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	04/03/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 Resident (R) (R50) of 2 residents. R50 was observed laying across another resident in their bed without clothes on. The potential allegation of abuse was not reported to the State Agency (SA) or local law enforcement. Findings include: The facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, with a revised date of September 2023, indicates: 1. If resident abuse, neglect, exploitation, misappropriation of resident property, or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and/or designee and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. the state licensing/certification agency responsible for surveying/licensing the facility 3. Law enforcement officials. On 4/2/24, Surveyor reviewed R50's medical record. R50 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and vascular dementia. R50's Minimum Data Set (MDS) assessment, dated 1/11/24, contained a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R50 was severely cognitively impaired. A behavior progress note, dated 9/28/23 at 6:30 AM, indicated: Writer was notified by Certified Nursing Assistant (CNA) around 1:00 AM that (R50) was out of (R50's) room. (R50) was found laying in another resident's room without any clothes on. (R50) was laying on top of the other resident's legs when found. (R50) was agreeable to redirection and escorted back to (R50's) room. (R50) was cooperative but confused. On 4/2/24, Surveyor requested information on the above incident which the facility was unable to provide. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 2:26 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B who indicated progress notes are reviewed daily in morning meeting, but R50's 9/28/23 behavior note was missed. NHA-A confirmed the potential allegation of abuse was not reported to the SA or local law enforcement. NHA-A indicated if NHA-A was aware of the incident prior to 4/2/24, NHA-A would have reported the incident.

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(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** 43361 Based on staff interview and record review, the facility did not thoroughly investigate a potential allegation of abuse for 1 Resident (R) (R50) of 2 residents. R50 was observed laying across another resident in their bed without clothes on. Facility administration was not aware the incident occurred and a thorough investigation was not completed. Findings include: The facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, with a revised date of September 2023, 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. I. Documents the investigation completely and thoroughly. On 4/2/24, Surveyor reviewed R50's medical record. R50 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and vascular dementia. R50's Minimum Data Set (MDS) assessment, dated 1/11/24, contained a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R50 was severely cognitively impaired. A behavior progress note, dated 9/28/23 at 6:30 AM, indicated: Writer was notified by Certified Nursing Assistant (CNA) around 1:00 AM that (R50) was out of (R50's) room. (R50) was found laying in another resident's room without any clothes on. (R50) was laying on top of the other resident's legs when found. (R50) was agreeable to redirection and escorted back to (R50's) room. (R50) was cooperative but confused. On 4/2/24, Surveyor requested the facility's investigation of the incident which the facility could not provide. On 4/2/24 at 2:26 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B who indicated progress notes are reviewed daily in morning meeting, but R50's 9/28/23 progress note was missed. NHA-A and DON-B were not sure which resident R50 was found in bed with. NHA-A and DON-B confirmed an investigation was not completed and protections were not put in place because they were not aware the incident occurred. NHA-A and DON-B confirmed an investigation should have been completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42248 Based on staff and resident interview and record review, the facility did not ensure consistent communication for 1 Resident (R) (R24) of 1 resident who received dialysis services. The facility did not provide R24 with a dialysis communication binder prior to routine dialysis appointments and did not have evidence of communication between the facility and the dialysis center on R24's dialysis days. Findings include: The facility's Care of Hemodialysis policy, with a revision date of January 2024, indicates: Purpose: To ensure the needs of the resident receiving hemodialysis are met by both the facility and the dialysis center. Residents receiving hemodialysis are transported routinely out of the facility. Communication is essential for continuity of care. Procedure: -Facility will provide ongoing assessment of the resident's condition and will monitor for