STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019940	A. BUILDING: _____ B. WING _____	C 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK ST CBRF	5006 CHADWICK ST WESTON, WI 54476

(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 11/12/2025, Surveyors conducted a complaint (x2) investigation at Chadwick St. CBRF. Data collection continued through 11/13/2025. The complaints were unsubstantiated. One deficiency was 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 send a written report to the Department within 3 working days after Resident 1 fell and was hospitalized. Findings include: The provider is licensed to care for up to 8 residents in the following client groups: physically disabled, traumatic brain injury, developmentally disabled. On 09/18/2025 and 10/03/2025, the Department received complaints alleging verbal abuse, care concerns (weight loss & hygiene) and facility maintenance (grab bars).	N 165		

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

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N 165	Continued From page 1	N 165		

On 11/12/2025 at approximately 9:00 AM, Surveyor interviewed Caregiver B. Surveyor asked about the census. Caregiver B reported that Resident 1 was a resident but was currently residing in a rehabilitation facility.

On 11/12/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/01/2023. Resident 1 had the following diagnoses: Generalized Weakness, High blood pressure, Diabetes mellitus type 2 (obese), Depressive disorder, Intellectual disability. According to a "Medical/Injury Incident Report Form," dated, 10/17/2025 (4:00 PM), Resident 1 fell off the toilet and "was stuck between toilet and wall" and was sent to the hospital. Resident 1's medical records indicated that Resident 1 was admitted to the hospital after falling off the toilet on 10/17/2025. Medical records noted that Resident 1 received medical care for the fall which resulted in x-rays, imaging and being placed in a protective shell ("turtle shell") around his/her torso.

On 11/12/2025 at approximately 10:30 AM, Surveyor interviewed House Manager (HM) A. Surveyor asked about Resident 1's fall on 10/17/2025. HM A reported that Resident 1 fell off the toilet on 10/17/2025 and was hospitalized. HM A stated that Resident 1 was currently in a rehabilitation facility in [Named City]. Surveyor asked HM A if the fall was reported to the Department. HM A responded, "I was told I did not have to report."

On 11/13/2025 Surveyor reviewed Department records. Department records did not contain a report involving Resident 1's fall on 10/17/2025.

On 11/13/2025 at approximately 1:37 PM, Surveyor interviewed HM A via telephone. HM A

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK ST CBRF	**5006 CHADWICK ST WESTON, WI 54476**

(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 165	Continued From page 2 verified that Resident 1 was hospitalized after falling at the facility on 10/17/2025, and had been out of the facility since. HM A indicated that Resident 1 was treated for a back injury. HM A confirmed that Resident 1 was currently residing at a rehabilitation facility in [Named City]. HM A verified that HM A did not report Resident 1's fall to the Department.	N 165		