STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525454	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Health Services	2512 New Pine Dr Altoona, WI 54720

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on interview and record review, the facility failed to protect the resident's right to be free from mental abuse by staff. This affected 1 of 3 residents (R1) reviewed for mental abuse. Staff held R1 down and forced R1 to be catherized against her wishes. As a result, R1 experienced severe trauma and fear, stating she did not feel safe in the facility and requested to be removed from the facility. The facility's failure to ensure R1 was free from abuse created a finding of immediate jeopardy that began on 2/01/25. Nursing Home Administrator (NHA) A, Director of Nursing (DON) B and [NAME] President of Success (VPS) G were notified of the immediate jeopardy on 2/12/25 at 3:32 PM. The immediate jeopardy was removed 02/01/25 and corrected on 02/03/25. Based on this determination, this citation is being cited as past noncompliance. This is evidenced by: Surveyor requested and received the facility policy titled Abuse, Neglect and Exploitation dated 7/15/2022. The facility policy states in part, Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. Abuse means the willful infliction of injury, unreasonable confinement. Resulting in .pain or mental anguish . Instances of abuse for all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict harm. Mistreatment means inappropriate treatment .of a resident. Policy Explanation and Compliance Guidelines: The facility will develop and implement policies and procedures that: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~Prohibit and prevent abuse . Identification of abuse . ~The facility will have written procedures to assist staff in identifying abuse . ~Possible indictors of abuse include .physical abuse of a resident observed .psychological abuse of a resident observed .sudden unexplained changes in behavior and/or activities such as a fear of a person or place . R1 was admitted to the facility on [DATE] with primary diagnosis of Parkinson's disease. R1 was her own decision maker. R1's most recent significant change in status Minimum Data Set (MDS) conducted 1/21/25, noted resident understands, is understood and has unclear speech. R1 is cognitively intact with indicators of depressed mood. R1 had no behavioral symptoms, no hallucinations and no delusions. R1 required substantial assistance for bed mobility, transfers and hygiene. R1's care plan noted focus areas as follows: ~Resistive/non-compliant with treatments/care (refusing to reposition self while in recliner) r/t (related to) belief treatment is not needed. Interventions: Provide education about risks of not complying with therapeutic regimen. Initiated: 9/23/24. ~Difficulty communicating r/t Parkinson's disease. Goal: Needs will be met with comfort and dignity. Initiated: 8/09/24 Interventions: Provide reassurance and patience communicating with resident, repeat information as needed. ~At risk for changes in mood r/t situational depression. Goal: Will maintain involvement with adl (activities of daily living) performance and social activities. Initiated: 8/09/24 Interventions: Mood assessment is indicating 5/mild depression. Resident does not have a diagnosis of mental health condition . Assess for physical/environmental changes that may precipitate change in mood. Offer choices to enhance sense of control. ~Added on 2/03/25: At risk for re-traumatization of past event or experience where reminders/triggers of event may cause behavioral changes or emotional distress. Other: having a medical procedure done to her that she did not want done. Initiated 2/03/2025. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Goal: Reminders/triggering events will be avoided with minimal impact during her stay within the facility. Approaches: Provide a safe environment. Remove/avoid situations that may trigger re-traumatization. R1's Psychosocial/Trauma Informed Care Assessments/Observations since R1's admission note the following in part, 8/09/24: Prior Trauma or hx/dx (history/diagnosis) pstd (post-traumatic stress disease)? None of the above. Other concerns: none. 10/28/24: Prior Trauma or hx/dx (history/diagnosis) pstd (post-traumatic stress disease)? None of the above. Other concerns: none. R1's trauma screen, dated 1/20/25, states in part, (check all those that apply) Does resident have any of the following that may affect her approach to care? Dx or Hx (diagnosis or history) of PTSD: unchecked Prior trauma: unchecked Newly identified trauma: unchecked None of the above: checked. Surveyor reviewed the Facility Reported Incident (FRI) with the following noted: Date occurred: 2/01/2025 Time occurred: 2:00 PM Briefly Describe the Incident: On 2/01/2025 it was reported [RN C] allegedly performed a straight catheterization on resident [R1], who was not in agreement. [RN C] directed two CNA's to assist her in the procedure [CNA D and CNA E]. An investigation was immediately begun. The accused employees have been suspended pending investigation. [R1] has a BIMS (brief interview of mental status) of 15 (cognitively intact) and is her own healthcare decision maker. [R1] is currently safe in the center and free from injury. Police department was contacted at 3:21 PM. Re-education of staff regarding abuse began on 2/01/2025. R1's trauma screen, dated 2/03/25, states in part, (check all that apply) Description: [R1] had a medical procedure done to her Saturday February 1, that she did not want done. [R1] reported that the nurse did that to me and those 2 girls held me down. [R1] reported she does not feel safe. Writer suggested a move to another hall and [R1] stated, That would probably help. