STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011595	A. BUILDING: _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD MANOR	**2675 OMRO RD OSHKOSH, WI 54904**

(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 From 07/09/2024 to 07/10/2024, Surveyor conducted 3 complaint investigations and a standard survey at Oakwood Manor, a CBRF in Oshkosh. Ten deficiencies were identified. Four deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) VD2Z11, dated 08/29/2022. Three of 3 complaints were unsubstantiated. Census: 19	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an occurrence when law enforcement responded to the facility as a result of an incident that jeopardized the welfare of residents was reported to the department. The provider did not complete a self-report when law enforcement responded to an allegation of theft. Findings include:	N 164		

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

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N 164	Continued From page 1 On 07/09/2024 at approximately 9:30 a.m., Surveyor interviewed Resident 2. Resident 2 stated in February 2024, a staff member stole $50 from the money clip stored in his/her dresser and s/he called law enforcement. Resident 2 stated s/he now always kept his/her money on him/her, locked his/her apartment and had a camera in the room. On 07/09/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 04/25/2022. Resident 2's record included a progress note, dated 02/21/2024, that stated Resident 2 had made a complaint about 2 caregivers going in his/her room and stealing $100. The note stated Resident 2 was going to call law enforcement. On 07/09/2024 at approximately 12:15 p.m., Surveyor reviewed department records and was unable to locate documentation of a self-report related to the 02/21/2024 incident. On 07/09/2024 at approximately 12:30 p.m., Surveyor asked RN B if law enforcement's involvement related to the 02/21/2024 allegations of theft was self-reported to the department. RN B stated s/he was on leave during that time and was unable to locate a report. On 07/09/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator E, RN B and Program Director A that Resident 2 made allegations of theft and had law enforcement called to the facility, but the provider did not complete a self-report. Administrator E stated s/he vaguely recalled the incident, but wasn't sure on details.	N 164		

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N 164	Continued From page 2 On 07/10/2024 at approximately 12:15 p.m., RN B followed up with Surveyor and stated s/he followed up with the local police department. RN B stated law enforcement did arrive to the scene and the provider sat in on law enforcements investigation but did not complete a self-report to the department.	N 164		
N 172	83.12(6) Documentation requirements for written report All written reports required under this section shall include, at a minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure residents ' health, safety and well-being. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the facility maintained a written report including all details related to allegations of theft. Resident 2 reported concerns that staff stole money from his/her room and the provider did not maintain a report of their investigation. Findings include: On 07/09/2024 at approximately 9:30 a.m., Surveyor interviewed Resident 2. Resident 2 stated in February 2024, a staff member stole $50 from the money clip stored in his/her dresser and s/he called law enforcement. Resident 2 stated s/he now always kept his/her money on him/her, locked his/her apartment and had a camera in the room. On 07/09/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 2's record. Resident	N 172		

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N 172	Continued From page 3 2 was admitted to the provider's facility on 04/25/2022. Resident 2's record included a progress note, dated 02/21/2024, that stated Resident 2 had made a complaint about 2 caregivers going in his/her room and stealing $100. The note stated Resident 2 was going to call law enforcement. On 07/09/2024 at approximately 12:15 p.m., Surveyor asked RN B for an investigation regarding the theft allegations. RN B stated s/he was on leave during that time and was unable to locate anything other than the progress note. On 07/09/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator E, RN B and Program Director A that Resident 2 made allegations of theft and the provider did not have documentation of an investigation. Administrator E stated s/he vaguely recalled the incident but wasn't sure on details. On 07/10/2024 at approximately 12:15 p.m., RN B followed up with Surveyor and stated s/he followed up with the local police department. RN B stated law enforcement did arrive to the scene and the provider sat in on law enforcements investigation but did not document details. Cross Reference: N0164 83.12(4)(b) Reporting When Law Enforcement Is Called	N 172		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the	N 219		

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N 219	Continued From page 4 procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 background checks reviewed were completed at the time of hire and every 4 years following the procedures in s. 50.065, Stats., and ch. DHS 12. Caregiver D's Department of Justice (DOJ) and Integrated Background Information System letter (IBIS) were completed greater than 60 days after his/her date of hire. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete CBC, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check" letter from the Department of Health Service, also referred to as the Integrated Background Information System (IBIS).	N 219		

