

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/29/2025
NAME OF PROVIDER OR SUPPLIER OUR HOUSE JANESVILLE MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4333 PHEASANT RUN RD JANESVILLE, WI 53546		
(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 01/27/2025, with information gathered through 01/29/2025, Surveyor conducted a verification visit and a complaint investigation. One deficiency was identified. Complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 13	{N 000}		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify 1 of 1 resident's representative when there was an allegation of abuse. Assistant Director (AD) F became physically aggressive towards Resident 3 during peri cares. Findings include: On 01/07/2025, the Department received a complaint alleging that a staff member had been physically aggressive with a resident during cares.	N 170		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 170	Continued From page 1 On 01/27/2025, Surveyor reviewed Resident 3's record. Resident 3 moved into the home, 11/14/2023, with diagnoses including major neurocognitive disorder with behavioral disturbance, depression, anxiety, and vascular dementia. On 01/27/2025, at approximately 1:00 PM, Surveyor asked Executive Director (ED) E if there was record of a staff to resident altercation involving Resident 3. ED E provided Surveyor with an internal investigation which documented: "Event Date: 12/26/2024. Investigator [Previous ED H]. 01/01/2025 10:23 AM - [Resident Care Assistant (RCA) G] reported to [ED H] that on 12/26/2024 around 7PM [s/he] was walking down the hallway with another resident when [s/he] heard [Resident 3] yelling from the bathroom. [RCA G] opened the door to find [Assistant Director (AD) F] holding [Resident 3's] hands above [his/her] head and [RCA I] putting [Resident 3's] pants on [him/her]. [RCA G] told [RCA I] and [AD F] that [s/he] would take over and asked them to leave. 01/01/2025 4:16 PM - [ED H] interviewed [RCA I]. Stated that [s/he] was changing and toileting [Resident 3] sometime after supper on 12/26/2024. [Resident 3] transferred onto the toilet fine but became upset while [RCA I] was changing [his/her] brief. [RCA I] asked [AD F] to take over for [RCA I] since [RCA I] was overwhelmed and needed to step away ... [RCA I] stated that [s/he] took a breath for a minute but heard some commotion from the bathroom so [RCA I] came back in to assist. When [s/he] entered the room, [Resident 3] had a strong grip on the top of [AD F's] shirt. [AD F] asked [RCA I] to "get [him/her] off [of her/him]." [RCA I] stated that [s/he] stepped in to attempt to break	N 170		

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N 170	Continued From page 2 [Resident 3's] grip ... After this, [RCA G] stepped in and took over and successfully calmed [Resident 3] down and got [his/her] cares done." On 01/27/2025, at approximately 5:15 PM, Surveyor interviewed Resident 3's Power of Attorney (POA) J. Surveyor asked POA J if s/he could explain to Surveyor how the provider explained the incident that occurred between staff and Resident 3 on 12/26/2024. POA J stated, "I have not been contacted about any staff concerns." POA J stated s/he would contact ED E and ask for an explanation. On 01/28/2025 at 5:38 PM, Surveyor emailed ED E to verify that Surveyor had been informed by POA J that s/he was not contacted regarding the 12/26/2024 incident. On 01/29/2025, at approximately 1:10 PM, Surveyor interviewed RCA G. RCA G stated, "I could hear [Resident 3] yelling when I was walking down the hallway, so I walked into [his/her] room and I saw [AD F] holding [Resident 3] by [his/her] wrists, above [his/her] head, while [s/he] was sitting on the toilet, and [RCA I] was providing cares." Surveyor stated s/he had read that Resident 3 had a firm grip on AD F's shirt, causing the commotion. RCA G stated, "That may have been the case prior to me walking into the room, but that is not what I observed." As of 01/29/2025 at 6:00 PM, Surveyor did not receive a response.	N 170			