STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	590134	A. BUILDING: _____ B. WING _____	C 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTRIDGE	**3841 96TH ST CHIPPEWA FALLS, WI 54729**

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M 000	INITIAL COMMENTS On 11/06/2024, Surveyor conducted a complaint investigation at Westridge. Data collection continued through 11/19/2024. The complaint was substantiated. Two deficiencies were identified. Census: 2	M 000		
M 572	88.10(3)(m) Freedom from Abuse Freedom from abuse. To be free from 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 neglect. On 07/07/2024 at 7:00 PM, Resident 1 had a disagreement with Resident 2 and called the police. Caregiver D feared the police and left the provider leaving 4 of 4 residents unsupervised by staff for approximately 20 minutes. Findings include: On 07/26/2024 the Department received a complaint alleging staff left the provider and residents unsupervised by staff after police arrived on 07/07/2024. The provider is licensed to care for 4 adults in the client groups developmentally disabled and emotionally disturbed/mental illness.	M 572		

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

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M 572	Continued From page 1 On 11/06/2024 at approximately 11:30 AM, Surveyor requested from Program Manager (PM) B, an incident report for the alleged incident on 07/07/2024. The incident report indicated Resident 1 called the police at 7:00 PM on 07/07/2024 due to a disagreement with another resident but did not refer to the caregiver leaving residents unsupervised. On 11/06/2024 at approximately 11:45 PM, Surveyor interviewed PM B. PM B confirmed Caregiver D was working the shift on 07/07/2024, when Resident 1 called the police. PM B indicated Caregiver D became scared when the police came and handed his/her keys over to the police, leaving the provider and residents unsupervised by staff for less than 30 minutes. PM B confirmed some residents required 24/7 supervision and Resident 2 was still on 15-minute checks for self-harm. Surveyor requested Caregiver D's record and the internal investigation for the incident. PM B called Regional Director (RD) A via phone. PM B stated RD A said s/he was at a conference and would not be able to get the documents until the following day. PM B confirmed Caregiver D was terminated the same day of the incident, an internal investigation was completed, and the Office of Caregiver Quality (OCQ) was notified. Surveyor requested from PM B, Resident 1's and Resident 2's records. Resident 1 was admitted to the provider on 10/29/2020 and had diagnoses that included disruptive mood dysregulation disorder, social phobia, generalized anxiety disorder, attention-deficit hyperactivity disorder, oppositional defiant disorder, and frontal lobe and executive function deficit. Resident 1 had a guardian. The Individual Service Plan (ISP), dated 03/26/2024, indicated Resident 1 required	M 572		

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M 572	Continued From page 2	M 572		

24/7 supervision due to elopement risk. A staff progress note for 07/07/2024, from 8:00 PM to 7:00 AM, written by Caregiver E, read in part, "[Resident 1] was outside with peer when staff arrived. There were 3 cops waiting for staff to arrive."

Resident 2 was admitted to the provider on 01/05/2021 and had diagnoses that included delusional disorders, schizoaffective disorder, major depressive disorder, post-traumatic stress disorder, factitious disorder imposed on self, mild cognitive impairment, and suicidal ideations. Resident 2 had a guardian. The ISP, dated 03/08/2024, indicated Resident 2 had a history of suicide attempts and if s/he threatened to hurt him/herself, s/he would be put on 10-to-15-minute checks or line-of-sight supervision. Staff progress notes indicated on 07/03/2024 that Resident 2 reported feelings of self-harm and suicide, along with cutting him/herself on the evening shift. Resident 2 was placed on 15-minute checks for the next 72 hours. Staff progress notes indicated on 07/07/2024 that Resident 2 was still having suicidal and self-harm thoughts.

On 11/07/2024 at 9:39 AM, Surveyor requested the police report for the 07/07/2024 incident. The police report indicated police arrived at the provider on 07/07/2024 at 7:03 PM, and read, in part, "Ultimately [Resident 1] calmed down and advised that [s/he] was just frustrated but both group home members reconciled. While at the residence [Caregiver D] became upset that law enforcement was on scene. Due to [Caregiver D's] frustration [s/he] proceeded to tell Deputies that [s/he] quit and provide [sic] us with the keys."