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Experience: Did any of these events bother you? Yes Comment on events resident was bothered by: [R1] is currently feeling unsafe due to the recent event that happened to her. Treatment: [R1] was happy with the idea of a room move. She feels that will help her feel safer. Additional comments: This is a new event for [R1], she will have her mood monitored for any significant changes . R1's nurse's notes from 1/29/25 at 12:42 PM state in part, Resident questioning if meds (medications) were given after given, repeatedly asking for duloxetine (antidepressant) and calling staff liars when 1:1 provided and reassured medications were given. Asking for pain meds for right arm pain. Offered Tylenol-refused. Voltaren gel applied, resident wiped off volteran gel with Kleenex. Weepy at times. Repositioned for comfort. Added to MD list of residents to be seen at next visit regarding right arm pain. Trying to use communication board. Several nurses offering meds-making suspicious comments 'no you didn't you are lying.' Nurse's note from 1/30/25 at 5:37 AM state in part, Resident assisted to the bathroom and after toileting said something inaudible, so writer asked resident to use communication board and she pin pointed HURTPEE, asked how she rates her pain and pin pointed. Tylenol given Voided a good amount and has not been frequenting the bathroom this shift .Encouraged to drink cranberry juice did not show any behavior such as crying or anger .AM nurse will be made aware . Nurse's note from 1/30/25 at 8:43 AM states in part, Provider contact: Reporting dysuria (discomfort when urinating), weepy with bathroom use/transfer this am, VSS (vital signs stable). Incontinent of urine. Provider response: Call back to request order to check for UTI. Physician Order dated 1/30/25: U/A (urinalysis), UC (urine culture) if positive due to dysuria for possible UTI (urinary tract infection) (may cath (catheter) if unable to do a clean catch) Situation/Change in condition: BP (blood pressure): 116/58, Pulse: 81, RR: 16.0, Temp: 98.8, increased confusion, other behavioral symptoms, painful urination Nurse's note from 1/30/25 at 7:00 PM states in part, On follow up for resident complaint of burning with urination. Status: VSS afebrile (vital signs stable without fever) has been pleasant and cooperative with staff this shift, no frequency, urgency or foul odor with urination. Attempt at urine catch was contaminated. No noted discomfort with void. Nurse's note form 1/31/25 at 6:54 PM states in part, Awaiting UA cultures, WBC (white blood cells) present, negative for bacteria and nitrates .refused dinner .trying to stand by self .witnessed fall . Nurse's note from 1/31/25 at 10:57 PM states in part, UA results received .nitrates negative, no bacteria, WBC's 21-50 awaiting culture (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse's note from 2/01/25 at 7:20 AM states in part, UA sent and positive for WBC, no bacteria or nitrates, awaiting culture results. No urinary complaints noted on noc (night) shift. Nurse's note from 2/01/25 at 1:55 PM states in part, Tele-Health Visit (physician visit): RN reporting urine culture grew 10-15,000 mixed genital flora likely contamination and this was culture result report. Patient was having some dysuria on Thursday not on antibiotics. Spoke with patient on the phone today having some dysuria but no urgency/frequency, no fever, chills or abdominal pain. Discussed with RN to get another UA with urine culture, no need antibiotics in the meantime. Surveyor reviewed the facility Criteria for Infection Form-Urinary Tract Infections which notes: Residents without an indwelling Catheter: Resident Exhibits: Fever greater than 100.0 of 2.4 degrees over baseline for 2 instances in past 12 hours And 1 or more: Dysuria, urgency, frequency, suprapubic pain, gross hematuria, flank pain, urinary incontinence, shaking/chills Resident meets criteria to order urine culture or does not meet Criteria. Of note, nurse's notes show no evidence R1 had a fever thus she did not meet criteria to order a urine culture and have the need for a straight catheterization procedure. Surveyor noted no nurse's note for the event that occurred on 2/01/24 at 2:00 p.m., that was described in the facility self report. Nurse's note from 2/01/24 at 8:59 PM states in part, Behavior as usual, no increased pain levels noted. Nurse's note from 2/02/25 at 1:08 AM states in part, Vital signs stable, rates pain at a 4 per communication board but did not want Tylenol, resting in recliner. Nurse's note from 2/02/25 at 6:06 PM states in part, Toilet without complaints of burning .no increased pain. UA returned from lab-final report says negative . Nurse's note from 2/03/25 at 11:18 PM states in part, Follow up to room change, VSS moved to a new room today with a new roommate, adjusting well to change. Nurse's note from 2/04/25 at 4:44 AM states in part, Has been sleeping well so far tonight in her new room . no complaints of pain or discomfort noted . Nurse's note from 2/04/25 at 9:53 PM states in part, Resident crying that she doesn't like room and does not want to be in it. