STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016937	A. BUILDING: _____ B. WING _____	C 10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESCARE GERMOND B	**2969B GERMOND RD RHINELANDER, WI 54501**

(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 10/26/2023, Surveyor conducted a self-report investigation at ResCare Germond B. Data collection continued through 10/30/2023. One deficiency was identified. Census: 4	M 000		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on record review and interview, the provider permitted the existence and continuation of a condition in the home which placed the health, safety and welfare of residents at risk. The facility was left unstaffed on 09/14/2023 and Resident 1 eloped. Findings include: The provider is licensed to care for 4 residents in the following client groups: traumatic brain injury, developmentally disabled and irreversible dementia/Alzheimer's disease. The facility shares a side-by-side duplex with the provider's licensed Adult Family Home (AFH) - ResCare Germond A. The Department received a self-report on 09/18/2023, reporting Resident 1 eloped on 09/14/2023 at approximately 8:00 AM. Resident 1 was located approximately 2 miles away at	M 230		

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

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M 230	Continued From page 1 Nicolet College. Nicolet College contacted Oneida County Sheriff's Department and Oneida County Sheriff's Department contacted the provider. Resident 1 was missing for approximately 15 minutes and was returned to the facility via staff. On 10/26/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 04/27/2018. According to Resident 1's ISP, dated 09/06/2023, Resident 1 was considered an elopement risk and required 24-hour supervision with awake overnight staff and door alarms. According to Resident 1's behavioral support plan (BSP), dated 03/14/2023, Resident 1 had an elopement history and the following elopement approaches were noted: Complete and document door chime checks every shift, Report if door chimes are not working to Site Supervisor or Area Supervisor immediately, Keep [Resident 1] within line of sight when possible. Resident 1's elopement severity was noted as "Severe." Per prior self-reports submitted to the Department, Resident 1 eloped on 07/30/2018, 08/16/2018, 01/12/2023 and 01/13/2023. A self-report submitted to the Department on 09/18/2023, read, in part, "[Resident 1], who has a history of eloping, eloped. Staff [Program Manager (PM) A] got other individuals up and ready for work and then left to transport informing Staff 2 [Caregiver C] that [Resident 1] was still in bed and that the door alarms were on. 15 minutes later Staff 2 reported that [Resident 1] had eloped and was by Nicolet College (2 miles away from the house.) Police were called, and Staff went to pick [Resident 1] up. [Resident 1] was missing for 15 minutes. A former employee stayed with [Resident 1] where [s/he] was found until police and Staff arrived."	M 230		

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M 230	Continued From page 2 According to accuweather.com, at the time Resident 1 eloped (8:00 AM on 09/14/2023), the outside temperature was 38 degrees. The provider is located approximately 2.3 miles from Nicolet College (5 minute via car ride, 47 minutes via walk). The facility is in a wooded, residential area with a main highway, Hwy 8, located nearby. On 10/26/2023 at 11:20 AM, Surveyor interviewed PM A. PM A reported that Resident 1 eloped a few minutes after PM A took Resident 2 and Person D (from provider's next door licensed AFH) to work at Headwaters on 09/14/2023 at 8:00 AM. PM A indicated that prior to taking Resident 2 and Person D to work, PM A informed Caregiver C (caregiver working at provider's next door licensed AFH) that Resident 1 was still sleeping. PM A indicated that along with Resident 1, two other residents (Resident 3 and Resident 4) were left and there were three residents next door (Person E, Person F, Person G) with Caregiver C. PM A reported that Site Supervisor (SS) B was scheduled to work at 8:00 a.m. on 09/14/2023 but was running late. PM A reported that s/he left Resident 1 and two other residents in the facility and instructed Caregiver C to check in on Resident 1, who was sleeping at the time. PM A reported that Resident 1 "must have eloped within 5 minutes" after PM A left the building. PM A stated that the door alarms have been "faulty" and have "worked on and off since they were put in." PM A noted the door alarm did not go off when Resident 1 eloped on 09/14/2023. PM A indicated Resident 1 was wearing a fleece jacket, sweatpants and shoes (no socks, no shirt) when s/he eloped. On 10/26/2023 at 11:45 AM, Surveyor interviewed Caregiver C. Caregiver C reported, "On 09/14/2023, I was working on Side A and [PM A]	M 230		

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M 230	Continued From page 3	M 230		

was working on Side B. [PM A] took [Resident 2] and [Person D] to work at Headwaters. [PM A] told me [Resident 1] and the other two [guys/gals] (Resident 3 and Resident 4) were sleeping. I was with three residents (Person E, Person F, Person G) on side A. [PM A] left around 8:00 AM. [SS B] was running late and was supposed to work at 8:00 AM on 09/14/2023. [Resident 1] must have eloped within five or so minutes after [PM A] left." Caregiver C indicated that s/he did not hear a door alarm. Caregiver C stated, "[Resident 1] needs one to one supervision...Typically if [Resident 1] is up when staff run errands, [s/he] either comes over to side A or s/he goes on the ride with staff."

On 10/26/2023 at 12:10 AM, Surveyor interviewed SS B. SS B indicated, "I was scheduled to work at 8:00 AM on 09/14/2023. I was running late. On my way to work - I got a call that [Resident 1] eloped and was at Nicolet College." SS B noted that Resident 1 needed one to one supervision and door alarms. SS B reported, "If [Resident 1] went next door (to side A) or went on the transport or if I was on time for work on 09/14/2023, there would have been 'zero chance' [Resident 1] would have eloped." SS B reported the door alarms do not always work. SS B reported that Resident 1 ran through the woods to get to Nicolet College.

In summary, the provider did not ensure the door alarms were working properly and did not provide supervision necessary for three residents; the provider permitted the existence and continuation of putting residents at risk of harm.