

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017223	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER REM INC ELMWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 6866 ELMWOOD DR MIDDLETON, WI 53562		
(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 07/28/2026, with information gathered through 07/29/2026, Surveyor conducted a standard licensing survey at REM Inc Elmwood, an AFH in Middleton, WI. Three deficiencies of Chapter DHS 88 were identified. Census: 3	M 000		
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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not safeguard 3 of 3 residents from environmental hazards. Toxic substances were not securely stored. Findings include: The provider is licensed to provide care for up to 4 individuals in the client groups of public funding, physically disabled, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, developmentally disabled, terminally ill, traumatic brain injury, or advanced aged.	M 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017223	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER REM INC ELMWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 6866 ELMWOOD DR MIDDLETON, WI 53562		
(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 278	Continued From page 1 On 07/28/2026 at approximately 10:30 AM, Surveyor toured the home and observed the following: In the kitchen, under the sink (no locks or barriers to access): - 1 tub of Cascade platinum plus dish detergent pods - 1 bottle of Seventh Generation toilet bowl cleaner - 1 bottle of Clorox disinfecting all purpose cleaner - 1 bottle of Method antibac all-purpose cleaner - 1 bottle of Method glass cleaner - 1 large can of Raid ant killer - 1 large can of Hot Shot ant & roach plus germ killer In the laundry room in the basement (which had a door with a lockable handle, but was unlocked and across from an occupied resident room): - 7 tubs of Lysol disinfecting wipes - 2 bags of Seventh Generation dishwasher detergent packs - 1 bottle of Method daily wood cleaner - 1 bottle of Method glass cleaner - 2 bottles of Method all purpose cleaner - 1 tub of Cascade platinum plus dish detergent pods On 07/28/2026 at approximately 10:35 AM, Surveyor asked to return to the basement for further review. Program Director A asked the other staff who were present (Program Supervisor B and Caregiver C) if the door downstairs was locked and they both stated "no". On 07/28/2026 at approximately 12:20 PM, Surveyor interviewed Program Director A regarding whether there was any history for the	M 278		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017223	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER REM INC ELMWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 6866 ELMWOOD DR MIDDLETON, WI 53562		
(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 278	Continued From page 2 current residents of ingesting non-edible items. Program Director A stated there was not. On 07/28/2026 at approximately 12:45 PM, Surveyor reviewed findings of the survey with Regional Director D and Program Director A. Both understood the expectation for keeping toxic substances secured and stated it would be addressed.	M 278		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following: This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 individual service plans (ISPs) included all required information. Resident 1's ISP did not include a complete and accurate description of services provided by the licensee to meet the assessed needs. Findings include: On 07/28/2026 at approximately 9:20 AM, Surveyor interviewed Resident 1. Resident 1 reported that staff assist with his/her medication administration. On 07/28/2026, Surveyor reviewed Resident 1's record and identified the following: Resident 1 admitted to the home on 03/01/2006	M 410		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017223	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER REM INC ELMWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 6866 ELMWOOD DR MIDDLETON, WI 53562		
(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 410	Continued From page 3 with diagnosis that included mild intellectual disability, PTSD, and reactive attachment disorder. Resident 1's ISP, dated 03/18/2026, documented s/he self-administers his/her medication. Resident 1's ISP did not contain information related to his/her needs for bathing, dressing, toileting, or mobility. On 07/28/2026 at approximately 11:22 AM, Surveyor interviewed Program Director A regarding Resident 1's assessed needs and ISP. Program Director A stated the last Program Director that worked with this home, who recently left, must have been using the provider's "abbreviated" ISP. Program Director A stated staff administered Resident 1's medications, but Resident 1 was independent with the other tasks and believed that is why the old Program Director used the shortened ISP. Program Director A stated that it was standard practice to use a full/complete ISP, so they would get that fixed.	M 410		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability.	M 570		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017223	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER REM INC ELMWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 6866 ELMWOOD DR MIDDLETON, WI 53562		
(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 570	Continued From page 4 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe environment. The provider's dryer had a semi-rigid vent. Findings include: On 07/28/2026 at approximately 10:30 AM, Surveyor toured the provider's laundry room with Caregiver C. Surveyor noted a semi-rigid dryer vent was being used. Surveyor noted a long piece of rigid dryer venting, unused, leaning in the corner of the room. On 07/28/2026 at approximately 10:40 AM, Surveyor interviewed Caregiver C. Caregiver C stated roughly 2-3 months ago the landlord had a company come to service the laundry facilities. S/he stated they replaced the dryer and changed part of the tubing at that time. On 07/28/2026 at approximately 12:40 PM, Surveyor reviewed survey findings with Regional Director D and Program Director A. They were unaware the vent had been changed, and Regional Director D stated s/he would notify the maintenance personnel.	M 570		