STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014847	A. BUILDING: _____ B. WING _____	C 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON MANOR LLC	N168W21041 MAIN ST JACKSON, WI 53037

(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
M 000	INITIAL COMMENTS On 03/07/2024, with information obtained through 03/08/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Jackson Manor LLC, an adult family home (AFH) located in Jackson, WI. As a result of the survey, 1 deficiency was identified. The complaint was substantiated. Census: 3	M 000		
M 614	88.11(3) INVESTIGATION OF ABUSE OR NEGLECT As soon as possible after being contacted under sub. (1) the licensing agency shall undertake an investigation of the reported abuse or neglect. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that an investigation of abuse, made by Resident 1, was investigated. Resident 1 alleged that s/he was punched in his/her left shoulder by Caregiver B around October 2023. This allegation was known by Caregiver A. No investigation took place into the alleged incident. Findings include: On 03/07/2024, Surveyor conducted an	M 614		

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
	0014847	A. BUILDING: _____ B. WING _____	C 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON MANOR LLC	N168W21041 MAIN ST JACKSON, WI 53037

(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
M 614	Continued From page 1	M 614		

investigation into concerns of resident abuse.

On 03/07/2024, at approximately 8:35 a.m., Surveyor interviewed Resident 2. Resident 2 reported s/he had no concerns for him/herself regarding staff treatment, but s/he heard from Resident 1 and a caregiver, who s/he was unable to identify, that Caregiver B had "touched" Resident 1. Resident 2 reported s/he was unaware of any further details of the incident, other than that it seemed to occur sometime before his/her own admission in January 2024.

At approximately 8:55 a.m., Surveyor interviewed Supervisor C. Supervisor C reported s/he was a fill-in supervisor who only oversaw things when Licensee E was out. Supervisor C reported s/he was unaware of any resident abuse allegations and was unfamiliar with Caregiver B. Supervisor C reported that when an allegation of resident abuse was made, the staff who was informed of the allegation would be expected to notify a manager or supervisor, who in turn would then conduct an investigation into the allegation, or notify Licensee E who would then conduct the investigation.

At approximately 9:20 a.m., Surveyor interviewed Caregiver A, with Supervisor C present. Caregiver A reported that around October 2023, Resident 1 told him/her that Caregiver B came up to him/her, slapped his/her phone out of his/her hand, and punched him/her in his/her left shoulder. Caregiver A reported that Resident 1 has complained since then of his/her left shoulder not being normal due to having pain and difficulties moving it. Caregiver A reported that Resident 1 told him/her that s/he told his/her doctor about the incident. Caregiver A reported that s/he told Manager D about the incident. Caregiver A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014847	A. BUILDING: _____ B. WING _____	C 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON MANOR LLC	N168W21041 MAIN ST JACKSON, WI 53037

(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
M 614	Continued From page 2	M 614		

reported s/he never heard anything more about the incident, but thought Manager D had talked with Resident 1 about it. Caregiver A reported that Resident 1 was "pretty reliable" and was not known to make allegations of abuse. Caregiver A reported that Resident 1 was his/her own legal representative.

At approximately 9:24 a.m., Surveyor interviewed Licensee E. Licensee E reported s/he was unaware of any abuse allegations involving Resident 1 and/or Caregiver B. Licensee E reported that if allegations had been known by management staff, they would have been investigated. Licensee E reported that Resident 1 was known to be aggressive.

On 03/07/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 07/18/2023 with diagnoses of epilepsy, weakness, and unspecified altered mental status. There was no information in Resident 1's record regarding left shoulder concerns or any incidents between Resident 1 and staff. Surveyor reviewed Resident 1's individual service plan (ISP), not dated, which documented the following:

- "Physically resistive to cares: No"
- "Self-injurious Behavior: No"
- "Offensive/Violent Behavior: No"

On 03/07/2024, at approximately 9:54 a.m., Surveyor interviewed Manager D. Manager D reported s/he was aware of Resident 1 complaining of left shoulder pain, but Resident 1 had reported to him/her that it was due to a recent fall s/he experienced. Manager D reported s/he was unaware of any abuse allegations involving Resident 1, except for when s/he entered the house earlier that morning for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014847	A. BUILDING: _____ B. WING _____	C 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON MANOR LLC	N168W21041 MAIN ST JACKSON, WI 53037

(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
M 614	Continued From page 3 survey and Caregiver A had mentioned something to him/her about the alleged incident between Resident 1 and Caregiver B. Manager D reported that the provider's procedure regarding abuse allegations was that staff who were made aware of any allegations would be expected to inform him/her. Manager D reported that after this, s/he would inform Licensee E who would then conduct an investigation into the allegation. Manager D reported that s/he typically has informal in-person check-ins with residents every 1-2 weeks and Resident 1 had never brought up the allegation to him/her. On 03/08/2024, at approximately 1:55 p.m., Surveyor interviewed Nurse F, from Resident 1's medical provider team. Nurse F reported that Resident 1 had a visit with his/her medical provider on 01/02/2024 where s/he reported pain in his/her left shoulder after being punched by Caregiver B when s/he tried to walk around him/her. Nurse F reported being unsure of when the incident occurred. Nurse F reported that Resident 1's left shoulder assessment had identified normal range of motion with no numbness/tingling of his/her left upper extremity. Nurse F reported that Resident 1 did not provide any other information about the incident.	M 614		