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 10/27/2025

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OAKSIDE	330 OAK AVE NEW RICHMOND, WI 54017

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{M 000}	INITIAL COMMENTS On 10/22/2025, Surveyor conducted a standard licensing survey and verification visit at Oakside. Data was collected through 10/27/2025. Four violations were identified. Two of 4 violations were repeat deficiencies. See Statement of Deficiencies (SOD) 3CV211, dated 06/27/2023 and 3CV212, dated 08/12/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on interview and record review, the provider permitted an existence or continuation of a condition that placed 1 of 1 sampled resident's health, safety, and welfare at risk. Resident 1 displayed behaviors that jeopardized his/her safety and the provider did not have interventions in place to address this risk. Findings include: On 10/22/2025 at 12:15 PM, Surveyor interviewed Caregiver A. Caregiver A stated Resident 1 had diabetes and paranoid schizophrenia. Caregiver A said Resident 1	M 230		

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

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M 230	Continued From page 1 refused his/her medications, preferred not to interact with staff, and preferred to spend all his/her time at the facility in his/her room (including meals which s/he prepared in his/her room). Caregiver A said Resident 1's guardian permitted Resident 1 to leave the facility whenever s/he wanted, even at night. Caregiver A stated s/he was unsure what Resident 1 did in the community, but Resident 1 was banned from the local library, gas station, and bar due to his/her behavior. Caregiver A shared Resident 1 had required police intervention for breaking into parked vehicles on the street and attempting to break into a home. Caregiver A stated s/he was unsure how staff were ensuring Resident 1's safety in the community or monitoring his/her activity. Surveyor reviewed the provider's correspondence with the Department. The provider submitted a self-report on 07/22/2025 that read, "[APM] was notified via law enforcement they had received complaints of [Resident 1] entering private vehicles... [S/he] was also said to have been walking in the middle of the road and not engaging with law enforcement...[S/he] was apparently non-compliant and aggressive at first encounter, but answered their questions... Care team meeting planned to discuss [Resident 1's] current status/suitability for the home. [Resident 1] refuses to engage or even acknowledge house staff most of the time. [S/he] displays extreme signs of paranoia and will lash out (screaming) from [his/her] room about [his/her] [guardian] being 'the devil' and [his/her] personal finances. [S/he] screams and curses profusely; or simply ignores staff altogether when attempts to engage are made." According to the report, the incident occurred at 11:45 PM on 07/21/2025.	M 230		

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M 230	Continued From page 2 On 10/22/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 05/02/2025 with diagnoses including abnormal involuntary movements, type 2 diabetes, paranoid schizophrenia, Tourette's disorder, and bilateral leg edema. Resident 1's individual service plan (ISP), updated 07/23/2025, indicated Resident 1 refused medication and physician recommendations to address his/her physical or mental health conditions. The ISP indicated Resident 1 would go days without eating, sit with his/her legs in a dependent position nearly all day and night, and displayed frequent anxiety, paranoia, and suspicion. The ISP read, "[Resident 1] does not have restrictions on [his/her] time in the community and [his/her] guardian does not require notification for [his/her] outings unless there is an incident/emergency. Because [Resident 1] keeps non-traditional awake/sleep hours, [s/he] may stay up all evening and sleep during the day/afternoon. For this reason, [Guardian B] is ok with [Resident 1] being out past traditional curfews. PM (program manager) and Guardian have requested [Resident 1] advise staff when [s/he] will be leaving the home, with potential best guess for an ETA (estimated time of arrival). [Resident 1] has thus far refused to engage w/ (with) staff to notify of community time, regardless of time of day." On 10/27/2025 at 1:00 PM, Surveyor interviewed Program Manager (PM) C and Regional Manager (RM) D. Surveyor inquired about interventions to address Resident 1's behavior, specifically his/her unsupervised time in the community. PM C stated, "We've been talking about this a lot... [Guardian B] said [Resident 1] has never not come back." PM C also noted that Resident 1's	M 230		

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M 230	Continued From page 3 behaviors and delusions continued to escalate, and the provider recently issued a 30-day involuntary discharge notice. PM C confirmed Resident 1 would leave the facility at night while staff were sleeping. PM C was unsure at what point staff would intervene by contacting police or when to consider Resident 1 an elopement. PM C stated Resident 1's guardian permitted unsupervised time in the community, so the provider was allowing Resident 1 this freedom.	M 230		
{M 466}	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered 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 observation, record review, and interview, the provider did not maintain a record of all prescription medication controlled, dispensed, or administered by the licensee. The provider did not maintain an accurate record of 1 of 1 sampled resident's medication. Resident 2's medication administration record (MAR) indicated Resident 2 had 2 lorazepam 0.5 mg tablets in supply but there was only 1 available on 10/22/2025. This is a repeat violation. See Statement of	{M 466}		

