STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015454	A. BUILDING: _____ B. WING _____	R-C 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAISERS OAKHAVEN S&C LLC	132 OAK CT SHAWANO, WI 54166

(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 A standard survey, verification visit, and investigation into one complaint was completed at Paisers Oakhaven S&C LLC BLDG I on 03/19/2024 with information gathered through 03/25/2024. As a result of this investigation all previous deficiencies were noted corrected. One of 1 complaint was substantiated with two new deficiencies identified. Per state statutes a $200.00 re-visit fee was assessed. Census: 4	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews, the provider did not take immediate steps to ensure the safety of all residents, thoroughly investigate, and maintain documentation of the investigation in response to a report received which alleged potential caregiver misconduct. On 11/3/2023, Administrator A was informed of an allegation that Former Caregiver G and Resident 1 were smoking meth in Resident 1's bedroom. After learning of the concern, the provider did not conduct or document a thorough investigation into the incident to rule out caregiver misconduct and to determine if the incident was reportable to the department. Additionally, the provider did not involve the local law enforcement to assist with the investigation when there was an alleged potential criminal offense. Findings include: On 11/07/2023, the department received a concern alleging staff had been taking illicit drugs and were working with residents. On 3/19/2024 at 10 AM, Surveyor interviewed Administrator A regarding the above allegation. Administrator A provided Surveyor with an email dated 11/3/2023 which Administrator A sent to Resident 1's care team, ED (Executive Director)-B, Former House Manager C, Former Staff D and Registered Nurse E. The email indicated the following, "This email is to inform you of a situation that occurred last evening that I was made aware of late this afternoon. It was reported [Resident 1] had a guest in [his/her] bedroom the evening of 11/2/23. Staff working the 2nd shift today in the other building reported this resident and employee from the small	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 158	Continued From page 2	N 158		

building were smoking meth in [his/her] bedroom. I immediately went to the facility and conducted drug screens on all staff that were present as well as [Resident 1]. It was found during my investigation that one of the reporters (Agency staff) left before I got there, and the other reporter/employee refused the drug test. The employee that worked the small facility and other staff working agreed and were tested. [Resident 1] tested positive for THC, Meth, BZD and PPX. During my investigation [Resident 1] advised that the visitor was a friend of one of the employee/reporters who told [Resident 1] they had a mutual acquaintance but [Resident 1] did not know or remember [her/him]. [Resident 1] explained [s/he] was initially outside smoking a cigarette with this employee and agency personal along and this visitor. [Resident 1] talked about while outside smoking, this person walked up (no vehicle) "made a transaction with the visitor" and it was after that [s/he] asked if [Resident 1] wanted to go to [his/her] room and smoke a little meth...[Resident 1] said sure! The employee that was working that facility just assumed [Resident 1] had a visitor and did not question [Resident 1] having a guest. [Resident 1] told me the guest had a pipe in which they smoked the product. [Resident 1] told me that the accused employee had nothing to do with this and described one of the reporters saying they and another person accused this employee of smoking meth with me but [s/he] didn't and had nothing to do with it...I had dismissed the reporter/employee that refused the drug test from working...[Resident 1] did not believe [s/he] suffered ill effects however it was noted [s/he] was awake much of the night drinking (decaf coffee) and smoking cigarettes. I have notified [Resident 1's family] leaving a message, my supervisor, our nurse and have a call into the MD also leaving a message and

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N 158	Continued From page 3 awaiting a return call as it is after hours..." On 03/19/2024 at 9:40 AM, Surveyor questioned Administrator A about the above email. Administrator A stated, "I received a call from [Agency Staff/Current Caregiver F's supervisor] on 11/3/2023. [Agency Staff/Current Caregiver F's supervisor] reported to me that during the PM shift on 11/2/23 [Former Caregiver G] and [Resident 1] had smoked meth in [his/her] bedroom. The allegation was the employees ([Agency Staff/Current Caregiver F] and [Former Caregiver H]) from Building 2 came over and observed [Resident 1] smoking meth with the staff. [Former Caregiver G] was the only caregiver working in the building." Administrator A went on to say, "I went to the facility on 11/3/23 and asked staff to take a drug test. [Former Caregiver G's] drug test showed a faint line for meth, [Former Caregiver H] refused to be tested and [Resident 1's] drug test was positive for meth. [Former Caregiver G] denied the allegations and I was told by [Resident 1] the visitor was friends with [Former Employee H] who supplied the meth and who [Resident 1] smoked it with, not [Former Caregiver G]." Surveyor then asked Administrator A if s/he had any additional documentation regarding the facility's investigation into the above allegation. Administrator A confirmed the email was the only documentation s/he had regarding her/his investigation. Surveyor asked if the allegation was reported to the local police department or state agency. Administrator A stated, "I reported the incident to [Resident 1's] care team and physician, but I was not given any direction by the management team to report to anyone else." Surveyor then asked Administrator A if s/he made attempts to talk with other residents and staff as part of the investigation. Administrator A stated,	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 158	Continued From page 4	N 158		

