STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018303	A. BUILDING: _____ B. WING _____	C 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISMARK HOME JOHN STREET	320 EAST JOHN STREET RICE LAKE, WI 54868

(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 07/08/2025, Surveyors conducted a standard survey and complaint investigation at Chrismark Home John Street. Data was collected through 07/09/2025. The complaint was substantiated. Two deficiencies were identified. Census: 6.	N 000		
N 345	83.32(3)(a) Rights of Residents: Communications In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Communications. Make and receive telephone calls within reasonable limits and in privacy. The CBRF shall provide at least one non-pay telephone for resident use. The CBRF may require residents who make long distance calls to do so at the resident ' s own expense. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not allow residents to make and receive telephone calls. Findings include: On 04/07/2025, the Department received a complaint regarding resident rights. The provider is licensed to care for 7 residents in the client groups emotionally disturbed/mental illness and developmentally disabled.	N 345		

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

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N 345	Continued From page 1 On 07/08/2025 at approximately 12:00 PM, Surveyor interviewed Resident 3, who stated the phone s/he and other residents use was locked up in a cabinet and they were not able to use the phone when they wanted. At approximately 12:30 PM, Surveyors interviewed Caregiver A, who stated s/he did not understand why phone calls were limited to 4 a day for each resident. At 12:50, Surveyors asked Caregiver A to indicate the location of the resident phone. Caregiver A pointed to a cabinet next to the staff desk. Caregiver A took his/her work keys from his/her pocket and unlocked the cabinet where the cordless phone was kept. Caregiver A stated staff must have the keys on their person at all times. Caregiver A stated that in order to use the phone, the residents have to ask staff and that s/he had heard other staff tell residents they could not use the phone. Caregiver A stated the phone used to sit on the staff desk but it had been moved into the locked cabinet about 6 months ago. At approximately 3:50 PM, Surveyors interviewed Caregiver A, who stated that if a resident went over the allotted 15 minutes to be on the phone, staff would tell them to end the call and get off the phone. On 07/09/2025, Surveyors reviewed a document titled [FACILITY NAME] House Rules that read, "All calls made from the house phone are to be limited to 15 minutes each and are also limited to the amount of calls made and received throughout the day." On 07/08/2025 at approximately 3:40 PM, Surveyors interviewed Director B, who stated they	N 345		

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N 345	Continued From page 2 encourage residents to limit calls to 4 a day. The provider did not allow residents access to a phone and limited the number of calls.	N 345		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure at least one qualified resident care staff was present, on duty and awake, when at least one resident was in need of supervision, intervention, or services on a 24-hour basis.	N 397		

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N 397	Continued From page 3 Findings include: The provider is licensed to care for up to 7 residents in the client groups of emotionally disturbed/mental illness and developmentally disabled. On 07/08/2025 at approximately 11:48 AM, Surveyor interviewed Resident 2, who stated that police had been called to the facility the evening prior due to Resident 1 acting like s/he was going to hit another resident. Resident 2 stated that Resident 1 was attempting to enter other resident rooms. At approximately 11:58 AM, Surveyors interviewed Caregiver A, who stated that Resident 1 was suicidal and had tried to access the kitchen knives. Caregiver A stated that Resident 1 tried to burn him/herself with a lighter the evening prior. At approximately 12:45 PM, Surveyors observed a twin bed located in the living room. Caregiver A stated the bed was for nightshift staff to use when they sleep. Caregiver A stated that the nightshift staff at the facility was allowed to sleep during their shift. Caregiver A stated that Resident 1 was an elopement risk but that there was an alarm on his/her door that would alert staff if s/he left his/her room. At approximately 1:52 PM, Surveyors interviewed Director B, who stated that the provider had "always been a sleep" location. At approximately 2:20 PM, Surveyor interviewed Resident 1, who stated that the alarm on his/her door was broken and had been for a couple of months.	N 397		

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N 397	Continued From page 4 At approximately 2:30 PM, Surveyors interviewed Director B. Director B stated that Resident 1 had once used a butter knife to gesture that s/he was going to stab him/herself. Director B stated that staff were directed to lock up all knives and forks as a precaution. Director B stated that Resident 1 eloped multiple times but had never done it during the night and that there was an alarm on Resident 1's door if s/he were to walk out. At approximately 4:00 PM, Surveyors observed that the alarm on Resident 1's room appeared to have a piece missing that would affect its functionality. On 07/09/2025, at approximately 10:00 AM, Surveyors reviewed Resident 1's record, which included the following information: - Resident 1's care plan indicated that s/he was in need of "some supervision." The care plan indicated that Resident 1 had elopement/wandering risks and directed staff to "provide supervision and redirection to avoid and prevent wandering episodes." - Resident 1's care plan listed him/her as having suicidal tendencies. Directions for staff were to "provide supervision and assistance in preventing and redirecting suicidal thoughts and behaviors" and stated that "it has been reported that [Resident 1] can become suicidal pretty quickly ...staff will need to keep a close eye on [Resident 1] when [s/he] seems upset to ensure that [s/he] does not try to harm [him/herself]." - Resident 1's care plan directed staff that s/he "must be supervised to help prevent and alleviate any destructive/abusive behaviors or incidents." - Resident 1's County Crisis Plan Referral listed him/her as having "a history of suicidal and homical [sic] threats."	N 397		

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N 397	Continued From page 5 - Observation notes, dated 05/30/2025, 06/12/2025, 06/25/2025, 07/02/2025, 07/04/2025, 07/07/2025, and 07/08/2025, described incidents where Resident 1 was threatening to kill and/or harm him/herself. - An observation note, dated 07/07/2025, stated that Resident 1 had taken another resident's lighter and was threatening to burn him/herself. S/he then threatened to hit another resident and attempted to get into another resident's locked room. The police were called to handle the behaviors. - An observation note, dated 06/12/2025, indicated Resident 1 was threatening another resident. - Observation notes, dated 06/08/2025, 06/12/2025, 06/16/2025, and 06/17/2025, described incidents where Resident 1 had eloped from the facility. At 3:20 PM, Surveyors interviewed Director B, who stated Resident 1 had eloped 5 times. Director B stated staff had always slept at night. The provider did not ensure there was a qualified resident care staff on duty and awake at all times to provide supervision for a resident at risk of elopement and who was self-abusive.	N 397		