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
	0011680	A. BUILDING: _____ B. WING _____	C 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOSEPHINE VERONICA HAUS	635 BONDOW DRIVE NEENAH, WI 54956

(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 04/07/2026, Surveyors conducted a complaint investigation at Josephine Veronica Haus. Additional information was collected through 04/09/2026. As a result one (1) deficiency was identified and the complaint was substantiated. Census: 10	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report an incident of abuse to the Office of Caregiver Quality within 7 calendar days from the date the provider knew of the abuse.	N 158		

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

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N 158	Continued From page 1 Between 11/10/2025 and 11/14/2025, the provider conducted an investigation into a possible abuse incident. The investigation concluded that on or about 11/08/2025, Caregiver C forcibly provided care to Resident 1 while s/he was on the toilet and actively resisting. This was contrary to Resident 1's individual service plan which instructed staff to disengage and re-approach later or see if Resident 1 will accept care from a different caregiver. During the incident, Resident 1 sustained injuries to both hands. As of 04/07/2026, the provider had not submitted a misconduct incident report to the Office of Caregiver Quality. Findings include: The Department received a complaint about staff treatment of residents. On 04/07/2026 at 9:00 AM, Surveyor reviewed Department records. --No misconduct incident reports (MIRs) were submitted to the Office of Caregiver Quality in association with this facility or for events occurring in November 2025. A MIR was submitted by Licensee A for a sister facility related to an incident of verbal abuse of a resident by Caregiver C that occurred on 12/14/2025. On 04/07/2026 at 9:30 AM, Surveyor reviewed records from Caregiver C's personnel file. Caregiver C was hired on 08/22/2025 and worked in 4 sister facilities including this one, all operated by Licensee A. The file included an incident report dated 11/10/2025, authored by Manager D. Surveyor noted the following: --"As writer was reading the weekend notes it	N 158		

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stated...[Resident 1] was being rough with [Caregiver C]. This morning when writer looked at [Resident 1]'s hands, both of them were swollen and red. The back of both fingers are bruised." The file included a photo of Resident 1's left hand, sent on 11/09/2025 to Manager D from a caregiver. The hand was in a palm up position and the ring finger had a dark purple bruise covering and wrapping around most of the finger. Along with the photo the caregiver wrote, "when I asked [Resident 1] what happened [s/he] stated [Caregiver C] did it."

--Manager D initiated an investigation and Caregiver C provided a statement via email. In Caregiver C's statement s/he acknowledged Resident 1 "attempted to avoid cares" and Caregiver C "calmly informed the resident, consistent with Wisconsin DHS caregiver requirements for maintaining resident routines and adhearing to care plans, that cares and medications needed to be completed before going to bed, per facility protocol...During cares, the resident alternated between brief periods of calm and sudden aggression...Each time my attention shifted back to providing care, the resident struck me...When I knelt down to apply the brief, the resident escalated and moved toward my face with raised hands. To prevent facial injury and maintained [sic] safety, I briefly held the resident's hands away from my face using the least amount of physical contact necessary...This action is consistent with OSHA (regulations)...(and) Wis. Stat § 50.065 and Wis. Admin. Code DHS § 13...Once it was safe to do so and cares were completed, I removed myself from the situation...Immediately following the incident...I assessed for possible injury to the resident. I visually inspected the resident's hands and asked whether [s/he] was hurt. The resident

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verbally stated [s/he] was not injured. No visible injury tor damage to the resident's hands was observed."

SURVEYOR NOTE: See below, Caregiver C gave a conflicting statement to Manager B about Resident 1's injuries. In addition, DHS administrative codes and Chapter 50 afford residents the right to direct their care and treatment, which includes their right to refuse care. Neither DHS administrative codes nor Chapter 50 require a caregiver to provide care when a resident is actively resisting.

--Manager D's investigation ended on 11/14/2025 and concluded, "After speaking with all staff who worked over the weekend, it is my understanding that [Caregiver C] was appropriately attempting to complete [Resident 1]'s evening cares. [Resident 1] has experienced difficulty in the past with both new staff and [caregivers of the same gender as Caregiver C], and this appears to have contributed to [his/her] reaction. During the routine, [Resident 1] began yelling and telling [Caregiver C] to step away. [Caregiver C] continued with the standard evening care process, as [s/he] was attempting to ensure [his/her] needs were met. This escalation caused [Resident 1] to become increasingly upset, and [s/he] began repeatedly hitting [his/her] hands on the bathroom counter....Afterward, it was discussed with [Caregiver C] that, given [Resident 1]'s known history and [his/her] right to refuse care from certain caregivers, the best approach in the future would be to step back and request assistance from another staff member..."

