STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018300	A. BUILDING: _____ B. WING _____	C 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREST	5601 SHERMAN STREET WAUSAU, WI 54401

(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 03/10/2025, Surveyor conducted a complaint investigation at Spring Crest. Data collection continued through 03/17/2025. The complaint was substantiated. Three deficiencies were identified. Two of the 3 were repeat violations. See Statement of Deficiency (SOD) SDM311, dated 06/30/2021, and SOD U2D311, dated 03/17/2022. Census: 8	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct an appropriate investigation or maintain documentation of an investigation, when Resident 1's cell phone went missing. The provider did not report the situation to the Office of Caregiver Quality (OCQ). This is a repeat deficiency. See Statement of Deficiency (SOD) U2D311, dated 03/17/2022 and SOD SDM311, dated 06/30/2021. Findings include: The provider is licensed to provide care for 8 adults from client groups emotionally disturbed/mental illness, developmentally disabled, and traumatic brain injury. On 01/06/2025, the department received a complaint related to misappropriation of resident property. On 03/10/2025, at approximately 11:45 AM, Surveyor interviewed House Supervisor (HS) A. HS A stated Resident 1's cell phone went missing in December 2024. HS A stated s/he talked to a few staff about the allegations. HS A stated his/her boss also talked to a few staff about the incident. Surveyor asked how s/he documented those investigations and HS A stated it was mostly a verbal investigation. HS A stated s/he would ask Human Resources (HR) B if s/he had any investigation documentation. HS A sent a message via his/her laptop to HR B. When asked if the incident was reported to the department, HS A provided a self-report that was sent to the Bureau of Assisted Living. HS A stated s/he did not know if the report was sent to the OCQ. HS A	N 158		

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N 158	Continued From page 2 stated the provider determined Caregiver C took the cell phone and was subsequently terminated. At 12:26 PM, HS A emailed Surveyor the response that was received from HR B regarding the investigation of Resident 1's missing property. HR B stated within the email, "Not a formal internal investigation. We spoke with some staff, and based on those conversations moved forward with terminating the employee suspected of the theft, contacted guardians, and contacted the police department to report." At 4:08 PM, Surveyor received an email from HS A about submitting the report of Resident 1's missing property to the OCQ. HS A stated, "Unfortunately, due to the departure of our previous Director of Resident Services, we currently do not have the ability to confirm if a caregiver quality report was made for the staff about the incident that took place on 12/20/2024." Cross Reference N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	N 158		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property.	N 348		

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N 348	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was free from misappropriation of property. Resident 1 had a cell phone stolen from the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) SDM311, dated 06/30/2021. Findings include: The provider is licensed to provide care for 8 adults from client groups of emotionally disturbed/mental illness, developmentally disabled, and traumatic brain injury. On 12/20/2024, the department received a self-report stating: "On 12/20/2024, the resident approached staff asking about when will [his/her] phone be returned [sic]. The resident then handed the staff A [sic] and Staff A noticed the screen was cracked. Staff A then took the phone to the House Suopervisor [sic]. The House Supervisor (HS) asked the resident where was [his/her] phone [sic]. The resident stated that [s/he] gave [his/her] phone to a different staff member to complete updates. Staff A and House Supervisor then asked to search the resident's room. The resident gave permission. The device was not recovered." Under an "Incident Outcome" section, it read, "Police was contated [sic] to attempt to retrives [sic] the device from the alleged staff." Under an "Action Taken" section, it read, "An internal investagation [sic] is conducted. There will be a meeting and re education [sic] on Residents Rights and Abuse, Neglect and Misappropriation."	N 348		

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N 348	Continued From page 4 On 01/06/2025, the department received a complaint related to misappropriation of resident property. On 03/10/2025, at approximately 11:45 AM, Surveyor interviewed HS A. HS A stated Resident 1's cell phone went missing in December 2024. HS A stated after speaking with staff about the incident, it was identified Caregiver C took Resident 1's cell phone. HS A stated the police were notified and Caregiver C was terminated after the incident. Surveyor requested Resident 1's records pertaining to the incident. Resident 1 was admitted on 12/20/2023 and had a guardian. An incident report, dated 12/20/2024, stated, in part, "[Resident 1] approached staff asking when [his/her] phone was going to be returned to [him/her]...[Resident 1] stated that the staff member took [his/her] phone to complete updates. House supervisor then asked [Resident 1] if they can go look in [his/her] room....House superivosr [sic] did contact the police to see if the device could be retrieved." At approximately 12:15 PM, Surveyor interviewed Caregiver D. Caregiver D stated a staff member took Resident 1's cell phone and lied about it. Caregiver D stated the lie caught up to the staff member and s/he no longer worked for the provider. On 03/11/2025, Surveyor requested any police reports involving Resident 1's misappropriation of property via email. At 12:54 PM, Surveyor received an event report dated 12/20/2024, from the police department. The nature of the report was described as	N 348		