complications before and after each dialysis treatment received at a certified dialysis facility. -Facility will have ongoing communication and collaboration with the dialysis facility The facility's Hemodialysis policy, with a revision date of January 2024, contained the following information: Dialysis Communication Record: -To be completed by the facility: -List the medications given within the last six hours prior to sending the resident for dialysis treatment. -Assessment of vascular access site -Time of last meal -Last weight at the facility, date of last weight -Note of any changes or information to resident's condition below. Include information on resident's compliance with fluid and diet restrictions. -Facility nurse signature -To be completed by the Dialysis Center: -List the medication given during/after the dialysis treatment (other than heparin). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Weights: Pre-treatment, Post-Treatment -Vital signs Pre-treatment, Post-Treatment -List what foods and how much the individual ate/drank, if applicable. -Special instructions/comments and/or changes in resident's condition. Include any lab results drawn and resident's tolerance to dialysis procedure. -Provide a copy of the Registered Dietitian's nutritional recommendations, if applicable. -Dialysis Center nurse signature/date From 4/1/24 to 4/3/24, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] with diagnoses including end stage renal disease and diabetes with chronic kidney disease. R24 was dependent on dialysis and attended dialysis on Tuesday, Thursday and Saturday. R24's Minimum Data Set (MDS) assessment, dated 1/11/24, contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R24 had intact cognition. Surveyor noted R24's medical record did not contain dialysis communication documentation. On 4/2/24 at 1:20 PM, Surveyor interviewed Director of Nursing (DON)-B who stated the facility does not have formalized communication with the dialysis center because the dialysis center does not fill out the data consistently and appropriately. DON-B stated DON-B started a new program in which the dialysis center sends lab reports with updates. DON-B stated the new program started on 3/20/24, however, reports were not provided for R24. On 4/2/24 at 2:58 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who stated the facility obtains a resident's vital signs and weight, and checks the resident's fistula (access port for dialysis) and medication prior to their dialysis appointment and upon their return. LPN-F thought there was a communication binder but verified there was not. LPN-F stated the dialysis center calls the nursing facility if there is a change in the resident's condition. On 4/2/24 at 4:02 PM, Surveyor interviewed dialysis center Registered Nurse (RN)-G via phone who stated the dialysis center has a communication form that is shared with the facility. RN-G stated if a resident doesn't arrive with a communication form, the dialysis center generates one. RN-G stated RN-G did not fill out a form for R24 and the facility did not send a form with R24. RN-G also stated the dialysis center would like a resident's Medication Administration Record (MAR) upon arrival. RN-G reviewed the dialysis center's electronic record which included a call from Medical Doctor (MD)-H on 4/1/24 to ask if R24 could have a general diet since R24 was refusing a renal diet (specific diet for dialysis patients). On 3/30/24, an RN called to remove a fluid restriction due to R24's refusals. On 2/29/24, the dialysis center faxed an order to the facility to make sure R24 received midodrine (a blood pressure medication) a half hour before R24's dialysis appointments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/24 at 9:51 AM, Surveyor interviewed dialysis center Clinic Manager (CM)-I who stated DON-B called CM-I on 3/20/24 regarding lack of communication between the facility and the dialysis center. DON-B stated DON-B would create a communication binder to be sent between the dialysis center and the facility. Since the call, CM-I stated CM-I did not receive a binder or hear anything from the facility. CM-I verified the dialysis center has a communication form that is used when the facility does not send one. On 4/3/24 at 11:26 AM, CM-I called Surveyor and verified after speaking with other dialysis staff members that the dialysis center has not seen a binder from the facility. CM-I stated the dialysis center and the facility communicate via phone calls. CM-I again stated the dialysis center has a document the center can fill out and send to the facility. On 4/3/24 at 1:15 PM, Surveyor interviewed DON-B who stated DON-B was aware of the facility's hemodialysis policy which states the facility will have ongoing communication and collaboration with the dialysis center and lists the pre-dialysis and post-dialysis communication requirements.