STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015059	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROST-HUEBNER HOUSE 2	N6728 LEFT FOOT LAKE RD CRIVITZ, WI 54114

(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 08/01/2025 with additional information gathered through 08/05/2025, Surveyor conducted a complaint investigation at Rost-Huebner House 2. As a result two deficiencies were identified. The complaint was substantiated. Census: 3	M 000		
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, record review and interview, the licensee permitted the existence or continuation of a condition in the home which placed the health, safety or welfare of residents at substantial risk of harm. Resident 1 was found with bruises between 03/16/2025 and 04/13/2025. On 04/20/2025, Resident 1 was discovered with significant bruising on his/her left hip, thigh and groin area. The licensee did not thoroughly investigate the bruises found on Resident 1 in attempt to determine the source of the injuries and to ensure mistreatment or neglect had not occurred. Findings include: On 05/07/2025, the Department received a	M 230		

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

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M 230	Continued From page 1 complaint regarding abuse and/or neglect allegations. On 08/01/2025, Surveyor reviewed the closed medical record of Resident 1. The face sheet indicated Resident 1 was admitted to the facility on 08/08/2019 with diagnoses to include intellectual disability and diabetes. Additionally, the record indicated Resident 1 had a guardian and was removed from the facility by the guardian on 05/01/2025. Resident 1's ISP (Individual Care Plan) dated 04/01/2025 indicated, Resident 1 required verbal reminders and staff assistance for dressing, toileting and bathing and was independent with transfers and ambulation, without devices. Additionally, the ISP stated, "[Resident 1] can communicate wants and needs...Memory is good...[Resident 1] attends WEI (Wausaukee Enterprises, Inc.) for work Monday through Thursday...Risks: [Resident 1] tends to walk fast and may lose his/her balance so keep a close eye on [Resident 1] and remind the resident to slow down. [Resident 1] had a few falls while getting on and off the work bus from moving too quickly, so staff walks [Resident 1] to the bus and meets [Resident 1] at the drop off to make sure [Resident 1] gets on and off safely. [Resident 1] also tends not to pay attention to surroundings, so [Resident 1] is prone to running into or tripping over things if [s/he] does not have a clear pathway..." On 08/01/2025, Surveyor reviewed Resident 1's "Shower/Body Check" sheets and noted the following: ~03/16/2025- " ...Large Bruise back of right arm." ~03/18/2025- " ...Bruise to hip, arm back right."	M 230		

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M 230	Continued From page 2 ~04/08/2025- " ...Bruise on right side." ~04/10/2025- " ...Bruise on arm." ~04/13/2025- " ...Bruises." On 08/01/2025, Surveyor reviewed Resident 1's "Care Notes" and the following was noted: ~03/16/2025- "During a shower found very large bruise on back of right arm. [Resident 1] doesn't know how it got there." ~04/16/2025- "Fall reported by Wausaukee Enterprises, knee scrapes observed." ~04/21/2025- "[Administrator A] received a call from [Guardian C] regarding [Family C and D] sending a picture of severe bruising on left thigh and groin area. [Guardian C] stated [s/he] didn't hear of a fall from facility or WEI. Staff stated they received a call from WEI on Wednesday that [Resident 1] had fallen while running to the bus at WEI. Another staff stated they thought it was on the steps as [Resident 1] was getting onto the bus. The guardian stated [Administrator A] could show the picture to the doctor, and anyone needed to find out timeline for bruising to have occurred ...Not aware of fall on Wednesday 04/16/2025. Now knowing bruising is most likely from the fall [Administrator A] asked RN (Registered Nurse) in the SNF (Skilled Nursing Facility) if that could've happened Wednesday afternoon and not been noticed until Sunday. [S/he] stated that yes, deep tissue bruising can just all of a sudden show up ...[Guardian C] stated [s/he] didn't know when [Resident 1] would be returning as [Family D and E] were accusing something of happening at the house." ~04/25/2025- "Meeting in House 2 with [Guardian C], Care team, [Former Manager F] and [Administrator A] on how to move forward. Guardian insists [Resident 5] stated [Resident 1] fell in the shower on Wednesday 16 of April and	M 230		

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[Resident 5] picked [Resident 1] up. According to documentation and staff [Resident 1] showered 04/15, 04/17 and 04/19. [Resident 1 and Resident 5] will be staying with [Family D] over the weekend and the care team will update us on Monday if [Guardian C] decides to have them return or go to other facility."
~05/01/2025- "[Resident 1] has been officially discharged."

