Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021192	A. BUILDING: _____ B. WING _____	C 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHO VALLEY	4401 ECHO VALLEY DRIVE EAU CLAIRE, WI 54701

(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 03/31/2026, Surveyor conducted a complaint investigation at Echo Valley. The complaint was substantiated. One deficiency was identified. Census: 3	M 000		
M 614	88.11(3) INVESTIGATION OF ABUSE OR NEGLECT As soon as possible after being contacted under sub. (1) the licensing agency shall undertake an investigation of the reported abuse or neglect. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an investigation was completed as soon as possible after allegations of caregiver misconduct were reported approximately one month ago. Findings include: This facility is licensed to serve up to 4 residents in the client groups developmentally disabled and emotionally disturbed/mental illness. On 01/15/2026, the Department received a complaint regarding caregiver misconduct. At approximately 10:35 AM, Surveyor interviewed	M 614		

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

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M 614	Continued From page 1	M 614		

Manager A about resident care and treatment. Manager A stated Caregiver B was removed from working in the home approximately one month ago due to his/her demeanor towards residents. Manager A informed Surveyor it was reported to Program Director (PD) C and Caregiver B was relocated to work in another home. Manager A stated s/he did not conduct an investigation.

At 10:55 AM, Surveyor interviewed Resident 1 about Caregiver B. Resident 1 stated, "[Caregiver B] would yell, a lot and it was scary. I felt like [s/he] was yelling at me and it increased my anxiety. I didn't like it."

At 11:00 AM, Surveyor interviewed Resident 2 about care and treatment. Resident 2 stated, "[Caregiver B] freaked out on me over food. I was really hungry and the new staff said I could have food before my meds (medications) so I had a yogurt. I have an eating disorder so I have specific portion controls. [S/he] yelled at me and I felt like [s/he] was restricting my food."

At 11:05 AM, PD C arrived on-site. When asked about Caregiver B's employment, PD C stated Caregiver B was transferred to another home in response to a guardian's request for him/her to not work in the home. PD C stated s/he was aware of "the hostility and butting heads with someone in the home." Surveyor asked PD C if an investigation was conducted related to the above allegations. PD C reviewed his/her email and confirmed no investigations were completed for Caregiver B's behavior towards residents.