

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013666	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/17/2024
NAME OF PROVIDER OR SUPPLIER OUR HOUSE REEDSBURG ASSISTED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 355 MACK DR REEDSBURG, WI 53959		
(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 01/17/2024, Surveyor conducted a complaint investigation and standard survey at Our House Reedsburg Assisted Care. Complaint was substantiated. 2 deficiencies were identified. Census 15	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect 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. This Rule is not met as evidenced by: Based on record review and interview the provider did not investigate and document an allegation of abuse or neglect of Resident 1. The	N 158		

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

TITLE

(X6) DATE

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N 158	Continued From page 1 provider did not report the incident to the Department within 7 calendar days from the date the provider knew or should have known about the abuse and neglect. Findings include: On 01/17/2024 at approximately 11:30 AM, Surveyor requested any documentation of caregiver misconduct investigations in the previous 3 months. Administrator B stated there was currently an open investigation regarding possible misconduct and gave Surveyor an investigation summary of the current investigation. The "Investigation Summary" dated 09/18/2023, stated a caregiver was refusing to change a resident who had a bowel movement in his/her depends. There was also allegations of drug use while working, and caregivers not doing what they are supposed to be doing. The investigation was inconclusive and did not include any information about the accused caregiver, Caregiver D. On 01/17/2024 at approximately 3:25 PM, Surveyor interviewed Assistant Administrator C with Regional Director A in the room. Assistant Administrator C confirmed staff have brought concerns to him/her regarding Caregiver D being moody and rough on residents. Assistant Administrator C confirmed s/he knew about some of the concerns regarding Caregiver D, and that s/he has talked to Caregiver D regarding their mood. Assistant Administrator C stated these concerns have been brought to his/her attention a couple of times and has been an on-going issue. Assistant Administrator C stated s/he did not investigate the allegations involving Caregiver D.	N 158		

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N 158	Continued From page 2 On 01/17/2024 at approximately 3:40 PM, Regional Director A stated Assistant Administrator C admitted to knowing about the allegations and should have done an investigation. Regional Director A stated s/he would be starting an investigation immediately and would be suspending the alleged staff until the investigation was completed.	N 158		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment 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. This Rule is not met as evidenced by: Based on interview and record review the provider did not ensure Resident 1 was free from neglect and abuse. Findings include: On 01/05/2024, the Department received a complaint alleging caregiver misconduct. On 01/17/2024 at approximately 1:20 PM, Surveyor interviewed Resident 1 who stated Caregiver D refuses to help him/her. Caregiver D will yell at him/her, not help with things that s/he needs help with, and tell Resident 1 to do things on his/her own that are not safe for them to do	N 348		

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N 348	Continued From page 3 independently. Resident 1 stated Caregiver D told him/her that s/he needed to transfer on his/her own from a powered recliner to the toilet. Resident 1, visibly upset, stated s/he was scared to death of falling again, and when s/he is made to transfer on his/her own s/he is very scared. Resident 1 recalled a time when Caregiver D instructed another caregiver not to assist Resident 1 into the bathroom because s/he could, "do it on his/her own." Resident 1 stated Caregiver D acts angry towards him/her and will yell at him/her. Resident 1 had fallen over a year ago and as a result broke his/her neck. After this fall related injury the doctor told him/her that another fall could paralyze them because it would not heal all of the way. Resident 1 confirmed that all of this had been reported to management and nothing had changed regarding Caregiver D's treatment of Resident 1. On 01/17/2024 at approximately 2:25 PM, Surveyor interviewed Caregiver F who confirmed s/he witnessed Caregiver D tell Resident 1 to do things independently that Resident 1 could not safely accomplish. Caregiver F observed Caregiver D being unkind to residents. Caregiver F stated s/he had reported this to Assistant Administrator C numerous times. On 01/17/2024 at approximately 2:35 PM, Surveyor interviewed Caregiver G who confirmed concerns regarding Caregiver D not assisting Resident 1 when needed. Caregiver G stated s/he witnessed Resident 1 report this to Assistant Administrator C about two weeks prior. Caregiver G stated s/he has come to work for his/her shift and has found Resident 1 crying and upset because of how s/he was being treated on first shift by Caregiver D.	N 348			

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N 348	Continued From page 4 On 01/17/2024 at approximately 2:55 PM, Surveyor interviewed Caregiver H who confirmed s/he has come into work to find Resident 1 visibly upset when Resident 1 found out that Caregiver D was working. Caregiver H stated s/he has been told by Resident 1 that Caregiver D will tell Resident 1 to transfer and do things him/herself when Resident 1 needs assistance with transferring. On 01/17/2024 at approximately 3:00 PM, Surveyor reviewed Resident 1's individual service plan. Resident 1's individual service plan indicated Resident 1 needs assistance when transferring or ambulating. Resident 1's individual service plan also indicated Resident 1 needs assistance when toileting. On 01/17/2024 at approximately 3:05 PM, Surveyor interviewed Caregiver I who reported that recently Resident 1 was at the table playing Yahtzee and Caregiver I was going to assist Resident 1 to the bathroom and Caregiver D yelled that Resident 1 can get themselves to the bathroom and not to help him/her. Caregiver I stated Caregiver D then yelled at him/her when s/he continued to assist Resident 1 to the bathroom and said, "why are you helping [him/her] when I told you not to." Caregiver I stated Assistant Administrator C was in the room when it happened and heard Caregiver D say this. On 01/17/2024 at approximately 3:25 PM, Surveyor interviewed Assistant Administrator C with Regional Director A in the room. Assistant Administrator C confirmed staff had voiced concerns to him/her regarding Caregiver D being "moody" and rough on residents. Assistant Administrator C confirmed s/he knew about some	N 348		

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N 348	Continued From page 5 of the concerns regarding Caregiver D, and stated that s/he has talked to Caregiver D regarding her mood. Assistant Administrator C confirmed that Resident 1 had voiced concerns regarding Caregiver D not assisting them with toileting. Assistant Administrator C stated these concerns have been brought to his/her attention a couple of times and it has been an on-going issue. Assistant Administrator C confirmed that s/he did not investigate the misconduct allegations for involving Caregiver D. On 01/17/2024 at approximately 3:40 PM, Regional Director A stated Assistant Administrator C admitted to knowing about the allegations. Regional Director A stated s/he would be starting an investigation immediately and would be suspending the alleged staff until the investigation was completed.	N 348		