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 07/25/2023

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

(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 On 07/25/2023, Surveyor conducted a complaint investigation and standard survey at Sienna Meadows of Oregon. One deficiency was identified. The complaint was unsubstantiated. Census: 19	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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
	0009869	A. BUILDING: _____ B. WING _____	C 07/25/2023

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

(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 239	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees reviewed had completed training in Department Approved training as required. Caregiver B, Caregiver C, and Caregiver D did not complete Department Approved training within 90 days after starting employment. Findings include: On 07/25/2023, Surveyor conducted a review of employee records to verify compliance with department approved training requirements: First Aid and Choking The record for Caregiver C, hired 09/07/2022, contained evidence of training in First Aid and Choking completed 05/22/2023, over 5 months after the 90-day requirement. The record for Caregiver D, hired 03/16/2022, contained evidence of training in First Aid and Choking completed 04/07/2023, over 9 months after the 90-day requirement. Fire Safety The record for Caregiver B, hired 11/03/2021, contained evidence of training in fire safety completed 06/07/2022, almost 4 months after the 90-day requirement. The record for Caregiver D, hired 03/16/2022, contained evidence of training in fire safety completed 08/11/2022, almost 2 months after the 90-day requirement.	N 239		

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 07/25/2023

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

(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 239	Continued From page 2 On 07/25/2023 at 1:00 PM, Surveyor interviewed Administrator A. Administrator A confirmed s/he knew Caregiver B, Caregiver C, and Caregiver D were out of compliance with Department Approved training's. Administrator A stated we had to take staff off the schedule until they completed the required training's.	N 239		