024, Surveyor conducted an abbreviated survey and 3 self-report investigations at Hearten House 1. Data collection continued through 08/13/2024. One deficiency was identified. Census: 8	N 000		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were adequately supervised. Resident 1 eloped 7 times between 04/10/2024 and 08/05/2024. Findings include: The provider is licensed to care for up to 12 residents in the client groups of: irreversible dementia/Alzheimer's disease and advanced age. Program Coordinator (PC) A submitted 6 self-reports to the department between	N 426		

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

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N 426	Continued From page 1 04/12/2024 and 08/06/2024, relating to Resident 1's elopements. A self-report, dated 06/04/2024, stated, in part, "On 06/02/2024 around 5:30pm [sic] [Resident 1] eloped out of the front door of the facility by holding the egress door for 15 seconds. Staff were present but unable to redirect [him/her] back inside. Due to there only being one employee in the building at the time of the incident, [Caregiver F] was unable to go outside with [him/her.] [Caregiver F] notified the police right away. [Caregiver G] was on [his/her] way in to work shortly after [Resident 1] had walked out. [Caregiver G] saw [Resident 1] sitting by the [Provider] sign at the end of our driveway on 7th street. [Caregiver G] pulled over to talk to [Resident 1] and [s/he] willingly got into [his/her] vehicle to go back to the facility. The police were updated that [s/he] was located and back safely inside the facility ..." A self-report, dated 07/24/2024, stated, in part, "On 07/21/2024 at 12:03pm [sic] resident left the building unattended by pushing the alarmed egress door for 15 seconds while [Caregiver H] was in other residents [sic] rooms assisting them with ADLs (activities of daily living.) [Caregiver H] states [s/he] was unable to hear the alarm and did not note that door was alarming until approximately 1:20pm when [s/he] noticed a visitor was in the building. [Caregiver H] asked the visitor how [s/he] had gotten in and [s/he] let [him/her] know the door was unlocked. [Caregiver H] had asked the visitor if [s/he] had saw [sic] anyone outside and [s/he] said [s/he] had not. [Caregiver H] then reset the alarms and began checking to make sure all the residents were accounted for. At that time [s/he] realized [Resident 1] was not in the building. Due to	N 426		

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[Caregiver H] being the only employee in the facility [sic] [Caregiver H] was unable to look outside the facility. [Caregiver H] notified the staff working at [Provider Holding Separate License Owned by Licensee] and the triage nurse. [Caregiver I] from [Provider Holding Separate License Owned by Licensee] immediately went outside and began looking for [Resident 1] but was unable to locate [him/her.] [Caregiver I] called 911 for assistance in finding the resident. The police located [Resident 1] at the corner of Wollan Place and 7th Street and safely returned [him/her] to the building at 1:55pm."

A self-report, dated 07/30/2024, stated, in part, "We are reporting two elopements that occurred within 2 hours of eachother [sic.] First elopement 07/25/2024 at 7:18pm. Second elopement 07/25/2024 at 8:51pm. On 07/25/2024 at 7:18pm [sic] resident left the building unattended by pushing the alarmed egress door for 15 seconds while [Caregiver G] was administering medication to another resident. [Caregiver G] immediately responded to the alarm and saw [Resident 1] was standing outside the front door of the facility. [Caregiver G] attempted to redirect [Resident 1] back inside but was unsuccessful and [Resident 1] continued walking towards 7th street. [Caregiver G] was unable to go outside to walk with [Resident 1] due to being the only employee in the facility at the time. [Caregiver G] then called [Caregiver J] who was working at [Provider Holding Separate License Owned by Licensee], which is right next door, to have [him/her] go outside to be with [Resident 1.] [Caregiver J] was able to redirect [Resident 1] back to [Provider], but [Resident 1] refused to go back inside the facility. [Caregiver J] did not have [his/her] cell phone with [him/her] so [s/he] went inside [Provider Holding Separate License Owned by

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Licensee] to grab it and contact the police to assist. The police located [Resident 1] by the 7th street boat landing and safely returned [him/her] to the building at 8pm. At 8:51pm [sic] [Resident 1] had another successful elopement by pushing the alarmed egress door for 15 seconds. [Caregiver G] was unable to redirect [Resident 1] back into the facility and there was not a second employee available to go outside to be with [Resident 1.] Per [Resident 1's] crisis plan, [Caregiver G] contacted the police so they could assist with locating resident. The police located [Resident 1] by the 7th street boat landing and safely returned [him/her] back to [Provider] at 9:20pm ...A 30 day discharge notice was given as resident is requiring a higher level of care than we are able to provide."

