Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017389	A. BUILDING: _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH ST HOUSE	207 CHURCH ST ONTARIO, WI 54651

(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 06/16/2023, Surveyor conducted a complaint investigation at Church St House. The complaint was substantiated. One deficiency identified. Census: 7	N 000		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all residents had the right to confidentiality of health and personal information and records. Findings include: The provider is licensed to care for 8 residents in	N 346		

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

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N 346	Continued From page 1	N 346		

the client groups terminally ill, physically disabled, developmentally disabled, alcohol/drug dependent, traumatic brain injury and emotionally disturbed/mental illness.

The department received a complaint alleging House Manager A left a file of a resident open on the computer system the facility uses to chart and store information about residents.

On 06/13/2023, Surveyor interviewed Resident 1's legal representative over the phone. Surveyor asked Resident 1's legal representative if they were ever able to see any confidential information regarding other residents residing at the facility. The legal representative stated s/he was able to go behind House Manager A and read confidential medical information regarding a resident, who was not his/her ward, that was uploaded and open on the computer. S/he stated a team member of Resident 1's Managed Care Organization (MCO) also witnessed this concern.

On 06/15/2023, Surveyor contacted Resident 1's MCO Team Member B who Resident 1's Legal Representative stated also witnessed the opened computer and information of a resident at the facility. MCO Team Member B stated Resident 1's Legal Representative walked up behind House Manager A and was looking at the confidential medical information displayed on the screen of the computer. MCO Team Member B stated House Manager A did not close the computer screen.

On 06/16/2023, at approximately 10:00 AM, Surveyor observed the kitchen and dining area of the facility. The computer used for resident information was sitting with the screen facing the room. The screen could easily be seen by

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N 346	Continued From page 2 someone walking up behind caregivers entering information about residents. At approximately 10:30 AM, Surveyor witnessed the computer was open with resident confidential information on the screen. Surveyor also witnessed a resident sitting at the table who could easily see the computer screen from the table. At approximately 12:00 PM, Surveyor interviewed House Manager A. House Manager A did recall the incident and remembered telling the complainant to not come up behind him/her and not to read the information on the computer about other residents in the facility. Surveyor asked House Manager A if s/he closed out the information so the person behind him\her could not see the information. House Manager A could not recall. The provider did not ensure confidential resident health and personal information was kept secure.	N 346		