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N 219	Continued From page 5 On 07/09/2024 at approximately 9:45 a.m., Surveyor reviewed Caregiver D's record provided by Program Director A. Caregiver D's record indicated s/he was hired on 06/07/2023. The record contained the following: - BID, dated 05/18/2023. - DOJ, dated 02/27/2024. - IBIS, dated 02/27/2024. On 07/09/2024 at approximately 2:00 p.m. Surveyor reviewed concern with Administrator E, RN B and Program Director A that Caregiver D's DOJ and IBIS were not completed until approximately 8 months after his/her hire. Administrator E stated that was odd because the provider was usually good about background checks.	N 219		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical,	N 243		

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N 243	Continued From page 6 social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 1 of 1 employees reviewed for initial orientation, obtained all training as required within 90 days after starting employment. Caregiver D did not have training in resident rights, recognizing, preventing, managing and responding to challenging behaviors and client groups within 90 days after starting employment. This is a repeat deficiency. See Statement of	N 243		

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N 243	Continued From page 7 Deficiency (SOD) VD2Z11, dated 08/29/2022. Findings include: On 07/09/2024 at approximately 9:45 a.m., Surveyor received training records for Caregiver D from RN B. Records indicated Caregiver D was hired on 05/18/2023. Resident Rights The record for Caregiver D did not contain evidence of training or evidence of meeting an exemption for resident rights. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for Caregiver D did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. Client Group The facility was licensed to provide care and services to residents within the client groups of physically disabled, advanced age, irreversible dementia/Alzheimer's and traumatic brain injury. The record for Caregiver D did not contain evidence of training or evidence of meeting an exemption for client group training. On 07/09/2024 at approximately 12:00 p.m., Surveyor asked RN B if s/he had any additional trainings to provide. RN B stated s/he had double checked Caregiver D's record and was unable to locate additional trainings or exemptions for resident rights, recognizing, preventing, managing and responding to challenging behaviors and client groups.	N 243		

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N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 caregivers reviewed received at least 15 hours of continuing education in 2022 and 2023. Caregiver C did not receive 15 hours of continuing education in 2022 and 2023. This is a repeat deficiency. See Statement of Deficiency (SOD) VD2Z11, dated 08/29/2022. Findings include: On 07/09/2024 at approximately 9:45 a.m., Surveyor reviewed employee records provided by RN B. Caregiver C's record indicated s/he was hired on 03/04/2019. Caregiver C's record included the following information regarding continuing education: - 2022: Completed 7 hours. Education did not include topics of medication, fire safety or	N 277		

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N 277	Continued From page 9 emergency procedures. - 2023: Completed 8 hours. Education did not include standard precautions, medications, resident rights, fire safety or emergency procedures. On 07/09/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator E, RN B and Program Director A that 1 of 1 caregivers reviewed for continuing education had not received at least 15 hours of education in 2022 and 2023. RN B made note of Surveyor's concern. Administrator E stated they were working on getting the facility caught up on things.	N 277		
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 provider did not ensure 1 of 3 individual service plans (ISP) reviewed was updated when there was a change in resident's needs and at least	N 389		

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N 389	Continued From page 10	N 389		

annually. Resident 1's ISP had not been reviewed in greater than 1 year and was not updated to include his history of an elopement, wandering and fall.

Findings include:

On 07/09/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 03/17/2017 and discharged on 06/17/2024. Resident 1's record included the following:

- 04/15/2024: Resident was not able to be located in the facility when gathering residents for lunch. Kitchen staff member and the owner of the building went out to search and located resident over by the roundabout by a local bank. Resident was safely returned to the facility.
- 04/23/2024: Was looking for another individual at 4:00 a.m. Easily redirected.
- 05/03/2024: Found in another resident's room. Resident because upset when caregiver attempted to redirect resident. Resident began banging on door.
- 05/03/2024: Resident has wanderguard on his/her walker.
- 05/18/2024: Fall while sitting on walker. Resident leaned too far forward and fell off walker. Resident hit his/her head and was sent to the ER.

Resident 1's most recent signed ISP, dated 05/16/2023, stated the following:

- Elopement Risk Assessment: Incomplete - Included instructions to complete upon admission or per facility policy.
- Wandering: No history of wandering.
- Fall Risk Assessment: Incomplete - included

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N 389	Continued From page 11 instructions to complete upon admission, fall, change in health condition or annually. On 07/09/2024 at approximately 1:00 p.m., Surveyor asked RN B if Resident 1 had an ISP that had been updated in the past year. RN B stated s/he did not have an updated ISP, but did provide Surveyor with an assessment, dated 05/28/2024. Surveyor reviewed the assessment and noted the assessment did include history of a fall or history of elopements. The assessment stated, "No history of wandering." On 07/09/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator E, RN B and Program Director A that Resident 1's ISP was not reviewed in the past year or with Resident 1's recent fall, wandering and elopement. Administrator E stated the provider's intervention for elopements was a Wanderguard and acknowledged the ISP was not updated to include the intervention.	N 389		
N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 2 of 2 residents reviewed that had resided at the provider's facility for greater than 1 year had been provided the	N 392		

