STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010812	A. BUILDING: _____ B. WING _____	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM WISCONSIN III INC - 31ST STREET	1406 N 31ST STREET SUPERIOR, WI 54880

(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 06/03/2026, Surveyor began an abbreviated licensure survey and a self-report investigation at REM Wisconsin III Inc - 31st Street. Data was collected through 06/04/2026. One violation was identified. Census: 4	M 000		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all residents were safeguarded from hazardous conditions. Resident 1 was transported without a seatbelt in his/her wheelchair and sustained injuries in a traffic incident. Resident 1 fell out of his/her wheelchair when the vehicle came to an abrupt stop. The vehicle was not equipped with a seatbelt for individuals utilizing a wheelchair, and the provider did not ensure proper internal inspection methods were followed.	M 570		

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

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M 570	Continued From page 1 Findings include: On 06/23/2025, the Department received a self-report indicating Resident 1 was involved in a motor vehicle incident on 06/18/2025. The report indicated Resident 1 had been injured as a result of the incident after having fallen out of his/her wheelchair when the operator of the vehicle braked suddenly. On 06/04/2026, Surveyor reviewed provider records. An incident report, dated 07/25/2025, contained the internal investigation the provider had done for the incident described in the self-report. According to the incident report: - Program Director (PD) B was driving Resident 1 home from an appointment on 06/18/2025. - Resident 1 was in the backseat of the van in a wheelchair with tie-downs. - The vehicle ahead of the vehicle driven by PD B stopped abruptly, causing PD B to brake hard. - Resident 1 slid out of his/her wheelchair and sustained injuries to his/her leg. - Emergency medical services (EMS) transported Resident 1 to the hospital. - Resident 1 had suffered two broken bones in his/her shin during the incident and underwent surgery for the injuries. - The van had been converted to a wheelchair accessible van. - A former staff member had inspected the vehicle when the provider first received it and was unable to be interviewed by the writer. The incident report also included results of staff interviews and a conclusion of fact. The report	M 570		

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M 570	Continued From page 2 read, in part: - "[Program Supervisor (PS) C] used the van on a few occasions and did notice that there was not a seatbelt attachment, but [sic] did not realize why it was not on there. [PS C] said [s/he] did not say anything to anyone about the missing seatbelt attachment because [s/he] figured the van was manufactured not to have one. [PS C] had shown staff how to use the wheel chair [sic] tie-downs but did not understand why there was not a seatbelt attachment in the van. [PS C] said [s/he] did not have any full training when it came to the new van that was brought over. Therefore, [s/he] assumed that the van didn't come with a seatbelt." - "[PS D] had driven two different persons served in the van and both of them had seatbelts on their wheelchair. Asked [sic] if people need the use of a van seatbelt to be fully secured, [s/he] said [s/he] did notice there wasn't a belt for someone not using a wheelchair in the van and thought [s/he] mentioned it to someone at the [other adult family home] but not a supervisor. [S/he] recalled being told that was just the way it came." - "[PD B] had received van training...but not training specific to this converted minivan. [PS C] did instruct [PD B] on how to position the tie down switch. [PD B] denied anyone had ever come to [him/her] questioning or reporting the lack of shoulder belt in the van. It did not occur to [PD B] to report it to anyone. [S/he] is more familiar with full size wheelchair accessible vans and since a shoulder belt wasn't in the minivan, [s/he] assumed that was how the minivan was set up. Asked [sic] if [s/he] realized [s/he] wasn't fully securing people in the minivan, [s/he] said [s/he] wasn't thinking how they weren't fully secure in that van, but [s/he] does think to always use the shoulder belt in the full size vans to secure a	M 570		

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M 570	Continued From page 3	M 570		

person because they have the shoulder strap present."

- "Examination of the van revealed that it did lack an installed shoulder strap for securing someone sitting in their wheelchair with the tie down straps applied."
- "Evidence supports that upon examination of the minivan used to transport [Resident 1], it was discovered that the van lacked a shoulder strap to secure individuals in wheelchairs."

At approximately 3:15 PM, Surveyor received an email from Supervisor A, which included an attached transportation policy. The email also included a forwarded message from the provider's quality improvement staff which indicated the policy had been dated in February of 2025. The policy read, in part:

- "The following procedures must be followed every trip in which any persons served are being transported..."
- "Departure Procedure...Conduct an exterior (360 Walk around) and interior visual inspection for the vehicle...If any safety concerns are found do not use the vehicle and notify your supervisor to determine next steps..."
- "Confirm seatbelts for all passengers (individuals and employees) are secured prior to initiating movement of the vehicle..."
- "As Needed - Securing Occupants and Wheelchairs...Conduct a visual inspection of the wheelchair restraint system...Properly secure Wheelchairs...Properly secure Occupants..."

On 06/04/2026, at approximately 1:33 PM, Surveyor interviewed Supervisor A. Supervisor A stated staff were supposed to do monthly checks on vehicles they would use to transport residents. Supervisor A stated that anytime a staff member

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M 570	Continued From page 4 was transporting a resident, they should do a walk-through inspection of the vehicle. When asked about the incident on 06/18/2025, Supervisor A stated s/he thought PD B likely saw the vehicle was missing a seatbelt for wheelchair users but did not think to report it to anyone. Supervisor A stated s/he thought it was likely PD B had just made a mistake. Supervisor A stated s/he would not have driven the vehicle that day if it had been him/her. Supervisor A stated the van used to transport Resident 1 on 06/18/2025 was from a different home and was just being used for Resident 1 that day. Supervisor A stated the vans typically used at the home were equipped with shoulder strap seatbelts for wheelchair users. The provider did not ensure residents were safeguarded from hazardous conditions.	M 570		