

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0009372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/20/2024
NAME OF PROVIDER OR SUPPLIER SPINEL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 264 N OAKWOOD RD OSHKOSH, WI 54903		
(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 02/14/2024, with information gathered through 02/20/2024, Surveyor conducted an abbreviated licensure survey and a complaint investigation. One deficiency was identified. Complaint was unsubstantiated. Census: 4	M 000		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not prevent conditions that put the safety of residents at risk. Resident 2, Resident 3, and Resident 4 were not removed from potential harm's way when Resident 1 had a behavioral episode. Findings include: On 10/26/2023, the Department received a concern that staff had to interact with residents that displayed aggressive behaviors. On 02/14/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver B. Caregiver B explained that Resident 1 would display physical aggression when s/he became upset. Caregiver B stated that during these episodes, the other residents will often go to their rooms, and "staff	M 230		

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

TITLE

(X6) DATE

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M 230	Continued From page 1 will also separate themselves from [Resident 1] by locking themselves in a different room." On 02/14/2024, Surveyor reviewed Resident 1's record. Resident 1 moved into the home on 05/07/2022 with diagnoses including anxiety, deafness, intellectual disability, seizure disorder, and visual impairment. Resident 1's Individual Service Plan, dated 11/14/2023, documented: "[Resident 1] can become agitated and anxious. [S/he] has a history of behaviors such as hair pulling, biting, hitting, kicking, throwing, and breaking items, yelling/screaming, and threatening to run away." "If [Resident 1] becomes physically aggressive, staff will encourage other clients to relocate to a safe area while keeping [Resident 1] in line of sight. ..." On 02/14/2024, at approximately 6:00 PM, Surveyor was in the office speaking with Regional Director (RD) A and Manager C when a resident came knocking on the door stating that Resident 1 was hurting Caregiver B. RD A, Manager C, and Surveyor walked out to the common area. Surveyor observed Caregiver B standing outside on the other side of the front entrance door, creating a barrier between Resident 1 and her/himself, leaving the residents in the common area with Resident 1. On 02/20/2024, at approximately 3:15 PM, Surveyor interviewed Regional Director (RD) A. Surveyor explained the scenario that had occurred during the survey on 02/14/2024 where Caregiver B stood outside, to create a barrier	M 230		

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M 230	Continued From page 2 between her/him and Resident 1. RD A stated s/he would have probably done the same thing and if possible, walk around through the garage door, into the office and come back into the common area. Surveyor asked if there would be concern of leaving Resident 2, Resident 3, and Resident 4 in the common area, unsupervised, with Resident 1, who is displaying aggressive behaviors. RD A stated the residents usually understand that when a resident displays behavior, they should move to an area where they feel safe, not necessarily their bedroom, but a part of the home that they feel safe in. RD A stated that interventions could be reviewed to determine how staff should handle those behaviors when there is only one staff member in the building. RD A stated, "I understand what you are saying."	M 230		