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Late entry nurse's note written by Director of Nursing (DON) B: Effective 2/05/25 at 5:26 PM states in part, Writer informed by [VPS (Vice President of Success) G]: resident stated she desired to go to the hospital to be in a place she felt safe. Resident told writer and MSW (Social Worker) earlier in the day that she feels safe in the facility, however this evening she wishes to be removed and be sent to the hospital. I did speak with resident before call to EMS (emergency medical services), I asked her again if she wished to go, to which she said yes. I asked if ok to accompany her to ED (emergency department) for continuity of care . resident clearly indicated it was ok with her transferred via a stretcher and EMS . Surveyor received and reviewed R1's skin assessments post incident which noted no new skin impairments. Surveyor reviewed R1's Hospital Internal Medicine Admission Note which states in part, On 2/05/25 at 7:34 PM: Chief Complaint: Generalized pain all over, patient has dementia that has worsened over past few months. History of present illness: patient having dementia with progressive delirium, starting to have intermittent hallucinations, but is still technically her own person. Patient accompanied by nurse at the nursing home, she is extremely familiar with the patient, they have a very good relationship, however, there has been increasing behaviors and increasing paranoia recently. Because of this they did a UA the mid-stream was unfortunately contaminated, so the doctor ordered a clean cath (catheter) sample, this was performed, and patient is alleging that she tried to refuse this, and it was forced on her anyway. Because of this APS (Adult Protective Services) was involved, they have completed in this investigation, they state patient states she feels uncomfortable and needs to be removed from the nursing home as soon as possible. Patient states that she feels comfortable in the nursing home as long as the nurse is there, however when the nurse goes home for the day she makes multiple statements about feeling uncomfortable, which triggered APS to advise removal from the nursing home today, which prompted her visit here .Nurse states that they did attempt to modify the patients living situation including moving contact with staff members she has poorly interacted with, changing to different room, however patient continues to make statements about feeling unsafe .Patient does have slurred speech but is intermittently able to be understood .she is refusing repeat urine. Nurse states patient with intermittently had hallucinations over last week, including children tickling her feet underneath her wheelchair and hearing giggling . Assessment/Plan: Patient presents for further evaluation of concerns about her safety at her home, patient having increased hallucinations and delusions over past week but not currently. Head CT (computed tomography) and basic labs .No explanation for symptoms identified, patient admitted for placement . On 2/05/25 at 7:53 PM: Hospital Internal Medicine Admission Note states in part, Chief Complaint: Feels unsafe at the [facility] (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	History of present illness: .presented to hospital today with complaints she was being mistreated, apparently patient has had worsening progressive dementia thought to be secondary to her Parkinson's and there were concerns that patient may have a UTI. A midstream clean catch urine was tested and was abnormal. A cathed urinalysis was ordered and patient had reported that when this was obtained, she refused but staff obtained it despite her refusal. Patient had complained to the director and reported this to Adult Protective Services. Adult Protective Services documented that the patient felt uncomfortable and unsafe at the nursing home. General Physical exam: no acute distress. Plan: admit for observation. Surveyor reviewed the police report for R1 which states the following in part, Incident Nature: Assault Date: 2/01/2025 at 3:22 PM Disposition: Arrest Brief Summary of Activity: Officer responded to an information case from a local assisting [sic] living. DHS (Department of Health) was contacted and informed of a possible elder abuse case. Details: On Saturday February 1, 2025, at approximately 3:30 PM officer was requested by dispatch to make contact with director from [facility name] . [NHA A] told me a nurse was ordered to collect a urine sample from a resident. She stated that the resident did not want to be subjected to a catheter. The nurse requested help from CNA's who held the residents' legs down and used the catheter. [NHA A] stated the resident [R1] was crying and asking them to stop. I arrived at [facility name] to speak with [R1] about what had occurred. I was greeted by another director at the building [DON B] .