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 47248 Based on staff interview and record review, the facility did not ensure 1 Resident (R) (R34) of 3 residents with a diagnosis of dementia received the appropriate care and services to attain or maintain their highest practicable well being. R34 had a diagnosis of dementia and exhibited physically and verbally aggressive behavior. The facility did not revise R34's plan of care in an attempt to provide effective dementia treatment and behavioral interventions to enhance R34's quality of life. Findings include: On 4/2/24, Surveyor reviewed R34's medical record. R34 had a diagnosis of dementia, moderate with agitation. R34's most recent Quarterly MDS (Minimum Data Set) assessment, dated 3/26/24, contained a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which indicated R34 had severe cognitive impairment. R34 had an activated power of attorney (POA). R34 had an activity of daily living (ADL) self-care performance deficit related to aggressive behavior and Alzheimer's disease care plan, dated 2/25/24. The care plan indicated R34 required the assistance of one staff with the use of a wheelchair and had impaired cognitive function/dementia or impaired thought process related to dementia. The care plan contained the following interventions: ask R34 yes or no questions; communicate with R34/family/caregivers regarding R34's capabilities and needs; use R34's preferred name; identify self during interactions; reduce distractions; provide R34 with necessary cues; stop and return if R34 is agitated; cue, reorient and supervise R34 as necessary; keep R34's routine consistent; present one thought, idea or question at a time. R34's medical record contained the following progress notes: A progress note, dated 3/10/24, indicated R34 was verbally aggressive toward another resident and struck the resident in the arm. R34's POA and physician were notified. The progress note indicated R34's POA noticed R34 was more aggressive lately. Surveyor noted R34's care plan did not indicate R34 had verbal or aggressive behavior and did not contain interventions to assist R34 with those behaviors. Surveyor also noted there were no interventions added to R34's care plan following the incident. A progress note, dated 3/29/24, indicated R34 was paranoid, suspicious, and mistrustful of staff. R34 swore at a Certified Nursing Assistant (CNA) and yelled help police in the hallway. The CNA attempted to redirect R34 but was unsuccessful. R34 remained in a doorway in the hallway and stated Watch her. I don't trust her, Be careful you are in danger, and I will tell you what is going on, but I can't trust you right now. R34 remained in the hallway for approximately one hour and 45 minutes then went back to bed and would not allow staff to assist R34 or R34's roommate. Surveyor noted R34's care plan did not indicate R34 had verbal or paranoid behavior and did not contain interventions to assist R34 with those behaviors. Surveyor also noted there were no interventions added to R34's care plan following the incident. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/24 at 2:30 PM, Surveyor requested a copy of R34's care plan and progress notes, dated 3/10/24 and 3/29/24, from Director of Nursing (DON)-B. On 4/2/24 at 10:00 AM, Surveyor reviewed R34's care plan and noted an intervention, dated 4/1/24, that indicated R34 had a behavior problem related to being suspicious of staff. The care plan indicated R34 yells and is resistant with cares and contained interventions to anticipate R34's needs, provide opportunity for positive interactions, explain procedures, monitor behavioral episodes and attempt to determine the underlining cause, and document behavior and potential causes. Surveyor noted the care plan did not contain interventions to assist with physically aggressive behavior or de-escalation of behavior. On 4/2/24 at 1:05 PM, Surveyor interviewed DON-B regarding dementia care and a behavioral care plan for R34. DON-B indicated R34 did not have a behavioral care plan. DON-B confirmed DON-B updated R34's care plan after Surveyor requested a copy of the care plan on 4/1/24. DON-B indicated R34's behaviors were identified and documented and stated the facility did not initiate care plan interventions to assist R34. DON-B indicated R34's behaviors were escalating and verbal, paranoid, and physically aggressive behaviors were observed. DON-B stated word of mouth is how nursing staff, including agency staff, are trained and informed on how to intervene and provide care to R34 during periods of aggressive and paranoid behavior.