On 08/01/2024, at approximately 12:15 PM, Surveyor interviewed Caregiver D. Caregiver D stated s/he typically worked alone between 6:45 AM and 2:30 PM. Caregiver D stated the provider was staffed with 1 caregiver per shift due to the provider's low census. Caregiver D stated it could get crazy working by him/herself. Caregiver D stated it was his/her understanding the provider would staff 2 caregivers per shift if the census was raised to 9 residents. When asked about Resident 1's elopements, Caregiver D stated it was not a good feeling when staff could not assist him/her back to the facility. Caregiver D stated s/he would first call the other home next door for assistance and if the staff from the other home could not redirect Resident 1, they would call 911. The home next door was separately licensed and owned by the same licensee. Caregiver D stated Resident 1 was never combative and had not attempted to harm staff during any past redirection attempts. Caregiver D stated Resident 1 loved when the police assisted him/her back to

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the facility. Caregiver D stated the provider started scheduling 2 staff during the PM (second) shift beginning last week.

At approximately 2:15 PM, Surveyor interviewed Caregiver E. Caregiver E stated there was typically 1 staff per shift because of a lower resident census. Caregiver E stated the provider recently added a second staff during the PM shift. Caregiver E stated s/he was working alone when Resident 1 eloped. Caregiver E stated s/he was unable to go after Resident 1 during an elopement and needed to call the home next door for assistance. When asked if Resident 1's assigned staff or the neighboring house assisting with Resident 1 was responsible for calling 911, Caregiver E stated s/he was not sure. When asked if Caregiver E was comfortable working alone, Caregiver E stated 1 staff was responsible for medications, personal cares, meals and assisting with resident behaviors. Caregiver E stated resident behaviors were unpredictable and a lot of staff would prefer to have 2 staff on all shifts to better meet the needs of the residents. Caregiver E stated when there was a single staff working, they could not assist residents with showers because there would be no one available to monitor for resident behaviors. Caregiver E stated the provider had excuses for not regularly scheduling 2 people per shift and those were believed to be related to finances.

At approximately 2:45 PM, Surveyor interviewed PC A, Registered Nurse (RN) B, and Director of Quality (DOQ) C. Surveyor shared concerns regarding supervision and the provider's use of law enforcement to manage Resident 1's elopements. Surveyor shared concerns regarding the provider's utilization of staff working in a different building than the one Resident 1 resided

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in. When asked about elopement prevention measures put in place for Resident 1, PC A stated the provider added additional tasks for staff to check pagers and to replace the batteries for the pagers weekly. RN B stated Resident 1's crisis planned was developed on 07/25/2024. PC A stated an outside agency was coming to add an extra alarm in each of the hallways to ensure alarm volume was enhanced. When asked if they felt those measures were meeting Resident 1's needs, PC A stated it was not a problem until it was. PC A stated they scheduled 2 staff when they could, starting on 07/25/2024. PC A stated Resident 1 would often ignore staff until the police arrived. PC A stated they relied on the home next door to assist with Resident 1's elopements. PC A stated the staff from the other home would go with Resident 1 until police arrived to ensure s/he had supervision. PC A stated a census of 9 was the provider's typical benchmark to regularly schedule 2 staff per shift. PC A stated the provider had single staffing due to a low census.

On 08/05/2024, Surveyor reviewed Resident 1's records.

Resident 1 was admitted on 03/18/2024. Resident 1 had an activated power of attorney for healthcare (POAHC) and multiple diagnoses, including severe vascular dementia with agitation and delusional disorders.

Resident 1's Individual Service Plan (ISP), dated 04/09/2024, identified Resident 1 as a wandering and elopement risk. The ISP identified the following resident goals and outcomes: To have proper precautions and redirection techniques in place to prevent wandering and elopements. The service provider responsibilities identified the following: Staff to document any elopement

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attempts and try to redirect if resident tries to leave facility. Staff will redirect resident when resident wandering. The measurable goals and outcomes section included the following: Resident will have no successful elopement attempts over the next six months.

