STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015387	A. BUILDING: _____ B. WING _____	C 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM WISCONSIN III INC REDWOOD	S7935 REDWOOD DRIVE EAU CLAIRE, WI 54703

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M 000	INITIAL COMMENTS On 09/04/2024, Surveyor conducted a standard survey, complaint investigation and self-report investigation at REM Wisconsin III INC Redwood. The complaint was substantiated. Four deficiencies were identified. One of the 4 was a repeat violation. See Statement of Deficiency (SOD) 1BP411, dated 03/29/2022. Census: 3	M 000		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was clean and well-maintained. This is a repeat deficiency. See Statement of Deficiency (SOD) 1BP411, dated 03/29/2022. Findings include: The provider is licensed to care for 4 residents in the client groups developmentally disabled, emotionally disturbed/mental illness, and traumatic brain injury.	M 276		

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

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M 276	Continued From page 1 On 09/04/2024, from approximately 8:00 AM to 1:00 PM, Surveyor was on site and observed the following: Upstairs Bathroom - Utilized by Residents -The lower right section of the bathtub had what appeared to be a plastic access door with a keyhole on it. The door had a hole approximately 4 inches wide and 4 inches long. -The light fixture above the sink allowed for 4 light bulbs. 2 light bulbs were functioning. 1 light bulb was burned out and 1 light socket did not contain a bulb. Backyard -Disabled Mag Lock was mounted on wooden gate with exposed wiring. -A freestanding basketball hoop attached to a pole and what appeared to be a weighted base was lying horizontally near the gate exit door. The branches and leaves of an outdoor bush had wrapped around the pole. Laundry Room -A door leading to the backyard from the laundry room was covered in dust and dirt. Stairway Wall -The wall above a hand railing from the main floor to the lower level had scuffed paint spanning a length of approximately 4 feet. Resident 2's Bedroom -The wall near Resident 2's bed had a hole	M 276		

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M 276	Continued From page 2 approximately 2 inches wide by 3 inches long. -The wall near the door had a small hole near the door handle. -The wall above the light switch had brown and yellow stains. At approximately 9:20 AM, Surveyor discussed observations made with Program Supervisor (PS) B. PS B stated it was hard to do certain maintenance given the needs of the residents. PS B stated the holes in Resident 2's room had been there for a few years and Resident 2 had eaten wet drywall in the past. At approximately 11:30 AM, Surveyor discussed observations made in the backyard with PS B. When asked about the basketball hoop, PS B stated it had been in that location for approximately 2 and a half years. PS B stated the bushes grew over it and s/he forgot it was there. When asked about the exposed wires, PS B stated the wires were disconnected. PS B stated the provider was waiting to see if Mag Locks would be re-installed. At approximately 12:45 PM, Surveyor interviewed PS B and Caregiver A. Surveyor reviewed concerns in the environment. PS B stated the provider would have the maintenance worker address the concerns.	M 276		
M 402	88.06(2)(c)8 RESIDENT RIGHTS AND GRIEVANCE A statement indicating that the resident rights and grievance procedures have been explained and copies provided to the resident and the resident's guardian or designated	M 402		

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M 402	Continued From page 3 representative, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents reviewed (Resident 1) received the resident rights and grievance procedure upon admission. Findings include: On 09/04/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 12/14/2021. Resident 1 had a legal guardian. Resident 1's binder included 2 empty page protectors with Post-it notes attached to them. The Post-it notes read, "Individual Bill of Rights" and "Grievance Policy." Resident 1's record did not include evidence that resident rights or the provider's grievance procedure was explained or provided upon admission. At 9:58 AM, Surveyor interviewed Program Supervisor (PS) B. PS B stated s/he was going to guess Resident 1 did not have evidence the resident rights and grievance procedure was provided and explained upon admission. PS B acknowledged the Post-it notes and stated s/he assumed s/he noticed that issue in the past and did not get back to it.	M 402		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility.	M 436		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1 received services as specified in his/her individual service plan (ISP), when Resident 1 was unsupervised in the community. Resident 1 eloped on 10/06/2023 and 06/06/2024.

Findings include:

The provider is licensed to care for 4 residents in the client groups developmentally disabled, emotionally disturbed/mental illness, and traumatic brain injury.

On 06/06/2024, the department received a complaint alleging residents had been found in neighborhood homes without staff supervision.

On 06/07/2024, the department received a self-report submitted by the provider. The report stated the incident occurred on 06/06/2024, at 8:09 AM. The incident description read, in part, "[Caregiver A] was outside on a break when a deputy approached [him/her] to go to the neighbor's house to help bring [Resident 1] home. Previously, [Caregiver A] had assisted [Resident 1] to the fenced in back yard [sic] where [s/he] likes to spend a lot of time, [sic] gone [sic] inside to use the restroom downstairs, went back upstairs, grabbed some of [his/her] things and went out front, believing [Resident 1] was in the backyard. [Caregiver A] acknowledged [s/he] didn't check to ensure the gate was closed as it always is and that in [his/her] experience, [Resident 1] doesn't try to open it without staff when it's shut. It is presumed lawncare service

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left the gate open after they performed their work. [Caregiver C] had been in the living room with the other two persons served ..." The incident outcome read, in part, "[Caregiver A] and the deputy went to the neighbor's and assisted [Resident 1] home ..."

