STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009105	A. BUILDING: _____ B. WING _____	R-C 03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM NAMEKAGON LOOP	1222 NAMEKAGON LOOP HUDSON, WI 54016

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{M 000}	INITIAL COMMENTS On 03/06/2025, Surveyor conducted a verification visit, self-report investigation, and complaint investigation at REM Namekagon Loop. Data was collected through 03/14/2025. The complaint was substantiated. Three violations were identified. One of 3 violations was a repeat deficiency. See Statement of Deficiencies (SOD) JZC611, dated 12/21/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
{M 246}	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 caregivers sampled, Direct Support Professional (DSP) J, completed 8 hours of continuing education training in 2024. This is a repeat violation. See Statement of	{M 246}		

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

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{M 246}	Continued From page 1 Deficiencies (SOD) JZC611, dated 12/21/2023. Findings include: On 03/11/2025, Surveyor reviewed staff training records. DSP J was hired on 01/20/2017. DSP J's record included 1 training certificate for 2024, a medication administration class completed on 09/24/2024. On 03/14/2024, Surveyor asked Regional Director (RD) G about DSP J's medication administration class and if s/he completed other training in 2024. Surveyor received the following emails from RD G on 03/14/2025: - At 3:06 PM, "If the training was in person, as it appears this one was based on the type of certificate it is 2 hours. I asked the leadership about [DSP J's] file and was told [s/he] was on leave for most of 2024 so I anticipate this is the only formal training [s/he] received during that time. - At 5:57 PM, "[DSP J] was not working February through June (2024). From June to November [s/he] worked very minimally (average 2 days per month). I recognize we still have to ensure that staff receive adequate continuing education regardless of how many shifts they work."	{M 246}		
M 534	88.09(2)(a)10 DOCUMENTATION OF DISCIPLINARY ACTION Description of any disciplinary action. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Direct Support	M 534		

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Professional (DSP) B's record included documentation of corrective action. Program Supervisor (PS) C and Program Director (PD) E were informed of concerns regarding DSP B's performance and transfer techniques on 2 occasions between November 2024 and January 2025. PD E and PD D investigated the concerns, talked to DSP B, and assigned DSP B to additional training to correct performance issues. The provider's records did not include documentation of these incidents.

Findings include:

On 12/12/2024, the Department received a caregiver misconduct incident report from the provider. The report indicated DSP A was terminated for violating Resident 2's right to be free from seclusion and for being "inappropriate and disrespectful" toward Resident 1 and Resident 2. The report indicated DSP B was aware of DSP A's behavior as early as June 2024, and DSP B did not report DSP A until November 2024.

On 02/26/2025, the Department received a complaint related to the provider's response to caregiver misconduct.

On 03/06/2025 at approximately 8:30 AM, Surveyor interviewed PS C. PS C shared details of 2 caregiver misconduct investigations of which s/he was aware. One was the incident reported to the Department on 12/12/2024; the second involved DSP B. PS C summarized the second incident for Surveyor. PS C stated Resident 1 sustained 2 head injuries (both requiring medical attention) between November and January, while DSP B was working. PS C stated the first incident occurred in November in the bathroom; DSP B hit

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M 534	Continued From page 3 Resident 1's head on the grab bar when s/he was transferring him/her. PS C stated s/he had observed DSP B transfer Resident 1 aggressively/abruptly in the bathroom before and PS C attempted to correct DSP B's transfer techniques prior to this incident, but DSP B continued to transfer Resident 1 his/her way. PS C stated upper management talked to DSP B and s/he was assigned a training course on safe transfer techniques after the November incident. PS C stated Resident 1 sustained an almost identical head injury in January while DSP B was working. According to DSP B's report, another resident (Resident 2) attempted to transfer Resident 1 when DSP B stepped away and Resident 1 fell. PS C stated s/he had concerns about the accuracy of DSP B's report, and this incident was investigated by upper management. On 03/06/2025, Surveyor requested the provider's internal investigation summaries for all incidents between November 2024 and January 2025. On 03/07/2025, Regional Director (RD) G sent Surveyor documentation, but it did not include evidence of an investigation into concerns about DSP B. On 03/11/2025, Surveyor sent RD G an email asking if the provider conducted any investigations on situations involving DSP B and Resident 1. RD G wrote back, "The incident with [Resident 1] and [DSP B] was not a formal investigation but was in incident report. In summary, staff was using the bathroom and heard a thud. Upon exiting the bathroom [sic] staff witnessed [Resident 1] on the floor with [his/her] housemate standing over [him/her]. Housemate stated [Resident 1] looked uncomfortable in [his/her] chair and was trying to help [him/her]. [Resident 1] was assessed at the ER (emergency room) and was admitted for UTI (urinary tract infection). See Incident number	M 534		

