STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525463	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Gardens Nur Ctr, Inc	1700 Midway Rd Menasha, WI 54952

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not thoroughly investigate an allegation of abuse for 2 residents (R) (R2 and R1) of 2 sampled residents. R2 reported an allegation of physical abuse on 1/19/25 that involved Certified Nursing Assistant (CNA)-E. The facility did not ensure CNA-E was removed from or supervised during resident care pending the results of the investigation. R1 reported to a nurse on 11/29/24 that R1 was recently raped by an unknown male staff. The facility did not thoroughly investigate the allegation of sexual abuse. Findings include: The facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, dated 9/3/24, indicates: Investigating Allegations: 1. All allegations are thoroughly investigated .7. The individual conducting the investigation at a minimum: a. Reviews the documentation and evidence. b. Reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident. c. Observes the alleged victim, including his or her interactions with staff and other residents. d. Interviews the person reporting the incident. e. Interviews any witnesses to the incident. f. Interviews the resident (as medically appropriate) or the resident's representative. g. Interviews the resident's attending physician as needed to determine the resident's condition. h. Interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident .l. Documents the investigation completely and thoroughly. 1. On 2/7/25, Surveyor reviewed R2's medical record. R2 had diagnoses including dementia, hip fracture and other multiple trauma, and arthritis. R2's Minimum Data Set (MDS) Assessment, dated 11/19/24, contained a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R2 had severely impaired cognition. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/7/25, Surveyor reviewed a facility-reported incident (FRI) that indicated R2 reported to a nurse on 1/19/25 that CNA-E slapped R2's hand and indicated R2 was stinky. The FRI indicated CNA-E was removed from the floor until Nursing Home Administrator (NHA)-A was contacted and provided further instructions. On 1/19/25, NHA-A interviewed CNA-E via phone. Following the conversation, CNA-E was moved to different unit and allowed to provide resident care. NHA-A spoke to R2's Power of Attorney for Healthcare (POAHC) who indicated staff should not interview R2 until 1/20/25 when R2's POAHC could speak to R2. R2's POAHC also indicated the facility should not call the police until 1/20/25. The FRI also indicated NHA-A only interviewed 3 (including CNA-E) of the 17 staff who were working when the incident occurred. On 2/7/25 at 2:06 PM, Surveyor interviewed NHA-A who indicated CNA-E was immediately removed from resident care after the allegation and NHA-A was notified. NHA-A indicated R2's POAHC did not want the facility to call or do anything until the morning when R2's POAHC could talk to R2. NHA-A indicated with the information NHA-A had at the time, NHA-A decided to move CNA-E to a different unit to care for other residents. NHA-A did not feel CNA-E was a threat to other residents. NHA-A also confirmed only 3 staff who were working when the incident occurred were interviewed. 2. On 2/7/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including severe vascular dementia with mood disturbance, anxiety, and cognitive communication deficit. R1's MDS assessment, dated 12/10/24, contained a BIMS score of 4 out of 15 which indicated R1 was severely cognitively impaired. R1 had a corporate Guardian (initiated on 1/23/25). R1 had a family member as Guardian at the time of the alleged incident. On 2/7/25, Surveyor reviewed a FRI that indicated R1 reported to a nurse on 11/29/24 that R1 was recently raped by a male staff. R1 could not describe the male staff. R1 also stated R1 thought R1 was dreaming and it was dark, but the male touched (R1) and then left. During a subsequent interview, R1 stated R1 thought the male was R1's husband, but then knew it was not. The nurse assessed R1 and noted no trauma or bruising. Surveyor reviewed the facility's investigation and staff schedule from 11/29/24 and noted 6 staff who were working on the PM shift when the allegation was made were not interviewed, including 2 male staff. On 2/7/25 at 2:07 PM, Surveyor interviewed NHA-A who indicated not all staff on the shift were interviewed. Surveyor and NHA-A reviewed the 11/29/24 schedule which included 6 staff who were not interviewed, including Licensed Practical Nurse (LPN)-C and CNA-D who were male. NHA-A indicated LPN-C and CNA-D were not interviewed because they were on a different unit than R1. When Surveyor asked how NHA-A can be sure staff have no knowledge of the alleged incident if they are not interviewed, NHA-A indicated NHA-A did not interview staff who were not on the same unit as R1. Surveyor noted all units were easily accessible to staff.