On 09/04/2024, at 8:30 AM, Surveyor interviewed Program Director (PD) D and Caregiver A. PD D stated Resident 1 had eloped 3 times and 2 of those times Resident 1 was unsupervised. PD D stated Resident 1 disrobed and entered a neighbor's home sometime last fall. PD D stated the neighbor called the police and the incident happened during the overnight hours. PD D stated Resident 1 eloped again to the same neighbor's home during the early part of summer. Caregiver A stated the lawncare service did not secure the backyard gate and s/he did not think to check it. Caregiver A stated that during the summer incident, an officer approached him/her for assistance with getting Resident 1 back home. Caregiver A stated that during the fall incident, Resident 1 was naked at the time of elopement. PD D stated Resident 1 likely snuck out when staff was using the bathroom or when staff was smoking. PD D determined Resident 1 was able to identify when staff was preoccupied. PD D stated the neighbor had snacks and items Resident 1 was interested in. PD D stated the provider updated the elopement plan and wanted to reapply for Mag Locks to be installed on the property.

At approximately 9:00 AM, Surveyor interviewed Program Supervisor (PS) B. Surveyor discussed the complaint allegations. PS B stated the complaint was valid and Resident 1 made it into the neighbor's home twice. PS B stated the first incident was confusing because staff had no idea

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when Resident 1 left the home. PS B stated the provider had implemented safety measures, including staff ensuring the screen door at the front of the house was locked.

At approximately 9:30 AM, Surveyor reviewed Resident 1's records.

Resident 1 was admitted on 12/14/2021. Resident 1's Individual Service Plan (ISP), dated 04/09/2024, indicated Resident 1 required 24/7 supervision due to his/her inability to ensure his/her own safety and his/her need for full assistance with all health monitoring, administration of medications, bathing, dressing, ADL's (Activities of Daily Living), behavioral challenges including elopement risk, and overall safety at home and in the community. On a page titled, "Medications," it included an Epi pen and identified Resident 1 had a bee sting allergy. On a page titled, "Individual's Rights," with a subsection titled, "Support Interventions Utilized (Check All that Apply)" it had boxes checked identifying, "1:1 supervision" and "2:1 supervision." Under a section titled, "Describe Support Interventions," it read, in part, "Supervision monitors for pica like behavior."

An Elopement Protocol specific to Resident 1, dated June of 2024, read, in part, " ...Since [his/her] admission in December 2021 admission [sic] [s/he] had now eloped twice off of the property. The first time was in October 2023 and the second time, June 6 [sic] 2024. In both situations, [Resident 1] went across the street and entered a neighbor's house. In both situations, [Resident 1's] exit from the property was unwitnessed ..." Under a "Medical Considerations and Allergies" subsection, it stated, "Diagnoses: Cerebral Palsy but is

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assumed (by [his/her] PCP (Primary Care Provider)) to also have undiagnosed autism and pica." Under a "Behavioral Considerations" subsection, it stated, in part, " ...In addition to the medical considerations, communicate that [Resident 1] is especially vulnerable because of some of [his/her] personal characteristics such as not understanding or applying boundaries with others, being overly trustful, [his/her] potential of being overly compliant, and a lack of sexual boundaries. Additionally, communicate [s/he] can be aggressive when upset but that the aggression is minor and [s/he] is of small frame but contains an incredible amount of strength. Food will be the best motivator when found to comply with returning [Resident 1] home."

On 10/09/2023, the provider submitted a self-report to the department. The report stated the incident occurred on 10/06/2023, at 7:01 AM. The report read, in part, "A neighbor came to the door and told [PS B] [s/he] saw a resident outside, nude, at a neighboring house's door. [PS B] ran to [Resident 1] and saw [s/he] had bm (Bowel Movement) on [his/her] legs which was likely why [s/he] had taken [his/her] clothes off. [Resident 1] resisted going back to [his/her] home and sat on the ground and scooted [his/her] bottom, causing some road rash. [Caregiver A] came to assist and [PS B] and [Caregiver A] got [Resident 1] home where [s/he] was further evaluated for injury with none noted."

On 09/04/2024, at approximately 10:35 AM, Surveyor interviewed PS B. When asked what safety measures were put into place after the October 2023 elopement, PS B stated the provider created the elopement protocol, but it was not in depth because they did not have supporting information to include. PS B stated

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M 436	Continued From page 8 that after the summer elopement, the provider added additional information to the protocol. PS B stated the provider implemented motion detectors and added an alarm on the patio door. PS B stated a behavior support plan (BSP) had been started but was still in the development phase. PS B stated Area Manager (AM) E was working on it. The provider did not ensure Resident 1 received staff assistance for services related to supervision specified in his/her ISP.	M 436		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a written order from the physician for 2 of 2 residents reviewed who required staff to administer their medications. Resident 1 and Resident 2 did not have a written order permitting the provider staff to administer medications.	M 464		

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M 464	Continued From page 9 Findings include: On 09/04/2024, at 9:30 AM, Surveyor reviewed resident records provided by Program Supervisor (PS) B. The records included the following: - Resident 1 was admitted on 12/14/2021. Resident 1's Individual Service Plan (ISP), dated 04/09/2024, indicated staff completed all tasks related to medication management and administration. Resident 1's record did not include a written physician order permitting staff to administer medications. - Resident 2 was admitted on 07/19/2012. Resident 2's ISP, dated 04/08/2024, indicated Resident 2 relied fully on staff for the preparation and administration of his/her medications. Resident 2's record did not include a written physician order permitting staff to administer medications. At 11:22 AM, Surveyor interviewed PS B. Surveyor asked PS B if Resident 1 and Resident 2's record included a written order for staff to administer medications. PS B stated s/he knew Resident 1's written order was missing. Surveyor observed PS B review both Resident 1 and Resident 2's binders. PS B stated it appeared Resident 2's order was also missing. PS B stated the provider would obtain the written orders and include them in Resident 1 and Resident 2's record.	M 464		