The file also included an email dated 11/12/2025 from Manager B (sister facility) to Licensee A and Manager D.

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N 158	Continued From page 4 --Manager B noted on 11/11/2025, Caregiver C offered additional explanation of the incident. Caregiver C said Resident 1 did not want him/her to provide cares and s/he was actively resisting and yelling loudly. Caregiver C said s/he did what s/he was taught at previous jobs and "this meant having [Resident 1's] left arm diagonally on the wall while [Caregiver C] completed [his/her] cares...also stated [s/he] noticed [Resident 1's] finger was starting to swell after cares were completed. I (Manager B) advised next time to report injury and file incident report to cover [his/her] bases." Surveyor interviewed Manager B about this email on 04/07/2026. S/he further explained (and demonstrated) Caregiver C's description of holding one of Resident 1's arms up against the wall while the resident was seated on the toilet and using his/her other hand to provide care. Surveyor reviewed Resident 1's resident record on 04/07/2026 at 3:00 PM. --Resident 1 was elderly and had a legal guardian. S/he had diagnoses to include schizophrenia, major depressive disorder, intellectual disabilities, anxiety disorder, generalized muscle weakness, cognitive communication deficit and and failure to thrive. The individual service plan (ISP) documented s/he was at risk for falls, used a walker for ambulation and relied on staff assistance with transfers and activities of daily living to include toileting assistance. The section titled "Maturation" was implemented in May 2023 and read, "...is able to make [his/her] needs known...sometimes has issues with staff. If [s/he] doesn't care for you [s/he] will let you know...has yelled and swore at staff to leave [him/her] alone.	N 158		

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Staff is encouraged to always have a smile on their face when approaching [Resident 1]." The ISP section titled "Attitude" was implemented in May 2023 and read, "[Resident 1] is usually a positive person that likes attention. [S/he] will often have a big smile on [his/her] face, but does have moments where [s/he] is sad...needs a lot of reassurance...will have behaviors from time to time. [S/he] will yell and swear at staff. Staff will need to walk away and give [him/her] a few moments. Please approach again with a big smile or if it is possible ask a coworker to take over the task..."

Surveyor interviewed Caregiver E on 04/07/2026 at 2:53 PM and Assistant Manager F on 04/07/2026 at 4:06 PM:

--Caregiver E recalled a few days after the incident, s/he observed Resident 1's hands which were bruised on the top near the wrists with small circular bruises resembling finger prints and the ring fingers on both hands were badly bruised. Caregiver E said the left finger "looked broken" but Resident 1 was still able to move it. Caregiver E said the 11/09/2025 photo of Resident 1's left hand "doesn't do it justice."

--Assistant Manager F said the bruising was reported via a message to Resident 1's primary care physician and the provider was instructed to apply ice. Manager F described the ring fingers on both hands as being badly bruised and thought those injuries were inconsistent with the resident banging his/her hands on a table or counter.

Surveyor reviewed the provider's policies regarding abuse, investigations and misconduct reporting on 04/07/2026. The policies defined

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N 158	Continued From page 6 abuse as an intentional act that contradicts the facility's policy and procedure and is not part of a care plan. The policies require all allegations of abuse and misconduct should be "reported immediately to the director of the facility and to the Division of Quality Assurance." On 04/09/2026 at 2:00 PM, Surveyors interviewed members of the management team including Managers B and D and Licensee A. The managers confirmed the incident occurred as documented in the reports, and they believed the incident date to be either 11/08 or 11/09/2025. Surveyor explained concerns that Caregiver C forcibly provided cares to Resident 2 while s/he was actively resisting and yelling. The caregiver's actions were contrary to the resident's care plan and caused injury to Resident 2. Based on this information, the provider was required to report the abuse incident to the Office of Caregiver Quality within 7 days from the day the provider knew or should have known about the abuse. Licensee A agreed with Surveyor's concerns and said they would promptly submit the misconduct incident report to the Office of Caregiver Quality and implement changes to their systems to ensure compliance moving forward.	N 158		