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N 348	Continued From page 5 criminal miscellaneous. The report indicated staff suspected Caregiver C of taking Resident 1's cell phone. It stated Resident 1 had a history of reporting to staff that his/her electronics were taken by staff and the reports had been dismissed. The report stated Resident 1's iPad had an identification photo that appeared to be Caregiver C. It stated staff noticed Caregiver C's boy/girl friend's headphones were detected on Resident 1's account. The phone had been turned off and was unable to be tracked. It stated that while officers were on the scene, Caregiver C's boy/girl friend's headphones disappeared from Resident 1's device. Caregiver C was searched, and the phone was unable to be located. Caregiver C denied having the phone. At 3:21 PM, Surveyor emailed HS A and asked about any efforts made by the provider to replace Resident 1's phone. On 03/12/2025, at 8:53 AM, Surveyor received an email from HS A. HS A stated the provider sent a check in the amount of $350 to Resident 1's guardian for the phone. The provider did not ensure Resident 1 was free from misappropriation of property, when his/her cell phone was taken from the facility. Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect	N 348		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas	N 481		

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N 481	Continued From page 6 shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide an environment that was safe, clean, comfortable, and homelike. Findings include: The provider is licensed to provide care for 8 adults in the client groups of emotionally disturbed/mental illness, developmentally disabled, and traumatic brain injury. On 01/06/2025, the department received a complaint related to facility cleanliness. On 03/10/2025, at approximately 11:35 AM, Surveyor noticed a strong odor upon entering the facility. At approximately 11:45 AM, Surveyor interviewed House Supervisor (HS) A. HS A stated housekeeping was a shared task among caregivers. HS A stated there were typically 4 staff scheduled during the morning shift, 4 staff during the afternoon shift, and 3 staff during the overnight shift. HS A stated cleaning tasks were completed daily but not documented. HS A stated s/he would walk around the facility to ensure cleanliness and if issues were identified, s/he would ask staff to address them accordingly. HS A stated s/he did not have any current concerns related to housekeeping. When asked about any recent staff misconduct, HS A stated Caregiver E had been recently terminated. Surveyor requested Caregiver E's disciplinary	N 481		

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N 481	Continued From page 7 documentation from HS A. At 12:57 PM, Surveyor observed 2 pieces of flooring that had started to curl upward, causing as a trip hazard. One of the pieces was separated and raised approximately 1 inch from the subflooring. The other piece was beginning to separate from the subflooring and had a slight incline. Both pieces of flooring were observed in the main dining area and accessed by all residents, staff, and visitors. At approximately 1:00 PM, Surveyor asked HS A about the flooring. HS A stated s/he was aware of the flooring concerns and stated the provider had a couple of quotes for new flooring. HS A stated new flooring was expected to be installed sometime in April. At approximately 1:30 PM, Surveyor reviewed records for Caregiver E, including a disciplinary action form, signed on 01/23/2025. The form stated that on 01/21/2025, the provider created a task list for Caregiver E to complete. Caregiver E was tasked with cleaning the residents' bathrooms and doing the residents' laundry. It stated that when the supervisor walked through the facility, they observed the bathrooms were not cleaned and laundry was not done. It included a subsection that indicated a prior discussion or warning on that subject was provided on 01/08/2025. A separation letter in Caregiver E's file indicated Caregiver E's last day of employment was 01/27/2025. At approximately 2:00 PM, Surveyor interviewed HS A about the odor that was noticed upon entering the building. HS A stated the trash cans stunk, and s/he recently ordered 6 new trash bins. HS A stated s/he hoped it would address the	N 481		

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N 481	Continued From page 8 present odor. The provider did not provide an environment that was safe, clean, comfortable, and homelike. The flooring was damaged and in need of repair. There was an unpleasant odor upon entering the building and a history of staff not completing cleaning duties as assigned.	N 481		