Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110075	A. BUILDING: _____ B. WING _____	C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OFFSHORE GROUP HOME	6418 OFFSHORE DR MADISON, WI 53705

(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 04/15/2026, Surveyor conducted a self-report review at Offshore Group Home, a CBRF located in Madison,WI. As a result of the investigation, 2 violations of Chapter DHS 83 were issued.	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on interview and record review, the provider did not develop a comprehensive assessment for Resident 1. Resident 1 was admitted 09/02/2025 and did not have a documented comprehensive assessment. Findings include: On 02/03/2026, Facility sent in a self-report indicating that Resident 1 had eloped from the facility and had not yet returned. On 04/15/2026 at 9:00 AM, Surveyor reviewed	N 381		

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
	110075	A. BUILDING: _____ B. WING _____	C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OFFSHORE GROUP HOME	6418 OFFSHORE DR MADISON, WI 53705

(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 381	Continued From page 1 Resident 1's medical record. Resident 1 was admitted 09/02/2025. There was no documented comprehensive assessment in Resident 1's file. On 04/15/2026 at 9:15 AM, Surveyor interviewed Manager A. Surveyor asked if there was an assessment completed at admission. Manager A stated, "no, we don't have that." Manager A acknowledged that each resident must have a comprehensive assessment developed upon admission, "and we don't have one for Resident 1." Manager A found the signature sheet for an assessment, but no other documentation that an assessment was conducted. Surveyor asked how caregivers knew Resident 1's needs, abilities and physical/mental condition? Manager A stated, "I'm not sure, there is no assessment here." Manager A stated that Resident 1 was previously homeless, routinely refused medications, left the house and came back when s/he pleased. Manager A stated that the facility was in contact with case managers from Managed Care Organization about Resident 1 regularly.	N 381		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110075	A. BUILDING: _____ B. WING _____	C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OFFSHORE GROUP HOME	6418 OFFSHORE DR MADISON, WI 53705

(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 386	Continued From page 2 methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on interview and record review, the provider did not develop a comprehensive Individual Service Plan (ISP) for Resident 1. Resident 1 was admitted 09/02/2025 and did not have a documented ISP. Findings include: On 02/03/2026, Facility sent in a self-report indicating that Resident 1 had eloped from the facility and had not yet returned. On 04/15/2026 at 9:00 AM, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted 09/02/2025. There was no documented ISP in Resident 1's file. On 04/15/2026 at 9:15 AM, Surveyor interviewed Manager A. Manager A acknowledged that there was no documented ISP for Resident 1. Manager A stated, "Resident 1 is own person and refused to let us develop an ISP for him/her." Surveyor asked if there was an assessment completed at admission which is used to develop the ISP. Manager A stated, "no, we don't have that either." Manager A stated that Resident 1 was previously homeless, routinely refused medications, left the house and came back when s/he pleased. Manager A stated that the facility was in contact with case managers from Managed Care Organization about Resident 1 regularly.	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110075	A. BUILDING: _____ B. WING _____	C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OFFSHORE GROUP HOME	**6418 OFFSHORE DR MADISON, WI 53705**

(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