"No...I did not talk to other residents...I just talk with [Resident 1]." Administrator A confirmed the documented investigation did not include information or attempts interviews were conducted with other residents or staff. Administrator A further confirmed the documented investigation did not provided information and/or results of the drug test for the staff that were tested."

On 03/20/2024 at 9:40 AM, Surveyor interviewed Agency Staff/Current Caregiver F regarding the above allegation. Agency Staff/Current Caregiver F stated, "On 11/2/23 and 11/3/23, I was working for an agency company, but now I work for the facility as a permanent employee...On 11/2/23, I was working in Building 2 from 2 PM-10 PM. I went over to Building 1 around 7 PM to pass meds for [Former Caregiver G], because [s/he] was not certified to pass meds. While I was over in Building 1 passing meds, I noticed [Resident 1] was shaky, fidgety and appeared to be a "crack head." [Resident 1] then came up to me and said [s/he] just smoked meth. I asked [Resident 1] how and with who? [Resident 1] said [s/he] didn't want to get anyone in trouble, but that [s/he] just smoked meth with [Former Caregiver G] outside." Agency Staff/Current Caregiver F went on to say, "I noticed [Former Caregiver G] was acting strange, fidgety and like a "crack head." I stayed in Building 1 for at least an hour because [Former Caregiver G] asked me to cover the house while [s/he] went to the store with [her/his] friend to get money. During the entire PM shift I noticed [Former Caregiver G's] friend parked in a black truck at the end of the road." Agency Staff/Current Caregiver F continued to say, "As soon as I returned to Building 2, I called [Former House Manager C]. I told [Former House Manager C] that [Former Caregiver G] just

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N 158	Continued From page 5 smoked meth with [Resident 1]. [Former House Manager C] came to the facility shortly after my call and I again explained what I heard and saw. [Former House Manager C] said to me, "[Former Caregiver G] is a recovering addict and I want to help [Former Caregiver G] because I'm a recovering addict, and we need bodies." Agency Staff/Current Caregiver F then stated, "I finished my shift on 11/2/23 and returned on 11/3/23 for the PM shift. On 11/3/23, I noticed [Former Caregiver G] was still working. When I called [Former House Manager C] to ask why [Former Caregiver G] was working, [Former House Manager C] response was "We need people." I then became frustrated because what I reported was not being addressed, so I told [Former House Manager C] that I did not want to continue working. I waited for my replacement to arrive at 5 PM and I left the facility. When I left I called my supervisor at the staffing agency and reported the entire incident." Surveyor asked Agency Staff/Current Caregiver F if s/he received any follow-up to her/his reported allegation. Agency Staff/Current Caregiver F stated, "There was no follow-up from anyone, no written statement was requested of me, and no phone call from anyone at the facility...I was never asked to take a drug test...I would have provided all the information they needed if they would have requested it." Surveyor noted the provider's documented investigation did not include: ---the steps that were taken to ensure the health, safety and well-being of the residents ---the identity of the reporter/employees ---information that an interview was attempted/conducted with Agency Staff/Current Caregiver F who reported the allegation to Former House Manager C and [her/his] staffing agency supervisor	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PAISERS OAKHAVEN S&C LLC	132 OAK CT SHAWANO, WI 54166

