STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018205	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONNIE HOME LLC	1308 NEW YORK AVE OSHKOSH, WI 54901

(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 08/04/2025, Surveyor conducted an onsite facility visit at Connie Home LLC to investigate one complaint and conduct a standard survey. Additional information was received through 08/05/2025. The complaint was unsubstantiated. One deficiency was identified. Census: 2	M 000		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not inform Resident 1's physician when Resident 1's blood pressure was consistently higher than identified parameters. Findings include: On 08/04/2025 at 2:00 PM and 08/05/2025 at 8:04 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted 07/11/2025. S/he had a legal guardian and diagnoses to include essential hypertension (persistently high blood pressure) and moderate intellectual disabilities. Resident 1 's individual service plan indicated s/he relied on staff to manage medications. Resident 1's medication administration record listed Losartin Potassium with instructions to take 1 tablet daily for hypertension and call the	M 448		

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
	0018205	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONNIE HOME LLC	1308 NEW YORK AVE OSHKOSH, WI 54901

(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 448	Continued From page 1	M 448		

physician if blood pressure readings are consistently greater than 140/90.

On the following dates in July and August 2025, Resident 1's blood pressure readings exceeded the parameters and neither the MAR nor observation notes indicated the physician was notified:

07/11 - 143/102
07/17 - 145/94
07/20 - 144/99
07/25 - 151/99
07/26 - 152/150
07/27 - 156/100
07/28 - 157/107
07/29 - 146/101
07/30 - 140/101

08/01 - 147/107
08/03 - 149/97
08/04 - 155/94
08/05 - 142/91

On 08/05/2025 at 8:59 AM, Surveyor interviewed Manager A. Manager A confirmed Resident 1 has high blood pressure and if values are above 140/90 the physician should be notified. Manager A said the process is for staff to inform Manager B and then Manager B would notify the physician and document in the observation notes. Surveyor informed Manager A the notes did not include documentation the physician was notified and Manager A did not have additional information to provide. During a subsequent interview with Manager A at 10:00 AM, s/he said s/he just called the physician to schedule an appointment and was told there was already an appointment scheduled for 08/11/2025. Manager A said s/he did not know if it was a routine appointment or if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018205	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONNIE HOME LLC	1308 NEW YORK AVE OSHKOSH, WI 54901

(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 448	Continued From page 2 Manager B made it in response to high blood pressure readings. On 08/05/2025 at 9:12 AM, Surveyor interviewed Manager B and asked if staff have reported any concerns with Resident 1's blood pressure. Manager B said, "No, it's been regular according to my understanding." Surveyor asked Manager B if s/he routinely audited MARs. S/he replied s/he has not and explained, "I'm still learning...about MARs and ECP (record system) so I'm not too much [sic] familiar with it." Surveyor informed Manager B of the documented blood pressures higher than the parameters and s/he replied, "Wow, no wasn't aware of that."	M 448		