STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015454	A. BUILDING: _____ B. WING _____	C 11/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAISERS OAKHAVEN S&C LLC	132 OAK CT SHAWANO, WI 54166

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N 000	Initial Comments On 11/18/2024, with additional information gathered through 11/29/2024, Surveyor conducted a monitoring visit at Paisers Oakhaven S&C LLC. Two deficiencies were identified. Census: 7	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess Resident 1's needs, abilities, and physical and mental condition before admitting him/her to the CBRF. Resident 1 was admitted to the facility on 11/08/2024 from the provider's sister facility on the same campus; no pre-admission assessment was conducted. Findings include: On 11/18/2024, Surveyor conducted a monitoring visit following a report of a fire involving Resident 1.	N 381		

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

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N 381	Continued From page 1 Surveyor requested to review Resident 1's record including all assessments. Surveyor reviewed Resident 1's record and noted s/he was admitted to the facility on 11/08/2024 from provider's sister facility on the same campus. Resident 1 had an activated Power of Attorney for Health Care (APOAHC) and diagnoses of cerebral infarction, hemiplegia and hemiparesis, adjustment disorder with mixed anxiety and depressed mood, insomnia, post-traumatic stress disorder, nicotine dependence, chronic obstructive pulmonary disease, and rheumatoid arthritis. Surveyor noted Resident 1 was admitted from a skilled nursing facility to provider's sister facility on 09/19/2024. Surveyor reviewed Resident 1's assessments and noted a "preadmission assessment" dated 09/05/2024, which was completed prior to admission to provider's sister facility. Surveyor reviewed Resident 1's observation notes and incident reports and noted documentation of Resident 1 refusing medications frequently, including insulin, using profanity towards residents and staff, disrobing and going into other resident's rooms and common areas, smoking in his/her room, rummaging through personal belongings, voicing a desire to not be there, and other behaviors that required supervision and redirection. Surveyor reviewed correspondence between the facility and Synergy physician and noted ongoing updates of Resident 1 having behaviors. Surveyor reviewed Resident 1's individual service plan (ISP) with print date 11/18/2024. Surveyor noted Resident 1's ISP listed Resident 1's admission date of 09/19/2024 to the sister facility	N 381		

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N 381	Continued From page 2 and did not have an updated date of admission to this facility. Resident 1's ISP did not speak to Resident 1's behaviors or interventions related to behaviors. Resident 1's ISP did not have updates or evidence of a new assessment of Resident 1's needs. At approximately 12:10 PM, Surveyor interviewed House Manager A who described Resident 1 as having increased behaviors and additional needs since admitting to the facility. House Manager A verified no pre-admission assessment was conducted prior to Resident 1's move on 11/08/2024.	N 381		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least	N 397		

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N 397	Continued From page 3 one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at least one qualified resident care staff was present when at least one resident was in need of supervision, intervention or service on a 24-hour basis to prevent, control or improve the resident's constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. At the time of a fire on the early morning of 11/15/2024, the census of the facility was 8. At least one resident, Resident 1 required 24-hour supervision, intervention or service and was identified as being agitated or emotionally upset with changing or unstable health conditions that required close monitoring. On the overnight of 11/14/2024 to 11/15/2024, Caregiver D was the only resident care staff on duty at the facility. Caregiver D was not qualified. Caregiver D reported having left the facility for an undetermined amount of time on his/her overnight shift from 11/14/2024 to 11/15/2024. Findings include: The provider is licensed to provide services for up to 15 residents who may be physically disabled, of advanced age, and/or have Alzheimer's/dementia. On 11/18/2024, Surveyor conducted a monitoring visit following the report of a fire at the facility	N 397		

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N 397	Continued From page 4 involving Resident 1. Surveyor note: According to DHS 83.02(42)"Qualified resident care staff" means an employee who has successfully completed all of the applicable training and orientation under subch. IV. DHS 83.19 Orientation. DHS 83.20 Department-approved training. DHS 83.21 All employee training. DHS 83.22 Task specific training. On 11/18/2024, Surveyor reviewed Caregiver D's employee record and noted s/he was hired as a resident care staff on 09/30/2024 and was not considered a qualified resident care staff. Surveyor reviewed Caregiver D's training records and noted s/he had not taken department-approved Fire Safety and First Aid and Choking trainings. At approximately 12:00 PM, House Manager B stated Caregiver D was scheduled to attend the trainings and any other needed trainings by the end of November. House Manager B indicated Caregiver D did not meet any exemptions for completing trainings. Surveyor noted Caregiver D had not received all employee training and task-specific training yet, as s/he had not been employed for more than 90 days at the time of onsite visit. Surveyor reviewed a copy of the provider's October-November 2024 staffing schedule. Surveyor noted Caregiver D was scheduled and worked alone from 10:00 PM to 6:00 AM or 6:00 PM to 6:00 AM approximately 14 times since s/he was hired. On 11/18/2024, Surveyor reviewed a fire report sent to the department as well as the provider's incident report regarding a fire that occurred on	N 397		