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N 158	Continued From page 6 ---information that an interview was attempted or completed with Former Caregiver H, who worked during the alleged incident ---information that an interview was attempted or completed with the accused Former Caregiver G who worked in the small building ---interviews with other staff to determine their knowledge of the incident or any inappropriate behavior they witnessed ---information indicating residents were interviewed to determine if their needs were met or if they had experienced similar incidents ---the drug test results for accused Former Caregiver G who worked in the small building ---the drug test results for staff that agreed to drug testing and were tested ---information a room search was attempted with Resident 1 ---information a building search was conducted to ensure illegal substance were not present ---information the local law enforcement was notified to assist with a potential criminal offense. ---the conclusion of the investigation or a determination if a MIR (Misconduct Incident Report) should be submitted to the Department On 3/20/2024 at 7:21 AM, Surveyor sent ED-B, Former House Manager C, Administrator A and Registered Nurse E an email requesting any additional documentation regarding the above allegation. No additional information was received. On 3/25/2024 at 3:15 PM, Surveyors conducted an exit interview with Administrator A and ED-B. Administrator A and ED-B verified the investigation did not include any of the above information and they had no additional information or documentation regarding the above alleged incident. Administrator A stated,	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015454	A. BUILDING: _____ B. WING _____	R-C 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 158	Continued From page 7 "The investigation could have been more through, I guess." The provider did not conduct a thorough investigation and maintain documentation into the alleged incident to rule out caregiver misconduct and to determine if the incident was reportable. Additionally, the provider did not involve the local law enforcement to assist with the investigation when there was an alleged potential criminal offense.	N 158		
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 interviews and record review, the provider did not review and revise the ISP (Individual Service Plan) for Resident 1 when the resident was known to use alcohol and illicit drugs. Staff either observed, witnessed, or suspected	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015454	A. BUILDING: _____ B. WING _____	R-C 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 389	Continued From page 8	N 389		

Resident 1 of using illicit drugs or being impaired from alcohol use. On 11/3/2023, Resident 1 admitted to using meth in his/her bedroom and tested positive for illicit drugs. Despite the facility's awareness of Resident 1's use of alcohol and illicit drugs, no changes or approaches were made to Resident's 1's ISP to prevent or reduce the resident's substance use that may be harmful to the resident or others.

Findings include:

On 3/25/2024, Surveyor reviewed Resident 1's medical record. The record indicated Resident 1's was admitted to the facility on 8/1/2023 with diagnosis to include Schizophrenia, dementia, anxiety, and tobacco use. Additionally, the medical record indicated Resident 1 was his/her own person, able to make decisions and capable of self supervision.

Resident 1's current ISP dated 3/23/2024 indicated, Resident 1 was independent for all activities of daily living (bathing, dressing, eating, toileting, mobility, transferring), and used tobacco products. Additionally, the ISP indicated Resident 1 would independently arrange transportation for community outings and needs. The ISP did not reflect Resident 1's use of alcohol or illicit drugs or approaches towards preventing and/or reducing the resident's substance use.

On 3/25/2024, Surveyor reviewed Resident 1's observation notes which revealed the following:

*09/02/2023- "When walking past resident's room writer noticed a smell similar to marijuana. Writer looked in resident's room and was unable to find any paraphernalia..."
*09/04/2023- "The other day there was a lurking

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N 389	Continued From page 9	N 389		

smell of Mary Jane coming from [his/her] room."
*11/20/2023- "Administrator Assistant (AA) was called over to the building where resident is, due to staff noticing very odd behavior. AA spoke with resident about the way [s/he] was acting. Resident closed the door on AA face. AA called care team and discussed a drug test. Care team agreed but resident refused ...Resident was starting to slur [his/her] words and stumble when walking."
*12/13/2023- "Fax sent to MD in regard to [Resident 1's] illegal drug use and increase in outbursts. Awaiting MD response for drug interactions."
*12/19/2023- " ...Resident has been restless tonight ...[S/he] hasn't been speaking clearly. [S/he] has been mumbling [his/her] words and appears unsteady on [his/her] feet ...If the writer didn't know better, the writer would suspect [s/he] has either been drinking or smoking something other than cigarettes ..."
*1/13/2024- "Resident left while staff was making dinner ...Resident came back. Resident smelt like alcohol. House Manager and Manager on call said to withhold the resident's narcs for the night ...Slurring the words and not able to walk straight ..."
*1/23/2024- "Resident came back from the store and seems to be impaired."
*1/26/2024- "Resident is acting off. Believe [s/he] may be drinking."
*1/27/2024- "Resident is showing signs of moderate anxiety. Resident has been pacing the floor, chain smoking, talking about money, randomly laughing loudly, and talking about [his/her] history of drug use."
*2/20/2024- "Resident left for Walmart via cab before 6 PM. [S/he] arrived back at 6:25 PM. Upon going into the individual's room to give meds it smelled like alcohol. Staff witnessed a

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	0015454	A. BUILDING: _____ B. WING _____	R-C 03/25/2024

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N 389	Continued From page 10	N 389		

"Shutter Home" bottle in the corner of the room on the floor. Resident was notified [s/he] could not have [his/her] medication while under the influence ..."
*2/21/2024- Resident is stumbling and talking gibberish, Resident is drunk ..."