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M 534	Continued From page 4 921192 for more detail." On 03/11/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/23/2020. DSP B wrote the following progress note in Resident 1's record on 11/27/2024: "Staff toileted [Resident 1] after [his/her] breakfast ... Staff got [him/her] in the shower [sic] dressed and ready for the day... [Resident 1] spent some time in the living room with the other [people of same sex] watching cartoons while doing [his/her] pegs. Staff got lunch ready early for [him/her] due to [Guardian H] picking [Resident 1] up for an appointment ... [S/he] was very whimpery [sic] and emotional today non stop [sic] crying... Staff checked in on [him/her] [sic] she had a nose bleed and was also bleeding from her head [sic] it was just about to drip down into her eyes. Staff grabbed a wash cloth [sic] with soap and cleaned [him/her] up nicely before [Guardian H] had came [sic]. Staff assumed that [Resident 1] had scratched and dug at the scabs on [his/her] head to cause the bleeding, scratching and picking is a regular thing. Staff notified [Guardian H] of both the emotions and the nose and head bleed ... Staff helped [Guardian H] and [Resident 1] to the car and into the car, staff reminded [Guardian H] of [Resident 1's] head. While [Guardian H] and [Resident 1] was being seen [sic] by the doctor [sic] staff was being questioned infront [sic] of doctor but with a tone of concern. Staff got nervous and contacted supervisor and director." The incident report, dated 11/27/2024 read: "What Happened? Staff checked in on [Resident 1] and saw [s/he] had a nose bleed [sic] and was also bleeding from [his/her] head. Staff cleaned [Resident 1] and helped stop bleeding. It	M 534		

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appeared the bleeding from [his/her] head was from [Resident 1] scratching at scabs [s/he] had on [his/her] head- scratching and picking is a regular behavior for [him/her]...
Describe the Administrative, Health/Safety, Treatment, and Other Actions Taken to Address the Incident to Date: ensure [sic] safety measures are being used in transfers...
Briefly describe the cause of injury. initial [sic] cause of scabs possibly occurred in transfer."

Resident 1's record did not provide more detail on the transfer that could have caused the scabs or injury.

DSP B wrote the following progress note in Resident 1's record on 01/12/2025: "Staff cleaned [him/her] up, sanitized all areas that got thrown up on and got [him/her] in the shower to have [him/her] feel better. Staff took our time with [him/her] and wanted [him/her] to enjoy [his/her] shower, [sic] staff got [Resident 1] in [his/her] pj's [sic](pajamas). Staff placed [him/her] in [his/her] living room recliner surrounded by pillows to prop [him/her] up and a blanket to keep warm feet was [sic] up. Staff stepped away to use the bathroom, [sic] staff heard a loud Boom [sic]. Staff hurried out and seen [sic] resident on the floor, and another resident that was questioning [Resident 1's] well being [sic] all day over [Resident 1's] body. Staff asked resident what happened? Resident stated that '[Resident 1] did't [sic] look comfortable, and it looked like [s/he] wanted to get up' [sic] [Resident 2] stated that '[s/he] was just trying to be helpful.' [sic] [Resident 2] was worried if [s/he] was in trouble? Staff got [Resident 1] to a sitting position and back into [his/her] wheelchair. Staff immediately called supervisor and directors. [Resident 1] was bleeding from [his/her] head, [sic] staff was

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directed to get [Resident 1] dressed and supervisor was to take [him/her] to the ER and [Guardian H] was going to meet them there. Staff washed down the wheelchair in the shower."

