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	410156	A. BUILDING: _____ B. WING _____	C 08/20/2025

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OAKS FAM CARE CTR - OAKLAND HO	126 N OAKLAND AVE GREEN BAY, WI 54303

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N 000	Initial Comments On 08/20/2025, Surveyor conducted a complaint investigation at Oaks Fam Care Ctr Oakland House. The complaint was substantiated. Eight deficiencies were identified. Census: 7	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after Resident 1 fell down the stairs, went to the emergency room (ER), and was diagnosed with a fractured clavicle. Findings include: On 05/21/2025, the department received complaint information alleging a resident fell down the stairs. On 08/20/2025, Surveyor conducted a complaint investigation. Surveyor reviewed Resident 1's record and was provided an incident report dated 04/05/2025 describing Resident 1 being found with a swollen and bruised right shoulder. Resident 1 was able to verbalize that s/he fell down the stairs, tripping	N 165		

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

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N 165	Continued From page 1 over a pair of shoes s/he had left at the top of the stairs. Resident 1 could not recall what time s/he fell down the stairs besides saying s/he "tripped on my shoes in the night" which would have been sometime between bedtime medications and 5:00 AM. Resident 1 was taken to the ER once the injury was identified and s/he was diagnosed with a right clavicle fracture. On 08/20/2025, Surveyor reviewed department provider records and did not find any evidence of a self-report from the incident on 04/05/2025. At approximately 1:00 PM, Surveyor interviewed Program Manager B who stated and verified s/he did not send self-report information regarding Resident 1's fall and injury on 04/05/2025 to the department.	N 165		
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 2 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 6 of 6 employees received training specific to the client group, emotionally disturbed/mentally ill, served, to include the physical, social, and mental health needs of the client group. Resident 3 was admitted to the facility on 06/07/2021 with diagnoses of bipolar disorder and epilepsy. Findings include:	N 243		

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N 243	Continued From page 3 The provider was licensed to provide care and services to up to 7 residents within the client group of developmentally disabled. On 08/20/20/25 at approximately 10:00 AM, Surveyor interviewed Program Manager B who stated Resident 3 did not have a developmental disability diagnosis. Surveyor reviewed Resident 3's record and noted s/he was admitted to the facility on 06/07/2021 with diagnoses of bipolar disorder and epilepsy. Surveyor inquired whether s/he and other staff received training on the client group emotionally disturbed/mentally ill and Program Manager B stated no. Surveyor reviewed 6 of 6 staff training records. (Surveyor note: months and years were provided for hire dates.) The record for Program Manager B, hired 03/2020, did not contain evidence of training for emotionally disturbed/mentally ill client group or evidence of meeting an exemption for client group training. The record for Resident Care Worker (RCW), hired 07/2020, did not contain evidence of training for emotionally disturbed/mentally ill client group or evidence of meeting an exemption for client group training. The record for RCW D, hired 09/2022, did not contain evidence of training for emotionally disturbed/mentally ill client group or evidence of meeting an exemption for client group training. The record for RCW E, hired 12/2014, did not contain evidence of training for emotionally disturbed/mentally ill client group or evidence of meeting an exemption for client group training. The record for RCW F, hired 06/2024, did not contain evidence of training for emotionally disturbed/mentally ill client group or evidence of meeting an exemption for client group training.	N 243		

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N 243	Continued From page 4 The record for Lead RCW G, hired 06/2004, did not contain evidence of training for emotionally disturbed/mentally ill client group or evidence of meeting an exemption for client group training. On 08/20/2025 at approximately 12:35 PM, Surveyor interviewed Licensee A and Program Manager B. Program Manager B verified s/he did not receive training in client group specific to Resident 3's client group. Licensee A acknowledged the facility was not licensed for Resident 3's client group and staff did not receive the specific client group training to serve Resident 3. Licensee A stated s/he was unaware Resident 3 was not in the developmentally disabled client group, but would ensure staff receive training, update his/her license and program statement and submit to the department. Cross Reference N0289 83.27(2)(a) Admissions Compatible with Program Statement	N 243		
N 289	83.27(2)(c) Admissions compatible with program statement A CBRF may not admit or retain any of the following persons: A person who has physical, mental, psychiatric or social needs that are not compatible with the client group as described in the CBRF ' s program statement. This Rule is not met as evidenced by: Based on record review and interview, the provider admitted and retained Resident 1 and Resident 3 who had physical, mental, psychiatric or social needs that were not compatible with the client group as described in the provider's program statement.	N 289		

