STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012532	A. BUILDING: _____ B. WING _____	C 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM WISCONSIN III INC WEST ISLE	**N5532 HWY 108 WEST SALEM, WI 54669**

(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 07/16/2025, Surveyor conducted a standard survey and complaint investigation at Rem Wisconsin III Inc West Isle. Data collection continued through 07/21/2025. The complaint was substantiated. One deficiency was identified. Census: 4	M 000		
M 548	88.10(3)(a) Fair Treatment Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was treated with courtesy, respect, and full recognition of their dignity and individuality. Findings include: The provider is licensed to care for 4 residents in the following client group: developmentally disabled. On 04/22/2025, the department received a complaint alleging staff yelled at residents at the home. On 07/16/2025, at approximately 11:30 AM, Surveyor interviewed Area Director (AD) A. When asked about any staff misconduct incidents, AD A stated Caregiver B received corrective action for	M 548		

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

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M 548	Continued From page 1	M 548		

swearing at Resident 1 during a behavioral episode. AD A stated Caregiver B did not intend to harm Resident 1 but Caregiver B emotionally lost control in the moment. AD A stated it was concluded Caregiver B did not raise his/her hand at Resident 1. Surveyor requested all staff misconduct reports and internal investigations involving Caregiver B.

At approximately 12:45 PM, Surveyor reviewed Resident 1's record. The following was identified:

Resident 1 was admitted on 09/19/2008 with multiple diagnoses, including disruptive behavioral disorder, pervasive developmental disorder, bipolar disorder and mild intellectual disability. Resident 1 had a guardian.

Resident 1's Individual Service Plan (ISP), dated 12/11/2024, indicated Resident 1 had the following behavioral challenges: aggressive to staff, aggressive to peers, verbal aggression, property destruction, sexualized behavior and elopement risk. The ISP included the following support interventions: 1:1 supervision and verbal redirection.

At 3:46 PM, Surveyor received an email from AD A including the following:

A corrective action plan for Caregiver B, signed on 04/10/2025. It read, in part, "[Caregiver B] was placed on suspension - administrative leave on 03/28/2025 for [his/her] actions during a challenging behavior incident that occurred on 03/26/2025 ...Yelling at, swearing at and instructing individuals to isolate can be considered abuse; however, findings concluded that [Caregiver B] did not have intent to harm with [his/her] actions ...[Caregiver B] is receiving a

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M 548	Continued From page 2	M 548		

final warming for violation of the abuse and neglect policy. [Caregiver B] will receive in-person abuse and neglect prevention [sic] individual rights training review prior to returning to work. [Caregiver B] will also receive training on appropriate behavioral prevention and intervention techniques for physically aggressive behavior ..."

On 07/17/2025, at 3:31 PM, Surveyor received an email from AD A that included the following:

An internal investigation, with a print date of 04/24/2025. Under a "Call 1 Event" heading, it read, in part, "[Caregiver B] admitted [s/he] became upset, raised [his/her] voice, and swore at [Resident 1], telling [him/her] to "go to [his/her] [expletive] room and calm down ..." The report indicated Caregiver D was on the phone with Caregiver B during part of the altercation and overheard dialogue exchanged between Resident 1 and Caregiver B. "[Caregiver D] reports that [Resident 1] asked multiple times to speak with [him/her] and [Caregiver B] stated, "I [expletive] said no," followed by, "Go to your [expletive] room now." [Caregiver D] reports that [s/he] heard two loud slapping sounds and [Resident 1] saying, "[Caregiver D], [s/he] hit me." [Caregiver D] believed the noises were [Caregiver B] hitting [Resident 1]. Under a "Supplemental Information" section, it read, in part, "[Caregiver D] reported that [Caregiver B] has previously pushed [Resident 1] and there have been multiple instances where [s/he] yelled or swore at [him/her]. [Caregiver D] believed three instances had happened, but could only detail one: [Caregiver D] wasn't there but later, [Caregiver B] told [him/her] [Resident 1] wouldn't move while [s/he] was sweeping, so [s/he] "elbowed [him/her] out of the way." Under the "Conclusions of Fact"

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M 548	Continued From page 3 section, it read, "There is insufficient evidence to support that [Caregiver B] intentionally struck or physically assaulted [Resident 1]. Evidence supports that [Caregiver B] raised [his/her] voice and swore at [Resident 1] during a moment of escalation." On 07/21/2025, at 12:30 PM, Surveyor interviewed AD A via phone. Surveyor shared concerns related to the treatment Resident 1 received during the behavioral incident resulting in Caregiver B's corrective action plan. AD A stated Caregiver B was caught off guard during the incident and the provider took the appropriate measures after the incident.	M 548		