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47248 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect 73 of 73 residents residing in the facility. Staff did not date items with open dates and received dates. Staff did not ensure food was stored in a sanitary manner. Staff did not wash hands when moving from dirty to clean activities. Staff did not wait two minutes to take microwave reheated food temperatures to ensure food was heated evenly. In addition, staff did not ensure microwaved foods reached the food safety temperature prior to serving. Findings include: Undated Items: The Food and Drug Administration (FDA) Food Code 2022 documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition (A): A food specified in 3-501.17 (A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17 (A) except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). During an initial kitchen tour that began on 4/1/24 at 8:19 AM with Dietary Manager (DM)-K, Surveyor noted undated food items in the dry storage area and walk-in freezer. Surveyor also noted items that were open, unsealed, and did not contain open dates. Surveyor noted the following open, unsealed, and undated items: Dry Storage Area: ~Four open, unsealed, and undated bags of snack chips. ~Six open and undated bags of individual snack chips. ~One open, unsealed, and undated bag of brown sugar. ~One open and undated bag of cereal. ~One open and undated box of Cream of Wheat ~Two unopened and undated boxes of Cream of Wheat (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~Two bags of undated marshmallows. Walk-In Freezer: ~One open and undated case of turkey pot pie. ~One unopened, undated case of turkey pot pie. ~One undated box of whipped topping. ~Eleven boxes that contained the following items: open pizza boxes with undated individual pizzas; undated hot dog and hamburger buns; undated frozen vegetables; undated chicken strips; various undated frozen foods. Surveyor interviewed DM-K who indicated the facility's process is to ensure all items are labeled with a received date or best-by date. DM-K indicated that the process for opening an item is to ensure an open date is placed on the item when opened. DM-K confirmed the items in the dry storage area and walk-in freezer did not contain received, best-by, or open dates. Sanitary Food Storage: The FDA Food Code 2022 documents at 3-305.11 Food Storage: (A) Except as specified in (B) and (C) of this section, food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. During the initial kitchen tour on 4/1/24, Surveyor observed eleven boxes of food items stacked on the floor of the freezer. Surveyor also observed an open case of frozen pizzas with individual pizzas stacked between the boxes on the floor. Surveyor interviewed DM-K who indicated food was delivered on 3/29/24 and indicated food is stored on the floor of the freezer because staff do not put the boxes away. DM-K confirmed the boxes should be removed from the floor and placed on shelves. Surveyor observed several open spaces in the freezer where boxes could be stored. Hand Hygiene: The FDA Food Code 2022 documents at 2-301.14 When to Wash: Food Employees shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: .(F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a continuous food service observation at the rehab dining room steam table that began on 4/2/24 at 7:25 AM, Surveyor observed Cook (CK)-L serve food from the steam table onto resident meal trays. Surveyor observed CK-L drop tongs from the sausage and bacon container on the kitchenette floor, put the tongs in the sink, and return to food service at the steam table without completing hand hygiene. With the same gloved hands, Surveyor observed CK-L put two pieces of bacon from of the steam table on a resident's plate. CK-L then picked up a piece of banana bread and put the banana bread on a resident's plate. With the same gloved hands, CK-L toasted and buttered a piece of bread and put the toast on a resident's plate. CK-L then removed gloves, cleansed hands, donned clean gloves, and continued preparing residents' trays at the steam table. Surveyor also observed CK-L complete the following activities during meal service without removing gloves and completing hand hygiene: ~CK-L took clean plates from the steam table to prepare residents' breakfast trays. While moving between the steam table and the stove, CK-L touched food items with the same gloved hands. ~CK-L put two pieces of bacon from the steam table on a resident's plate. CK-L then walked to the stove, cracked an egg, and touched a stove knob, cooking utensil, and a pan. CK-L then threw an egg in the garbage, finished cooking the egg on the stove, and placed the egg on a resident's plate. ~CK-L put a piece of banana bread on resident's plate. CK-L then toasted and buttered a piece of bread and placed the bread on a resident's plate. ~CK-L put two sausage links from the steam table on a resident's plate. CK-L then toasted and buttered a piece of bread and put the bread on a resident's plate. CK-L then touched items in a drawer, removed a pepper packet from a box in the kitchenette, and put the packet on a resident's plate. CK-L then returned to the steam table and continued with food service. ~CK-L put a piece of banana bread on a resident's plate. CK-L then