

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/26/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1720 DUCKTAIL COURT NEW RICHMOND, WI 54017		
(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 09/26/2023, Surveyor conducted an abbreviated licensing survey and self-report investigation at Bear Creek House. One violation was identified. Census: 4	M 000		
M 218	88.04(2)(b) AWAKE STAFF FOR CONTINUOUS CARE The licensee shall ensure that he or she or a service provider is present and awake at all times if any resident is in need of continuous care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a service provider was present and awake at all times when a continuous care resident was present. Resident 1 eloped while staff were asleep on 08/07/2022 and 10/14/2022. Findings include: The provider is licensed to care for 4 residents from the following client groups: terminally ill, traumatic brain injury, developmentally disabled, alcohol/drug dependent, emotionally disturbed/mental illness, physically disabled, advanced aged, and irreversible dementia/Alzheimer's disease. On 08/10/2022, the Department received a self-report from the provider indicating Resident 1 eloped during sleeping hours between 08/07/2022 and 08/08/2022. The report stated	M 218		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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M 218	Continued From page 1 that on 08/07/2022, Licensee B questioned Resident 1 about an alleged incident involving cannabidiol (CBD) gummies that occurred earlier that day. Because of this situation, Director A asked Licensee B to check on Resident 1 throughout the night to ensure s/he did not elope. The report read, "[Director A] reminded [Licensee B] to keep checking on [Resident 1] to ensure [s/he] was still home during the night. [Licensee B] reported to [Director A] that [s/he] checked a few times and it appeared [Resident 1] was in [his/her] bed and asleep. [Licensee B] reported [his/her] last check was at approx (approximately) 2 AM on 08/08/2022. At approx 8:30 AM, [Director A] received a text message from [Guardian C] stating that [Resident 1] showed up at their neighbor's house at approx 1130PM on 08/07/2022. This is where [s/he] stayed the night. Staff went to check for [Resident 1] after [Director A] called the house...When staff entered [his/her] room, [his/her] screen was off the window." On 08/10/2022, Director A sent a separate report to Surveyor indicating Licensee B slept during his/her noc (overnight) shift on 08/07/2022 and 08/08/2022. On 09/26/2023, Surveyor reviewed Resident 1's record. Resident 1 resided at the facility from 06/20/2022 through 10/15/2022. His/her diagnoses included oppositional defiant disorder, pervasive developmental disorder, PTSD (post-traumatic stress disorder), and fetal alcohol syndrome. According to Resident 1's record, s/he eloped during the night on 08/07/2022 and on 10/14/2022. On 10/14/2022, Resident 1 was arrested for breaking into a grocery store. Resident 1 did not return to the facility.	M 218		

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M 218	Continued From page 2 On 09/26/2023 at 11:15 AM, Surveyor interviewed Director A. Director A stated Licensee B was no longer involved with the daily operation. Director A stated Licensee B would occasionally return to the area and work a weekend shift to relieve the staff, which is what s/he was doing when Resident 1 eloped on 08/07/2022. Director A described Resident 1 as a "wild card." At the time of his/her pre-admission assessment, Resident 1 was "on the run" from his/her home. Director A stated the facility did not have awake staff during noc shift currently or at any point when Resident 1 resided at the facility. Director A stated that, in hindsight, Resident 1 should have had awake staff and overnight supervision.	M 218		