STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410133	A. BUILDING: _____ B. WING _____	R-C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN PARK HOUSE	109 W LAKE ST WAUPACA, WI 54981

(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 06/04/2025, Surveyors conducted an onsite visit to verify correction of five previous deficiencies and to investigate three complaints. Five (5) of 5 previous deficiencies were corrected. Two (2) of 3 complaints were substantiated. Three (3) new deficiencies were identified. Census: 10 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{N 000}		
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, 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	N 243		

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

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N 243	Continued From page 1 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 Caregiver F received training in resident rights within 90 days after starting employment. Findings include: On 06/04/2025 at approximately 11:10 AM, Surveyor reviewed Caregiver F's record to confirm compliance with training requirements. Caregiver F's record did not contain evidence of training in resident rights at any time after his/her hire date of 11/01/2024. On 06/04/2025 at 2:24 PM, Surveyor interviewed Licensee A and Manager B. They confirmed Surveyor's review of the record and	N 243		

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N 243	Continued From page 2 acknowledged Caregiver F did not receive resident rights training. Manager B stated s/he did not think Caregiver F needed to have the training because s/he received it during a previous period of employment. Both Licensee A and Manager B confirmed that upon hire on 11/01/2024, at least 1 year had passed since Caregiver F had previously been employed. Cross Reference: Y3234 Ch. 50.09(1)(e) Treatment	N 243		
N 492	83.45(1)(a) Exterior areas. Exterior areas. The CBRF shall maintain the yard, any fences, sidewalks, driveways and parking areas of the CBRF in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure the exterior sidewalk used by residents was kept free of hazards. Five locations on the cement sidewalk were observed to be uneven creating a tripping hazard to residents who are ambulatory. On 05/12/2025 a resident tripped on a section of sidewalk with a raised lip approximately 1 inch in height while walking to the designated smoking area. The fall resulted in a fractured nose, sprained wrist, and abrasions to his/her face. Findings include: The facility is licensed to serve up to 14 individuals who are ambulatory and emotionally disturbed/mental illness and/or of advanced aged. On 5/14/2025, the Department received an	N 492		

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update to a complaint alleging concerns regarding the safety of the sidewalk.

On 06/04/2025 at 9:10 AM, Surveyor interviewed Resident 3. S/he volunteered to surveyor concerns about an incident where s/he tripped on the sidewalk and broke his/her nose. Resident 3 lead Surveyor outside and identified a portion of the concrete sidewalk leading to the smoking area. Surveyor observed Resident 3 shuffled his/her feet when s/he walked. Surveyor also observed an uneven crack in between the two concrete slabs which created a lip approximately 1 inch higher than the subsequent concrete slab. White tape was applied to the concreate and ran parallel to the elevated lip in the sidewalk. Resident 3 stated staff had applied the tape following the incident in an attempt to alert residents of the tripping hazard and stated they should, "put more cement down there so nobody else trips over it."

Resident 3 showed Surveyor four (4) additional areas on the sidewalk which s/he was concerned about including:

-- A square concrete slab on the south-west corner of the facility which was used to store furniture and a red walker. The edge of the concrete slab leading to the attached sidewalk was raised and created a lip approximately 1.5 inches high. Resident 3 said the walker was his/hers and the provider wanted him/her to use it while s/he ambulated over the uneven concrete.
-- A raised section of the sidewalk on the east side of the facility. At the highest section, the cement edge created an uneven lip approximately 2 inches high.
-- The designated smoking area consisting of a circular table, umbrella, and six (6) chairs. The

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cement slabs were uneven and a section of concrete approximately 7 inches by 12 inches appeared sunken in.
-- The end of the cement ramp located in the front entrance of the home had a crack spanning the entire width of the ramp which contained an overgrowth of weeds approximately 2 inches wide.

On 06/04/2025 at 9:45 AM, Surveyor interviewed Manager B. S/he recalled the incident and stated Resident 3 "fell because of the sidewalk...[s/he] scared me so much"

On 06/04/2025 at 2:10 PM, Surveyor reviewed Resident 3's record which included emergency room discharge paperwork and an incident report.

