STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016937	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESCARE GERMOND B	**2969B GERMOND RD RHINELANDER, WI 54501**

(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 01/17/2024, Surveyor conducted a self-report (x3) investigation at ResCare Germond B. Data collection continued through 01/23/2024. Two deficiencies were identified. One of the deficiencies was a repeat violation, see statement of deficiency (SOD) HULK11, dated 02/22/2023. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report within 24 hours when Resident 2 eloped on 01/03/2024. Findings include: The provider is licensed to care for 4 residents in the following client groups: traumatic brain injury, developmentally disabled and irreversible dementia/Alzheimer's disease. The Department received a self-report on	M 134		

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

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M 134	Continued From page 1 01/01/2024, reporting Resident 2 eloped on 12/27/2023. Staff called the police. Resident 2 returned to the facility within 15 minutes and before the police arrived. On 01/17/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 11/17/2017. According to Resident 2's Individual Service Plan (ISP), dated 10/17/2023, Resident 2 was considered an elopement risk and required 24-hour supervision with awake overnight staff. According to Resident 2's behavioral support plan (BSP), dated 10/17/2023 and revised on 01/04/2024, Resident 2 "attempts to leave premises unsupervised." According to an incident report, dated 01/03/2024 (time of incident: 2:15 PM), Resident 2 walked out of the facility. Staff were able to redirect Resident 2 and Resident 2 returned to the facility. According to an incident report, dated 01/03/2024 (time of incident: 3:35 PM), [Resident 2] said [expletive] this place. I'm walking. [S/He] left the property [sic] staff then called cops." On 01/17/2024 at 10:00 a.m., Surveyor interviewed Executive Director (ED) A. ED A indicated staff needed to have Resident 2 "in line of sight" when Resident 2 was outside. ED A confirmed Resident 2 eloped on 01/03/2024 at 3:35 PM. ED A stated, "[Resident 2] is on [Depakote] and this new medication may be contributing to some behaviors and Resident 2 has been wanting to smoke." ED A reported Resident 2 had been allowed to smoke outside the front door as long as Resident 2 stays in the "line of sight" of staff. Surveyor asked ED A if Resident 2's 01/03/2024 elopement was reported to the Department. ED A indicated that ED A was unsure if Resident 2's elopement was reported. ED A stated that ED A would check with his/her	M 134		

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M 134	Continued From page 2 quality assurance team to see if the elopement was reported. On 01/22/2023, a check of Department records concluded there was no self-report for Resident 2's elopement on 01/03/2024. On 01/22/2023 at 8:09 AM, Surveyor emailed ED A and asked, "Did the facility report [Resident 2's] elopement on 01/03/2024 to the Department?" On 01/23/2024 at 6:28 AM, ED A reported, "My quality assurance team did not report the last elopement of [Resident 2] on 1/3 [sic]. This will be done today.	M 134		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure services were provided as directed in the individual service plan (ISP) for Resident 1. Resident 1 eloped on 11/14/2023 and 11/30/2023. This is a repeat violation. See Statement of Deficiency (SOD) HULK11, dated 02/22/2023. Findings include:	M 436		

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M 436	Continued From page 3 The provider is licensed to care for 4 residents in the following client groups: traumatic brain injury, developmentally disabled and irreversible dementia/Alzheimer's disease. The Department received a self-report on 11/16/2023, reporting Resident 1 eloped on 11/14/2023 and was located by the police and returned to the facility within two hours. The Department received a self-report on 12/04/2023, reporting Resident 1 eloped on 11/30/2023. The police were notified and Resident 1 was located within 5 minutes and was returned to the facility. On 01/17/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 04/27/2018. According to Resident 1's ISP, dated 09/06/2023, Resident 1 was considered an elopement risk and required 24-hour supervision with awake overnight staff and door alarms. According to Resident 1's behavioral support plan (BSP), dated 03/14/2023, Resident 1 had an elopement history and the following elopement approaches were noted: Complete and document door chime checks every shift, Report if door chimes are not working to Site Supervisor or Area Supervisor immediately, Keep [Resident 1] within line of sight when possible and [Resident 1] utilizes a project lifesaver transmitter. Resident 1's elopement severity was noted as "Severe." Per prior self-reports submitted to the Department, Resident 1 eloped on 07/30/2018, 08/16/2018, 01/12/2023, 01/13/2023 and 09/14/2023. According to a progress note, dated 11/30/2023, staff noted, "The cops found [him/her] and brought [him/her] back right away but stated for [his/her] safety and our peace of mind we should consider moving [him/her] elsewhere because 3 vehicles almost ran [him/her] over and had to	M 436		

