STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009869	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIENNA MEADOWS OF OREGON	989 PARK STREET OREGON, WI 53575

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N 000	Initial Comments On 08/12/2024, Surveyors conducted 2 complaint investigations at Sienna Meadows of Oregon. Three deficiencies were identified. One complaint was substantiated. One complaint was unsubstantiated. Census: 19	N 000		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a written report was sent to the Department within 3 working days after Resident 1's whereabouts were unknown when s/he eloped from the facility on 06/19/2024. Findings include: On 07/10/2024, the Department received a	N 163		

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

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complaint alleging concerns with a resident elopement.

On 08/12/2024, Surveyors reviewed Department records for the provider. There was no evidence of any self-reports sent to the Department for Resident 1's elopement on 06/19/2024.

On 08/12/2024, Surveyors reviewed Resident 1's record and identified the following:

Resident 1 was admitted to the facility on 10/5/2021 with diagnosis including Alzheimer's. Resident 1 had an activated healthcare power of attorney.

Resident 1's individual service plan (ISP) dated 06/25/2024 documented:
"Supervision: Needs 24-hour supervision. [Resident 1] has been diagnosed with late onset Alzheimer's disease. [His/her] memory is poor, and [s/he] has "word salad" and may need to be redirected to maintain [his/her] dignity and well-being. Overall, [Resident 1] is pleasant. Updates/Changes: [Resident 1] can be combative when redirected. Two staff reapproach when needed. 6.4.24-Redirect exit seeking with coffee or gentle coaxing avoid holding [his/her] arm due to increased agitation-stay with [him/her] until return to the building."

Surveyor reviewed Oregon Police Department case number OR2404878 dated 06/19/2024:
"On 6/19/24, at approximately 4:09 p.m., Dispatch advised that the staff of LSM Chiropractic called to report that a [fe/male] had walked in who possibly had dementia. Dispatch clarified this by stating that the [fe/male] does not know who [s/he] is and does not remember [his/her] own name ....This [fe/male] was later identified as

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[Resident 1]. LSM Chiropractic advised they observed [Resident 1] proceed on foot into their business coming from the area of the intersection of Park st. and Janesville st .....advised that staff members from the provider would be responding to LSM Chiropractic to retrieve [Resident 1] as [s/he] was a resident at the provider ....asked how [Resident 1] was able to leave the facility and was not known to be gone ....[Manager B] advised that the security alarm system was not going off, nor sounding off when it should have been. [Manager B] stated these issues with the security system disarming and re-alarming for the front door have been occurring since yesterday (6/18/24). [Manager B] stated [s/he] had opened the front door of the facility as a new resident's family was coming to visit between 4:15 p.m. and 4:20 p.m. [Manager B] then changed this time to between 4:20 and 4:30 p.m ....[Manager B] reported that [s/he] and other staff did not notice that [Resident 1] was gone for approximately 30 to 45 minutes. [Manager B] clarified that floor staff did not realize that [Resident 1] was gone until approximately 5:07 p.m."

On 08/12/2024 at 10:40 AM, Surveyor interviewed Administrator A and Manager B. Administrator A confirmed the provider's alarm system had glitches around 06/19/2024. Administrator A stated Resident 1 walked out of the facility with another resident's family member on 06/19/2024. Manager B stated Resident 1 was last seen at 3:45pm in the facility and we did not know s/he was gone until police called at approximately 4:30pm. Surveyor asked if a self-report was submitted regarding Resident 1's unknown whereabouts on 06/19/2024. Administrator A stated the self-report is still sitting on his/her desk and the department's 3-day requirement does not make sense when

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N 163	Continued From page 3 corrective action was taken right away. Administrator A acknowledged s/he did not submit a self-report regarding Resident 1's elopement on 06/19/2024. Cross Reference: N0426 DHS 83.38(1)(b) Supervision	N 163		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the individual service plan (ISP) was not updated for 1 of 1 resident record reviewed when there was a change in resident needs and abilities. Resident 1's ISP was not updated to identify him/her as a fall risk. Findings include: On 08/12/2024, Surveyor reviewed Resident 1's	N 389		

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record and identified the following:

Resident 1 was admitted to the facility on 10/5/2021 with diagnosis including Alzheimer's. Resident 1 had an activated healthcare power of attorney. Resident 1's ISP dated 06/25/2024 did not address his/her fall risk.

Resident 1's progress notes documented:
"7/10/24: Resident rolled out of bed and bruising on right side forehead and bruising on right arm.
7/14/24: Resident lost balance and hit head on table. Staff observed the fall and called for other staff help.
7/18/24: Resident was found on the floor of [his/her] room with blood coming from [his/her] nose.
7/26/24: ...Resident was on the hallway floor with a bloody nose.
8/4/24: Resident was on the hallway floor sliding around.
8/6/24: Resident was found in hallway and lunging at other residents.
8/9/24: Resident was on the floor by resident's door and scooting on the floor.
8/12/24 Noc pm: staff observed resident was on resident's bedroom floor by the door scooting on the floor .....Resident was found on the floor next to [his/her] bed wrapped in blankets."