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N 289	Continued From page 5 The provider is licensed as a Class AA (ambulatory) community-based residential facility (CBRF) to provide services to up to 7 individuals with developmental disabilities. Resident 1 had diagnoses of dementia with mood disturbance, alcoholism, osteoarthritis, seizures, and depression. Resident 3 had diagnoses of bipolar disorder and seizures. Resident 1 and Resident 3 did not fit in the licensed client group described in the provider's program statement and approved by the department. Findings include: On 05/21/2025, the department received complaint information alleging a resident fell down the stairs. On 08/20/2025, Surveyor conducted a complaint investigation. At the time of survey, 7 of 7 residents resided at the facility. On 08/20/2025 at approximately 10:00 AM, Surveyor interviewed Program Manager B who stated Resident 1 fell down the stairs in April. Program Manager B indicated Resident 1 had diagnoses of dementia. Surveyor reviewed Resident 1's record and noted s/he was admitted to the facility on 09/12/2024. Surveyor noted Resident 1's hospital discharge paperwork listed Resident 1 to have diagnoses of dementia with mood disturbance, alcoholism, osteoarthritis, seizures, and depression. Program Manager B described Resident 1 as exhibiting behaviors such as plugging the toilet with paper towels, flooding the upstairs bathroom, paranoia, turning on the gas stove, rummaging, and urinating and defecating on the carpeting in his/her room. S/he said s/he was pleasantly confused and easily redirected.	N 289		

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N 289	Continued From page 6 Surveyor and Program Manager B discussed other resident conditions. Program Manager B indicated Resident 3 had diagnoses seizures. Surveyor reviewed Resident 3's record and noted s/he was admitted to the facility on 06/07/2021. Surveyor reviewed Resident 3's August 2025 medication administration record (MAR) and noted s/he had diagnoses of bipolar disorder, epilepsy, and recurrent seizures. Program Manager B stated s/he did not know Resident 3 had bipolar disorder. On 08/20/2025 at approximately 12:35 PM, Surveyor interviewed Licensee A. Licensee A provided Surveyor with the provider's most recent program statement. Surveyor noted developmental disability was listed as the client group. Activities, staffing, and services provided were listed in relation to developmental disability client group. Dementia/Alzheimer's and emotional disturbance/mentally ill were not client groups listed on Licensee A's license and program statement. S/he verified s/he was licensed for developmental disability client group. Licensee A stated because Resident 1 and Resident 3 had involvement in the day service program prior to admission, Licensee A made the assumption that Resident 1 and Resident 3 were in the same client group as other residents at the facility. Licensee A stated s/he will add the related client groups and submit an updated program statement to the department for approval. Cross Reference N0165 83.12(4)(c) Reporting Incidents With Serious Injury N0243 83.21(1)-(3) All Employee Training N0381 83.35(1)(a) Pre-Admission and Ongoing Assessments	N 289		

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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 record review and interview, the provider did not assess 2 of 2 residents (Resident 1 and Resident 2) reviewed needs, abilities and physical and mental condition before admitting the person to the CBRF, when there was a change in needs, abilities or condition, and at least annually. Resident 1 was admitted to the facility on 09/12/2024. Resident 1 was not assessed prior to admission or upon change in condition. Resident 2 was admitted to the facility on 04/24/2023 and was not assessed annually. Findings include: The provider is licensed to serve up to 7 residents with developmental disabilities. On 05/21/2025, the department received complaint information alleging a resident fell	N 381		

