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 _____	R-C 11/27/2024

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 11/26/2024, Surveyor conducted a verification visit and complaint investigation at Chrismark Home Woodard St. Data was collected through 11/27/2024. The complaint was substantiated. Two deficiencies were identified. Census: 10	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report neglect to the Department	N 158		

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

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N 158	Continued From page 1	N 158		

within 7 calendar days from the date the CBRF (community based residential facility) knew or should have known about the neglect.

Findings include:

On 09/27/2024, the Department received a complaint that a caregiver was coming into work intoxicated and leaving the home unattended.

The provider is licensed to care for 12 residents in the client groups emotionally disturbed/mental illness and developmentally disabled.

On 11/26/2024 at approximately 12:00 PM, Surveyor interviewed Administrator A, who stated there had been 2 incidents with Caregiver B. Administrator A provided 2 documents titled Employee Warning Notice, dated 05/30/2024 and 09/11/2024. The 05/30/2024 incident indicated Caregiver B violated company policies and was found intoxicated at work. The 09/11/2024 incident indicated Caregiver B was working on personal matters and violated company policies and procedures. The document read, "[Caregiver B] took vehicle [sic] for personal errand during work hours + [sic] in process accidently damaged vehicle." Caregiver B was suspended for 1 week.

At 1:52 PM, Administrator A stated they did not report the 09/11/2024 incident to the Department and was not sure of the reason.

At approximately 2:00 PM, Licensee C stated they did not have a formal investigation policy but would ensure this was put in place.

At approximately 12:55 PM, Surveyor interviewed Caregiver B, who stated that on 09/11/2024, s/he left the residents unattended for about 5-10

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N 158	Continued From page 2 minutes when s/he drove the provider's transport vehicle to a local store to purchase cigarettes and a bottle of alcohol. Caregiver B stated s/he knew what s/he did was wrong. On 11/27/2024 at 8:46 AM, Surveyor received an email communication that included an investigation of the 09/11/2024 incident, completed by Administrator A. The investigation read, in part, "I went to [local store] to see if they could look at the camera ...I was able to speak to the manager on 09/17/2024 ...the manager emailed pictures of camera shots with our vehicle arriving approximately 8:30pm." From 2:56 PM to 3:17 PM, Surveyor interviewed Administrator A, who stated they did not report the 05/30/2024 incident to the Department because the situation was handled, and they did not think of submitting. Surveyor asked Administrator A if the incident was neglect and s/he stated Caregiver B was still doing the job. Administrator A stated they did not report the 09/11/2024 incident to the Department but did not know why. Administrator A stated s/he deferred to Licensee C and that an investigation was completed but they did not think of submitting to the Department. The provider did not report 2 incidents of neglect to the Department.	N 158		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical	N 169		

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N 169	Continued From page 3 or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify the resident's legal representative and the resident's physician when there was an incident or injury to the resident. Findings include: On 09/27/2024, the Department received a complaint that a caregiver was coming into work intoxicated and leaving the home unattended. The provider is licensed to care for 12 residents in the client groups emotionally disturbed/mental illness and developmentally disabled. On 11/26/2024 from 12:12 PM to 12:38 PM, Surveyor interviewed Administrator A, who stated there had been 2 incidents involving Caregiver B. The first incident occurred on 05/30/2024, when Caregiver B had called Administrator A. Administrator A felt s/he was not acting normally and suspected s/he might be under the influence. Administrator A went to the provider and sent Caregiver B home. The warning notice indicated Caregiver B was intoxicated at work. The incident on 09/11/2024 indicated Caregiver B used the provider's transport vehicle to purchase personal items at a local store. Administrator A stated an investigation had been completed and determined Caregiver B left the residents unattended for approximately 5-10 minutes.	N 169		

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N 169	Continued From page 4 At approximately 12:40 PM, Administrator A stated they did not report either incident to the guardians, county or managed care organizations (MCO). At 1:52 PM, Administrator A confirmed that during the 05/30/2024 incident, there were 11 residents residing in the home. Ten of those residents were under guardianship. Administrator A confirmed that during the 09/11/2024 incident, there were 10 residents that resided in the home and all the residents were under guardianship. On 11/27/2024 at approximately 3:00 PM, Surveyor asked Administrator A why the residents' legal representatives were not notified of the incidents. Administrator A stated they just did not think of it but would be working on writing procedures to ensure the correct steps were followed. The provider did not notify the residents' legal representatives when 2 incidents occurred involving staff intoxicated at work and leaving the workplace unattended.	N 169		