STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014321	A. BUILDING: _____ B. WING _____	07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM WISCONSIN NOBLE DRIVE	2009 NOBLE DRIVE EAU CLAIRE, WI 54703

(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 07/01/2026, Surveyor conducted an abbreviated licensure survey at REM Wisconsin Noble Drive. Data was collected through 07/07/2026. One deficiency was identified. Census: 4	M 000		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each residents' medication remained secure and in their original container. Caregiver B set up Resident 1's, Resident 2's, Resident 3's and Resident 4's medications and placed them on the table prior to each resident consuming their medications. The medications were not secured and were accessible to others. The medications did not remain in their original container.	M 458		

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

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M 458	Continued From page 1 Findings include: On 06/30/2026, Surveyor reviewed the Department's electronic file, including self-reports, while conducting offsite review for the provider's licensure survey. On 10/28/2025, the provider submitted a self-report to the Department for an incident that occurred 10/21/2025 at 7:00 p.m. The report read, in part: "[Resident 1] was sitting at the table for snack and medication. [Direct Support Professional (DSP) C] prepared [Resident 1] and [his/her] housemate [sic] their medication. [Resident 1] took [his/her] medication and put [his/her] the [sic] cup in [his/her] drinking cup. When [s/he] was getting up from the table, [DSP C] saw a med (medication) cup with meds and asked [Resident 1] if [s/he] was going to take [his/her] meds and [Resident 1] said 'oh I forgot.' At that time the other housemate came back to the table and asked [DSP C] where [his/her] meds were. [DSP C] at that time realized [Resident 1] had [his/her] meds and [his/her] housemate's. Poison Control was contacted and instructed staff to send [him/her] to the ER (emergency room) to monitor [him/her] and take labs ... [Resident 1] was released from the ER around 2:30 a.m. [s/he] appeared very tired and came home and went to bed. A 7 day watch was started." The report indicated medication administration retraining and corrective action were actions taken to ensure residents' health, safety and well-being. The report was submitted by Quality Improvement Specialist (QIS) D. On 07/01/2026 at approximately 11:45 a.m., Surveyor observed DSP B place medication cups on the table. Surveyor was seated at the table reviewing safety reports. A medication cup with pills in it was placed on the table near the patio	M 458		

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M 458	Continued From page 2	M 458		

door. A box of eye drops was on the table there too. After DSP B placed the medication cup on the table, s/he went back to the laundry room where the medications were stored in a locked cabinet. The table was not visible from the laundry room. Resident 2 was seated across the table from Surveyor. DSP B came from the laundry room and placed a medication cup with a powdered substance in front of Resident 2 and asked Resident 2 if s/he wanted his/her cream. Resident 2 said yes, and DSP B placed a box of Diclofenac gel on the table. DSP B went back to the laundry room. Resident 2 got up from the table and went to the kitchen and got some applesauce. Resident 2 returned to the table and mixed his/her powdered medication in with the applesauce. Resident 2 consumed his/her medications. Resident 3 was seated in the living room. Resident 3 came to the table and took the medications that were placed on the table near the patio door. DSP B then came back to the table and placed a medication cup with 1 pill in it on the table to the left of Surveyor. DSP B went back to the laundry area and then returned and placed a cup of multiple medications on the table to the right of Surveyor. DSP B then rubbed the Diclofenac gel on Resident 2's leg. DSP B went back to the laundry room. DSP B then returned back out in the kitchen and began preparing lunch. Surveyor left the table but continued to observe the medications placed on the table. At approximately 12:15 p.m., Resident 1 came to the table. S/he seated him/herself at the table where multiple pills were in a medication cup. At this time, DSP B went to Resident 4's room and knocked to see if Resident 4 was coming out for lunch and medications. At 12:22 p.m., Resident 4 came out of his/her room, sat at the table, and took his/her medication. At 12:30 p.m., Surveyor observed Resident 1 take his/her medications.

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M 458	Continued From page 3 At approximately 12:35 p.m., Surveyor interviewed DSP B and explained concerns about not keeping medications secured while administering medications. DSP B told Surveyor that was how s/he was trained to complete medication administration. On 07/02/2026, Surveyor emailed Regional Director (RD) A and Program Director E. Surveyor explained concerns with medication administration, along with previous self-report of Resident 1 taking other residents' medications in the past. On 07/06/2026, RD A emailed Surveyor, which indicated s/he would follow-up with DSP B. The provider did not ensure each residents' medications remained secured. DSP B set up medications and left them unattended which had the potential for a resident to accidentally consume other residents' medications.	M 458		