STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018468	A. BUILDING: _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISMARK HOME WOODARD ST	251 WOODARD ST CHETEK, WI 54728

(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
N 000	Initial Comments On 02/27/2024, Surveyor conducted a self-report and complaint investigation at Chrismark Home Woodard St. Data was collected through 02/29/2024. The complaint was not substantiated. One deficiency was identified. Census: 9	N 000		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide services to manage Resident 2's behaviors that may have been harmful to others. Findings include: This provider is licensed to care for up to 12 residents in the client groups of: emotionally disturbed/mental illness and developmentally disabled. On 02/27/2024 at approximately 10:00 a.m.,	N 433		

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

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N 433	Continued From page 1 Surveyor interviewed Administrator A about Resident 1's suicide. Surveyor asked if Resident 1 had any recent changes in behavior prior to the suicide. Administrator A said Resident 1 was having issues with Resident 2. Surveyor asked Administrator A to explain. Administrator A said Resident 2 was delusional and accused Resident 1 of being a wo/man and molesting a staff member's child. Administrator A said Resident 2 also accused other residents and staff of burning his/her soul with their third eye. Administrator A said Resident 2 was given a 30-day notice to discharge as Resident 2 was not compliant with medications, medical care, and psychiatric care. On 02/27/2024 at approximately 11:45 a.m., Surveyor interviewed Caregiver B. Caregiver B told Surveyor Resident 2 was "bullying" Resident 1. Caregiver B said Resident 2 accused Resident 1 of molesting Caregiver B's child. Caregiver B said s/he told Resident 1 that s/he knew Resident 1 did not do that but s/he said that accusation was a trigger to Resident 1. Caregiver B said Resident 2 would "lash out" at everyone. S/he said one time Resident 2 called the cops on Resident 3. Surveyor asked if Resident 2 had increased supervision to prevent him/her from his/her behaviors towards the other residents. Caregiver B said Resident 2 had the same supervision as all the other residents. Caregiver B said that on the weekends, there was only 1 staff member in the house and Resident 2's behaviors would escalate. On 02/27/2024 at approximately 11:50 a.m., Surveyor interviewed Caregiver C. Caregiver C described Resident 2 as being "manic." S/he said Resident 2 came up with weird things that never happened. S/he said Resident 3 still locks his/her door, even though Resident 2 is gone, because	N 433		

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Resident 2 would barge into Resident 3's room at night.

On 02/27/2024 at approximately 12:15 p.m., Surveyor interviewed Administrator A. Surveyor asked what interventions were in place for Resident 2's behaviors. Administrator A said staff would intervene. S/he said some days Resident 2 would be fine but his/her behaviors were escalating. Administrator A said Resident 2 was unpredictable. S/he would go into other resident's rooms at night and yell at them. Administrator A said Resident 2 was given a 30-day discharge notice on 10/05/2023, as Resident 2 stopped going to his/her medical appointments and would not have anything to do with the staff. Administrator A said s/he was in contact with Resident 2's team at least once/week. S/he said s/he tried to get an increase in Resident 2's rate but it did not go through. S/he said if they could have gotten an increase in rate, they would have tried to have 2 staff on at all times during the day. Administrator A said s/he contacted adult protective services (APS) as s/he felt Resident 2 required a legal guardian. S/he said APS did send a psychiatrist to do an evaluation but s/he never heard back from APS. Administrator A told Surveyor Resident 2 stated the psychiatrist was sucking his/her soul out.

On 02/28/2024, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the facility on 01/17/2022 and had multiple diagnoses, including: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, and anxiety disorder.
Resident 2 had a 30-day discharge notice, dated 10/05/2023, signed by Resident 2 and

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Administrator A. The reason for discharge was: "Resident wishes to leave and does not feel comfortable with facility assistance of medical care anymore."

An incident report, dated 09/26/2023, read: "The chetek [sic] police was called, and the officer stated that [Resident 2] called the police since [s/he] thinks that the owner [initials] is controlling the residents with [his/her] 3rd eye and that the staff stated [initials] poisoned the garden. The officer stated that [s/he] could tell that [Resident 2] was in a spiral [sic] the staff let the officer know that [his/her] team knows, and this is like the beginning of it. [Resident 2] wanted the officer to take a sample of the dirt to make sure that it was not poison."

An incident report, dated 11/23/2023, indicated Resident 2 accused staff of putting something in his/her cigarette and poisoning the food. Resident 2 said his/her mind was burning.

An incident report, dated 11/25/2023, indicated Resident 2 accused another resident of "spiritually raping [him/her] last night."

An incident report, dated 01/05/2024, read: "cops come [sic] in and asked staff if they know [sic] they were called, staff said no, cops said [Resident 2] said [s/he] was spiritually raped. so [sic] staff went n [sic] looked for [Resident 2] to find out what was going on and cops talked to [Resident 2], then cops came back into kitchen and talked to staff that [Resident 2] stated [Resident 3] a [sic] another resident of chetek [sic] spiritually raped [him/her] and cops had to respond."

Staff documented Resident 2's behaviors towards

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staff or other residents on the following dates: 01/08/2024, 01/11/2024,01/13/2024, 01/21/2024, 01/24/2024, 01/26/2024, 01/28/2024, 01/30/2024, 01/31/2024, 02/02/2024, 02/06/2024, 02/08/2024, 02/10/2024, 02/11/2024, and 02/19/2024.

On 02/19/2024, Resident 2 was discharged to another facility.

Resident 2's individual service plan (ISP), with a print date of 02/27/2024, read, in part: "Displays no destructive/abusive behaviors ... Redirect negative attitudes. Notify appropriate provider (psychiatrist, doctor) when necessary ... resident displays positive interaction with others independently and without incident ... resident displays no aggressive/combative behaviors ... resident displays healthy one on one interaction with other residents and staff."

On 02/28/2024, Surveyor emailed Administrator A and requested any behavior support plan that was in place for Resident 2 and his/her behavior tracking. Administrator A replied to Surveyor, stating the behavior tracking would be in the staff notes. Administrator A did not provide a behavior support plan for Resident 2.

On 02/29/2024 at approximately 10:00 a.m., Surveyor interviewed Administrator A on the phone. Surveyor explained concerns that Resident 2's behaviors towards residents and staff were not identified in Resident 2's ISP. There were no interventions identified for staff to prevent the behaviors and protect the other residents. Administrator A said s/he agreed there should have been something in place. S/he said s/he reached out to APS and Resident 2's managed care organization for help and s/he did not receive assistance.

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N 433	Continued From page 5 The provider did not provide services to manage Resident 2's behaviors. Staff told Surveyor Resident 2 bullied Resident 1, which may have contributed to Resident 1 committing suicide.	N 433		