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 _____	R-C 10/21/2024

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 10/15/2024, Surveyor conducted a verification visit, complaint investigation and self-report investigation (x2) at Rescare Germond B. Data collection continued through 10/21/2024. One deficiency was corrected in statement of deficiency (SOD) ZEYW11. The complaint was substantiated. Two deficiencies were identified. One of the deficiencies was a repeat violation, cited for the third. See Statement of Deficiency (SOD) ZEYW11, dated 01/23/2024 and SOD HULK 11, dated 02/22/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
{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 05/01/2024.	{M 436}		

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

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{M 436}	Continued From page 1 This is a repeat violation, cited for the 3rd time. See Statement of Deficiency (SOD) ZEYW11 dated, 01/23/2024 and SOD HULK11, dated 02/22/2023. 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 05/03/2024, reporting Resident 1 eloped on 05/01/2024 at approximately 9:50 PM, and was located by the police and returned to the facility within two hours. On 10/15/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 04/27/2018. According to Resident 1's ISP, dated 03/19/2024, 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 03/19/2024, "[Resident 1] has eloped one time from [his/her] parent's home (5/2019) and 4 times from the [Facility Name] home (1/2023, 9/2023, 10/2023, & 11/2023). While [his/her] elopements have significantly decreased, an elopement protocol is in place as well as safety alarms to alert staff should [s/he] attempt to elope." The BSP noted, "Alarms are on all doors and windows. Alarms are triggered by the doors opening. If the alarm triggers, staff are to make visual contact with [Resident 1]." According to a self-report submitted to the Department on 05/03/2024, Resident 1 eloped on 05/01/2024 at approximately 9:50 PM. The	{M 436}		

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{M 436}	Continued From page 2	{M 436}		

self-report read, in part, "[Resident 1] has a history of elopement. [Resident 1] went to bed at 9:30 PM. [Caregiver B] was working on bookwork, then turned the door alarm off at 9:50 PM for [Caregiver C]. [Caregiver B] went to the bathroom, [Caregiver C] arrived on shift and was in the living room until the police showed up at 11:30 PM with [Resident 1]. [Resident 1] was out of sight of staff for about an hour and a half. [Caregiver C] checked [Resident 1] over and noticed small scratches and a blister."

According to accuweather.com (retrieval date - 10/21/2024), at the time Resident 1 eloped (9:50 PM on 05/01/2024), the outside temperature was 40 degrees. The facility is in a wooded, residential area with a main highway located nearby.

On 10/15/2024 at 11:15 AM, Surveyor interviewed Program Manager (PM) A. Surveyor asked PM A about Resident 1's elopement on 05/01/2024. PM A reported that Caregiver B used the bathroom at 9:50 PM on 05/01/2024 and turned off the door alarms prior to Caregiver C arriving for shift change at 10:00 PM. PM A reported that Resident 1 eloped while Caregiver B was in the bathroom.

On 10/15/2024 at 2:25 PM, Surveyor interviewed Caregiver B. Surveyor asked Caregiver B about Resident 1's elopement on 05/01/2024. Caregiver B stated, "I will take blame. I turned off the door alarms too early before shift change." Caregiver B reported that Caregiver B turned off the door alarms at 9:50 PM on 05/01/2024 and Resident 1 eloped while Caregiver B was in the bathroom.

The provider did not ensure services were provided as directed in the ISP for Resident 1.

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M 548	Continued From page 3	M 548		
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 2 was treated with courtesy, respect and full recognition of his/her dignity and individuality. 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. On 09/04/2024, the Department received a complaint alleging a caregiver verbally abused a Resident. On 10/15/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 11/01/2017. Resident 2 was given a 30-day notice on 05/07/2024. Resident 2 was discharged and transferred to another facility on 07/15/2024. On 10/15/2024, Surveyor reviewed Caregiver E's file. Caregiver E was hired on 07/06/2023 and was terminated on 07/21/2024. On 10/15/2024 at approximately 2:25 PM, Surveyor interviewed Caregiver B. Caregiver B reported that s/he was hired on 04/10/2024. Caregiver B stated s/he received on the job training from Caregiver E for several weeks.	M 548		

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M 548	Continued From page 4	M 548		

Caregiver B reported that Caregiver E "yelled at [Resident 2] sometimes." Caregiver B stated, "[Caregiver E] would tell [Resident 2] to shut up." Caregiver B commented that Caregiver E was not always nice and s/he would scream at Resident 2 and yelled at him/her a lot. Caregiver B stated, "I didn't think it was the best method to interact with the residents. [Caregiver E] was like an enforcer at times with [Resident 2]." Caregiver B commented, "[Resident 3] told me how much [Caregiver E] yelled at [Resident 2]. It's gotten calmer since [Caregiver E] and [Resident 2] left."

On 10/16/2024, the provider e-mailed an Investigation Summary, dated 07/01/2024 - 07/05/2024, to Surveyor. The Investigation Summary read, in part, "On 07/01/2024, [PM A] received a call from [Caregiver D] and [sic]reported [s/he] can hear [Caregiver E] through the walls yelling at [Resident 2]. [Caregiver E] was placed on administrative leave and an investigation was started." According to the Investigation Summary, Caregiver E admitted to raising his/her voice "but did not scream at [Resident 2]." The Investigation Summary noted, "[Resident 3], Person Served, has lived at the [Named Facility] home since 2017. [Resident 3] reports [Caregiver E] is crabby at [Resident 2]. [Resident 3] reports [s/he] is not very nice and [s/he] yells at [Resident 2]. [Resident 3] reports [s/he] wants [Caregiver E] to move on."

On 10/18/2024 at approximately 8:06 AM, Surveyor interviewed Caregiver C via telephone. Caregiver C reported s/he had worked at the facility for over two and a half years. Surveyor asked Caregiver C if there were any concerns with staff interactions with residents. Caregiver C stated there were no current concerns with staff interactions with residents. Caregiver C stated,

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M 548	Continued From page 5 "[Caregiver E] got fired. [S/he] did a lot of yelling and it seemed like [s/he] took out [his/her] frustrations on [Resident 2]." Caregiver C reported that Caregiver E was "really crabby and yelled at [Resident 2] a lot and was not very nice to [him/her]." Caregiver C stated, "[Caregiver E] was overboard with yelling at [Resident 2] and telling [him/her] to go to [his/her] room." Caregiver C reported that Caregiver E would tell Resident 2 to "be quiet;" "stop talking;" "I am done with you today and I am done with your crap." Caregiver C commented, "I observed [Caregiver E] be mean on a few occasions." Caregiver C indicated s/he reported the concerns to PM A. On 10/18/2024 at approximately 8:23 AM, Surveyor interviewed Caregiver D via telephone. Caregiver D reported that Caregiver E would "raise [his/her] voice from time to time." Caregiver D reported (recalling a time in July 2024), "I was in the office and I could hear [Caregiver E] yell at [Resident 2]." Caregiver D indicated that s/he brought the concern to PM A. Caregiver D reported that Caregiver E was the only staff member who yelled at residents. The provider did not ensure Resident 2 was treated with courtesy, respect and full recognition of his/her dignity and individuality.	M 548		