STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017003	A. BUILDING: _____ B. WING _____	R-C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKSIDE	330 OAK AVE NEW RICHMOND, WI 54017

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{M 000}	INITIAL COMMENTS On 08/07/2024, Surveyor conducted a verification visit at Oakside. Data was collected through 08/12/2024. Three violations were identified. One of 3 violations was a repeat deficiency. See Statement of Deficiency (SOD) 3CV211, dated 06/27/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Department was notified within 24 hours when a resident's whereabouts were unknown. Resident 1 eloped 6 times between 07/01/2024 and 08/07/2024. Findings include: On 08/07/2024 at 11:15 AM, Surveyor arrived at	M 134		

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

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M 134	Continued From page 1 the facility. Nobody was home, so Surveyor was about to leave when Resident 2 was dropped off by a community transport van. Resident 2 allowed Surveyor inside and stated Assistant Program Manager (APM) A was probably out looking for Resident 1. Resident 2 stated Resident 1 took off often. At 11:26, Resident 1 entered the facility and briskly walked to his/her room and shut the door. Moments later APM A arrived. APM A knocked on Resident 1's door and asked where s/he had gone "this time." At 11:30 AM, Surveyor interviewed APM A. APM A stated Resident 1 "took off" around 6:25 AM and Program Manager (PM) B told APM A to give Resident 1 until 11:00 AM to return on his/her own. APM A stated s/he and Resident 3 left the home at 11:00 AM to look for Resident 1. Surveyor reviewed Resident 1's observation notes from 06/01/2024 through 08/07/2024. Staff documented in the notes that Resident 1 left the facility and his/her whereabouts were unknown on 07/01/2024, 07/04/2024, 07/14/2024, 08/02/2024, and twice on 08/03/2024. On 08/12/2024 at 1:04 PM, Surveyor asked PM B if the incidents noted in observation notes were reported to the Department. PM B responded at 3:54 PM, "These were not submitted via a state-self report as required."	M 134		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the	M 424		

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M 424	Continued From page 2	M 424		

resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 resident individual service plans (ISPs) reviewed (Resident 1 and Resident 2) were updated in writing when their supervision needs changed.

Findings include:

RESIDENT 1
On 08/07/2024 at 11:26 AM, Resident 1 entered the facility and briskly walked to his/her room and shut the door. Moments later, Assistant Program Manager (APM) A arrived onsite. APM A knocked on Resident 1's door and asked where s/he had been "this time."

At 11:30 AM, Surveyor interviewed APM A. APM A stated Resident 1 left the facility around 6:25 AM and Program Manager (PM) B told APM A to give Resident 1 until 11:00 AM to return on his/her own. APM A stated s/he and Resident 3 left the

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M 424	Continued From page 3	M 424		

home at 11:03 AM to look for Resident 1. APM A said Resident 1 had been struggling lately and kept taking off. APM A stated Resident 1 was allowed to have up to 2 hours unsupervised time in the community before staff were supposed to contact police. APM A reviewed Resident 3's ISP with Surveyor and stated the ISP needed to be updated. The ISP read, "...is allowed to be in the community unsupervised for up to 60 minutes (90 minutes with prior approval from PM). In the event that [Resident 1] has not returned within [his/her] allotted 60 to 90 minutes, PM should be notified. Law Enforcement should be contacted if [Resident 1] has not returned after 2 hours."

Surveyor reviewed Resident 1's progress notes from 06/01/2024 through 08/07/2024. The notes indicated Resident 1's whereabouts were unknown 6 times between 07/01/2024 and 08/07/2024. Emergency services were contacted to assist in locating Resident 1 multiple times. On 08/02/2024, PM B wrote, "...we're unable to keep [him/her] safe, even with alarms on windows/doors...[Resident 1] needs to be evaluated medically to attempt to get back to [his/her] previous baseline or determine more appropriate level of care going forward."

On 08/07/2024 at 7:39 PM, Surveyor received a copy of Resident 1's current, signed ISP from PM B. The ISP was signed 01/11/2024, and included the same verbiage regarding supervision needs as stated above.

RESIDENT 2
On 08/07/2024 at 11:15 AM, Surveyor arrived at the facility. Nobody was home. As Surveyor was leaving, Resident 2 was dropped off by a community transport van. Resident 2 invited Surveyor inside and stated the staff, APM A, was

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M 424	Continued From page 4 probably out looking for Resident 1. At 11:26 AM, APM A returned to the facility. On 08/07/2024, at 12:32 PM, Surveyor requested a copy of Resident 2's current, signed ISP from APM A. At 4:27 PM, Surveyor received an email from Area Supervisor (AS) C indicating PM B would send the requested document to Surveyor. At 7:39 PM, Surveyor received an email from PM B with Resident 2's ISP. The ISP was signed by Resident 2's guardian on 02/16/2024, and read, "...must have staff supervision for all community outings...has been able to self-supervise in the past. However, at this time [s/he] does NOT self-supervision [sic] at the home due to the falls/imbalance/vertigo like symptoms ... Staff will remain on site at all times when [Resident 2] is home." On 08/12/2024 at 1:04 PM, Surveyor asked PM B if Resident 2's supervision needs changed since February 2024. PM B replied at 3:54 PM via email that Resident 2's supervision needs changed in May 2024. PM B stated, Resident 2's guardian approved Resident 2 to have up to 60 minutes community time and 30 minutes self-supervision at home. According to PM B, this took effect on 05/30/2024, and Resident 2's new guardian recently signed off on the plan.	M 424		
{M 466}	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered	{M 466}		

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{M 466}	Continued From page 5 by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 resident medication administration records (MAR) reviewed (Resident 1 and Resident 2) were complete. This is a repeat violation. See Statement of Deficiency (SOD) 3CV211, dated 06/27/2023. Findings include: On 08/07/2024 at 11:30 AM, Surveyor interviewed Assistant Program Manager (APM) A. APM A stated all residents (3) received medication services. Surveyor reviewed Resident 1's August 2024 MAR, and found no evidence of administration, omission, or refusal for 08/05/2024 or 08/06/2024 8:00 PM medications. These medications included Benztropine 0.5 mg and Metoprolol Succ ER 100 mg. Surveyor reviewed Resident 2's August 2024 MAR. Resident 2's MAR indicated all daily medications were scheduled for 8:00 AM, but the MAR also stated, "[Resident 2] may take meds daily at whatever time [s/he] decides to take them (6am-10pm)... If [s/he] refuses through 10pm then a refusal will be charted on the MAR."	{M 466}		

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{M 466}	Continued From page 6 Resident 2's MAR had no evidence of administration, omission, or refusal for the following medications on 08/05/2024 and 08/06/2024: - Citrus Calcium + D Tablet - Divalproex SOD ER 500 mg - Dutasteride Cap 0.5 mg - Tamsulosin HCL 0.4 mg - Venlafaxine HCL ER 150 mg - Venlafaxine CHL ER 75 mg At 11:56 AM, Surveyor interviewed APM A. APM A stated sometimes evening staff accessed the electronic MAR through their phone, and they have had trouble with the documents saving when accessed through the mobile portal. APM A showed Surveyor each resident's medication cards to show the medications listed above were removed from the pharmacy packages.	{M 466}		