STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019739	A. BUILDING: _____ B. WING _____	C 09/17/2025

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CHIPPER	1505 CHIPPER LN SUN PRAIRIE, WI 53590

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M 000	INITIAL COMMENTS On 09/09/2025, with information gathered through 09/17/2025, Surveyor conducted a standard licensure survey and a complaint investigation. Six deficiencies were identified. Complaint was substantiated. Census: 3	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 to the Department within 24 hours a significant change when Resident 1 was admitted to the hospital after ingesting an ink tube from a magenta-colored pen. Findings include: On 09/03/2025, the Department received a concern alleging residents were not provided with required staffing levels. On 09/11/2025, Surveyor reviewed Resident 1's	M 134		

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

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M 134	Continued From page 1	M 134		

record.

Resident 1 moved into the home, 02/03/2025, with diagnoses including suicidal ideations, major depressive disorder, generalized anxiety disorder, borderline personality disorder and post-traumatic stress disorder.

Resident 1's "Incident Reports" documented:
07/04/2025 4:00 PM - [Resident 1] was in the bathroom while [Caregiver C] was present in [his/her] bedroom. [Resident 1] informed staff that [s/he] had removed and swallowed the ink tube from a magenta-colored pen. Staff responded immediately and located the remaining parts of the pen in the room. Staff transported [Resident 1] to the ER for medical evaluation. After assessment at the ER, s/he was admitted to [hospital] for further observation and care.

On 09/16/2025, Surveyor reviewed Resident 1's managed care organization (MCO) records provided by his/her MCO provider which documented:
07/09/2025 - [Licensee A] stated that member was still at hospital following an incident on 07/04/2025
07/10/2025 - Updated on hospitalization for Member on 07/04/2025. Member attempted to commit suicide by injecting magnets. Member required colonoscopy for removal of foreign body and polyp.

On 09/17/2025, Surveyor reviewed the providers department file and determined there were no written reports since licensure, 10/13/2023.

On 09/17/2025 at 10:00 AM, Surveyor interviewed Manager B. Manager B stated s/he

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M 134	Continued From page 2 had hired someone to assist him/her with required documentation submittals.	M 134		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider permitted an existence and continuation of a condition in the home which placed the health, safety, and welfare for 1 of 1 resident at substantial risk of harm. Resident 2 was a two-person assist and only one staff member was scheduled for the NOC (8:00 PM to 7:00 AM) shift. Resident 2 could not easily exit his/her bedroom door due to the turning radius available for his/her electric wheelchair. Findings include: The provider was licensed to provide cares for up to 4 residents in client groups: advanced aged, alcohol/drug dependent, terminally ill, irreversible dementia/Alzheimer's, and developmentally disabled. On 09/03/2025, the Department received a concern alleging residents were not provided with required staffing levels.	M 230		

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M 230	Continued From page 3 On 09/09/2025, at approximately 11:40 AM, Surveyor observed Resident 2 operating his/her electric wheelchair as s/he exited his/her bedroom. Resident 2 had to go forward and backward a few times before the wheelchair could make the turn out of his/her bedroom into the hallway. Surveyor commented to Resident 2 that it was a tight fit maneuvering [his/her] wheelchair out of [his/her] bedroom. Resident 2 commented, "Yeah, I do my best but sometimes I scuff the wall." Surveyor noted that the hallway was approximately 36 inches wide. On 09/09/2025, Surveyor reviewed Resident 2's record. Resident 2 moved into the home, 11/06/2024, with diagnoses including cerebral palsy and paraplegia. Resident 2's "Resident Evacuation Assessment," dated 11/06/2024, documented: "Needs Full Assistance or Very Slow: The resident may require physical assistance from a staff member during most of the evacuation or the total time required for staff assistance and for the resident to evacuate the facility, is greater than the required evacuation time for the facility." "Needs Full Assistance from Two Staff. Resident requires assistance from two persons during most of the evacuation." On 09/16/2025, Surveyor reviewed the provider's August 2025 staff schedule which documented 2 staff were scheduled for the AM and PM shift, but only one staff member was scheduled for the NOC shift. On 09/17/2025 at 10:00 AM, Surveyor interviewed Manager B. Surveyor discussed the	M 230		