An incident report dated 05/13/2025 documented a fall which occurred on 05/12/2025 and read in part, "[Resident 3] ...Location concrete walkway in backyard ...At 4:30 pm [Resident 3] was walking on concrete pathway to smoking area where [s/he] tripped and fell on [his/her] face. [Licensee A] took [him/her] to ER, [s/he] has [sic] broken nose ...sprained ...wrist."

A document titled, "EMERGENCY DEPARTMENT SUMMARY" dated 05/12/2025 read in part, " ...Reason for Visit ...Fall ...Diagnoses ...Closed fracture of nasal bone, initial encounter ...multiple abrasions ...contusion of right hand, initial encounter ..."

On 06/04/2025 at 3:37 PM, Surveyors interviewed Licensee A and Manager B. Licensee A stated s/he witnessed Resident 3's fall on 05/12/2025. S/he stated, "[S/he] tripped on the sidewalk, it looked like it was flat to me but apparently there

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N 492	Continued From page 5 is ...a rise out there it's less than an inch." Licensee A stated following the fall, Manager B applied white tape to the area and Licensee A told Resident 3 to use his/her walker if s/he was going outside "because [s/he] shuffles." Licensee A said Resident 3 refuses to use the walker. Licensee A stated Resident 3 "was going to sue us that's why I told [him/her] if you're not going to use your walker ...you have to be careful, use your walker." Licensee A acknowledged Resident 3 does not require the use of a walker while inside the building or on even ground. Surveyor shared the concern that Resident 3 should not be made to use a walker as an intervention regarding a maintenance issue. Licensee A agreed and said they intended on remediating the issues with the sidewalk at some point. On 06/04/2025 at approximately 4:35 PM, Surveyors walked around the exterior of the home with Licensee A and identified each of the aforementioned sidewalk hazards. Licensee A acknowledged each of the areas and agreed s/he would start to address the concerns.	N 492		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom	Y3234		

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Y3234	Continued From page 6 the resident comes in contact. This Rule is not met as evidenced by: Based on interview and record review, the provider did not to ensure all residents were treated with courtesy and respect by all employees of the facility. In early March, Caregiver F pressured Resident 5 to serve as the go between in a staffing matter with another caregiver. Caregiver F was frustrated with Resident 5's response and called him/her a "liar." On 03/31/2025 after being terminated, Caregiver F banged aggressively on Resident 5's bedroom door and demanded s/he return items Caregiver F felt belonged to him/her. Resident 5 stated during the two aforementioned incidents and other times, Caregiver F spoke in an angry and aggressive tone towards him/her. Findings include: The facility is licensed to serve up to 14 residents from the following client groups; advanced age and emotionally disturbed/mental illness. The Department received a complaint alleging resident treatment concerns. Prior to the onsite visit, Surveyor reviewed the provider's survey history. Statement of Deficiency I2MS11, dated 01/11/2018 included a deficiency for lack of a caregiver misconduct investigation after Licensee A was made aware of an allegation	Y3234		

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Caregiver F yelled and swore at a resident. A deficiency was also issued for Licensee A permitting a condition of risk by allowing Caregiver F to frequent the facility after the incident and employment separation, which was upsetting to residents.

During the entrance conference on 06/04/2025 at 9:12 AM, Manager B provided the staff roster. Caregiver F's name was listed with a hire date of 11/01/2024 and a handwritten note that read, "fired 3-31-25." Manager B said Caregiver F was fired because "[s/he] could not get along well with residents or staff." Manager B suggested Surveyor talk with Resident 5.

On 06/04/2025 at 10:38 AM, Surveyor interviewed Resident 5. Resident 5 said s/he had "very big issues several times" with Caregiver F. S/he explained there were times when Caregiver F spoke in an angry or aggressive tone to him/her and Resident 6.