Resident 1's medical record did not include additional documentation regarding the resident's bruises. On 08/01/2025 at 1 PM, Administrator A confirmed Resident 1 had no documented fall reports for March 2025 or April 2025.

On 08/01/2025 at 1:15 PM, Surveyor interviewed Family D regarding Resident 1. Family D stated, "On 04/20/2025, [Family E] discovered a large dark bruise on [Resident 1's] hip, thigh and groin area. We immediately told [Guardian C]. [Guardian C] told the care team and facility but there was no record of a fall, but there were notes that [Resident 1] had a bruise. On 04/21/2025, I took [Resident 1] to the ED to get checked out. The ED doctor told me the bruise was old, and the ED doctor was going to file a concern because of how bad the bruise looked...That very same day, 04/21/2025, [Guardian C] gave me permission to have [Resident 1] and [Resident 5] reside at my home until alternative placement could be found."

On 08/01/2025 at 2:50 PM, Surveyor interviewed Guardian C regarding Resident 1. Guardian C confirmed s/he was the guardian for Resident 1 and Resident 5. Guardian C stated, "On 04/20/2025, [Family E] informed me and sent me pictures of significant bruising to [Resident 1's] left hip, thigh and groin area. The bruising was

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extensive, it started on [Resident 1's] outer left hip, wrapped around into the groin area, and went halfway down [Resident 1's] left thigh ...I immediately called [Administrator A] and sent [her/him] the pictures of [Residents 1's] bruises. When I spoke with [Administrator A] [s/he] stated the bruises looked terrible and [s/he] would be discussing this with staff and the residents to see what they know. I told [Administrator A] I would plan for [her/him] to talk with [Resident 1] and [Resident 5] since they were no longer residing at the house, but [Administrator A] never made arrangements to talk with [Resident 1] or [Resident 5] and hasn't interviewed either one." Guardian C went on to say, "[Family D] took [Resident 1] to the ED (Emergency Department) on 04/21/2025 to have the bruises looked at. The ED doctor said the bruising was old and did not occur overnight. [Resident 1] had x-rays taken in the ED, which confirmed no hip fracture. [Resident 5] told me [Resident 1] fell while in the shower and [Resident 5] went into the shower to help [Resident 1] up because [Caregiver G] was on the phone not paying attention. When I asked [Resident 5] if [s/he] told [Caregiver G] about [Resident 1] falling, [Caregiver G] said, "[Resident 1] is fine." Both [Resident 1] and [Resident 5] told me they were told not to tell anyone what happened, or they would be in "Big trouble" ... [Resident 1] and [Resident 5] don't just make things up." Guardian C then stated, "I'm upset because I was never made aware of a fall and have no idea of what happened or if an investigation was completed."

On 08/01/2025 at 9 AM, Surveyor interviewed Caregiver H regarding Resident 1. Caregiver H stated, "I recall a small bruise starting on [Resident 1's] hip around April 2025. I was told [Resident 1] had a fall at WEI, but no one ever

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M 230	Continued From page 5 called the guardian." On 08/01/2025 at 9:45 AM, Surveyor interviewed Caregiver B regarding Resident 1's bruises. Caregiver B stated, "Sometime in April 2025, I seen pictures of [Resident 1's] bruises from [Family E] and it was bad. [Caregiver G] told me [s/he] saw a bruise on [Resident 1's] hip, but it wasn't bad. I did my own investigation to get answers but kept getting different stories. No story was adding up. WEI wasn't given me much." Surveyor then asked if s/he documented any investigation into the bruise(s). Caregiver B stated, "I didn't document anything, but I told [Administrator A] and [Former Manager F] about the bruises because I've never came across a bruise like that." On 08/01/2025 at 11:45 AM, Surveyor interviewed Administrator A regarding bruising on Resident 1. Administrator A stated, "[Caregiver H] saw a bruise on [Resident 1's] leg during a shower on 04/17/2025 and then on 04/20/2025 I became aware of a large bruise on [Resident 1's] leg. On 04/20/2025 at 11 AM, [Guardian C] sent me a text message of [Resident 1's] bruises." Administrator A then showed Surveyor images s/he received of Resident 1's bruises from Guardian C on 04/20/2025 at 11 AM. Surveyor noted the images showed a significant dark purple, reddish bruise on Resident 1's upper left thigh and hip area. The bruise covered a large portion of the outer thigh extending from the hip area downward toward the mid-thigh. A second image showed an extensive dark purple, reddish bruise to Resident 1's groin area. Administrator A went on to say, "I was told [Resident 1] was running to get into the van and fell on the steps getting into the van ...WEI told me they would gather statements of the incident and fax them to	M 230		

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me, but I don't recall getting any statements ... [Guardian C] told me [Resident 5] told [her/him], [Resident 1] fell in the shower at the house and [Resident 5] picked [Resident 1] up off the floor ... [Resident 1] wouldn't have gone in the shower by [himself/herself]." Surveyor asked Administrator A if s/he had any additional information into the bruises. Administrator A verified all documentation regarding the investigation was within [Resident 1's] "Care Notes" and s/he had no further documentation.

