STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017618	A. BUILDING: _____ B. WING _____	C 10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADULT RESIDENTIAL CARE	34700 VALLEY RD OCONOMOWOC, WI 53066

(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 10/20/2025, Surveyors conducted a complaint investigation at Adult Mental Health Residential Care. One deficiency was identified. The complaint was substantiated. Census: 24	N 000		
N 362	83.33(1)(d) Grievance procedure: written summary The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide Resident 1 with a written summary of the grievance, the findings and the conclusions and any action taken by the provider to address his/her concerns. Findings include: On 09/02/2025, the department received a complaint alleging concerns with the provider's grievance procedure. On 10/20/2025, Surveyors conducted a complaint investigation. Surveyors reviewed the closed record of Resident	N 362		

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

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N 362	Continued From page 1 1. Resident 1 was admitted to the provider from 06/05/2025 to 08/04/2025 with diagnoses including generalized anxiety disorder, major depressive disorder, and obsessive compulsive disorder. Surveyor reviewed Resident 1's progress notes documenting that Resident 1 was presenting with an annoyed affect and reported feeling irritated with the dynamic with the mental health technicians (MHT). Resident 1 had reported their staff-initiated exposures were not occurring making it hard to get exposure response prevention (ERP) therapy done. On 06/12/2025, Clinical Director C noted that Resident 1 had started to test out various exposure ideas for him/herself rather than MHT initiated exposures. On 06/23/2025, Resident 1 reported that s/he was discontinuing his/her exposures due to not wanting to interact with MHT staff. Behavior Specialist D challenged Resident 1 to continue working on ERP, as it was part of his/her treatment and challenged resident to keep his/her current exposure set working with MHTs. Resident 1 was encouraged to share his/her idea to change his/her treatment with the treatment team and voice concerns with the program to Manager B. At 12:07 p.m., Patient Advocate A stated that the provider was aware that Resident 1 had brought his/her concerns and grievances about the program to the attention of Manager B. Patient Advocate A stated that provider's procedure would be to file the grievance and put it in Resident 1's chart, however, Manager B's staff were unable to find the documentation of Resident 1's grievances. Patient Advocate A stated that it appeared that Resident 1's grievance had been lost and the provider was	N 362		

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N 362	Continued From page 2 unable to relocate. Patient Advocate A stated that Resident 1 has reached out to the provider after his/her treatment and continued to address his/her grievances about his/her time in treatment. Patient Advocate A provided Surveyor with a document that was sent to Resident 1 on 09/16/2025, documenting: "Summary of Concerns and our Observations: Concern #1: Not receiving copies of the grievance forms Based on our review of your concerns, we believe there is an opportunity for improvement in some of the current operational procedures or staff education at Rogers. Therefore, we are recommending the following actions be taken in response to your concerns, re-educating staff on the proper standard work of scanning required forms. After reviewing your case, we discovered that certain documents were not properly scanned into our system as they should have been. This was an error on our part, and we deeply regret any confusion or delays it may have caused. Please know that we are taking this matter seriously. We are currently addressing the issue internally to ensure that such oversights do not happen in the future." At 12:23 p.m., Patient Advocate A stated that s/he met with Manager B. Patient Advocate A stated that staff have been re-trained and that the provider continues to work with Resident 1 in an attempt to resolve concerns s/he had while receiving treatment from the provider. The provider did not document a written summary of Resident 1's grievance while in treatment, the findings and any conclusions or action taken.	N 362		