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N 381	Continued From page 8 down the stairs. On 08/20/2025, Surveyor conducted a complaint investigation. At approximately 9:45 AM, Surveyor interviewed Program Manager B who reported Resident 1 had a fall down the stairs on 04/05/2025 and sustained a clavicle fracture. Surveyor reviewed Resident 1's record and noted s/he was admitted to the facility on 09/12/2024 with diagnoses of dementia with mood disturbance, left eye blindness, anxiety, depression, history of alcoholism, and osteoarthritis. There was no evidence of a pre-admission assessment and change in condition assessment post fall in Resident 1's record. Program Manager B reviewed Resident 1's paper record and computer record and verified s/he did not have Resident 1's pre-admission assessment. Program Manager B stated s/he did not complete any change in condition or ongoing assessments since admission and fall for Resident 1. Surveyor reviewed Resident 2's sample record and noted s/he was admitted to the facility on 04/24/2023 with diagnoses of attention-deficit hyperactivity disorder, autism, and anxiety. Surveyor noted there was no evidence of ongoing assessments annually in his/her record. At approximately 11:00 AM, Surveyor interviewed Program Manager B who verified assessments were not completed for Resident 2. Surveyor inquired how resident care needs were determined and s/he said s/he based it off of the managed care organization's member-centered	N 381		

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N 381	Continued From page 9 plan (care plan). Program Manager B indicated s/he did not know s/he had to do assessments. At approximately 12:35 PM, Surveyor interviewed Licensee A who stated Resident 1 moved in quickly and so it was possible the pre-admission assessment was not completed. Licensee A acknowledged Resident 1 did not have a change in condition assessment and Resident 2 did not have ongoing assessments. Cross Reference N0289 83.27(2)(a) Admissions Compatible with Program Statement N0385 83.35(2) Temporary Service Plan N0386 83.35 (3)(a) Comprehensive Individual Service Plan N0389 83.35(3)(d) Service Plans Updated Annually or on Changes	N 381		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not prepare and implement a written temporary service plan to meet the immediate needs of Resident 1, including persons admitted for respite care, until the individual service plan (ISP) is developed and implemented. Findings include: On 05/21/2025, the department received	N 385		

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N 385	Continued From page 10 complaint information alleging a resident fell down the stairs. On 08/20/2025, Surveyor conducted a complaint investigation. At approximately 9:45 AM, Surveyor reviewed Resident 1's incident report. Surveyor noted Resident 1 moved into the facility on 09/12/2024. Surveyor requested from Program Manager B Resident 1's ISPs. Program Manager B stated s/he did not have a temporary ISP for Resident 1. Program Manager B stated it should be in the file on the folder, but it was not. At 12:35 PM, Surveyor interviewed Licensee A and Program Manager B. Program Manager B indicated s/he could not find any ISP's for Resident 1 in his/her paper or computer record. Licensee A acknowledged Resident 1 did not have a temporary ISP and advised Program Manager B to reach out to their information technology (IT) department to see if it could be recovered on the computer. As of 06/21/2025, Resident 1's temporary ISP was not provided to Surveyor. Cross Reference N0289 83.27(2)(a) Admissions Compatible with Program Statement N0381 83.35(1)(a) Pre-Admission and Ongoing Assessments	N 385		
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	N 386		

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N 386	Continued From page 11	N 386		

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 methods for delivering needed care and who is responsible for delivering the care.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not develop a comprehensive individual service plan (ISP) for Resident 1 within 30 days after admission.
There was no evidence in Resident 1's record to include a plan highlighting Resident 1's needs and desired outcomes, program service, frequency and approaches provided by the community-based residential facility, identified goals, and methods and responsible parties for any care delivered.

Findings include:

On 05/21/2025, the department received complaint information alleging a resident fell down the stairs.

On 08/20/2025, Surveyor conducted a complaint investigation.
At approximately 9:45 AM, Surveyor reviewed Resident 1's incident report. Surveyor noted Resident 1 moved into the facility on 09/12/2024. Surveyor requested from Program Manager B Resident 1's ISP's. Program Manager B stated s/he did not have an ISP for Resident 1. Surveyor inquired what was reviewed at Resident