Surveyor noted the documentation did not include:
~Documentation an interview with Resident 1 was attempted or completed to obtain more information about the bruises
~Documentation an interview was attempted or completed with Resident 5 who may have knowledge of an incident or witnessed a fall at the house
~Documentation of interviews with Caregiver B, G and H who may have either witnessed or were informed of the bruises
~Documentation an interview was attempted or completed with Family D and E, who initially reported and discovered the bruises
~Documentation of interviews with other staff to determine if they witnessed or had information about the bruises
~Documentation to show interviews were attempted or completed with WEI staff to determine their knowledge of a possible incident or cause to the injury
~Documentation to show an interview was attempted or completed with the van transport driver who may have witnessed an incident while getting on/off the bus
~Documentation of interviews with other residents to determine if their needs were met, or if they

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M 230	Continued From page 7 had experienced similar incidents ~The conclusion of the investigation or a determination if a MIR (Misconduct Incident Report) should be submitted to the Department In conclusion, the licensee did not conduct a thorough investigation into the bruises found on Resident 1 to determine the complete factual circumstances surrounding the bruises in an attempt to determine the source of the injuries and to ensure mistreatment or neglect had not occurred.	M 230		
M 552	88.10(3)(c) Confidentiality Confidentiality. To have his or her records kept confidential as described in s. HSS 88.09(1)(b). This Rule is not met as evidenced by: Based on observation and staff interview, the licensee did not ensure 3 of 3 residents the right to confidentiality. Personal and medical information and records concerning 3 of 3 residents were not kept in a manner which ensured confidentiality as described in s. DHS 88.09(1)(a). Records were kept unsecured in an area not protected against unauthorized access. The facility is licensed to provide care for up to 4 residents who may be developmentally disabled, physically disabled, emotionally disturbed and who may have mental illness. The home is located on the same grounds as two sister facilities with a paved walkway located between the facilities. Findings include:	M 552		

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M 552	Continued From page 8 On 05/07/2025, the department received a concern regarding confidentiality of health and personal information. On 08/01/2025 at 9 AM, Surveyor conducted a facility tour accompanied by Caregiver B. During the tour, Surveyor observed a time clock/medication room. The room was open and unsecured and did not have a lockable door. Surveyor observed the following unsecured private health information within the room: ~ An unlocked desk, containing full medical records for Residents 2, 3 and 4. ~"Care Note" binders for all 3 residents sitting on top of a table, which also contained notes and care plans relating to both physical and mental health conditions. ~A binder with Medication Administration Records (MARs) for all 3 residents on top of the medication cart ~A binder labeled "Resident Shower/Body Check Chart" for all 3 residents on top of the medication cart. On 08/01/2025, following the above observation Surveyor interviewed Caregiver B who stated the room was used as an office and as a time clock room for all staff on the campus. Surveyor asked if the door was usually kept open or closed/locked or unlocked. Caregiver B stated the door was, "Usually always open and never locked...It can be closed not locked, but usually people are able to just come in and out." Caregiver B verified s/he was unable to lock the time clock/medication room door. Surveyor discussed with Caregiver B resident records need to be kept secured against unauthorized access to ensure the confidentiality of resident information. Caregiver B stated, "The time clock/medication room door needs to stay unlocked because this house is the only house	M 552		

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M 552	Continued From page 9 with the time clock, and staff from the sister houses need access to the room to be able to clock in and out." On 08/01/2025 from 9:00 AM until approximately 1:00 PM, Surveyor observed the time clock/medication room door open, unsecured and unsupervised. The confidential resident information was not safeguarded against unauthorized access. Surveyor was able to see resident private health information without staff's knowledge. On 08/01/2025 at approximately 1:05 PM, Surveyor interviewed Administrator A. Administrator A acknowledged resident information must be kept secured. Administrator A verified resident private health information was not being kept secured from unauthorized access in the time clock/medication room and stated, "I will work with maintenance to have a lock placed on the time clock/medication room door."	M 552		