On 08/12/2024 at 12:02 PM, Surveyor interviewed Administrator A and Manager B. Both staff acknowledged Resident 1 had an increase in falls the last 2 months. Manager B reviewed Resident 1's ISP and confirmed s/he was not identified as a fall risk. Administrator A explained to Manager B if Resident 1 had an increase in falls, this should had been reflected on his/her ISP. Administrator A stated to Manager B where to address fall risk in Resident 1's ISP. Both staff

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N 389	Continued From page 5 noted they would update Resident 1's ISP.	N 389		
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 record review and interview, the provider failed to provide supervision appropriate to Resident 1's needs. The result was Resident 1 wandering from the facility unsupervised for approximately 45 minutes on 06/19/2024. Findings include: The provider is licensed to care up to 20 residents within the client groups of advanced age, traumatic brain injury, and irreversible dementia/Alzheimer's. On 07/10/2024, the Department received a complaint alleging concerns with a resident elopement. On 08/12/2024, Surveyors reviewed Resident 1's record and identified the following:	N 426		

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Resident 1 was admitted to the facility on 10/5/2021 with diagnosis including Alzheimer's. Resident 1 had an activated healthcare power of attorney.

Resident 1's individual service plan (ISP) dated 06/25/2024 documented:
"Supervision: Needs 24-hour supervision. [Resident 1] has been diagnosed with late onset Alzheimer's disease. [His/her] memory is poor, and [s/he] has "word salad" and may need to be redirected to maintain [his/her] dignity and well-being. Overall, [Resident 1] is pleasant. Updates/Changes: [Resident 1] can be combative when redirected. Two staff reapproach when needed. 6.4.24-Redirect exit seeking with coffee or gentle coaxing avoid holding [his/her] arm due to increased agitation-stay with [him/her] until return to the building."

Resident 1's incident report dated 6/19/24 documented:
"Type of incident: Elopement
Specifics of Incident: Please explain what the incident was and how it occurred. At 5pm Oregon Police Department called asking if we are missing a resident. Resident walked across the street and was sitting at a business across the street.
What corrective action has been taken? Visuals every 30 minutes.
Management Follow-up: Increased visual checks and there is now a stop sign on our front door. Panel was not working promptly and was replacement."

Surveyor reviewed Oregon Police Department case number OR2404878 dated 06/19/2024:
"On 6/19/24, at approximately 4:09 p.m., Dispatch advised that the staff of LSM Chiropractic called to report that a [fe/male] had walked in who

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possibly had dementia. Dispatch clarified this by stating that the [fe/male] does not know who [s/he] is and does not remember [his/her] own name ....This [fe/male] was later identified as [Resident 1]. LSM Chiropractic advised they observed [Resident 1] proceed on foot into their business coming from the area of the intersection of Park st. and Janesville st .....advised that staff members from the provider would be responding to LSM Chiropractic to retrieve [Resident 1] as [s/he] was a resident at the provider ....asked how [Resident 1] was able to leave the facility and was not known to be gone ....[Manager B] advised that the security alarm system was not going off, nor sounding off when it should have been. [Manager B] stated these issues with the security system disarming and re-alarming for the front door have been occurring since yesterday (6/18/24). [Manager B] stated [s/he] had opened the front door of the facility as a new resident's family was coming to visit between 4:15 p.m. and 4:20 p.m. [Manager B] then changed this time to between 4:20 and 4:30 p.m ....[Manager B] reported that [s/he] and other staff did not notice that [Resident 1] was gone for approximately 30 to 45 minutes. [Manager B] clarified that floor staff did not realize that [Resident 1] was gone until approximately 5:07 p.m."

On 08/12/2024 at 10:20 AM, Surveyor interviewed Cook C. Cook C stated the provider's alarm system was not working for a few days in June 2024. Cook C noted a resident had gotten out but s/he did not know who it was.

On 08/12/2024 at 10:40 AM, Surveyor interviewed Administrator A and Manager B. Administrator A confirmed the provider's alarm system had glitches around 06/19/2024. Administrator A stated Resident 1 walked out of

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N 426	Continued From page 8 the facility with another resident's family member on 06/19/2024. Manager B stated Resident 1 was last seen at 3:45pm in the facility and we did not know s/he was gone until police called at approximately 4:30pm. Manager B stated Resident 1 did not have any injuries and was located across the staff at a local business. Manager B stated the front door alarm system would randomly stop working without alerting staff. Surveyor asked if additional checks were put into place when the provider was made aware the alarm system was failing. Manager B stated "no" but noted the provider did add additional checks after Resident 1's elopement incident. Administrator A stated they called Midwest Alarm Services after made aware of the concern and they fixed the issue on 6/20/24. Cross Reference: N0163 DHS 83.12(4)(a) Reporting When Resident's Whereabouts Unknown	N 426		