STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017999	A. BUILDING: _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON ST HOUSE	**300 BUTTS AVENUE TOMAH, WI 54660**

(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 07/14/2023, Surveyor conducted a complaint investigation and a standard licensure survey at Jackson St House. Information for this survey was received and reviewed through 07/27/2023. The complaint was substantiated. Two deficiencies were identified. Census: 7	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the department was notified when Resident 1 was taken to the emergency room (ER) and then hospitalized. Findings include: The provider is licensed to care for 8 residents in the client groups developmentally disabled, physically disabled alcohol and drug dependent, terminally ill, emotionally disturbed/mental illness, and traumatic brain injury. The department received a complaint stating	N 165		

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

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N 165	Continued From page 1 Resident 1 ingested antifreeze at the facility on 06/07/2023. Resident 1 was taken to the ER in Tomah and then to the hospital in La Crosse. On 07/14/2023 at approximately 10:00 AM, Surveyor reviewed an incident report, dated 06/07/2023, with Administrator A. The incident report indicated Resident 1 was taken to the ER in Tomah and then to the hospital. Surveyor asked Administrator A if Resident 1 was treated in the ER and hospitalized. Administrator A stated yes and that Resident 1 did not return to the facility after being hospitalized. Survey asked Administrator A if a report was sent to the department regarding the hospitalization of Resident 1 on 06/07/2023 or 06/08/2023. Administrator A stated a report was not sent to the department regarding Resident 1 being hospitalized.	N 165		
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 adequate supervision for	N 426		

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N 426	Continued From page 2 Resident 1, who had a history of suicide attempts. Findings include: The provider is licensed to care for 8 residents in the client groups developmentally disabled, physically disabled, alcohol and drug dependent, terminally ill, emotionally disturbed/mental illness, and traumatic brain injury. The department received a complaint regarding Resident 1. On 07/14/2023 at 9:30 AM, Surveyor asked for the any incident reports regarding Resident 1. Surveyor also asked for the facility file for Resident 1. The facility file indicated Resident 1 was diagnosed with alcoholism. Surveyor was provided an incident report, dated 06/07/2023. The report indicated Resident 1 ingested antifreeze on 06/07/2023 and was both coherent and not coherent after the ingestion. The report indicated that Resident 1's speech was slurred. The report also indicated Resident 1 was taken to the ER in Tomah by emergency medical technicians and then to the hospital in La Crosse. Resident 1 was incubated and lab testing results indicated Resident 1 ingested antifreeze. On 07/27/2023, Surveyor reviewed the initial assessment completed by the provider for Resident 1. The assessment was dated 02/01/2023. The assessment indicated Resident 1 was a suicide risk and had several attempts of suicide in the past. The assessment did not indicate Resident 1's preference for suicide attempts. The assessment indicated Resident 1 should be supervised when shopping. On 07/14/2023 at approximately 10:30 AM,	N 426		

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N 426	Continued From page 3 Surveyor interviewed Administrator A regarding Resident 1 ingesting antifreeze at the facility. Administrator A stated Resident 1 purchased the antifreeze at a local store without staff knowing it was purchased. Resident 1 brought the antifreeze in the facility undetected by staff and Resident 1 ingested the antifreeze in his/her room without the knowledge of staff. Administrator A stated Resident 1 was taken to the ER and later hospitalized. Resident 1 did not return to the facility after being hospitalized. Administrator A stated staff would monitor Resident 1's shopping and purchases for alcohol but did not realize they would need to supervise Resident 1 for antifreeze purchases. On 07/27/2023 at 11:00 AM, Surveyor again interviewed Administrator A. Administrator A stated the initial assessment was done face to face with Resident 1 and there was mention of antifreeze being used in a prior suicide attempt during that assessment. Administrator A stated Resident 1 should have been supervised better but there was no real indication that Resident 1 would attempt suicide by consuming antifreeze. Administrator A was not sure if Resident 1 drank alcohol while ingesting the antifreeze.	N 426		