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{M 466}	Continued From page 4 Deficiencies (SOD) 3CV211, dated 6/27/23 and 3CV212, dated 08/12/2024. Findings include: On 10/22/2025 at 1:55 PM, Surveyor observed the provider's medication storage with Caregiver E. Caregiver E stated the provider maintained a record of controlled substances like lorazepam. Caregiver E showed Surveyor the record for Resident 2's lorazepam 0.5mg tablet which included the date and time of administration and remaining number of tablets in supply. The record indicated Resident 2 had 2 lorazepam 0.5 mg tablets in supply. Surveyor and Caregiver E reviewed Resident 2's medication supply and found there was 1 lorazepam 0.5 mg tablet prescribed to Resident 2 in the provider's medication supply. Surveyor asked Caregiver E about the discrepancy between the supply and the record. Caregiver E reviewed Resident 2's lorazepam supply and confirmed there was only 1 lorazepam 0.5 mg tablet left. Caregiver E guessed staff forgot to record an administration. Caregiver E stated staff were supposed to count controlled substances at every shift change with 2 staff present; both staff were supposed to sign the controlled substance record to verify the count was accurate. Surveyor observed Caregiver E signing the controlled substance record without another staff member present. Caregiver E stated s/he would normally ask Program Manager (PM) C to count the medications with him/her, but PM C was busy. Caregiver E stated s/he did not do the count with the outgoing staff at shift change because the	{M 466}		

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{M 466}	Continued From page 5 staff member left in a hurry. On 10/27/2025 at 1:00 PM, Surveyor interviewed Program Manager (PM) C and Regional Manager (RM) D. PM C stated every staff was responsible for ensuring medication records were complete and controlled substances were accounted for. PM C said staff should be counting controlled substances at every shift change together. PM C stated, "There shouldn't be a time when only 1 staff counts." PM C stated s/he was not aware of a controlled substance count concern in the time s/he had been employed at the facility (date of hire 09/14/2021). RM D stated staff were trained to immediately notify PM C if they found an issue with a controlled substance count. PM C stated s/he was unaware that Resident 2's lorazepam 0.5mg count was off; no caregiver notified PM C of the discrepancy between 10/22/2025 and 10/27/2025.	{M 466}		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored in a sanitary manner on 10/20/2025. This is a repeat violation. See Statement of Deficiencies (SOD) 3CV211, dated 06/27/2023. Findings include:	M 474		

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M 474	Continued From page 6 The provider is licensed to care for 4 residents in the client groups alcohol/drug dependent, terminally ill, irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, traumatic brain injury, developmentally disabled, and advanced aged. On 10/22/2025 at approximately 12:30 PM, Surveyor interviewed Assistant Program Manager (APM) A. APM A stated most of the residents preferred to cook for themselves. APM A said Program Manager (PM) C did the grocery shopping and residents were able to request items they wanted for their meals. At approximately 1:30 PM, Surveyor observed the provider's food supply and storage. The following concerns were identified: - Six cases (boxes of 12 individual cups) of yogurt with best by dates ranging from 06/06/2025 to 10/14/2025. - A bag of flour with a best by date of 09/23/2025. - A carton of eggs with a best by date of 07/03/2025. - An unwrapped, uncovered burrito in the freezer. - Moldy cucumbers and green beans in the produce bins of the upstairs refrigerator. - Single-serve cups of yogurt with a best by date of June 2025. - A package of moldy sweet corn muffins with a best buy date of 10/09/2025. - A box of expired corn starch. - An uncovered cup of unlabeled seasoning mix. On 10/27/2025 at 1:00 PM, Surveyor interviewed Program Manager (PM) C and Regional Manager (RM) D. PM C stated all staff were responsible for ensuring food was stored and prepared sanitarily. PM C stated s/he ordered groceries on a	M 474		

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M 474	Continued From page 7 bi-weekly basis. PM C stated s/he last observed the food storage and supply about 1 month ago.	M 474		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed (Resident 2) received his/her medication as prescribed. The provider did not ensure Resident 2's previous prescription/dosage was removed from the medication cart and the provider did not update Resident 2's medication administration record (MAR) timely. Resident 2 received the incorrect lorazepam dosage 4 times in September 2025. Findings include: On 10/22/2025 at 1:55 PM, Surveyor observed the provider's medication storage with Caregiver E. Resident 2 had 2 cards of lorazepam in supply. One card contained 0.5 mg tablets, take 1 tablet by mouth twice daily as needed (PRN), and one card contained 2 mg tablets, give 1/2 tablet (1 mg) by mouth 3 times a day PRN. Surveyor	M 582		

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M 582	Continued From page 8	M 582		

asked how staff determined which dosage to give Resident 2, and Caregiver E stated the medication MAR indicated which one to give.