picked up two pieces of bacon from the steam table and placed the bacon on a resident's plate. ~CK-L put a piece of banana bread on a resident's plate. CK-L then put two sausage links from the steam table on a resident's plate. ~CK-L put a piece of banana bread on a resident's plate. CK-L then scooped oatmeal from the steam table and put the oatmeal on a resident's plate. Surveyor noted the last food trays were delivered at 8:25 AM. On 4/2/24 at 1:30 PM, Surveyor interviewed DM-K regarding hand hygiene. DM-K stated DM-K provided previous education to CK-L to remain at the steam table to ensure cross contamination does not occur. DM-K also provided education that CK-L should use a tongs or scoop when serving food and obtain a clean utensil if a utensil is unavailable or dropped during service. DM-K stated CK-L was previously told to not use CK-L's hands to put food on residents' plates. Microwave Reheating/Food Safety Temperature: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The FDA Food Code 2022 documents at 3-403.11 Reheating for Hot Holding: (A) Except as specified under (B) and (C) and in (E) of this section, time/temperature control for safety food that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 74 degrees Celsius (C) (165 degrees Fahrenheit (F)) for 15 seconds. (B) Except as specified under (C) of this section, time/temperature control for safety food reheated in a microwave oven for hot holding shall be reheated so that all parts of the food reach a temperature of at least 74 degrees C (165 degrees F) and the food is rotated or stirred, covered, and allowed to stand covered for 2 minutes after reheating. The FDA Food Code 2022 documents at section 3-403.11: .(C) and (D) Food that is taken from a commercially processed, hermetically sealed container or intact package cooked to a temperature of 135 degrees F. During a continuous food service observation at the rehab dining room steam table that began on 4/2/24 at 7:25 AM, Surveyor observed CK-M cook or reheat the following food in the microwave: ~CK-M microwaved Cream of Wheat for thirty seconds, stirred the Cream of Wheat, and microwaved the Cream of Wheat for another thirty seconds. CK-M stirred the Cream of Wheat again and put the Cream of Wheat in a bowl on a resident's tray. CK-L did not temp the Cream of Wheat after it was covered or allow the Cream of Wheat to stand for two minutes to obtain a safe temperature. ~CK-M microwaved Cream of Wheat for thirty seconds and put the Cream of Wheat in a bowl on a resident's tray. CK-M did not temp the Cream of Wheat after it was covered and allow the Cream of Wheat to stand for two minutes to obtain a safe temperature. ~CK-M microwaved a breakfast burrito for 20 seconds and put the burrito on a resident's plate. CK-M did not obtain a temperature to ensure the burrito reached 165 degrees F or allow the burrito to stand covered for two minutes prior to service. ~CK-M obtained a coffee cup from a resident in the dining room who stated the coffee was cold. CK-M microwaved the coffee for thirty seconds and gave the coffee to the resident. On 4/2/24 at 1:30 PM, Surveyor interviewed DM-K regarding microwaving food, not obtaining food temperatures when cooking or reheating food, and not covering and letting the food stand for two minutes prior to service. DM-K confirmed DM-K expected staff to follow the procedure to ensure foods are reheated properly and to a safe temperature.

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	04/03/2024

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 0882 Level of Harm - Potential for minimal harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 42248 Based on staff interview and record review, the facility did not ensure a staff person designated as the Infection Preventionist (IP) completed specialized training in infection prevention and control. This practice had the potential to affect all 73 residents residing in the facility. IP-J did not complete specialized training for infection prevention and control. Findings include: The facility's Infection Preventionist policy and procedure, last reviewed September 2023, indicates: Specialized Training: 1. The infection preventionist has obtained specialized IPC (infection prevention and control) training beyond initial professional training or education prior to assuming the role, including in the following topics .2. Evidence of training is provided through a certificate(s) of completion or equivalent documentation . On 4/3/24 at 2:39 PM, Surveyor interviewed IP-J who verified IP-J started as the IP in August of 2023 and did not have specialized infection control training. IP-J stated IP-J was informed about the required training on 4/2/24. On 4/3/24 at 2:57 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B was aware of the IP specialized training and stated IP-J and DON-B will complete the Centers for Disease Control and Prevention (CDC) training modules.