

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018468	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/12/2026
NAME OF PROVIDER OR SUPPLIER CHRISMARK HOME WOODARD ST		STREET ADDRESS, CITY, STATE, ZIP CODE 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 07/20/2026, Surveyor conducted a complaint investigation at Chrismark Home Woodard St. Data was collected through 08/12/2026. One of 1 complaint was substantiated. One new violation was identified. Census: 10.	N 000		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the CBRF (community based residential facility) did not provide supervision appropriate for Resident 1's needs. Findings include: On 05/08/2026, the Department received a complaint regarding supervision. The provider is licensed to care for 12 residents in the client groups developmentally disabled and	N 426		

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

TITLE

(X6) DATE

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N 426	Continued From page 1 emotionally disturbed/mental illness. On 07/20/2026 at approximately 10:04 AM, Surveyor interviewed Caregiver A who stated that Resident 1 was on 15-minute checks. Surveyor asked if staff knew how to shut off the doorbells and s/he responded, "I have no idea." Surveyor asked about Resident 1 and if s/he was an elopement risk and s/he responded s/he thinks s/he may have tried to elope this weekend and stated right after Resident 1 moved in s/he took off and was found by the police in a neighbor's yard. Caregiver A stated s/he had no concerns that the door alarms were not functioning. At approximately 10:08 AM, Surveyor interviewed Administrator B who stated Caregiver C was working the nighttime shift (NOC) the night Resident 1 eloped. Administrator B stated s/he was aware Caregiver C had not been recording 15-minute checks because s/he reported being too busy. Administrator B stated the doorbell alarms were installed on the front and back doors on 04/02/2026 and were installed because Resident 1 was assessed as a high elopement risk. Administrator B stated Caregiver D, who worked the AM shift the morning of Resident 1's elopement, stated s/he found the front door alarm had been shut off. Administrator B stated there had been no reports of residents messing with the door alarms. Administrator B stated s/he believed there was an on/off button on the door alarm, and when it was "on" the doors chimed when opened. Surveyor observed there were doorbell alarms on the front and rear exit doors. Surveyor observed that there was a button on the door alarm that could slide to the on or off position.	N 426		

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N 426	Continued From page 2 On 08/12/2026, Surveyor reviewed Resident 1's records. -Resident 1 was admitted on 04/02/2026. -Resident 1's Initial Assessment, dated 04/02/2026, read, in part, " ...Behavior Patterns ...Wandering/Elopement - Supervision ...To receive full supervision and redirection from staff to avoid and prevent wandering episodes. [Resident 1] is a very high wander risk [sic] staff need to complete 15 [sic] minute checks. There are also door bells [sic] on both doors, if staff hear the doorbell alarm they need to check and ensure [Resident 1] has not left the building ..." -Observations for Resident 1 read, in part, " ...04/02/2026 12:30 PM ...[Resident 1] is a very high wander risk ...has dementia and will become confused ...[Administrator B] ... 1:15 PM ...Did attempt to take off a few times, didn't make it to the parking lot the first time, the second time [s/he] went out the back door and around the building [sic] staff met [him/her] in the parking lot ...[Caregiver A]... 04/03/2026 1:15 PM ...Did try to leave/wander out the door ...somewhat easily directed back into the house ...[Caregiver A] ... 3:00 PM ...[S/he] didn't try to elope besides a few times ...[Caregiver D]... 04/04/2026 7:00 AM ...up all night ttrying [sic] doors ...[Caregiver C]... 04/05/2026 9:15 AM ...Late charting 4/4 Upon [sic] staff arrival they were told [Resident 1] was missing, staff looked around whole building and couldn't find [him/her] ...Staff called dispatch, they ended up finding [him/her] and brining [sic] [him/her] to the hospital ...[Caregiver D]..." -Investigation completed by Administrator B regarding Resident 1's elopement read, in part, " ...[Caregiver C] ...statement ...[Resident 1] was	N 426		

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N 426	Continued From page 3 going back and forth opening the front door and the back door literally all night long every 5 minutes ...At 5:30am [s/he] stumbled and landed on the floor ...the rest of the time till 7:30am [s/he] continued going from door to door and setting alarms off ...at 7:45am [Caregiver C] noticed [s/he] wasn't going from door to door ...couldn't find [him/her] ...[Caregiver D] called 911 ... [Caregiver D] ...statement ...clocked in at 7:45am ...When I walked in the front door the alarm didn't go off and I was bombarded from ...[Caregiver C] ...talking very fast ...told me [Resident 1] was somewhere in the house ...asked two residents about the last time anyone had seen [Resident 1]One...said about 6am [sic] and the other said ...5:30am and [s/he] told me [s/he] told [Caregiver C]that [Resident 1] had gotten out but [Caregiver C] did not listen ... [Caregiver E] ...statement ...[Caregiver E] asked [Caregiver C] where [Resident 1] was and [s/he] responded ...sleeping in [his/her] room ... [Resident 2] ...statement ...witnessed [Caregiver C] go over to the doors and turn the alarms off ... Conclusion of investigation ...Time of elopement was not able to be determined ...A second camera will be added to the property ..." On 07/21/2026 at 3:10 PM, Surveyor received an email communication from Investigator F (from the Office of Caregiver Quality), that contained a report from the [City] Police Department dated 04/04/2026 7:54 AM that read, in part, " ... [Resident 1] was missing and had not been seen since around 5:30am ...dispatch received a call from... [community member] ...noticed ... [Resident 1] laying [sic] face down on the ground ...[Resident 1] stated that [s/he] fell and could not get up ...grabbed a blanket for [Resident 1] ... [s/he] was visibly shaking from how cold [s/he]	N 426		

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N 426	Continued From page 4 was ...[s/he] was wearing a black t-shirt style shirt, jeans, shoes, and had a purse ...not wearing a coat ...shaking/shivering from how cold [s/he] was ..." On 07/20/2026 at approximately 10:45 AM, Surveyor interviewed Administrator B who stated Resident 1 went to the hospital where s/he spent a week and had been diagnosed with a urinary tract infection (UTI). Administrator B stated their investigation into Caregiver C was unsubstantiated, but Caregiver C had been suspended during the investigation and was counseled about completing his/her job duties. The provider did not ensure Resident 1's supervision when s/he eloped and his/her whereabouts were unknown for at least 15 minutes up to approximately 2 hours.	N 426			