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M 230	Continued From page 4	M 230		

identified concerns. Manager B confirmed that Resident 2 could not easily exit his/her room into the hallway. Manager B stated s/he the provider had a live-in staff member who was always available in an emergency. Surveyor asked if the provider could guarantee that the live-in staff member was available during the NOC shift. Manager B stated that the live-in staff was required to be available. Manager B stated that the live-in staff were required to sign a contract attesting to this availability. Manager B and Surveyor reviewed the provider's August 2025 staff schedule. Manager B stated that Caregiver D was the live-in staff for August. Surveyor requested Caregiver D's contract. Manager B also stated that there were manager's that lived within 10 minutes of the home that could provide assistance.

On 09/17/2025 at 2:03 PM, Manager B forwarded Surveyor a copy of the "Live-In Staff Agreement" template which stated:
"Reside on-site 24 hours a day, 7 days a week at the Chipper Lane location. Staff shall maintain a daily schedule consisting of 12 hours awake/on duty and 12 hours rest/sleep, unless otherwise directed by the House Manager."
This contract was not signed by Caregiver D.

On 09/17/2025 at 2:20 PM, Surveyor reviewed the August 2025 staff schedule again. The schedule documented that Caregiver D was scheduled to work the AM (7:00 AM - 2:00 PM) and PM (2:00 PM - 8:00 PM), 29 of the 31 days in August. Caregiver D was also "on-call" each day in August although his/her name was not listed on the staff schedule.

On 09/17/2025, Surveyor reviewed Resident 1's record, another resident in the home. Resident

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M 230	Continued From page 5 1's managed care organization (MCO) documentation provided by his/her contracted provider, which documented: "Current staffing pattern in Member's residence or at their day program is: Member is in 4-bed AFH (adult family home), with 3 staff on 1st, 2nd, and 3rd shifts ... "	M 230		
M 235	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult family home shall comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all service providers involved in the operation of the adult family home complied with the universal precautions contained in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. Caregiver C did not complete annual training regarding universal precautions in 2024. Findings include: U.S. OSHA Standard 29 CFR 1910.1030 states, in part: "The employer shall train each employee with occupational exposure in accordance with	M 235		

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M 235	Continued From page 6 the requirements of this section. Such training must be provided at no cost to the employee and during working hours. The employer shall institute a training program and ensure employee participation in the program. Training shall be provided as follows: At the time of initial assignment to tasks where occupational exposure may take place; At least annually thereafter." The provider was licensed to provide cares for up to 4 residents in client groups: advanced aged, alcohol/drug dependent, terminally ill, irreversible dementia/Alzheimer's, and developmentally disabled. On 09/11/2025, Surveyor reviewed Caregiver C's training records. Caregiver C was hired 03/21/2023. Caregiver C's record did not contain annual training for universal precautions related to the control of blood-borne pathogens in 2024. On 09/16/2025, at approximately 7:15 AM, Surveyor interviewed Manager B. Manager B stated that s/he would contact the vendor they contract with regarding training and ensure that staff received required training each year.	M 235		
M 278	88.05(3)(b) FREE OF HAZARDS The home shall be free from hazards and kept uncluttered and free of dangerous substances, insects and rodents.	M 278		

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This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure that the home was a safe environment and that residents were safeguarded from environmental hazards.

Toxic chemicals were not securely stored.

Findings include:

The provider was licensed to provide cares for up to 4 residents in client groups: advanced aged, alcohol/drug dependent, terminally ill, irreversible dementia/Alzheimer's, and developmentally disabled.

On 09/03/2025, the Department received a concern alleging residents were not provided with required staffing levels.

