STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012501	A. BUILDING: _____ B. WING _____	C 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM WISCONSIN III INC - WINGET	**5502 WINGET DR EAU CLAIRE, WI 54703**

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M 000	INITIAL COMMENTS On 07/28/2026, Surveyor conducted an abbreviated licensure survey and 2 complaint investigations at REM Wisconsin III Inc - Winget. Data was collected through 08/13/2026. One of the 2 complaints was substantiated. One deficiency was identified. Census: 4	M 000		
M 440	88.07(2)(b)1 SUPERVISNG & ASSISTING WITH ADLS Supervising or assisting a resident with or teaching a resident about activities of daily living. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide supervision with eating as specified in Resident 1's individual service plan (ISP). Resident 1 choked, was hospitalized and died. Findings include: On 06/04/2026, the Department received a self-report from the provider. The report indicated on 05/28/2026, Resident 1 went to the hospital and/or emergency room, not for a fall. The outcome was listed as: "Individual Passed Away." The report read, in part: "[Resident 1] refused [his/her] lucnh [sic] option and chose dry cereal which is a regular choice for [him/her]. Staff went to the office area to prepare to leave the shift.	M 440		

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

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M 440	Continued From page 1 Staff heard [Resident 1] coughing and in distress. Staff responded and offered [Resident 1] a drink and [s/he] drank it, spilling some. [Resident 1] went to the couch and then fell. Staff assisted [Resident 1]. [Resident 1] was moaning but not indicating any area of [his/her] body in distress or pain, but appeared to not be breathign [sic]. Staff attempted Heimlich but [Resident 1's] size and position made this impossible. Staff guided [Resident 1] to the floor and started chest compressions and called 911. 911 continued instructions to staff. EMTs (emergency medical technicians) arrived and treated [Resident 1] and took [him/her] to [hospital]... [Resident 1] was trasnported [sic] to the hospital via ambulance. [S/he] was treated but was unable to recover. Consulting with doctors, [Resident 1's] [guardian] chose organ donation and withdrawal of life support. [Resident 1] passed away on June 1." The report was signed by Quality Improvement Manager (QIM) A. On 06/04/2026, the Department received a complaint that alleged a resident required supervision while eating and drinking, had choked and aspirated while s/he was not being supervised. On 07/28/2026 at approximately 9:30 a.m., Surveyor interviewed Caregiver B. Caregiver B told Surveyor s/he was the staff working when Resident 1 had the incident of choking. Caregiver B said Resident 1 was eating breakfast and "chugging" his/her juice. Caregiver B said s/he went downstairs to the office to get medications. Caregiver B explained to Surveyor that while s/he was downstairs, s/he heard Resident 1 stumbling around upstairs and could tell something was not right. Caregiver B said s/he ran upstairs and tried to give Resident 1 the Heimlich maneuver, but	M 440		

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M 440	Continued From page 2	M 440		

Resident 1 collapsed. Caregiver B said s/he called 911 and started to give Resident 1 chest compressions until the ambulance arrived. Caregiver B said once the ambulance arrived they used an automatic chest compressor and inserted an airway and Resident 1 began to breathe again. Surveyor asked Caregiver B if Resident 1 always "chugged" his/her juice. Caregiver B said s/he did. Caregiver B described Resident 1 drinking liquids as s/he would always "knock it back." Surveyor asked if Resident 1 was on thickened liquids. Caregiver B told Surveyor Resident 1 was not on thickened liquids. Surveyor asked Caregiver B if s/he was working alone when this incident occurred. Caregiver B said s/he was working by him/herself.