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M 436	Continued From page 4 swerve." A self-report submitted to the Department on 11/16/2023, read, in part, "[Resident 1] has a history of elopement -[sic] [Resident 1] eloped [sic] 01/13/23 and 09/14/23 this year. [Resident 1] also found out that his/her [parent] passed away last week around 11/07/23. Staff [Site Supervisor B] were [sic] out with all individuals (4) doing pick-ups from community engagements. Once home [sic] Staff was walking up to the front door with the individuals and punched in the door code [sic] when Staff turned around [Resident 1] was gone. [Resident 1] was located by police by 7:30 PM." The self-report indicated Resident 1 eloped on 11/14/2023 at 6:40 PM. Resident 1 was located in the woods by police at 7:30 PM and was returned to the facility at 8:30 PM after being evaluated by emergency medical services. A self-report submitted to the Department on 12/04/2023, read, in part, "[Resident 1] has a history of elopement - [sic] [Resident 1] eloped out of the house after just coming back from picking up another individual. Staff was just setting things down to set the alarm when another individual said, '[Resident 1] just ran.' Staff ran to the door and called [Resident 1's] name and then called 911. [Resident 1] eloped 01/13/23, 09/14/23, and 11/14/23 this year. [Resident 1] was located within 5 minutes of police being called. Once home [sic] [Resident 1] told staff '1 more day' (in reference to going to his/her [parent's]) and then said 'broken' while pointing at his/her heart." The self-report indicated Resident 1 eloped on 11/30/2023 at 6:45 PM. Resident 1 was located down the road from the facility. According to accuweather.com (retrieval date - 01/17/2024), at the time Resident 1 eloped (6:40	M 436		

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M 436	Continued From page 5	M 436		

PM on 11/14/2023), the outside temperature was 49 degrees. According to accuweather.com (retrieval date - 01/17/2024), at the time Resident 1 eloped (6:45 PM on 11/30/2023), the outside temperature was 29 degrees. The facility is in a wooded, residential area with a main highway located nearby.

On 01/17/2024 at 10:00 AM, Surveyor interviewed Executive Director (ED) A. ED A indicated that Resident 1 needed to be in "line of sight" of staff when outside. Surveyor asked ED A about Resident 1's elopements on 11/14/2023 and 11/30/2023. ED A indicated Resident 1 has not attempted to elope since 11/30/2023. ED A reported that Site Supervisor B was working when Resident 1 eloped on 11/14/2023 and 11/30/2023. ED A indicated that Site Supervisor B did not follow Resident 1's ISP and BSP. ED A commented, "We all know [Resident 1] will elope. We have implemented every procedure possible that we can think of to ensure [Resident 1's] safety." ED A stated that Resident 1 "knows when people aren't paying attention." ED A reported that Site Supervisor B was not paying attention to Resident 1 on 11/14/2023 and 11/30/2023 when Resident 1 eloped. ED A indicated that most of Resident 1's elopements occurred when Site Supervisor B worked.

On 01/22/2024 at 11:30 AM, Surveyor interviewed Program Manager (PM) C. PM C indicated that Resident 1's elopements seemed "directly related to staff working" and the elopements seemed to happen when Site Supervisor B worked. PM C reported that PM C spoke to Site Supervisor B about Resident 1's elopements on 11/14/2023 and 11/30/2023. PM C stated, "I believe [Site Supervisor B] was not paying attention to [Resident 1]." PM C reported, "I think [Site

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M 436	Continued From page 6 Supervisor B] was probably distracted and not focusing on [his/her] job on 11/14/2023 and 11/30/2023. [Resident 1] seemed to elope when [Site Supervisor B] worked." PM C indicated Site Supervisor B worked his/her last shift on 12/01/2023 and no longer works at the facility.	M 436		