On 11/08/2024 at 1:13 PM, Surveyor requested via email from RD A, additional documentation

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M 572	Continued From page 3	M 572		

(including face sheets and ISPs for Resident 3 and Resident 4), any incident investigations, and the period of time the residents were left without staff at the provider on 07/07/2024, when Caregiver D left the provider.

On 11/11/2024 at 4:59 PM, Surveyor received the requested documents via email from RD A. RD A responded to how long the residents were left alone at the provider, "The clients were left without staff for approximately 20 minutes."

Resident 3 was admitted to the provider on 11/28/2022 and had diagnoses that included schizophrenia, depression, attention-deficit hyperactivity disorder, cognitive deficit, and suicidal ideations. Resident 3 was his/her own decision- maker. The ISP, dated 03/11/2024, indicated Resident 3 required 24/7 supervision but had privileges to self-supervise at the provider for up to 4 hours.

Resident 4 was admitted to the provider on 11/21/2023 and had diagnoses that included schizoaffective disorder, body dysmorphic disorder, anorexia nervosa, and trichotillomania. Resident 4 had a guardian. The ISP, dated 04/08/2024, indicated Resident 4 required 24/7 supervision but had privileges to self-supervise at the provider for up to 2 hours.

A statement by PM B, dated 07/08/2024, indicated police were called to the provider on 07/07/2024 by Resident 1 due to a disagreement with Resident 2. Caregiver D expressed concern via phone to PM B that s/he was fearful of being arrested. PM B reassured Caregiver D the police were there to de-escalate the situation and not arrest anyone. Caregiver D informed PM B s/he had called Caregiver E to come in and relieve

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M 572	Continued From page 4	M 572		

him/her as s/he was still anxious about the situation. The statement indicated that 15 minutes later, PM B received a phone call from Caregiver D "stating that [s/he] threw [his/her] keys at the officer, told the officer [s/he] quit, and they can do what they want to [him/her] as [s/he] was not going to be arrested." Caregiver D informed PM B s/he was already driving in his/her car. PM B explained, "to [him/her] how [s/he] could not leave clients unattended as this would be neglect and asked [him/her] to wait until [Caregiver E] arrived. [Caregiver D] again stated, 'I'm not going to be arrested' then hung up." The officer called PM B to update him/her on Caregiver D quitting, throwing his/her keys at police, and driving off in his/her car. PM B worked with RD A to get another caregiver from a closer provider to cover until Caregiver E could cover the rest of the shift.

A text message from Caregiver D to PM B, dated 07/09/2024 at 8:02 AM, read, in part, " ...I am fearful of police [sic] they have done bad things to me and I got scared [sic] I have lot to lose so I went home ..."

The investigation report, dated 07/09/2024, indicated Caregiver D was working on 07/07/2024, from 3:00 PM to 7:00 AM. The report indicated the police agreed to remain at the provider with the residents until a relief staff arrived. The relief staff arrived 15 minutes later. The police left the provider after the relief staff arrived and relief staff remained at the provider until Caregiver E arrived. Caregiver D continued to not answer PM B's and RD A's phone calls. The report read, in part, "[Caregiver D] was immediately terminated ...when [s/he] left the provider during [his/her] shift and leaving the clients unattended."