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N 386	Continued From page 12 1's service plan review and s/he said the managed care organization's (MCO) member-centered plan was reviewed. Surveyor requested a copy of Resident 1's member-centered plan and Program Manager B indicated s/he was waiting for the most recent plan to come in the mail. Surveyor inquired whether the ISPs were kept anywhere else, and s/he said no. Surveyor inquired whether the MCO had a copy and s/he said s/he would ask. Surveyor inquired how staff knew what cares to provide Resident 1 and Program Manager B indicated Resident 1 was pretty independent with cares, but staff communicated from one shift to the next shift staff about resident care. Surveyor reviewed Resident 1's hospital discharge summary dated 04/09/2025 and noted diagnoses of unspecified dementia with mood disturbance, alcoholism, seizures, depression, and left eye blindness. At 12:35 PM, Surveyor interviewed Licensee A and Program Manager B. Program Manager B indicated s/he could not find any ISP's for Resident 1 in his/her paper or computer record. Licensee A acknowledged Resident 1 did not have an ISP and advised Program Manager B to reach out to their information technology (IT) department to see if it could be recovered on the computer. As of 06/21/2025, Resident 1's comprehensive ISP was not provided to Surveyor. Cross Reference N0289 83.27(2)(a) Admissions Compatible with Program Statement N0381 83.35(1)(a) Pre-Admission and Ongoing Assessments N0385 83.35(2) Temporary Service Plan N0389 83.35(3)(d) Service Plans Updated	N 386		

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N 386	Continued From page 13 Annually or on Changes	N 386		
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 residents' individual service plans (ISP) were reviewed and the resident or resident's legal representative had signed the ISP, acknowledging their involvement in, understanding of and agreement with the ISP at least annually and upon change of condition. Seven of 7 resident ISPs were not signed by the resident or resident's legal representative. Findings include: On 05/21/2025, the department received complaint information alleging concerns with resident special diets.	N 389		

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OAKS FAM CARE CTR - OAKLAND HO	126 N OAKLAND AVE GREEN BAY, WI 54303

(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 389	Continued From page 14 On 06/20/2025 at approximately 11:06 AM, Program Manager B indicated Resident 3 and Resident 4 had special diets. Surveyor reviewed Resident 3's record and noted s/he moved into the facility on 06/07/2021. Surveyor reviewed Resident 3's most recent ISP dated 06/2025. Surveyor noted the ISP did not include signatures from any involved parties, including Resident 3's legal representative. Surveyor reviewed Resident 4's record and noted s/he moved into the facility on 11/18/2015. Surveyor reviewed Resident 4's most recent ISP dated 11/2024. Surveyor noted the ISP did not include signatures from involved parties and Resident 4's legal representative. At 11:30 AM, Program Manager B stated care reviews were done every 6 months with him/herself, the resident's care team, and resident's legal representative. Surveyor inquired whether signatures were gathered upon discussion and review and Program Manger B stated all parties signed the managed care organization's (MCO) member-centered plan (care plan). Surveyor inquired about copies of the MCP with signatures or any other evidence of the reviews and Program Manager B indicated the care team gets the signatures. Program Manager B verified signatures were not obtained for the provider's ISPs. Surveyor reviewed other residents' records and noted the following: Resident 2 was admitted on 04/24/2023 and did not have an ISP with signatures acknowledging involvement, understanding, agreement and review. Resident 5 was admitted on 11/05/2020 and did	N 389		

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N 389	Continued From page 15 not have an ISP with signatures acknowledging involvement, understanding, agreement and review. Resident 6 was admitted on 02/02/2018 and did not have an ISP with signatures acknowledging involvement, understanding, agreement and review. Resident 7 was admitted on 08/26/2021 and did not have an ISP with signatures acknowledging involvement, understanding, agreement and review. At approximately 12:35 PM, Surveyor interviewed Licensee A and Program Manager B. Licensee A acknowledged signatures were not obtained from resident legal representatives upon ISP reviews for 7 of 7 residents. Licensee A advised Program Manager B to add a signature page for all ISP reviews going forward. Cross Reference: N0386 83.35(3)(a) Comprehensive Individual Service Plan	N 389		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the living environment was safe, clean, comfortable, and homelike.	N 481		

