STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012316	A. BUILDING: _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM WISCONSIN INC COVEY	1535 COVEY DR RIVER FALLS, WI 54022

(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 000	INITIAL COMMENTS On 07/31/2025, Surveyor conducted a complaint investigation at REM Wisconsin Inc Covey. The complaint was substantiated. One deficiency was identified. Census: 4	M 000		
M 610	88.11(1) REPORTING OF ABUSE AND NEGLECT A licensee or service provider who knows or has reasonable cause to suspect that a resident has been abused or neglected as defined in s. 46.90 or 940.285, Stats., shall immediately contact the licensing agency. Providing notice under this subsection does not relieve the licensee or other person of the obligation to report an incident to law enforcement authorities. If the licensee has reason to believe a crime has been committed, the incident shall immediately be reported to law enforcement authorities. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the licensing agency when the service provider had reasonable cause to suspect 4 of 4 residents were neglected by Caregiver B when s/he used the company van for	M 610		

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

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M 610	Continued From page 1	M 610		

personal use and left the home unsupervised.

Findings include:

On 05/06/2025, the Department received a complaint regarding caregiver misconduct.

On 07/31/2025 at approximately 11:00 AM, Surveyor interviewed Program Supervisor (PS) A and asked if there were any recent allegations of caregiver misconduct. PS A stated there was an incident regarding Caregiver B that was reported by Resident 1's day program where Resident 1 alleged Caregiver B pushed him/her down. PS A stated the allegation was reported to his/her supervisor (Program Director (PD) C) and Caregiver B was suspended pending the investigation. PS A stated s/he also noted concerns with the van mileage the same day s/he was notified of the allegation. PS A informed Surveyor s/he questioned Caregiver B via text message and asked if s/he had driven the van. Caregiver B stated s/he took the residents out for ice cream but the residents denied an outing with Caregiver B. PS A stated the investigation showed Caregiver B most likely ran personal errands after s/he put the residents to bed, leaving the home and 4 residents unsupervised.

Surveyor requested to review all provider internal investigations related to Caregiver B.

On 07/31/2025 at approximately 3:30 PM, Surveyor received an email from PD C with Caregiver B's employment record, and documentation of the internal investigation related to Caregiver B. The internal investigation contained the following information:

- Resident 1 reported to staff at his/her day

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M 610	Continued From page 2	M 610		

program that Caregiver B pushed him/her.
- Caregiver B was placed on suspension pending internal investigation.
- Date of the investigation: 04/03/2025-04/22/2025.
- Resident 1 has a history of making complaints against staff.
- PS A noted the van mileage was off when Caregiver B worked - 8 miles were un-accounted for in the mileage logbook. Caregiver B reported s/he took the residents to get ice cream, but could not provide a receipt for reimbursement when asked by PS A.
- Resident 1 informed another staff that Caregiver B pushed him/her to shower, so it was determined that Caregiver B did not physically push Resident 1.
- Caregiver B was contacted several times by the provider, and did not respond. A letter was mailed to Caregiver B requesting contact by 04/22/2025. The provider considered his/her termination voluntary as Caregiver B did not make contact with the provider by the date requested.

The investigation conducted by the provider concluded there was no evidence to support Caregiver B pushed Resident 1, as Resident 1 could not state if anyone had harmed him/her and his/her story was not consistent with what was reported.

The investigation further concluded there was evidence Caregiver B used the company van for personal use and purposefully left 4 residents at home alone, knowing it was not approved in their "ISP (individual service plan) level of supervision, creating safety risks to all persons served." Caregiver B stated s/he took residents out for ice cream, but no receipt was available, and the residents stated they did not go with Caregiver B

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M 610	Continued From page 3 to get ice cream. On 07/31/2025 at approximately 4:00 PM, PD C emailed Surveyor and stated a misconduct report was completed and sent to the Office of Caregiver Quality (OCQ) related to Caregiver B. On 07/31/2025, Surveyor reviewed misconduct reports received by OCQ in the Department's electronic records. A misconduct report, dated 04/03/2025, was submitted related to Resident 1's allegation s/he was pushed by Caregiver B. No additional reports were received related to the additional concern of neglect by Caregiver B when s/he left the home unsupervised. The provider did not notify the licensing agency when a subsequent caregiver misconduct incident arose regarding Caregiver B during the investigation. The provider's internal investigation determined Caregiver B used the company van for personal van and left 4 of 4 residents unsupervised in the home during his/her scheduled shift.	M 610		