A document titled, "Elopements," included the following guidance for staff: If you SEE a resident walk outside, call the other house (either [Provider] or [Provider Holding Separate License Owned by Licensee] depending which house you are working in) immediately and have one of the staff working go out and be with [him/her]. (If a staff member is not available to go outside by [him/her] right away, 911 needs to be called immediately) [sic] If you DID NOT SEE resident walk outside, and cannot tell where they are outside, call 911 immediately so the police can assist with locating them. The police will need to know resident's name and what they are wearing. Staff should also call the other house to see if one of the staff members working can go outside and also look for [him/her].

A document titled, "[Resident 1's] Behavioral Crisis Plan - Elopements," read, in part, "Staff is to be aware [Resident 1] has a history of successful elopement attempts. During these behavioral episodes, [s/he] is found to exit seek multiple times and ignore redirection techniques. During these episodes, staff is to attempt to provide redirection." A section titled, "Pathway when you are working ALONE," stated, in part, "If you SEE [Resident 1] walk outside, call [Provider Holding Separate License Owned by Licensee] immediately and have one of the staff working go out to be with [him/her.] (If a staff member is not available to go outside by [him/her] right away, 911 needs to be called immediately.) If staff are

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outside with [him/her] and [s/he] is not able to be redirected back inside the facility, staff need to stay with [Resident 1] and call the non-emergency police to come and escort [Resident 1] back to the facility ...If you DID NOT SEE [Resident 1] was outside, and cannot tell where [s/ he] is outside, call 911 immediately so the police can assist with locating [him/her] ...Staff should also call [Provider Holding Separate License Owned by Licensee] to see if one of the staff members working can go outside and also look for [him/her.]"

Staff observation notes included the following:
On 03/26/2024, at 6:30 AM, Resident 1 was up twice during the night and needed physical redirection to go back to his/her room safely.
On 03/28/2024, at 5:45 AM, Resident 1 was up and wandering multiple times between 11:00 PM and 1:00 AM, trying to leave facility. Resident 1 woke up neighboring resident and had to be physically redirected back to bed multiple times.
On 03/30/2024, at 1:45 PM, Resident 1 started to exit seek around 12:30, when a family had come to visit another resident. During the first attempt, Resident 1 pushed on the door and shook the handle. It took some prompting to redirect resident. Staff suggested resident come in to eat lunch or to visit with staff but [s/he] refused but later did come into the common area. Resident attempted 4 other times and was easily redirected.
On 04/09/2024, at 3:00 AM, Resident 1 was in the living room around 3:00 AM with clothes from his/her closet and stated to staff [s/he] was going to be leaving soon.
On 04/21/2024, at 2:15 PM, Resident 1 was trying to leave the building around 1:00 PM but was easily redirected. S/he also wanted to leave around 2:00 PM but was redirected and staff

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introduced him/her to a building activity.
On 05/01/2024, at 6:30 AM, Resident 1 was awake in the living room most of the night. S/he went to the front door 3 times but did not attempt to leave.
On 05/06/2024, at 1:30 PM, Resident 1 was exit seeking, and did not want to come back into the building.
On 05/06/2024, at 1:45 PM, Resident 1 eloped from the building, walked with staff outside and was able to be redirected back to building.
On 05/08/2024, at 4:45 AM, Resident 1 was up in the living room/dining room most of the night.
On 05/08/2024, at 9:45 PM, Resident 1 walked to the front door at 9:40 and looked out the window. When staff approached and reminded Resident 1 about the time of day, Resident 1 got mad and walked back to the living room.
On 05/09/2024, at 2:30 PM, Resident 1 was exit seeking after lunch and set off alarms several times. Resident 1 would walk away from the door for about 5-10 minutes and would head back to the door and set the alarm off. After several attempts to redirect the resident from setting off the alarm, staff was able to find an activity Resident 1 stayed focused on.
On 05/10/2004, at 1:00 PM, Resident 1 attempted to leave the facility multiple times and had set off the alarm.
On 05/10/2024, at 6:15 PM, Resident eloped and was later found by the police and returned to the building.
On 05/10/2024, at 9:45 PM, Resident 1 tried to exit the facility numerous times around 9:40, pushing on the front entrance and setting off alarms 3 separate times.
On 05/18/2024, at 2:15 AM, Resident 1 was having a hard time sleeping and getting up every hour.
On 05/23/2024, at 3:30 PM, Resident 1's team