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N 392	Continued From page 12 opportunity to complete an evaluation of the resident's level of satisfaction with the CBRF's services. Resident 1, Resident 2 and/or their legal representatives were not provided the opportunity to complete a satisfaction evaluation. Findings include: On 07/09/2024 at approximately 12:00 p.m., Surveyor reviewed resident records, which indicated Resident 1 was admitted on 03/17/2017 and Resident 2 admitted on 04/25/2022. Surveyor requested documentation from RN B to indicate Resident 1, Resident 2 and/or their legal representatives were provided an opportunity to complete a satisfaction evaluation within the past year. On 07/09/2024 at approximately 12:15 p.m., RN B informed Surveyor s/he did not have documentation of a satisfaction evaluation to provide. RN B stated satisfaction surveys were usually provided during ISP reviews and there was no documentation to indicate this occurred. On 07/09/2024 at approximately 2:00 p.m., Surveyor reviewed concern with Administrator E, RN B and Program Director A that 2 of 2 residents reviewed who resided at the facility greater than 1 year were not provided the opportunity to complete a satisfaction evaluation. Administrator E stated RN B had been on leave and the provider was working on getting things in order.	N 392		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and	N 499		

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N 499	Continued From page 13 toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all cleaning compounds and toxic substances were stored in a secure area. The provider had cleaning agents accessible to residents in the unlocked laundry room. Findings include: On 07/09/2024 at approximately 8:15 a.m., Surveyor toured the provider's facility. Surveyor observed the laundry room door wide open. Inside the laundry room, Surveyor observed laundry detergent with a label "WARNING: DO NOT INGEST," disinfectant spray and bleach. On 07/09/2024 at approximately 12:30 p.m., Surveyor observed the laundry room door remained propped wide open. Surveyor asked Caregiver F if the laundry room and cleaning agents were typically kept secured. Caregiver F replied, "That would make sense to [secure]. We have residents come in here." Caregiver F then "unpropped" the door and began to close the door. Surveyor and Caregiver F then observed the door handle did not have the ability to lock. On 07/09/2024 at approximately 1:15 p.m., Surveyor asked Administrator E if the laundry room had typically been kept locked. Administrator E stated the laundry room had always been unlocked and they hadn't learned until recently when licensing a new facility that chemicals needed to be stored secured.	N 499		

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(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 525	Continued From page 14	N 525		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were completed at least quarterly with both employees and residents. This is a repeat deficiency. See Statement of Deficiency (SOD) VD2Z11, dated 08/29/2022. Findings include: On 07/09/2024 at approximately 10:00 a.m., Surveyor reviewed the provider's binder of environmental inspections and drills. Surveyor was able to find documentation of 2 drills completed from 01/01/2023 to 07/09/2024. Documentation indicated a fire drill was	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011595	A. BUILDING: _____ B. WING _____	C 07/10/2024

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N 525	Continued From page 15 completed on 03/30/2023 at 2:30 p.m. and 05/18/2023 at 1:14 p.m. Surveyor updated Program Manager A that s/he was only able to locate 2 fire drills completed since 01/01/2023. On 07/09/2024 at approximately 12:00 p.m., Surveyor followed up with Program Manager A and RN B regarding fire drills. Program Manager A stated s/he was unable to locate documentation of any additional drills being completed. RN B stated the previous manager would have been responsible for fire drills and s/he was no longer in that position effective approximately 2 weeks ago.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure other evacuation drills, such as tornado, flooding, or other emergency or disaster drills, were conducted at least semi-annually. This is a repeat deficiency. See Statement of Deficiency (SOD) VD2Z11, dated 08/29/2022. Findings include: On 07/09/2024 at approximately 10:00 a.m., Surveyor reviewed the provider's binder of environmental inspections and drills. Surveyor was unable to locate documentation of evacuation drills, such as tornado, flooding, or	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011595	A. BUILDING: _____ B. WING _____	C 07/10/2024

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N 526	Continued From page 16 other emergencies. Surveyor updated Program Manager A that s/he was only able to locate documentation of evacuation drills. On 07/09/2024 at approximately 12:00 p.m., Surveyor followed up with Program Manager A and RN B regarding evacuation drills. Program Manager A stated s/he was unable to locate documentation of any evacuation drills being completed. RN B stated the previous manager would have been responsible for drills and s/he was no longer in that position effective approximately 2 weeks ago.	N 526		