Surveyor reviewed Resident 2's record. Resident 2 was admitted on 12/13/2018 with diagnoses that included paranoid schizophrenia.

Resident 2's progress notes included the following:
- 09/09/2025, Caregiver G wrote, "[Resident 2] asked for a prn lorazepam [s/he] stated [s/he] now gets 1 mg staff didn't find any 1mg or in mar [sic] so unsure of what [Resident 2] is stating but [s/he] did take the 0,5 [sic]."
- 09/11/2025, Nurse F responded, "[Resident 2] is correct: This is on his MAR. (1 mg Lorazepam) ... PM/APM (program manager/assistant program manager): Please make sure the card matches, and the 0.5 mg tablet (if any in home PRN are removed)."
- 09/11/2025, Program Manager (PM) C wrote: "MAR updated/current to reflect PRN adjustment ...Lorazepam 1mg twice daily as needed ...PRN 0.5mg tablets have been removed."

Resident 2's September MAR indicated Resident 2 had 2 lorazepam PRN orders:
- Lorazepam 0.5 mg tablets, give 1 tablet by mouth once daily PRN. This medication was added to the MAR on 07/21/2024.
- Lorazepam 2 mg tablets, give 1/2 tablet (1 mg) by mouth twice daily (BID) PRN. This medication was added to the MAR on 08/30/2025.

According to the MAR, Resident 2 received lorazepam 0.5 mg PRN 10 times between 09/01/2025 and 09/10/2025. Per orders, Resident 2 should have received 1 mg of the medication at each of these administrations. On 09/06/2025,

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M 582	Continued From page 9	M 582		

Caregiver E administered this medication (0.5 mg) to Resident 2 twice, once at 5:00 PM and once at 7:00 PM which was not consistent with the 0.5 mg daily order or the 1 mg BID order.

Resident 2 received lorazepam 1 mg PRN 29 times between 09/12/2025 and 09/30/2025. On 09/21/2025, Caregiver E administered 3 doses of lorazepam 1 mg PRN to Resident 2 at 8:00 AM, 5:00 PM, and 8:00 PM; this was 1 more dose than what s/he was supposed to receive per the order.

Resident 2's controlled substance record indicated Caregiver H administered Resident 2 lorazepam 0.5mg PRN (not 1 mg) at 7:00 PM on 09/24/2025 and 09/25/2025. This was not consistent with the orders as transcribed in the MAR.

On 10/27/2025 at 1:30 PM, Surveyor interviewed PM C and Regional Manager (RM) D. PM C stated s/he did not remove Resident 2's lorazepam 0.5 mg card from supply on 09/11/2025 like s/he indicated in progress notes. PM C stated PMs were responsible for adding medications accurately to the MAR and staff were responsible for ensuring medications on the MAR matched the pharmacy label prior to administering a medication. PM C stated Resident 2's lorazepam order changed on 09/26/2025 to 3 times a day.

On 10/27/2025 at 5:07 PM, Surveyor received the following message from PM C:
"Just putting together Lorazepam info for [Resident 2]. Looks like [Resident 2's physician] authorized an increase to 1mg Twice Daily PRN on 8/28. We do not change the MAR until we receive the new order/card from our pharmacy.

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M 582	Continued From page 10 The pharmacy delivered the 1MG PRN card on 9/10." Surveyor received the following orders from PM C: - Lorazepam 1 mg, take 1 tablet by mouth twice a day, PRN; effective 08/28/2025 - Lorazepam 1 mg, take 1 table by mouth three times a day, PRN; effective 09/26/2025 On 10/27/2025, Surveyor reviewed Resident 2's October MAR which was obtained from PM C on 10/22/2025. Resident 2's MAR was not consistent with Resident 2's 09/26/2025 lorazepam orders. Lorazepam 1 mg, take 1 table by mouth three times a day PRN had not been added to the October MAR.	M 582		