[DON B] stated that multiple other staff members could hear yelling and crying from [R1's] room when the incident took place .[DON B] told me she received the report and returned to work, she found [R1] in her room with her pants still around her lower legs. I met with [R1] in her room to speak with her about what happened. [R1] said that she was in bed when a nurse came in to take a urine sample. [R1] said that during the urine sample she asked them to stop several times and never consented for the sample to be taken. [R1] stated she tried to fight but her hands and legs were held down and out of the way of the procedure. [R1] stated she was in pain during the procedure and was still in pain. I called and spoke with [CNA E] to speak with her about what happened. [CNA E] stated .around 1:55 PM she was asked by [RN C] to assist with getting a urine sample. When she entered the room, [RN C] was going over the procedure with [R1]. [RN C] began cleaning [R1's] vaginal area and [R1] was saying no several times .was instructed to assist holding one of [R1's] legs to open the vaginal area. [R1] began resisting and crying. [RN C] then told [CNA E] to get help to hold [R1]. [CNA E] went into the hallway .and asked [CNA D] to come into the room. [CNA E] said her and [CNA D] each took a side of [R1] and held her down while [RN C] inserted the catheter. When both [CNA D] and [CNA E] held her down [R1] began to cry and yell louder. [CNA E] said she felt bad and quickly realized it was wrong. However, she felt she was in a tough spot because she was instructed to do so from the nurse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/11/25 at 3:58 PM, Surveyor spoke with CNA F. CNA F indicated she had worked for the nursing home many years and works the PM shift. CNA F expressed she works R1's hall and is familiar with R1. CNA F indicated on the day of the incident she entered the facility by the back door by the timeclock for her PM shift. Upon entering she could hear R1 screaming from her room (108) which is up the hall from timeclock, around the nurse's station and halfway up hall A. CNA F indicated R1 was very loud but the words could not be understood. CNA F asked CNA D and CNA E what was going on as they exited R1's room. CNA F expressed the CNAs said R1 was upset with catheter procedure she did not want. CNA F told CNA E and CNA D to report the situation. It was obvious R1 was very upset and continued to be upset until about 3:30-4:00 PM, when she settled down. CNA F reported the next day R1 transferred to another hall. CNA F expressed she did not hear R1 say she felt unsafe after the incident. On 2/12/25 at 8:15 AM, Surveyor spoke with RN C via the phone. RN C reported working at the facility [AGE] years. RN C reported working the AM shift and the wing where R1 resided. RN C reported R1 had an overall decline in the past few months. R1 was not as active, lowering herself to the floor, had increased complaints of discomfort and behavioral changes. RN C reported R1 had urinary incontinence at end of January which was unusual and R1 reported it hurt with urination. R1's physician was contacted and gave an order for a urine sample. Surveyor asked RN C if R1 had any fever with her complaints. RN C indicated R1 did not have a fever. Surveyor discussed the facility's criteria for obtaining a urine culture included reports of a fever. RN C indicated she was not aware the criteria specified a fever as part of the criteria. RN C indicated a clean catch urine was obtained for R1 by another staff nurse. On Saturday 2/01/25 the culture results showed contamination with WBCs and the on-call MD (physician) was called and discussed resident symptoms. MD spoke with resident who said burns. MD explained the 1st clean catch specimen was contaminated and the need to collect another one. RN C gathered supplies for a straight catheter to obtain the specimen, entered R1's room and assisted with lowering R1's blankets and pants. RN C explained she assisted R1 with peri care with wipes and saw no issues. R1 was calm. With swabbing, R1 became kind of rigid and RN C instructed CNA E to spread her legs. RN C said she knew it was not going to be easy due to R1's rigidness and asked CNA D to get help. CNA D got CNA E. The two CNAs were on each side of R1's bed with RN C at the foot of bed. RN C instructed the CNAs to spread R1's legs. RN C said it was quiet in the room and she had an issue with the first catheter and had another kit there to try. RN C said she has cathed many people and the second one filled, was removed and the CNAs were trying to re-dress R1 when she noticed she was weepy. RN C expressed she did not notice any objection from R1, did not see resident moving away and did not see any non-verbal cues resident was upset. RN C expressed, The CNAs are there to watch the patient and their comfort. The CNAs did not alert her to any issues. RN C expressed she did not know there was an issue until contacted later that day by DON B. RN C stated she would have stopped had she known R1 was objecting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525454	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Health Services	2512 New Pine Dr Altoona, WI 54720

