STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410189	A. BUILDING: _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE 7 FIELDCREST	3003 FIELDCREST KAUKAUNA, WI 54130

(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 10/18/2024-10/30/2024, Surveyor conducted an abbreviated survey and complaint investigation at Agape 7 Fieldcrest. Two deficiencies were identified. The complaint was substantiated. Census: 8	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate injuries of unknown source. Between 06/06/2024-06/14/2024, staff and the day program provider reported bruising to Resident 1's inner thighs that were not investigated. Resident 1 had diagnoses to include cognitive disability and was unable to explain the sources of the injuries. Administrator B did not ensure injuries of unknown source were investigated. Findings include: On 07/18/2024, the Department received a	N 161		

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

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complaint alleging the provider did not report concerns of sexual abuse in a timely manner.

On 10/18/2024, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 admitted to the facility on 07/30/2016 with diagnosis of cerebral palsy, cognitive disability, and seizure disorder. Resident 1 had a guardian that assisted in decision making.

Resident 1's individual service plan (ISP) dated 06/19/2024 documented: "[Resident 1] requires full assistance with most cares. [Resident 1] uses a wheelchair at all time and is able to ambulate around the home on [his/her] own but needs full assistance when out in the community. Due to [his/her] cerebral palsy, [his/her] fine motor skills are affected so [s/he] requires assistance from staff much of the time. [Resident 1] requires full assistance with all activities of daily living. [Resident 1] makes vocalization and physical gestures that help in expressing [his/her] wants and needs."

Resident 1's body check forms documented:
"06/06/2024: Bruise on inside of right thigh with scratch.
06/07/2024: Bruise on inner thigh with scratch. No improvement.
06/08/2024: Bruise on inner thigh with scratch. No improvement.
06/09/2024: Bruise on inner thigh with scratch. No improvement.
06/10/2024: Bruises on the inner thighs with scratch. Slight improvement. Both thighs were circled on the body diagram.
06/11/2024: Bruise on inner thigh with scratch. Slight improvement.
06/12/2024: Bruises on inner thighs with scratch.

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Slight improvement. Both thighs were circled on the body diagram."

Resident 1's day program provider sent Administrator B the following email dated 06/10/2024: "SC to group home. [Resident 1] has a scratch surrounded by a bruise on [his/her] inside right thigh. [S/he] pointed it out to staff upon arrival. Group Home response: Yes, we are aware of the scratch and bruise, we believe it came from [his/her] dog at [his/her] [moms/dads]."

A review of Services Coordinator A's investigation dated 06/14/2024 into Administrator B documented:
"When I asked [Administrator B] why [s/he] didn't follow up on the bruises on [Resident 1's] legs, [s/he] stated that bruising on various areas of [Resident 1's] body is common and [s/he] thought they were from the family dog, that often jumps up on [Resident 1's] lap, again, in [his/her] opinion this was not unusual. I reminded [Administrator B] of the expectation that [s/he] needs to follow up on any injuries that [s/he] would find unusual or of unknown source. [Administrator B] stated that [s/he] understood."

On 10/28/2024, Surveyor reviewed police record #H24002214 dated 06/14/2024. The report included the following interview between police and Administrator B: "On 06/19/2024, I made contact with [provider's name] group home manager, [Administrator B] and explained that I was looking into the possible sexual assault allegations of [Resident 1]. [Administrator B] was aware of the bruising to [his/her] inner thigh. [Administrator B] stated it is not uncommon for [Resident 1] to have bruises on [his/her] body as [s/he] does hit [him/herself], scratch [his/her] skin,

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and bump into objects. However, the placement of the bruises to [Resident 1's] inner thigh are irregular and not in a normal spot. [Administrator B] first noticed the bruises to [Resident 1's] inner thigh around June 6th and last week there was a baseball sized bruise on [his/her] inner thigh. The most recent ones found were much smaller, around the size of [his/her] fingernail."

Interviews:

On 10/18/2024 at 10:05 AM, Surveyor interviewed Caregiver C. Caregiver C reported s/he started working at the provider in April. Caregiver C stated s/he had told Administrator B about suspicious bruising to Resident 1's inner thighs at least 4x but s/he never investigated further. Caregiver C reported Resident 1 would visit Person D weekly and upon returning s/he had bruising to their inner thighs. Caregiver C stated Resident 1 did not use any equipment that would lead to bruising in that area.

On 10/18/2024 at 11:15 AM, Surveyor interviewed Services Coordinator A. Surveyor asked for the investigation into Resident 1's bruising reported to his/her inner thighs on 06/06/2024 and 06/10/2024. Services Coordinator A reported s/he did not have evidence an investigation was completed and would need to talk with Administrator B who was on vacation until Monday.

On 10/21/2024 at 8:48 AM, Surveyor interviewed Day Program Director D. Day Program Director D stated s/he reported suspicious bruising on Resident 1's inner thighs to the CBRF on 6/10 and 6/14. Day Program Director D reported Resident 1 does tend to bump into things and does have bruising from time to time but never

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N 161	Continued From page 4 observed on inner thighs. On 10/30/2024 at 3:00 PM, Surveyor interviewed Services Coordinator A. Services Coordinator A reported after talking with Administrator B, Resident 1's record did not contain an investigation into bruising documented on 06/06/2024 and 06/10/2024. Services Coordinator A reported Administrator B thought the bruising to Resident 1's inner thighs was from the family dog jumping up when on home visits. Services Coordinator A acknowledged the CBRF should have conducted an investigation describing the steps taken to reach that conclusion.	N 161		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the Department within 3 working days after law enforcement personnel was called to the facility as a result of an incident that jeopardized the health, safety, or welfare of resident or employees. On 06/14/2024 and 06/19/2024,	N 164		

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police responded to the facility to investigate allegations of sexual abuse.

Findings include:

On 10/18/2024 at 10:05 AM, Surveyor interviewed Caregiver C. Caregiver C reported law enforcement came to the facility to talk to me about allegations of sexual abuse towards Resident 1. Caregiver C reported s/he was not at work when police came but made contact via telephone.

On 10/18/2024, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 admitted to the facility on 07/30/2016 with diagnosis of cerebral palsy, cognitive disability, and seizure disorder. Resident 1 had a guardian that assisted in decision making.

On 10/28/2024, Surveyor reviewed police record #H24002214 dated 06/14/2024. This report showed 2 different times law enforcement had been on site at the CBRF on 06/14/2024 and 06/19/2024 related to sexual abuse concerns involving Resident 1. These included the following:

06/14/2024: ...."[S/he] further told me that [Resident 1] and [his/her] caretaker, [Caregiver C] had left the emergency department and returned to the group home in [facility city]. I went to the group home to interview [Caregiver C], however I was advised by staff that [his/her] shift had ended and [s/he] went home. I was provided with a phone number for [Caregiver C]."

06/19/2024: "I made with contact with the [provider's name] group home manager,

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N 164	Continued From page 6 [Administrator B], and explained that I was looking into the possible sexual assault allegations to [Resident 1] .....I then cleared from [provider's name] and traveled to [name of day program] in Kimberly to speak with employees regarding their involvement from 06/14." On 10/28/2024, Surveyor reviewed Department records. There were no self-reports in the Department files regarding the above incidents. On 10/30/2024 at 3:00 PM, Surveyor interviewed Services Coordinator A regarding the above incident law enforcement responded to the facility. Services Coordinator A reported being aware police responded to the CBRF but stated "they initiated contact, we did not call." Surveyor reviewed the regulation related to notifying the Department of law enforcement involvement. Services Coordinator A reported s/he did not report the above incidents when law enforcement responded to the facility.	N 164		