Resident 5 went on to state the following:

In early March 2025, Caregiver F demanded Resident 5 take a picture of the schedule on Resident 5's cell phone and then call 2nd shift staff to ask if they would arrive as scheduled to relieve Caregiver F. Resident 5 said s/he likes to help at the facility and specifically in the kitchen but commented, "I don't work here." Resident 5 described feeling pressured to make the call so s/he did. Resident 5 said s/he relayed the 2nd shift caregiver's response to Caregiver F and Caregiver F "got mad" and accused Resident 5 of things. Resident 5 could not elaborate on the accusations.
After the incident, Licensee A made Caregiver F apologize and Licensee A thanked Resident 5 for

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giving Caregiver F "a second chance." However, Resident 5 said s/he continued to have problems with Caregiver F. S/he said, "I kept going in my room when [s/he] was here. I didn't feel comfortable around [Caregiver F] anymore...And they knew. They knew [s/he] screamed at me ...why didn't somebody stand up for me?...It was really hard for me." Surveyor observed Resident 5 get emotional with tears in his/her eyes.
A couple of weeks after the early March incident, Licensee A decided to fire Caregiver F. In response to the termination, Caregiver F pounded aggressively on Resident 5's bedroom door and demanded items back that s/he had given to Resident 5 for sewing projects. Resident 5 said s/he felt intimidated, returned the items and asked Caregiver F to "remove [him/herself] from my room."
Resident 5 said in the past week, Caregiver F has visited the facility at least three times, staying longer during each visit. Resident 5 said, "[S/he] brought groceries in and a pie in yesterday...I just don't want to be around [him/her]. [S/he] made me uncomfortable with [his/her] actions...I don't why [s/he] is here. [S/he] doesn't belong here." Resident 5 said when Caregiver F is in the building, s/he feels like s/he has to stay in his/her room to avoid Caregiver F.

On 06/04/2025 at 11:28 AM, Surveyor interviewed Resident 4. S/he confirmed Caregiver F was hanging around the facility in the past week and added, "[S/he] is trying to get back here but [s/he] don't [sic] belong here."

On 06/04/2025 at 12:18 PM, Surveyor interviewed Resident 7. S/he recalled a time over the winter when [Resident 6] was talking bad about Caregiver F. Caregiver F "got mad" and approached Resident 6 to "stick up" for

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him/herself. Resident 7 said, "[Caregiver F] comes and goes since getting fired, [s/he] dropped off the dessert we had today."

Surveyor reviewed Caregiver F's record on 06/04/2025 at 11:13 AM. It contained a handwritten document authored by Licensee A which read in part:

03/05/2025 - a caregiver reported "verbal abuse" over the weekend. Licensee A looked into the matter and determined Caregiver F tried to call the incoming caregiver and s/he did not answer so Caregiver F "asked [Resident 5] to call. [Resident 5] (called as requested and) left a message and [Caregiver F] called [him/her] a 'liar'. [Resident 5] just tried to stay in [his/her] room."
"I told [Caregiver F] [s/he] needs to get some counseling for anger management." Caregiver F apologized to Resident 5. Caregiver F was placed on "probation" at the facility and "will be supervised and will not work alone on weekends...[Resident 5] and [Caregiver F] have forgiven each other...I am hopeful that [Caregiver F] will understand how [his/her] loudness and anger can affect all people in the house."
03/24/2025 - another caregiver reported ongoing problems with Caregiver F's interactions with staff and told Licensee A if s/he did not fire Caregiver F, "it would be reported."
03/31/2025 - "I told [Caregiver F]...I had to let [him/her] go....[Caregiver F] stormed into the kitchen tore up menu plan...erased menu board and left. [S/he] went up to [Resident 5]'s room to gets some of the sewing projects [Resident 5] was doing or had done for [him/her]."

On 06/04/2025 at 3:37 PM, Surveyors interviewed Licensee A. S/he confirmed the information in the

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Y3234	Continued From page 10 handwritten document. S/he said it was completely inappropriate for Caregiver F to have Resident 5 contact another staff member about a scheduling issue and then to make accusations to Resident 5 about the situation. Licensee A also confirmed Resident 5 was very upset about the way s/he was treated by Caregiver F. Licensee A said Caregiver F has other good qualities and s/he believes in helping people. S/he confirmed since termination, Caregiver F has been onsite to obtain money for shopping and delivery of food items on Licensee A's behalf. Surveyor informed Licensee A of the concerns with how Caregiver F's presence was impacting Resident 5. Licensee A acknowledged Surveyor's concerns. Cross Reference: N0243 DHS 83.21 All Employee Training	Y3234		