The incident report, created on 01/12/2025 at 3:00 PM, read: "Staff had transferred [Resident 1] to [his/her] rocking chair. Staff had gone to use the restroom. Staff heard a thud. When staff come [sic] out of the restroom, they saw [Resident 1] on the ground and [Resident 1's] housemate standing over [him/her]. Staff asked what happened and the housemate said that they were only trying to help and make [Resident 1] more comfortable. Housemate had adjusted [Resident 1's] chair and [Resident 1] had fallen out of the chair and had a mark on [his/her] head. PS responded to take [Resident 1] to the emergency room...
What are the characteristics of the injury? Suspected Head Injury...
What caused the injury? Fall"

On 03/11/2025 at 4:40 PM, Surveyor interviewed Guardian H. Guardian H shared details of the 11/27/2024 head injury. Guardian H stated s/he arrived at the facility to pick Resident 1 up for an appointment. When s/he approached Resident 1, s/he saw s/he was bleeding. Guardian H stated to DSP B, "Oh my God! What happened?" Guardian H said DPS B said s/he thought s/he had stopped the bleeding. Guardian H said s/he brought Resident 1 to his/her scheduled appointment, and the physician recommended Resident 1 be seen at the emergency department (ED) because the wound needed stitches. Guardian H said s/he brought Resident 1 to the ED and they closed the wound with liquid sutures. Guardian H said s/he was later told staff bumped Resident 1's head on the bar in the bathroom and staff were retrained

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on proper transfer techniques. Guardian H provided Surveyor a picture of the wound before it was glued; the wound appeared to be a laceration approximately 1 to 1.5 inches in length. Guardian H also provided a picture of Resident 1's head injury from the 01/12/2025 incident. The injury appeared to be of similar size, but slightly closer to the forehead hairline than the first. Guardian H stated s/he was happy with the services overall, but s/he felt that sometimes the reports s/he received on incidents did not seem plausible. Guardian H stated s/he questioned what happened on 01/12/2025 and stated s/he voiced his/her concern to PS C after the incident. Guardian H stated Resident 1 and Resident 2 had lived together for years and Resident 2 had never attempted to transfer or reposition Resident 1 before. Guardian H stated the injury also did not seem likely from a fall out of the recliner.

On 03/12/2025 at 8:00 AM, Surveyor interviewed PS C. PS C stated Guardian H reported his/her concern to PS C about the 01/12/2025 incident. PS C stated s/he did not bring the concern to upper management until about 9 days later when s/he heard Resident 2's recap of the incident. PS C stated s/he and Resident 2 were making a dessert on 01/21/2025 and Resident 2 stated, "I'm sorry I helped put [Resident 1] in [his/her] chair." PS C stated the comment was unprompted, and s/he asked questions to find out what Resident 2 was talking about. PS C said Resident 2 said "[DSP B] had me put [Resident 1] back in [his/her] chair." PS C stated Resident 2 said the incident occurred in the bathroom during Resident 1's shower. Resident 2 told PS C that Resident 1 fell, and DSP B called for Resident 2 (who was in the living room at the time) to come and help DSP B get Resident 1 off the bathroom floor and into his/her chair. PS C stated s/he

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immediately notified PD E. Surveyor asked PS C what correction measures were taken as a result of the concerns s/he reported to PD D and PD E. PS C said PD E came to the home, sat in the recliner DSP B reported Resident 1 fell out of, and could not figure out how the injury occurred. PS C stated PD D and PD E then met with DSP B at the facility while PS C was on site. PS C stated the directors questioned DSP B about the incident. PS C stated s/he heard PD D discuss another example of a caregiver who reported an incident falsely and the provider found the truth from a resident; PD D explained it was grounds for immediate termination. PS C stated PD D and PD E told PS C that they did not believe the incident on 01/12/2025 happened as DSP B reported it, but there was nothing they could do about it. Surveyor asked why DSP B would lie about the incident. PS C stated because DSP B had just gotten into trouble for improperly transferring Resident 1 in November. PS C stated that when Guardian H brought Resident 1 to the doctor on 11/27/2024, Guardian H called DSP B at the home so the physician could ask DSP B what happened. PS C stated the physician questioned how DSP B could believe the injury was just a scratch. PS C stated Guardian H called PS C after the appointment and discussed everything with PS C. PS C stated s/he reported the situation to PD E and DSP B was talked to and was reassigned a training on transfers. PS C stated that after the 01/12/2025 incident, DSP B did not shower Resident 1 again. DSP B was transferred to another home owned by the licensee shortly after.