On 07/28/2026, Surveyor reviewed Resident 1's record. Resident 1's ISP, review date 01/05/2026, indicated Resident 1 was admitted to the facility on 06/01/1997. S/he had multiple diagnoses including: autistic disorder, anxiety disorder, obsessive-compulsive disorder, self-injurious behaviors, developmental delay, and intellectual disability. The ISP indicated Resident 1 was on a general diet. The ISP read, in part: "[Resident 1] does not have a modified diet per a provider's orders, however, [s/he] presents a significant choking risk due to [his/her] documented history of the following: taking medications that are sedating, increased coughing while eating, eating too quickly, putting too much in [his/her] mouth at once, not chewing thoroughly, taking food from others and eating very quickly, choosing to eat while standing, food seeking, and eating and/or drinking until [s/he] throws up yet then eating and/or drinking more soon after. Staff is to provide close proximity and visual supervision whenever [Resident 1] is eating, to cut foods for [him/her], to provide verbal prompts to slow down

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and take drinks, and to serve smaller portions with a plan to offer seconds or thirds (in other words, don't overload [his/her] plate)."

On 07/28/2026 at approximately 10:40 a.m., Surveyor interviewed Area Director (AD) C. AD C told Surveyor Resident 1 snacked all the time and was a high choking risk. Staff were to give Resident 1 reminders to slow down or take small drinks.

On 07/28/2026 at approximately 11:20 a.m., Surveyor interviewed QIM A on the phone. Surveyor asked QIM A what s/he determined happened to Resident 1. QIM A said Resident 1 had a habit of taking food to his/her room and that was Resident 1's preference. QIM A said the ISP conflicted with what Resident 1's needs were and that Resident 1 did not require visual supervision with eating. QIM A said staff that was working was downstairs when the staff member heard Resident 1 choking. The staff member responded promptly and called 911. Resident 1 was intubated at the hospital and placed on life support. QIM A said Resident 1 did have cereal in his/her mouth at hospital. Resident 1 had a cardiac event, but it was not clear if the cardiac event was before or after the choking incident. QIM A said they were in the process of reviewing all of their member's ISPs to ensure the member's support needs matched what the member actually required.

On 07/28/2026 at approximately 11:25 a.m., Surveyor interviewed Program Director (PD) D. Surveyor asked if Resident 1 had any previous choking incidents. PD D told Surveyor Resident 1 said "nothing serious" but s/he would cough when s/he was drinking.

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On 08/13/2026, Surveyor reviewed Resident 1's hospital record. Resident 1's hospital record read, in part: "[Resident 1], a [age]-year-old [fe/male] with autism spectrum disorder, severe intellectual disability, GERD (gastroesophageal reflux disease), and diverticulosis, was admitted following an out-of-hospital cardiac arrest secondary to a choking event during a meal at [his/her] group home; [s/he] is now deceased, declared dead at 19:53 on 6/1/2026. [S/He] was found pulseless by EMS (emergency medical services) with asystole as the initial rhythm, received five rounds of CPR (cardiopulmonary resuscitation) and three doses of epinephrine, and achieved return of spontaneous circulation after approximately 30 minutes. Initial evaluation included bedside ultrasound, which was unremarkable, and CT (computed tomography) imaging that revealed left anterior rib fractures (5th-7th) and left lower lobe opacities suggestive of aspiration pneumonitis; CT head, chest, and abdomen were otherwise negative. Emergent bronchoscopy was performed due to concern for foreign body aspiration, but no foreign material was visualized and only minor secretions were removed ... [S/He] was admitted to the ICU (intensive care unit) for post-cardiac arrest management, ...Throughout the admission, [s/he] remained intubated and mechanically ventilated, with ongoing myoclonic jerks and severe hypoxic-ischemic encephalopathy confirmed by neurology and EEG (electroencephalogram) findings. [S/He] was hemodynamically stable in the final days, with no further hypotension or bradycardia, and transitioned to comfort care after family consent for donation after circulatory death (DCD). Propofol and valproate were discontinued during the course of care. [S/He] was extubated in the OR (operating room) at 18:24 (6:24 p.m.) on

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M 440	Continued From page 5 6/1/2026, and death was declared at 19:53 (7:53 p.m.) ..."	M 440		