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N 481	Continued From page 16 Toxic substances were not secured, the carpeting on the stairs and hallway leading to resident rooms was dirty and stained, baseboards and walls had layers of dust, debris, and dirt, Resident 1's room was unclean, the bathtub had limescale stains, the shower floor had brown stains, vents and radiator vents had layers of dust and stains, the first floor bathroom tile grout was sticky, dirty, and grimy, there were multiple brown finger print-like stains on the register in the first floor bathroom, and the stairwell walls had layers of cobwebs. Findings include: The provider is licensed as a class AA (ambulatory) CBRF who may provide services to up to 7 residents who may be developmentally disabled. Surveyor note: In addition, Resident 1 was in the client group, dementia/Alzheimer's and Resident 3 was in the client group, emotionally disturbed/mentally ill. On 05/21/2025, the department received complaint information alleging uncleanliness of the facility and staff not following the cleaning schedule. On 08/20/2025, Surveyor completed a complaint investigation. At approximately 11:43 AM, Surveyor and Program Manager B toured the facility and noted the following: Stairs - -the 2 sets of tan, carpeted stairs leading up to 3 of the resident rooms on the second floor had approximately 12 inch darkened walking stains on each step, various dark stains throughout each step, and visible debris and dirt on each step -the walls had multiple cobwebs spanning from	N 481		

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N 481	Continued From page 17 the floor, mid-wall, and ceiling of the open stairwell Hallway - -the carpeting in the hallway in front of Resident 1's room had an approximately 12 inch by 6 inch large brown stain -the carpeting throughout the hallway was dirty, dusty, stained brown, had stained footprints, and was covered in debris -the wallpaper had brown stains and cobwebs 2nd floor bathroom - -the walk-in shower floor was stained brown around the tub drain and along the caulk lines connecting the base to the walls Resident 1's room - -Resident 1's room had a thick layer of dust on his/her baseboards, dusty, dirty and stained surfaces, dusty ceiling vent, dirty windowsill with an apparent leak or condensation stains, and stained walls -Resident 1's room door had stickers on it that Program Manager B stated they could not get off. One of the stickers had a previous resident name on it First floor - -in the small hallway connecting the kitchen and the bathroom, there was debris throughout the floor and dirty grout between the tiles -a 2 door unlocked/unsecured cabinet that spanned from the floor to ceiling had various bottles of toxic substances: deep cleaning mist, toilet bowl cleaner, air fragrance spray, window cleaner, furniture polish, Drano, mold and mildew bleach cleaner, dish soap, bleach, and other chemicals. The cabinet was located at the bottom of the stairs, next to the kitchen and hallway that residents pass through regularly First floor bathroom - -a missing baseboard next to the toilet which revealed water damage stains, dirt, and debris	N 481		

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N 481	Continued From page 18	N 481		

-the grout between the small tiles around the toilet were dark black and thickened, sticky, dirty, and grimy
-the baseboard heating register had at least 15 various fingerprint-sized brown marks across the front of it
-the baseboards and baseboard heating register had a layer of dust on them
-approximately 6 inch yellowish- orange staining surrounding the entirety of the tub drain and up the walls of the bathtub; dirt on the floor of the bathtub; dust along the edges of the bathtub
-brown and black debris and dirt along the entire edge of the bathtub and the floor

Surveyor reviewed a sign on the wall in the living room corkboard titled "Weekly Room Cleaning." Resident initials were listed on various week days. Surveyor noted the following was handwritten, "Room cleaned, Mop or vacuum, Dust, Laundry, Bedding...Staff are to be completing these task. [sic] Resident can help if they would like."

Surveyor reviewed shift tasks provided by Program Manager B:
"1st Shift...vacuum upstairs/stairs...clean kitchen up after lunch including floors...clean pink bathroom and other bathrooms as needed...Both 2nd and 3rd Shifts splits duties on weekends."
"2nd Shift...clean kitchen up after dinner including floors...clean 2nd floor bathroom (including filling soap and paper towels.]...vacuum the main floor...clean showers after use."
"3rd Shift...Clean downstairs bathroom (including soap and paper towels)...Mop around toilet/scrub nightly."

At approximately 12:15 PM, Surveyor interviewed Program Manager B who stated all staff have

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N 481	Continued From page 19 tasks and help clean. S/he said residents were responsible to clean their own room to promote their independence, but staff are to assist and clean if they don't. Program Manager B provided a sample task list check for Resident 1 and Resident 2. Surveyor noted multiple blanks on the daily task sign outs. Program Manager B stated "looks like certain staff don't know they need to fill this out." At approximately 12:35 PM, Surveyor interviewed Licensee A and Program Manager B who acknowledged concerns with cleanliness, safety, and comfort of the home. Licensee A stated s/he would plan to start carpet replacements on the 2nd floor.	N 481		