On 03/11/2025, Surveyor reviewed DSP B's record provided by RD G on 03/11/2025. DSP B was hired on 11/17/2023. DSP B's record did not include any corrective action or evidence of

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conversations s/he had with management related to failing to report abuse/neglect or providing adequate care to residents.

On 03/13/2025 at noon, Surveyor interviewed PD D, PD E, Quality Improvement Director (QID) F, and RD G. RD G stated staff were expected to immediately report any allegations of abuse or neglect to their director. The director who received the report would consult with QID F to determine the next step. PD E stated DSP B was talked to during the investigation regarding DSP A because s/he did not report concerns immediately. PD E stated, "[S/he] should have contacted us immediately when [s/he] was aware of the concern." PD D said they assigned DSP B an online training course on abuse and neglect prevention and resident rights. RD G stated, "In hindsight, we should have had more of a formal conversation with [DSP B] about it."

PD D stated concerns were brought to his/her attention about DSP B not using proper transfer techniques when transferring Resident 1. PD D said s/he learned of these concerns after DSP B hit Resident 1's head on the bathroom grab bar. PD D recalled that Guardian H picked up Resident 1 for a routine appointment that same day and the physician looked at the injury. Surveyor asked when this incident occurred. QID F and RD G reviewed the record and could not find record of the incident. Surveyor referred the management team to Resident 1's 11/27/2024 progress note and incident report that referenced Resident 1 bleeding from picking scabs on his/her head. PD E confirmed this was the day the transfer incident happened, although the record did not reflect this. PD E stated s/he was called after Resident 1's appointment on 11/27/24, but s/he was not aware Resident 1's

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M 534	Continued From page 10 physician questioned DSP B about the incident. PD E stated s/he was informed by PS I that PS I found blood on the grab bars in the bathroom on 11/27/2024. PD E stated s/he later questioned DSP B about the incident and injury; "[DSP B] couldn't give me a clear answer... [s/he] thought [Resident 1] scratched [him/herself] with [his/her] fingernail." PD E stated s/he asked DSP B if something happened in the bathroom, but PD E said DSP B could not give a clear answer. RD G stated, "In hindsight, we should have looked into this... this should have been investigated." QID F stated, "It should have triggered an injury of unknown origin investigation... that is definitely the procedure." At approximately 12:40 PM, Surveyor asked the management team if they were aware of any concerns related to Resident 1's fall on 01/12/2025. PD E stated concerns were brought to his/her attention. PD E stated s/he went to the facility, sat in the recliner, and tried to determine how Resident 1 could have fallen to cause the injury s/he sustained to his/her head. PD D stated s/he and PD E also met with DSP B to discuss the incident. PD D stated they did not document this meeting. Surveyor asked if the incidents referenced above should have been recorded in DSP B's record. RD D responded, "I think the key piece we are missing is we didn't document." Cross reference: M0572 DHS 88.10(3)(n) Freedom From Abuse	M 534		
M 572	88.10(3)(m) Freedom from Abuse Freedom from abuse. To be free from	M 572		

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M 572	Continued From page 11 physical, sexual or mental abuse, neglect, and financial exploitation or misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were free from abuse. In November 2024, the provider investigated allegations that Direct Support Professional (DSP) A mistreated Resident 2. The allegations were substantiated. The investigation found that staff failed to report allegations of misconduct for over 5 months. Findings include: The provider is licensed to care for 4 residents from the client groups physically disabled, emotionally disturbed/mental illness, and developmentally disabled. On 12/12/2024, the Department received a caregiver misconduct incident report (MIR) from the provider. The MIR, dated 12/11/2024, indicated the provider was notified of DSP A's misconduct on 11/21/2024. DSP A was placed on suspension, and internal investigation was conducted, and DSP A was terminated. The allegations investigated included: - DSP A would not allow Resident 2 to come out of his/her room until 7:00 AM when the morning staff came in. - DSP A engaged in verbal abuse. - DSP A refused to perform necessary care to residents. The investigation read, "It can be concluded most likely true that [DSP A] has violated [Resident 2's] individual right to be free from seclusion.	M 572		

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It can be concluded most likely true that [DSP A] has engaged in conduct that was inappropriate and disrespectful toward and about [Resident 2]."