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N 397	Continued From page 5 11/15/2024 at approximately 3:30 AM. Caregiver D was working at the facility overnight independently when the smoke alarms sounded. Caregiver D located Resident 1 in his/her room engulfed in flames. Caregiver D was able to pull Resident 1 out of his/her wheelchair to the ground, pat down and extinguish the fire on Resident 1, Resident 1's wheelchair, and the carpet using a clothing item found near Resident 1 prior to police and the fire department's arrival. A burnt cigarette and lighter was found in Resident 1's wheelchair. Resident 1 sustained substantial burns to at least 40% of his/her body and smoke inhalation. Resident 1 was taken off of life support and passed away from his/her injuries from the fire on 11/18/2024. Cause of the fire and death are still under investigation by city detectives and the medical examiner office. Surveyor reviewed Resident 1's record and noted s/he was admitted to the facility on 11/08/2024 with diagnoses of cerebral infarction, adjustment disorder with depressed mood and anxiety, insomnia, nicotine dependence, and diabetes, among other co-morbidities. On 11/25/2024 at approximately 11:07 AM, Surveyor interviewed Caregiver D who was working on 11/14/2024 from 10:00 PM to 6:00 AM when a fire occurred in Resident 1's room at approximately 3:30 AM. Supervision Needs Caregiver D described Resident 1 as being up most of the night, rummaging and disheveling his/her room. Caregiver D recalled going into Resident 1's room to assist him/her in cleaning up his/her room and bathroom the night of 11/14/2024. S/he indicated Resident 1 was often emotionally upset and had unstable health conditions that required close monitoring.	N 397		

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N 397	Continued From page 6	N 397		

Caregiver D stated s/he had not worked with Resident 1 since s/he moved to this facility and did not feel s/he knew Resident 1 very well. Caregiver D could not recall the last time s/he had checked on Resident 1 on the overnight of 11/14/2024, but recalled it being a few hours prior to the fire occurring. Caregiver D indicated Resident 1 was known to smoke in his/her room and s/he thought his/her cigarettes and lighter were in the medication cart.

Training

Caregiver D voiced feeling nervous and confused having to work alone on 11/14/2024. S/he stated s/he had not participated in a fire drill prior to working the shift and had not completed all of his/her trainings yet, including Fire Safety and First Aid and Choking, and other trainings.

Facility Left Unattended

Caregiver D reported that a few hours prior to the fire, s/he had gone into the parking lot for an unknown amount of time to visit with his/her friends that stopped by. Caregiver D thought that s/he was outside for approximately 10 minutes or less, but did not know for sure. Caregiver D indicated it was not uncommon for staff to leave the building unattended for short periods of time as staff would often need to get cleaning supplies, food, and other items that were stored at the provider's sister facility on the same campus.

On 11/25/2024, Surveyor reviewed the police report and narrative from Detective F. S/he indicated Caregiver D was listed as the only employee working the overnight shift from 11/14/2024 and 11/15/2024 when the fire broke out. Detective F noted that Resident 1 had a history of behaviors including smoking in his/her room. The report noted an interview between Detective F and Caregiver D who indicated s/he

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N 397	Continued From page 7 had friends stop at the facility "a little before" the incident. S/he said s/he left the building and went to the parking. S/he could not tell Detective F a time or how long s/he was outside of the building. On 11/26/2024 at approximately 11:00 AM, Surveyor interviewed House Manager A and Executive Director C who acknowledged Resident 1 had behaviors and changing mental health requiring supervision and redirection. House Manager A acknowledged Caregiver D did not receive all of his/her trainings to be a qualified resident care staff and working alone. Executive Director C stated s/he was not aware of Caregiver D going into the parking lot an undetermined amount of time and stated staff are trained to know that they should not be leaving the facility unattended for any reason. In conclusion, on 11/15/2024 at approximately 3:30 AM, a fire started on Resident 1 engulfing him/her in flames. Caregiver D was the only resident care staff working at the time. Caregiver D had not received all of his/her training including Fire Safety, so s/he was not qualified to work alone. Caregiver D reported having left the facility for an undetermined amount of time on the same overnight shift. Resident 1 was identified as being a resident who required 24/7 supervision and having an unstable mental condition requiring a qualified resident care staff in the facility at all times. Cross Reference: N0381 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 397		