Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019946	A. BUILDING: _____ B. WING _____	C 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN OAKS	227 EAST WASHINGTON STREET SLINGER, WI 53086

(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 10/01/2025, Surveyor conducted a complaint investigation at Autumn Oaks, a Community-Based Residential Facility (CBRF) in Slinger, WI. One deficiency identified. Complaint substantiated. Census: 25	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's needs, abilities, and physical and mental condition for 1 of 1 resident (Resident 1) reviewed when there was a change in needs, abilities or condition. Resident 1 went to a mental health institute and was ready to be discharged back to the facility. The provider did not assess Resident 1 to see if his/her needs could be met. The provider refused to take the	N 381		

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

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N 381	Continued From page 1 resident back due to his/her previous exit-seeking behaviors. Findings include: On 10/01/2025 at 10:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 08/22/2022, with diagnoses of depression with suicidal ideation, alcohol dependence in remission and generalized anxiety disorder. Resident 1's Individual Service Plan (ISP), dated 08/05/2025, stated the following: -"Elopement-Exit Seeking: Resident has a history of exit seeking and wandering behaviors. Resident at times believes that [s/he] has to go outside for appointments or to exercise Staff will attempt to redirect resident with activities or talking about [his/her child], or provide 1:1. Daily monitoring through observation and communication. Any changes will be documented and reported to Physician. Staff monitors wander guard system on each shift to ensure proper placement and function. MD order in chart for wander guard. Resident also has a picture in wander guard book as well as other inventions put in place. Wander safety assessment completed annually or with any changes. Resident will remain safe in a supervised environment." Resident 1's observation notes stated the following: 09/11/2025 at 7:00 AM -"Staff went into resident room to help [him/her] get ready for the day. Staff noticed that resident had 2 pair of pants on, when staff went to assist [him/her] to take 1 pair of pants off resident pushed the staff member, grabbed staffs arm, kicked and stomped RN on staff members foot.	N 381		

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N 381	Continued From page 2 Resident then kicked [him/her] basket across the room. Resident then pushed the staff member onto the bed." 09/12/2025 at 8:30 AM -"Resident did not allow staff to assist [him/her] with cares this morning. [S/he] was being argumentative with staff, slamming doors, and rearranging items in [his/her] room. Resident refused [his/her] meds despite multiple attempts. MCO team notified. PCP notified." 09/13/2025 at 10:45 AM -"Staff observed resident heading to the door. Staff did go outside with resident. Resident was in the parking lot pacing back and forth. Resident did walk on the sidewalk up the street with staff member. Resident was redirected and did come back to the facility without issues. MCO team, guardian and PCP notified." 09/15/2025 at 3:30 PM -"At 7:15 AM resident refused all medications for staff and also writer's attempt. Resident was sitting in the breezeway and was observed to have taken [his/her] pull-up off and shredded it up. Writer asked what happened. Resident stated, 'I ain't wearing that anymore. You clean it up.' Writer left the immediate area as resident was getting more agitated. Staff continued to check on resident. Then at around 7:45 AM, resident was seen outside of the facility and proceed to cross the road and began running up the sidewalk. Staff member tried to call resident back into the facility. Resident kept running up the street. Writer, nurse practitioner and [Administrator A] all got into our cars to go look for resident. Regional Director of Operations also present. Police were notified who then also called crisis response team. Resident was	N 381		

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N 381	Continued From page 3	N 381		

located inside the church, safe attending mass at the time. Police officer then walked with resident for over an hour and a half along with the crisis team. They were eventually able to get resident back into the facility. Frequent checks were made on resident to ensure safety. Resident did try to leave the facility again and Regional Director of Operations was able to get resident to come back into the facility. At 1:00 PM resident was again leaving the facility, staff member was following resident outside to try to get [him/her] to come back to the facility. Resident started to run and when [s/he] turned around [s/he] swung a plastic bag with an object in it hitting the staff member in the face. Police were called again. NP and police officer were able to get resident back into the facility. Crisis was called and they came back to the facility. After collaboration with NP, crisis member and Watertown hospital, resident was take to Aurora in Hartford to get medically cleared for possible admission to Watertown Hospital Behavioral Health unit. MCO and guardian were all involved in today's events."

Resident 1's record did not include assessments addressing the increase in exit seeking behaviors.

On 10/01/2025 at 11:30 AM, Surveyor requested to review any assessments completed for Resident 1. Regional Manager B stated s/he had an assessment completed on 08/28/2025 and 09/09/2025 regarding his/her behaviors.

On 10/01/2025 at 12:00 PM, Surveyor interviewed Administrator A and Regional Manager B. Administrator A and Regional Manager B stated a 30-day notice was given to Resident 1 on 09/15/2025 due to repeated incidents of attempted elopement. Administrator

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N 381	Continued From page 4 A stated Resident 1 needed a more secure facility and they were not able to accommodate Resident 1's exit seeking behaviors anymore. Surveyor asked if Resident 1 was re-assessed after s/he was ready to discharge back to the facility after his/her short admission to Winnebago Mental Health Institute (WMHI). Regional Manager B stated the Regional Director of Operations C had reached out via phone to WMHI and based on Resident 1's current needs at the time, they did not believe they could meet his/her needs at the facility and Resident 1 needed a higher level of care. Surveyor requested to review an assessment to to show the changes of Resident 1's needs since Resident 1's ISP stated Resident 1 had exit seeking behaviors and was an elopement risk. Regional Manager B stated the only recent assessments were on 08/28/2025 and 09/09/2025 regarding his/her behaviors. There was no assessment completed after Resident 1's incident on 09/15/2025. Administrator A and Regional Manager B acknowledged there were no assessments completed for Resident 1 when there was a change in needs, abilities or condition.	N 381		