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was updated about a successful elopement attempted yesterday.
On 05/28/2024, at 1:45 PM, Resident 1 was exit seeking, and had set the alarms off.
On 05/27/2024, at 7:45 PM, Resident 1 was difficult to redirect when wandering/exit seeking.
On 05/26/2024, at 7:45 PM, Resident 1 tried to elope after dinner, setting off the alarms.
On 06/02/2024, at 5:30 PM, Resident 1 successfully eloped, and police were called to assist.
On 06/02/2024, at 5:15 PM, Resident 1 was exit seeking. RCA (Resident Care Assistant) attempted to redirect resident and after a few moments, resident went back to the common room to sit down.
On 06/07/2024, 9:45 AM, Resident 1 exhibited exit seeking behaviors and restlessness. Resident 1 walked to the door multiple times, setting off door alarm.
On 07/25/2024, at 9:15 PM, in part, "Resident had another successful elopement at 8:52pm. While staff was assisting another resident, the door alarm and pager went off. Writer immediately went to the front door [sic] but the resident had already had the door open and would not come back inside. Writer called [Provider Holding Separate License Owned by Licensee], but they only had one staff as well. Writer called 911 immediately ...This resident cannot be left alone for any amount of time or [s/he] sees it as an opportunity to elope."
On 07/25/2024, at 7:15 PM, stated, in part, "Resident tends to elope when [s/he] notices that staff is helping other residents."

A 30-Day discharge notice, dated 07/26/2024, read, in part, "Per our conversation, the decision to issue this notice of discharge is necessary for [Resident 1's] safety due to repeated elopements

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N 426	Continued From page 10 because of the imminent risk to [him/herself.]" On 08/06/2024, the department received an additional self-report indicating Resident 1 eloped on 08/05/2024. The summary stated, in part, "On 08/05/2024 at 12:30am [sic] resident left the building unattended by pushing the alarmed egress door for 15 seconds while [Caregiver K] was in another room completing [his/her] scheduled tasks. [Caregiver K] heard the door alarm and immediately responded but [Resident 1] was already outside the front door. [Caregiver K] was unable to redirect [him/her] back into the facility. Due to [Caregiver K] being the only employee in the facilioty [sic] at the time, [s/he] was unable to redirect [him/her] back into the facility. [Caregiver K] contacted the police and they were able to locate [Resident 1] and safely return [him/her] to the facility at 12:42am." At 8:26 am, Surveyor received a voicemail from PC A. PC A stated Resident 1 eloped again during the early morning hours on 08/05/2024. PC A stated Resident 1 was only gone about 10 minutes and law enforcement returned Resident 1 back to the facility. PC A stated the provider put double staffing on their overnight shifts and pulled an emergency meeting with Resident 1's care team. The team sent a referral to a locked facility and hoped to have Resident 1 placed at a different facility by the end of the week. On 08/13/2024, at 11:00 AM, Surveyor interviewed PC A, RN B, DOQ C and Administrator L. Surveyor discussed findings and concerns related to Resident 1's elopements. Administrator L stated the provider added interventions and took steps to support Resident 1. Administrator L stated Resident 1 was difficult and his/her behavior continued to get worse.	N 426		

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N 426	Continued From page 11 Administrator L stated the provider did their best to meet Resident 1's needs by constantly adding interventions but those interventions were not fully successful. Administrator L stated Resident 1 would be discharging into a more secure facility. The provider did not provide adequate supervision to meet the needs of Resident 1. The provider was aware of Resident 1's elopement risk as noted in his/her ISP, completed within 30 days after admission. Staff observation notes indicated exit seeking, wandering and elopement attempts were frequently observed by staff. The provider had approaches in place to redirect Resident 1 during elopement attempts but those approaches were not effective as evidenced by the numerous calls to police for intervention.	N 426		