On 3/19/2024, Administrator A provided Surveyor with an email. The email was written by Administrator A and sent to Resident 1's care team, ED (Executive Director)-B, Former House Manager C, Former Staff D and Registered Nurse E on 11/3/2023. The email indicated the following, " ...It was reported [Resident 1] had a guest in [his/her] bedroom the evening of 11/2/23. Staff working the 2nd shift today in the other building reported this resident and employee from the small building were smoking meth in [his/her] bedroom ... [Resident 1] tested positive for THC- (cannabis with psychoactive properties), Meth (methamphetamine- a synthetic simulant that is additive and can cause considerable health adversities that can sometime result in death), and PPX. (Propoxyphene a narcotic analgesic compound bearing structural similarity to methadone). During my investigation ...[Resident 1] told me the guest had a pipe in which they smoked the product ..."

A physician fax undated, sent by ED-B indicated, " ...[Resident 1] has openly admitted to using Meth and marijuana outside the facility. [Resident 1] will leave and come back to the facility clearly impaired noting erratic thoughts and seemingly very high strung for quite some time, then crashes and becomes very irritable and agitated ..."

A physician home visit note for Resident 1 dated 12/15/2023 indicated, " ...Own Person, Chief

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N 389	Continued From page 11	N 389		

Complaint-Behavioral issues, and substance use management. History of Present Illness-[Resident 1] was seen in a home visit for management of [his/her] psychiatric conditions and substance use. The facility reports that [Resident 1] acknowledges using methamphetamine and other drugs frequently and often returns to the facility quite impaired. The staff is uncertain about managing [his/her] psychotropic medications during these times. [Resident 1] has a psychiatrist, although [s/he] has not been seen for the last 3 to 4 months. When questioned about [his/her] illicit drug use, [s/he] became very angry, walked away, and shut [his/her] door. The ongoing concern is [his/her] mental status and the freedom [s/he] has to obtain medications, which [s/he] is currently doing ...Hold all psychotropic medications -Hold medications when patient appears intoxicated or under the influence and then readminister when [s/he] is sober or has appropriate mentation." ***Surveyor noted this information was not listed on Resident 1's ISP or on Resident 1's eMARs (electronic Medication Administration Record) from 12/2023 through 3/2024 to assist staff.

On 3/19/2024 at 9:40 AM, Surveyor interviewed Administrator A regarding Resident 1. Administrator A stated, "[Resident 1] was living in an apartment and had friends coming over to do drugs with [him/her] prior to coming here. [Resident 1] comes and goes as [s/he] pleases and we believe [s/he] may be using substances when [s/he's] gone ...[Resident 1] is not appropriate for this facility ..."

On 3/20/2024 at 12 PM, Surveyor interviewed Caregiver I regarding Resident 1. Caregiver I stated, "Everyone knows [Resident 1] uses illicit drugs and alcohol. About a month ago [Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015454	A. BUILDING: _____ B. WING _____	R-C 03/25/2024

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PAISERS OAKHAVEN S&C LLC	132 OAK CT SHAWANO, WI 54166

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N 389	Continued From page 12 1] went outside and came back in smelling like weed and alcohol ...A few weeks ago [Resident 1] took a taxicab to the store and came back drunk. [Resident 1] has also reported using meth to me." Surveyor then ask Caregiver I what directions s/he was given when Resident 1 reports using alcohol/drugs or when s/he witnesses/suspects Resident 1 of using alcohol and illicit drugs. Caregiver I stated, "The direction is to document and talk to management. Management does nothing ...I guess it's ok for [Resident 1] to leave and come back high or drunk ...Management is failing to keep [Resident 1] and others safe." On 03/25/2024 at 3:15, Surveyors conducted an exit meeting with Administrator A and ED-B. Administrator A confirmed Resident 1's most recent updated ISP was dated 3/23/2024. Administrator A then verified Resident 1's use of alcohol and illicit drugs was not listed on Resident 1's current ISP. In conclusion, the provider did not review and revise Resident 1's ISP when the resident was known to use alcohol and illicit drugs. Resident 1's ISP did not indicate the resident used illicit drugs or alcohol or identify approaches to assist staff with providing services to prevent and/or reduce the resident's substance use, which could by harmful to the resident or others.	N 389		