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 |
|---|---|---|---|
| | 0011681 | A. BUILDING: _____ B. WING _____ | C 04/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FRIEDA MAE HAUS | 625 BONDOW DRIVE NEENAH, WI 54956 |

| (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 |
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| N 000 | Initial Comments<br><br>On 04/07/2026, Surveyors conducted a complaint investigation at Frieda Mae Haus. As a result three (3) deficiencies were identified and the complaint was substantiated.<br><br>Census: 11 | N 000 | | |
| N 158 | 83.12(2)(a) Caregiver: Investigating abuse & neglect<br><br>Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not ensure an allegation of neglect received on 11/06/2026 was investigated.<br><br>Findings include: | N 158 | | |

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

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The Department received a complaint alleging concerns with resident care.

On 04/07/2026 at 9:30 AM, Surveyor reviewed records from Caregiver C's personnel file. An undated note with an unidentified author described an "observation from [Caregiver C]." The observation indicated Caregiver C arrived at the facility at 2:35 PM for second shift and found both second shift staff were in the office "chilling...while resident (unnamed) was incontinent in (the) dining room." Caregiver C noted an "obvious smell" when s/he entered the building which persisted while staff did the shift change medication count. Caregiver C believed the resident had been that way for a while because at 3:45 PM when they cleaned the resident, it took 25 minutes and the feces was "cold to the touch" and "dried." The observation read, "Writer then notified (on call staff) of neglect."

Surveyor asked Licensee A and Manager B about Caregiver C's observation note. Neither had independent recall of the date, author or impacted resident. Eventually, Manager B determined s/he wrote the note and it was regarding an incident on 11/06/2025 involving Resident 1. Manager B subsequently provided documentation from the on call communication log on 11/06/2025:

--4:35 PM - "[Caregiver C] called to complain (that when s/he came in) "[Resident 1] was soaked and had BM...said it was terrible, 2nd shift had to change everything...clothes, bedding everything was covered with (bowel movement)."
--4:52 PM - Manager B replied, "Thank you...I didn't observe any of that today" and s/he thought 1st shift staff tried to provide care. Manager B wrote that Caregiver C could "leave me an

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observation note" if s/he wanted to.

Surveyor reviewed portions of Resident 2's record on 04/07/2026 at 11:44 AM, including the most recent individual service plan (ISP). Resident 3 was not able to make his/her needs known and relied on staff for assistance with transfers. S/he was frequently incontinent of bowel and urine, wore incontinence briefs and required "full assistance from staff to complete toileting tasks...Staff will assist with toileting every (2) hours."

Surveyor conducted a joint interview with Licensee A and Manager B about the records at 10:45 AM. Manager B recalled the situation and said sometimes Resident 1 would refuse toileting and s/he felt part of the responsibility fell on Caregiver C for not promptly providing care at 2:35 PM when s/he arrived and noted signs of incontinence. Surveyor asked if s/he investigated the incident by conducting interviews or reviewing records to determine when Resident 2 last received toileting assistance and/or if refusals occurred. Manager B said s/he didn't really remember the details but added, "I don't think I reviewed it at the time." Manager B also indicated s/he did not have any documentation of his/her response to the allegations made by Caregiver C.

Both Manager B and Licensee A acknowledged the allegations should have been investigated and said moving forward they would ensure that occurred.

At 12:35 PM, Surveyor requested and received a copy of the provider's policy for investigating abuse and neglect. The policy read in part, "Neglect...a careless or negligent act that: Fails to follow facility procedure or care plan...Possible

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| N 158 | Continued From page 3<br>Examples...leaving a client wet or soiled...all reports of resident abuse, neglect...shall be promptly reported and thoroughly investigated by facility management as required by the Department of Health Services..."<br><br>Cross Reference:<br>N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment<br>Z0010 Ch 50.065(2)(bb) Determine Final Disposition of Charges | N 158 | | |
| N 348 | 83.32(3)(d) Rights of Residents: Free from mistreatment<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure Resident 2 was free from verbal abuse. On 12/14/2025, Caregiver C spoke to Resident 2 in a loud, aggressive and rude tone after s/he asked for a cup of coffee. Caregiver C ignored requests by another caregiver and Resident 2 to stop the behavior and followed Resident 2 to his/her room where s/he continued to engage in verbal abuse towards Resident 2.<br><br>Findings include: | N 348 | | |