On 09/09/2025, at approximately 11:40 AM, Surveyor toured the home and observed the following unsecured cleaning compounds:
Under the kitchen sink:
-10 ounce bottle of cooktop and oven cleaner and restorer
-32 ounce bottle of all purpose cleaner (lemon breeze scent)
On top of the kitchen counter:
-3 pound container of powder style stain remover

(2) 32 fluid ounce bottle of cleaner with bleach, a gallon of bleach, a quart of bleach, a 32 fluid ounce bottle of all purpose cleaner sitting on a table next to the mop bucket in the laundry room that was open to residents
A 33.8 fluid ounce bottle of scented multi-purpose

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M 278	Continued From page 8	M 278		

cleaner, A 32 fluid ounce bottle of all purpose degreaser, (2) gallon jugs of hand sanitizer and (2) 32 fluid ounce bottles of window cleaner were located under the kitchen sink.

On 09/11/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home, 02/03/2025, with diagnoses including suicidal ideations, major depressive disorder, generalized anxiety disorder, borderline personality disorder and post-traumatic stress disorder.

Resident 1's "Incident Report" documented: 08/28/2025 11:00 PM - [Resident 1] reported that [s/he] sprayed Lysol disinfecting spray into [his/her] mouth. At the time, staff were cleaning [his/her] room with Lysol spray and mopping, as [Resident 1] was in quarantine due to COVID-19. ...Staff transported [Resident 1] to [emergency room] for evaluation. ... Resident was discharged from the emergency department in stable condition. Staff were instructed to continue monitoring and to ensure all cleaning products remain secured and out of resident access. Reinforce staff training on securing all cleaning products after use. Review safety protocols with all staff regarding resident access to cleaning agents."

When Surveyor was onsite 09/09/2025, Surveyor observed Resident 1 ambulating in and out of the kitchen.

On 09/17/2025 at 10:00 AM, Surveyor interviewed Manager B. Manager B stated s/he would discuss the concern with staff and ensure that cleaning compounds were securely stored.

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M 332	Continued From page 9	M 332		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the licensee did not ensure required fire extinguishers in the home were in readily usable condition and inspected annually by an authorized dealer or the local fire department. Findings include: On 09/09/2025, at approximately 11:50 AM, Surveyor toured the home's physical environment with Licensee A. Surveyor observed 2 fire	M 332		

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M 332	Continued From page 10 extinguishers tagged to show they had been inspected by an authorized dealer or the local fire department in 08/2023. The fire extinguishers should have been inspected in 08/2024 and 08/2025. Licensee A stated s/he would follow up on the concern immediately.	M 332		
M 434	88.07(1)(e) Supervision The licensee shall arrange for a service provider to be present in the home when the licensee is gone overnight or when the licensee's absence prevents the resident from receiving the services, training or supervision specified in the resident's individual service plan under s. HSS 88.06(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1:1 (dedicated staff) supervision level for 1 of 1 resident (Resident 1) that had been identified in his/her individual service plan (ISP). Findings include: DHS 88 defines "Continuous Care" as the need for supervision, intervention or services on a 24-hour basis to prevent, control and ameliorate a constant or intermittent mental or physical condition which may break out or become critical during any time of the day or night. Examples of	M 434		

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persons who need continuous care are wanderers, persons with irreversible dementia, persons who are self-abusive or who become agitated or emotionally upset and persons whose changing or unstable health condition requires monitoring."

The provider was licensed to provide cares for up to 4 residents in client groups: advanced aged, alcohol/drug dependent, terminally ill, irreversible dementia/Alzheimer's, and developmentally disabled.

On 09/03/2025, the Department received a concern alleging residents were not provided with required staffing levels.

On 09/09/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home, 02/03/2025, with diagnoses including suicidal ideations, major depressive disorder, generalized anxiety disorder, borderline personality disorder and post-traumatic stress disorder.