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/12/25 at 11:37 AM, Surveyor spoke with Adult Protective Services (APS) I who indicated she received a report of incident on 2/03/25 by law enforcement. APS I reported to the facility on [DATE] and spoke with R1. R1 indicated she told staff she did not want straight catheter procedure when the nurse was explaining the procedure, as in the past it hurt. The nurse (RN C) had 2 CNA staff (CNA D and CNA E) hold her down by her arms and legs to do the catheter even though she said no several times. R1 said it hurt very bad and she did not consent to the procedure. R1 said she wanted to press charges as she doesn't want it to happen to another resident. R1 requested to move, as she did not feel safe. The facility moved her to another room but R1 requested a move as she continued to not to feel safe at the facility regardless of the change in room and the fact that the alleged staff had been suspended. APS I expressed she informed R1's managed care organization coach about the request to move; as well as facility administrator for R1's safety and wellbeing. R1 was transferred to the hospital that day. On 2/12/2025 at 1:13 PM, Surveyor spoke with DON B about the incident on 2/01/25 with R1. DON B indicated she was called by CNA E just after 2:00 PM stating she was uncomfortable with R1's straight catheter procedure. CNA E reported R1 did not want the procedure, and the procedure was done anyway. DON B said she came into the facility immediately and called NHA A when in route. Once at the facility she asked RN C about the straight catheter procedure and if R1 consented to the procedure. RN C said she did not decipher R1 did not want it done and she did not hear no but R1 was tearful. RN C was asked to leave the building and informed an investigation would be conducted. RN C did not note the incident in the nurse's notes. DON B stated she talked to CNA D next. CNA D explained she was asked to assist with the procedure. R1 was tearful and did not want the procedure done. CNA D said she was told to hold R1 in a position to obtain catheter urine. R1 was tearful. CNA D was asked to leave the facility was and informed of investigation. DON B said she then went to speak with R1. R1 said she wanted a clean catch and questioned why a straight catheter was done. DON B explained the specimen was contaminated and the provider gave an order for straight catheter. R1 did not want it done and did not give consent. R1 said no and no means no. Resident rights were violated by not being allowed to refuse treatment. Based on facility policies abuse occurred. DON B stated the facility immediately began training staff on resident rights and provided training to all staff before they reported to work. On 2/12/25 at 1:59 PM, Surveyor spoke with NHA A about the incident with R1 on 2/01/2025. NHA A indicated she was called by DON B around 2:15 PM on 2/01/2025 reporting CNA E said she was part of getting a urine sample from R1 when R1 said no and that R1 was upset. NHA A indicated she called law enforcement right away and started reporting to the state of Wisconsin Department of Health Services. NHA A reported DON B talked with RN C. NHA A indicated APS came in on 2/05/25 and reported to her R1 did not feel safe in the building, R1 wanted to press charges and APS I was going to contact the MCO regarding placement. VPS G spoke with R1 who stated she did not feel safe because staff were putting toys in pillowcases and on her bed making her lay on them. R1 was saying a little girl was under her wheelchair which was new for her. R1 was transferred to the hospital 2/05/25 around 5:30 PM and has not returned to the facility. On Monday 2/03/25 the facility continued staff education related to abuse, definitions, who to contact, allegations, reporting and resident rights. Specifically, what to do when someone says no. Surveyor asked NHA A if R1's rights were violated. NHA A responded R1's right to refuse treatment was violated as the CNAs held her legs down to obtain urine sample that resident said she did not want. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to protect vulnerable residents from mental abuse created serious harm which led to a finding of immediate jeopardy. The immediate jeopardy was removed on 02/01/25 when involved staff were removed from work. In addition the deficiency was corrected on 02/03/25 after the facility completed the following: - Re-education was immediately given to staff on duty and in [NAME] [TRUNCATED]