The investigation found that DSP B was witness to DSP A's behavior as early as June 2024. DSP B did not report DSP A until November 2024. Program Supervisor (PS) C was also witness of DSP A's behavior prior to 11/21/2024.

On 03/06/2025 at approximately 8:45 AM, PS C provided a verbal summary of each resident. PS C stated Resident 2 (admitted to the home on 02/29/2008) had the strongest verbal communication skills of the residents in the home and was the most independent. PS C said Resident 2 was diagnosed with downs syndrome. Resident 2 required cues, supervision, and reassurance.

PS C stated s/he observed a positive change in Resident 2's behavior, anxiety, confusion, and level of comfort in the home after DSP A left.

On 03/12/2025 at 8:00 AM, Surveyor interviewed PS C. PS C stated s/he began working at the facility on 06/03/2024. PS C said within the first 10 days, s/he began addressing concerns with DSP A. PS C said s/he started taking personal notes due to the way DSP A responded to his/her feedback. PS C stated s/he tried to handle things on his/her own first, but eventually reported DSP A to Program Director (PD) E via written statement in July 2024. PS C stated s/he did not have a copy of the statement, but it was a summary of the personal notes s/he kept. PS C stated this resulted in PD D and PD E meeting with DSP A on 07/26/2024 to discuss a variety of performance concerns. PS C stated DSP A's behavior improved slightly after the meeting, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009105	A. BUILDING: _____ B. WING _____	R-C 03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM NAMEKAGON LOOP	1222 NAMEKAGON LOOP HUDSON, WI 54016

(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 572	Continued From page 13 s/he continued to have concerns with the way DSP A treated residents. PS C said it always came down to PS C's word against DSP A's word, so nothing was done about it. On 11/21/2024, PS C learned that DSP B received text messages from DSP A that called Resident 2 vulgar names and stated DSP A refused to help residents. PS C said s/he went above his/her supervisors and reported the issued to Regional Director (RD) G. PS C stated, "I don't know if anything before got up to [RD G]." On 03/12/2025, Surveyor reviewed PS C's personal notes. The notes indicated DSP A engaged in a variety of disruptive behaviors such as yelling and swearing at staff in front of residents, slamming doors, ripping up the menu, gossiping about staff, etc. The notes outlined the following concerns specific to DSP A's behavior toward Resident 2: - 06/07/2024, DSP A ignored Resident 2. Resident 2 continued to try to engage in a conversation with DSP A. DSP A told Resident 2 that s/he was not allowed to speak to DSP A. DSP A continued to ignore Resident 2 and refused to speak to Resident 2 through 06/17/2024. - 06/29/2024, Resident 2's family came to take Resident 2 on an outing. Resident 2 wanted to wear a dress, but DSP A would not allow it. PS C's notes indicate DSP A's tone was "very rude" to Resident 2. According to the provider's investigation report, DSP B received text messages from DSP A on 06/15/2024 and 11/04/2024 that called Resident 2 inappropriate names. On 06/15/2024, DSP A's text message included, "[Resident 2] can stay in [his/her] room till u [sic] get there. I'm done with [him/her]... [S/he] stays n [sic] [his/her] room till 7	M 572		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 572	Continued From page 14 (AM) person get there. Bottom line." On 03/13/2025 at noon, Surveyor interviewed PD D, PD E, Quality Improvement Director (QID) F, and RD G. RD G stated staff were expected to immediately report any allegations of abuse or neglect to their director. The director who received the report would consult with QID F to determine the next step. PD E stated PS C reported concerns about DSP A's attitude toward staff and gossiping. PD E denied knowing about resident-related concerns prior to 11/21/2024. RD G stated, "[PS C] as a program supervisor, should have followed up immediately... I feel like [s/he] tried to address [DSP A's] behavior, but nothing formal... what kicked it off was [DSP B] talked to [PS C] and reported [his/her] concerns." PD E stated DSP B was talked to during the investigation because s/he did not report concerns immediately. PD E stated, "[DSP B] should have contacted us immediately when [s/he] was aware of the concern."	M 572		