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M 572	Continued From page 5 On 11/15/2024 at 11:06 AM, Surveyor interviewed Guardian F. Guardian F indicated s/he filed a report with the county's adult protective services (APS) due to the caregiver leaving the provider. Guardian F stated s/he was told they would not investigate due to the police remaining with the residents until relief staff arrived. On 11/19/2024 at 1:30 PM, Surveyor interviewed RD A. RD A stated s/he was not sure if Resident 2 was still on 15-minute checks when Caregiver D left the provider on 07/07/2024. RD A stated that staff may have charted on a separate form and would provide it by 5:00 PM. On 11/19/2024 at 4:10 PM, Surveyor received via email from RD A, staff documentation of 15-minute checks for Resident 2. Surveyor reviewed the checks, which indicated Resident 2 was on 15-minute checks from 07/03/2024 to 07/07/2024. The documentation indicated Caregiver D did not chart 15-minute checks on 07/07/2024 at 7:30 PM and 7:45 PM. The provider did not ensure residents were free from neglect when Caregiver D left the provider and 4 out of 4 residents were unsupervised by staff on 07/07/2024, for approximately 20 minutes. During the time of the incident, Resident 2 was still on 15-minute checks for suicidal and self-harm thoughts and Resident 1 required 24/7 supervision. Cross Reference M0618 DHS 88.11(5) Completed Investigation Notification	M 572		

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M 618	Continued From page 6	M 618		
M 618	88.11(5) COMPLETED INVESTIGATION NOTIFICATION After the investigating agency has completed its investigation, the investigating agency shall notify the parties identified in sub. (2) of its findings and shall, in addition, notify the following agencies if the report of abuse or neglect has been substantiated: This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the Office of Caregiver Quality (OCQ) of its findings after completing a caregiver misconduct investigation. Findings include: On 07/26/2024 the Department received a complaint alleging staff left the provider and residents unsupervised by staff after police arrived on 07/07/2024. On 11/06/2024 at approximately 11:30 AM, Surveyor requested from Program Manager (PM) B, an incident report for the alleged incident on 07/07/2024. The incident report indicated Resident 1 called the police at 7:00 PM on 07/07/2024, due to a disagreement with another resident, but did not refer to the caregiver leaving residents unsupervised. On 11/06/2024 at approximately 11:45 PM, Surveyor interviewed PM B. PM B confirmed Caregiver D was working the shift on 07/07/2024 when Resident 1 called the police. PM B indicated Caregiver D became scared when the	M 618		

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M 618	Continued From page 7	M 618		

police came and handed his/her keys over to the police, leaving the provider and residents unsupervised by staff for less than 30 minutes. Surveyor requested Caregiver D's record and the internal investigation for the incident. PM B called Regional Director (RD) A via phone. RD A stated s/he was at a conference and would not be able to get the documents until the following day. PM B confirmed Caregiver D was terminated the same day of the incident, an internal investigation was completed, and the results were submitted to OCQ.

On 11/08/2024 at 2:23 PM, Surveyor received Caregiver D's record and the report to OCQ. The misconduct incident report for OCQ had "DRAFT" labeled across the pages and had no name or date by the report submission.

On 11/08/2024 at 9:43 AM, Surveyor reached out to OCQ to confirm if the provider sent in a report for the 07/07/2024 incident. OCQ responded back at 9:49 AM with the following, "There is nothing submitted searching by facility, incident number and named accused. The report you attached says "draft" below the incident number, they likely did not finalize and submit."

On 11/08/2024 at 1:13 PM, Surveyor requested via email from Regional Director (RD) A, documentation confirming a report was sent to OCQ for the incident on 07/07/2024.

On 11/11/2024 at 4:59 PM, Surveyor received other requested documents from RD A, but did not receive documentation confirming a report was sent to OCQ for the incident on 07/07/2024.

On 11/19/2024 at 1:30 PM, Surveyor interviewed RD A. RD A stated s/he was responsible to

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M 618	Continued From page 8 submit the report to OCQ and it had been his/her first time submitting one. RD A stated s/he went to submit the report to OCQ the day after the incident occurred. Surveyor requested a report submission confirmation by 5:00 PM. On 11/19/2024 at 4:10 PM, Surveyor received an email from RD A, which read, in part, "I must not have submitted the caregiver misconduct report correctly or there was some type of issue because I just hit the submit button again and it gave me this report that I attached." Surveyor reviewed the attached reported and confirmed it now indicated who submitted the report and the date of report submission for 11/19/2024 at 4:07 PM. The provider did not notify OCQ of its findings after completing a caregiver misconduct investigation for an incident that occurred on 07/07/2024. Cross Reference M0572 DHS 88.10(3)(m) Freedom From Abuse	M 618		