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| N 348 | Continued From page 4<br>The Department received a complaint staff yell at residents.<br><br>Surveyor reviewed Department records on 04/07/2026. Licensee A submitted a misconduct incident report (MIR) to the Office of Caregiver Quality (OCQ). The MIR detailed an incident of verbal abuse on 12/14/2025 by Caregiver C towards Resident 2. The incident began when Resident 2 requested a cup of coffee. Caregiver C slammed the cup of coffee in front of Resident 2 and proceeded to speak to Resident 2 in a loud, aggressive and rude tone. Caregiver C said, "you drink too much coffee and all you do is ask for coffee and [expletive for urinating] your pants and wet your bed on purpose for us to clean up." Caregiver D tried to intervene but Caregiver C continued. Resident 2 tried to disengage by going to his/her room but Caregiver C followed and continued to berate Resident 2. While in the room, Resident 2 repeatedly asked Caregiver C to stop, was trying to shut his/her door and was getting very upset.<br><br>The MIR included an email Licensee A sent to Resident 2's care team on 12/18/2025 which read, "The individual involved is no longer employed with us. We sincerely apologize that this incident occurred. [Resident 2] does not deserve this type of treatment, and it is completely contrary to the standards of care, dignity, and respect that we are committed to upholding."<br><br>Surveyor interviewed Caregiver D on 04/07/2026 at 2:53 PM. S/he described the 12/14/2025 the incident in a manner consistent with the MIR and said it happened shortly after the dinner meal. Caregiver D said the incident was very upsetting to Resident 2 who said s/he felt "belittled" when | N 348 | | |

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s/he "couldn't drink what [s/he] wanted in [his/her] own house." Caregiver D said on the night of the incident, s/he documented the situation in Resident 2's observation notes, but s/he did not notify the on call person. S/he said in hindsight, "I probably should have called."

On 04/07/2026 at approximately 11:30 AM, Surveyor interviewed Licensee A and Manager B. Manager B recalled that s/he learned about the incident the following day, 12/15/2025. In response, s/he suspended Caregiver C and conducted an investigation. Licensee A and Manager B said Caregiver D should have called the on call person immediately instead of just making an observation note. Because they were not immediately aware of the incident, Caregiver C was allowed to finish his/her shift on 12/14/2025. Licensee A and Manager B said as of the date of Surveyor's visit, Caregiver D had not received retraining on reporting requirements for abuse or neglect.

During the interview, the managers also provided documentation from Caregiver C's personnel file, hired 08/22/2025. Caregiver C was trained to work in all 4 of Licensee A's sister facilities. Surveyor reviewed the record and noted a history of concerns:

-09/27/2025: Caregiver C was working in a sister facility and blew vape smoke in a resident's face. The resident asked him/her stop. Caregiver C said s/he could do whatever s/he wanted and reminded the resident s/he had keys to his/her room. In response, Caregiver C was reassigned to work in a sister facility, Josephine Veronica Haus.
-10/28/2025: Performance review with Licensee A, Manager B and other managers. Manager B

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went over concerns including his/her "outbursts and tone when feeling overwhelmed...discussed strategies to [him/her] calm down, such as taking a break, venting to on-call staff, or stepping outside or into a quiet room."
-11/08/2025: Caregiver C was working at Josephine Veronica Haus. A resident refused cares and Caregiver C proceeded to provide the cares while the resident physically resisted. The resident sustained injuries to both hands during the incident. In response, Caregiver C was reassigned to work in Frieda Mae Haus and on 11/11/2025, Licensee A sent Caregiver C an email reiterating residents have the right to refuse care and treatment and attached a copy of the resident rights policy. NOTE: an investigation was completed but a misconduct referral was not made to the Office of Caregiver Quality.
-12/07/2025: While working in Frieda Mae Haus, Caregiver C was advised by a senior staff member to follow a resident's care plan during a transfer. Caregiver C refused, "went off on the senior staff member" and transferred the resident in a manner that nearly resulted in a fall.

Surveyor interviewed Manager B at Licensee A on 04/07/2026 at approximately 11:45 AM. Both managers acknowledged concerns with Caregiver C that predated the verbal abuse incident on 12/14/2025. Licensee A said they tried to address each incident as it occurred and thought with time, coaching and new settings, Caregiver C's behavior would improve. Licensee A acknowledged after the 12/14/2025 incident, it became clear Caregiver C was "untrainable" and in hindsight, they gave Caregiver C too many chances.

Cross Reference:
N0518 DHS 83.12(2)(a) Caregiver Investigating

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| N 348 | Continued From page 7<br>Abuse & Neglect<br>Z0010 Ch 50.065(2)(bb) Determine Final Disposition of Charges of Charges | N 348 | | |
| Z 010 | 50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE<br><br>If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge.<br><br>If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint.<br><br>If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. | Z 010 | | |

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not obtain the judgement of conviction and criminal complaint after learning Caregiver C was convicted of disorderly conduct 947.01 within the 5 years of employment.

Findings include:

On 04/07/2026 at approximately 12:30 PM, Surveyor reviewed Caregiver C's employee record. Caregiver C was hired on 08/22/2025 and terminated on or about 12/15/2025 after engaging in verbal abuse of a resident. Caregiver C's background check results were dated 08/26/2025. The Department of Justice results documented a conviction on 01/30/2023 for Disorderly Conduction in violation of Wisconsin §947.01. The record did not contain a copy of the judgement of conviction or criminal complaint associated with the conviction.

Surveyor interviewed Licensee A on 04/07/2026 at 12:37 PM. Licensee A confirmed the record did not contain the judgement of conviction or criminal complaint. S/he indicated s/he is aware of the requirement and said s/he was unsure why s/he missed it.

Cross reference
N0518 DHS 83.12(2)(a) Caregiver Investigating Abuse & Neglect
N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment