STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019968	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY	375 NORTH AVE KEWASKUM, WI 53040

(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 07/22/2025 with information gathered through 07/23/2025, Surveyor conducted a complaint investigation at Gateway, an Adult Family Home (AFH) in Kewaskum, WI. One deficiency identified. Complaint substantiated. Census: 3	M 000		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents were able to make decisions related to his/her food preferences and needs. Resident 1 wanted more food at dinnertime and Caregiver C refused to give him/her more food. Findings include: On 05/28/2025, the Department received a	M 556		

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

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M 556	Continued From page 1	M 556		

complaint alleging caregiver mistreatment of residents.

On 07/22/2025 at approximately 9:00 AM, Surveyor interviewed Resident 2. Resident 2 stated s/he was in the kitchen when the incident with Resident 1 and Caregiver C occurred. Resident 2 stated Resident 1 wanted to make some sandwiches and Caregiver C would not let him/her because Resident 1 already had two wraps. Resident 2 stated Resident 1 became upset and Caregiver C and Resident 1 were arguing/very close to each other so the cops were called to assist.

On 07/22/2025 at approximately 10:05 AM, Surveyor interviewed House Manager B. House Manager B stated Resident 1's family member pulled him/her from the house right after the situation happened. House Manager B stated s/he was not working and received a call after the cops were called and informed about the situation. House Manager B stated Caregiver C was refusing to give Resident 1 more food after s/he had ate dinner. House Manager B stated Caregiver C should not have denied Resident 1 more food. House Manager B stated Caregiver C no longer works there.

On 07/22/2025 at approximately 5:12 PM, Surveyor reviewed Incident Report dated 05/14/2025. Incident Report stated the following:

"Date of incident: 05/14/2025
Home: Gateway
Incident: Resident wanted more food which was denied by staff. Resident agitated and pushed staff which resulted in staff contacting the police.
Investigation: [Program Director A (PD A)] interview on May 22nd 2025:

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M 556	Continued From page 2 [PD A] noted that [s/he] first became aware of the incident on May 14, 2025 at 7:19 PM through a phone call with [Caregiver C]. [Caregiver C] let [DP A] know that there was an incident at Gateway with [Resident 1]. [Caregiver C] indicated during the call that [Resident 1] wanted more food at dinnertime and [Caregiver C] refused to give [him/her] more food, indicating there was not enough wraps for [him/her] to get more and still enough for another meal. At that time, [Caregiver C] told [DP A] that [Resident 1] became upset and started screaming at [him/her]. [Caregiver C] indicated during the call with [DP A] that [Resident 1] pushed [him/her] resulting in a call to the police. [Caregiver C] noted that [s/he] and [him/her] co-worker, [Caregiver D] walked outside of the home to wait for the police, leaving home out of ratio. [DP A] then spoke with police officer who at the time was at Gateway. [DP A] indicated the police officer told [him/her] that [s/he] was going to give [Resident 1] a disorderly conduct as a result of [Resident 1] pushing of [Caregiver C]. [DP A] then call [Caregiver C] and let [him/her] know that [s/he] needed to complete a report and needed to be completed before [s/he] left the facility. [DP A] did not follow up with [Caregiver C] and no report was timely submitted. [DP A] received a phone call from [Caregiver D] at approximately 9:20 PM stating that [Resident 1's family member] was at Gateway. [Resident 1's family member] called [DP A] and let [him/her] know that [Caregiver C] had told [him/her] if [Resident 1] took the bread, [s/he] would be guilty of theft and further indicated that [his/her family member] did not push [him/her] body but pushed [his/her] hand away. [DP A] indicated that [Resident 1's family member] was upset and came to remove both [him/her] and property as [s/he] did not want [him/her] charged with disorderly conduct."	M 556		

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M 556	Continued From page 3 " [Caregiver C] interviewed on May 23, 2025: [Caregiver C] indicated that was familiar with BTP [Behavior Treatment Plan] for [Resident 1]. On May 14, 2025, [Caregiver C] indicated that [Resident 1] refused dinner and later in the evening made [s/he] made [him/herself] two sandwiches along with some snacks. [Resident 1] returned shortly there after and asked for more food. [Caregiver C] said [Resident 1] could not have any more food. [Resident 1] became agitated and an argument ensured. [Caregiver C] indicated [s/he] was done with the conversation and found [him/herself] in the corner of the kitchen with [Caregiver D] on the other side of the counter. [Resident 1] grabbed [his/her] wrist and twisted it. [Caregiver C] then called the police, but not the [Care Team Manager] or [DP A]. [Caregiver C and Caregiver D] went outside of the home leaving the two individuals served in the home by themselves. [Caregiver C] wanted to press charges against [Resident 1] to teach [Resident 1] a lesson." "[Caregiver D] interviewed on May 28, 2025: [Caregiver D] noted that [s/he] did see [Caregiver C] arguing with [Resident 1] on the evening of May 14, 2025, because staff would not allow [Resident 1] more food. [Caregiver D] did not attempt to deescalate the situation between [Caregiver C] and [Resident 1]. [Caregiver D] saw [Resident 1] push [Caregiver C's] hand away but did not see [Resident 1] grab [Caregiver C's] wrist and twist it. [Caregiver D] was in the home when [Caregiver C] called police. [Caregiver D] indicated that [House Manager B] told [him/her] that if individuals served escalated to call 911. When waiting for the police, [Caregiver D] left the home with [Caregiver C] as [Caregiver C] indicated that [s/he] wanted [Caregiver D] by	M 556		

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M 556	Continued From page 4 [his/her] side and waited outside leaving the home out of ratio. [Caregiver D] knew that [Caregiver C] wanted to file charges against [Resident 1]. [Caregiver D] witnessed [Caregiver C] calling [House Manager B] and [PD A] after the police arrived. [Caregiver D] did not contact anyone regarding the incident. [House Manager B] and [PD A] contacted [Caregiver D]. [Resident 1's family member] then came and loaded [him/her] up [his/her] property to remove [him/her] from the premises. [Caregiver D] then indicated that [s/he] started the [facility report] over the phone and then completed it several days later." "Findings: 1. No report completed. 2. Lack of communication with [Care Team Manager]. 3. Failure to deescalate 4. Rights restriction in not providing [Resident 1] food. 5. Leaving Gateway out of ratio." On 07/23/2025 at approximately 1:40 PM, Surveyor interviewed DP A. DP A stated s/he understood Resident 1 was not able to have more food due to Caregiver C refusing to give him/her more food which was a resident right violation.	M 556		