STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012325	A. BUILDING: _____ B. WING _____	R-C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRU GROUP HOME INC BROWN DEER MANOI	8238 N 44TH ST BROWN DEER, WI 53209

(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 05/01/2024, Surveyor conducted a verification visit and 1 complaint investigation at CRU Group Home Brown Deer Manor. Three deficiencies were identified. Two of 3 were repeat deficiencies. One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 7	{N 000}		
{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 all residents received the supervision identified in their Individual Service Plans (ISPs) for 7 of 7 residents. Former Caregiver (FC) Q left Residents 4, 5, 7, 8, 9, 10, and 11 unattended on 04/10/2024, from 11:38 PM until 04/11/2024 at 12:22 AM, when Operations Manager (OM) B arrived. Some residents required 24-hour supervision and cares throughout the night.	{N 426}		

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

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{N 426}	Continued From page 1 This requirement is being cited for third time. See Statement of Deficiency (SOD) KJ5Z11, dated 01/25/2023, and SOD KJ5Z12, dated 08/01/2023. Findings include: On 04/18/2024, the department received a complaint alleging residents were alone between approximately 11:38 PM until 12:22 AM on 04/10/2024 and 04/11/2024. FC Q called the police and stated [their] relief has not shown up to work and [they] needed to pick up [their] child. Operations Manager (OM) B was notified there was no staff at the home. OM B arrived at the facility at 12:22 AM. FC Q was terminated as a result of his/her actions. On 04/11/2024, OM B submitted a self-report which identified FC Q left the residents before the next shift caregiver arrived. On 05/01/2024, Surveyor reviewed Brown Deer Police Department Incident Report Number 24-004704, dated 04/10/2024, authored by responding Police Officer R. The police report stated, "On 04/10/2024, [FC Q] was on-duty and employed as a caregiver at the Brown Deer Manor Group Home when [s/he] left the facility for approximately one hour without being relieved by another caregiver. [FC Q] left several adults with various physical and cognitive disabilities home alone without any caregivers or responsible adults to care for them. This case will be referred to the Milwaukee County District Attorney's Office for charging considerations." On 05/01/2024, Surveyor reviewed resident records and identified the following:	{N 426}		

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{N 426}	Continued From page 2 -Resident 4 was admitted on 03/27/2009. Resident 4's ISP, dated 04/26/2023, identified Resident 4 required 24-hour supervision and total assistance for all activities of daily living. Resident 4's check and change schedule was identified as daily at 10:00 PM, 2:00 AM, and 6:00 AM and toileting as needed to remain clean and dry. -Resident 5 was admitted on 09/30/2020. Resident 5's ISP, dated 03/28/2023, identified Resident 5 required 24-hour supervision and total assistance for all activities of daily living. Resident 5's check and change schedule was identified as daily at 10:00 PM, 2:00 AM, and 6:00 AM and toileting as needed to remain clean and dry. -Resident 7 was admitted on 09/13/2017. Resident 7's ISP, dated 03/31/2023, identified Resident 7 required "some supervision" but did not specify what some supervision was for Resident 7. Resident 7 required repositioning and changes daily at 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 AM, 4:00 PM, 6:00 PM, 8:00 PM, and 10:00 PM. Resident 7 had a history of pressure ulcers and positioning every 2 hours was required to prevent further pressure ulcers from developing and promote healing. -Resident 8 was admitted on 03/16/2019. Resident 8's ISP, dated 03/07/2023, identified Resident required 24-hour supervision. The ISP stated, "Staff monitoring and/or reminders and cues to complete toileting tasks." -Resident 9 was admitted on 08/14/2023. Resident 9's ISP, dated 08/17/2023, identified Resident required 24-hour supervision. The ISP stated, "Resident displays destructive behaviors.	{N 426}		

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{N 426}	Continued From page 3 [They] will become verbally intrusive, demanding, paranoid and makes false accusations. Staff to encourage [them] to decrease stimulation by going outside, smoking a cigarette, or listen to music that calms [them] down when this occurs. Allow resident to go to hospital if [s/he] feels this is helpful." -Resident 10 was admitted on 03/06/2023. Resident 10's ISP dated 04/27/2024, identified Resident required 24-hour supervision and staff assistance with pain management. -Resident 11 was admitted on 03/07/2024. Resident 11's ISP dated 03/02/2024, identified Resident requires 24-hour supervision. The ISP stated, "Resident has history of bipolar and schizoaffective. S/he will at times have irrational thoughts." On 05/01/2024, at approximately 11:30 AM, Surveyor interviewed OM B. OM B reported the residents were left alone from 11:38 PM when caregiver left until 11:41 PM when the officer arrived. OM B stated, "I arrived at the house at 12:24 AM." OM B reported all residents were safe when s/he arrived at the facility. OM B confirmed FC Q left his/her shift before the next shift arrived and was terminated as a result.	{N 426}		
N 531	83.47(4)(a) Fire extinguishers: type and inspection. At least one portable dry chemical fire extinguisher with a minimum 2A, 10-B-C rating shall be provided on each floor of the CBRF. All fire extinguishers shall be maintained in readily usable condition. Inspections of the fire extinguisher shall be done by a qualified	N 531		

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N 531	Continued From page 4 professional one year after initial purchase and annually thereafter. Each fire extinguisher shall be provided with a tag documenting the date of inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 3 of 3 fire extinguishers were maintained in readily usable condition and inspected by a qualified professional annually in 2023. Findings include: On 05/01/2024, at approximately 1:30 PM, Surveyor toured the facility. Surveyor observed 3 fire extinguishers located throughout the facility. All fire extinguishers had inspection tags dated December 2022. There was not an inspection conducted by a qualified professional in 2023 or the first 4 months of 2024. On 05/02/2024 at approximately 2:30 PM, Surveyor interviewed Director of Maintenance (DM) S and asked if they were aware the fire extinguishers were out of compliance. DM S stated they were not aware but would get them inspected right away.	N 531		
{N 639}	83.59(2)(a) One-hand, one-motion door operation All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 3 exterior doors were able to	{N 639}		

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{N 639}	Continued From page 5 be opened from the inside with a one-hand, one-motion (OHOM) operation without having to turn the locks on the doors to disengage the lock, affecting 7 of 7 residents residing in the facility. This requirement is being cited for the third time. See Statement of Deficiency (SOD) KJ5Z11, dated 01/25/2023, and SOD KJ5Z12, dated 08/01/2023. Findings include: On 05/01/2024, Surveyor observed levered door handles on the west exit (main entrance) and the southeast exit (dining room) of the facility. The levered door handles contained a turn lock button on the handle. Surveyor engaged the lock on the west exit (main door) and attempted to open the door by pushing on the handle. The lock did not disengage, and the door did not open. The exit door was not equipped with OHOM latching hardware. Surveyor engaged the lock on the southeast exit (dining room) and attempted to open the door by pushing on the handle. The lock did not disengage, and the door did not open. The exit door was not equipped with OHOM latching hardware. On 05/01/2024, at 1:45 PM, Surveyor interviewed Operations Manager B. Operations Manager stated, "I thought maintenance replaced those after the last surveyor was here." On 05/02/2024 at approximately 2:30 PM, Surveyor interviewed Director of Maintenance (DM) S. DM S stated they had replaced the doorknobs after the last state visit but said they must have installed the wrong kind.	{N 639}		