Resident 1's "Incident Reports" documented:
02/11/2025 9:20 PM - [Resident 1] was in [his/her] room with the caregiver present. [S/he] requested a glass of water. The caregiver left the room to retrieve water from the kitchen. Upon returning, [Resident 1] showed the caregiver an empty 30 ML (milliliter) bottle of eye glass cleaner, indicating that s/he had consumed it. Staff promptly transported [Resident 1] to the Emergency Room (ER) for medical evaluation and treatment.
04/05/2025 6:00 PM - [Resident 1] was in [his/her] bedroom after taking a shower. While the staff was in the process of cleaning [his/her]

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bathroom and removing [his/her] shower items, [Resident 1] called out to the staff and informed them that [s/he] had swallowed a thermometer battery. ... Supervisor instructed staff to send [Resident 1] to the ER for further evaluation and treatment.
07/04/2025 4:00 PM - [Resident 1] was in the bathroom while [Caregiver C] was present in [his/her] bedroom. [Resident 1] informed staff that [s/he] had removed and swallowed the ink tube from a magenta-colored pen. Staff responded immediately and located the remaining parts of the pen in the room. Staff transported [Resident 1] to the ER for medical evaluation. After assessment at the ER, s/he was admitted to [hospital] for further observation and care.
08/28/2025 11:00 PM - [Resident 1] reported that [s/he] sprayed Lysol disinfecting spray into [his/her] mouth. At the time, staff were cleaning [his/her] room with Lysol spray and mopping, as [Resident 1] was in quarantine due to COVID-19. ...Staff transported [Resident 1] to [emergency room] for evaluation. ... Resident was discharged from the emergency department in stable condition."

Resident 1's "Care Plan," dated 07/11/2025, documented:
"Supervision: 24-hour supervision"

On 09/09/2025, at approximately 12:30 PM, Surveyor interviewed Licensee A. Surveyor asked for clarification regarding Resident 1's required staffing level. Licensee A stated that s/he has 1:1 staffing, a staff member is always with [him/her]. Even when [s/he] went with [his/her] [mom/dad] today for lunch, the staff member went with [him/her], while still giving [him/her] space to respect [his/her] time."

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M 434	Continued From page 13 On 09/11/2025, Surveyor reviewed Resident 1's managed care organization (MCO) documentation provided by his/her contracted provider, which documented: -01/16/2025 - Faithful Care called and stated they had received their 1:1 contract -02/17/2025 - Member Centered Plan - "Description of the modification(s): Member's room and belongings are searched regularly for potential lethal items due to member's high suicidal ideation and past attempts. Member's items are locked for [his/her] safety and member can ask for items and use while being monitored 1:1. Member has 1:1 intensive staffing in line of sight during all waking hours and every 10-15 min checks during sleeping hours. ... Current staffing pattern in Member's residence or at their day program is: Member is in 4-bed AFH (adult family home), with 3 staff on 1st, 2nd, and 3rd shifts ... Intensive staffing is need when Member is in need of in line of sight staffing 16 hour per day and then 8 hours at night [s/he] needs 10 minute checks ..." -06/03/2025 - Behavioral Health Progress Note: sent an incident report from member's provider stating: "Sunday, May 25 at approximately 4:45 PM. While [Resident 1] was taking a nap, [s/he] had blankets covering [him/her], and staff was present with [him/her]. During this time, [s/he] managed to retrieve a paperclip from [his/her] wallet and scratched [him/herself] on [his/her] right arm. Staff immediately removed the paperclip and checked [his/her] wallet for any additional items, but none were found. On 09/17/2025 at 10:00 AM, Surveyor interviewed Manager B. Surveyor asked for clarification on how Resident 1 was provided 1:1 supervision. Manager B stated that Resident 1	M 434		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019739	A. BUILDING: _____ B. WING _____	C 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHIPPER	1505 CHIPPER LN SUN PRAIRIE, WI 53590

(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 434	Continued From page 14 had a designated staff member 24 hours a day. Manager B explained that at times, it was difficult to allow Resident 1 his/her personal space, for example utilizing the restroom. Manager B stated, "[Resident 1] did not want staff watching [him/her] use the toilet, but then when [s/he] was done and staff re-entered the room, [s/he] would say [s/he] had consumed something. We would have to take [his/her] word for it, because we weren't in the room. There were times [s/he] would say [s/he] consumed something, like spraying Lysol into [his/her] mouth for 3 minutes straight, staff would state that did not occur, but [Resident 1] would be adamant about seeking medical attention and we would honor [his/her] wishes." Manager B stated that staff have been re-educated on making sure Resident 1 is always in the line of sight.	M 434		