STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525266	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Park Nursing and Rehab Center	718 Jupiter Drive Madison, WI 53718

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 3 residents (R1) reviewed for abuse.The facility did not implement their Abuse policy when the facility was made aware R1 was verbally abused by a family member. The facility did not put interventions in place to prevent further abuse, the facility did not report nor investigate the allegation of abuse.This is evidenced by:The facility's policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/21, includes: Residents have the right to be free from abuse. This includes but is not limited to freedom from . verbal.abuse. 1. Protect residents from abuse.by anyone including, but not necessarily limited to: f. family members; 2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents; 8. Identify and investigate all possible incidents of abuse. 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations. R1 admitted to the facility on [DATE]. R1's BIMS (Brief Interview for Mental Status) completed on 10/17/25 has a score of 13, indicating R1 is cognitively intact. On 10/29/25 at 12:30 PM, Surveyor interviewed R4. R4 indicated she had been discharged home and was no longer at the facility. R4 explained on 10/22/25, she heard FM E (Family Member) in R1's room. R4 stated FM E was screaming and using profanity toward R1. R4 indicated it seemed FM E was mad and yelling at R1. R4 had a visitor in her room at the time, RV D (Resident's Visitor). R4 stated hearing the interaction between FM E and R1 was scary and sickening. R4 stated It tore me up to hear the way R1 was being treated. R4 indicated she reported the abuse to SS C (Social Services).On 10/29/25 at 12:35 PM, Surveyor interviewed RV D regarding the interaction between FM E and R1. RV D indicated she was visiting R4 when she heard screaming next door. RV D indicated she left R4's room and was standing outside of R1's room. RV D indicated she saw FM E standing at the foot of R1's bed screaming and yelling. RV D indicated FM E had a hanger in her hand and while she was yelling at R1, FM E threw the hanger across the floor and the hanger hit the wall. RV D stated nobody should be treated that way and she was furious that someone would treat another person like that. RV D stated That's abuse. It was awful. It's elder abuse. I'm glad she not at home with her. RV D indicated SS C came into R4's room and asked about the incident. RV D indicated she told SS C what happened.On 10/29/25 at 10:28 AM, Surveyor interviewed SS C (Social Services) regarding R1 and FM E (Family Member). SS C stated on 10/22/25, R4 and RV D reported the incident to her. SS C stated FM E was yelling and swearing at R1 and FM E threw a hanger against the wall in R1's room. SS C stated she reported this to the previous NHA (Nursing Home Administrator), NHA F. SS C stated she did not talk to R1 regarding the incident because FM E is R1's activated power of attorney and FM E instructed the staff they cannot speak to R1 without FM E being present. SS C indicated FM E visits daily. SS C indicated FM E will go into R1's room and shut the door and when FM E comes out, she appears frustrated. SS C indicated she feels the incident on 10/22/25 is considered abuse and that is why she reported it to NHA F. SS C indicated she is not aware of any plan or interventions the facility has put in place to keep R1 safe and free from further abuse. On 10/29/25 at 10:48, Surveyor interviewed NHA A (Nursing Home Administrator) regarding R1 and FM E. NHA A indicated the interaction on 10/22/25 between R1 and FM E could be considered abuse. NHA A indicated the facility has not interviewed R1 because FM E is R1's activated power of attorney and has to be present for staff to talk with R1. NHA A indicated staff want the residents to be safe and staff are encouraged to report and document any incidents. NHA A indicated staff try to monitor the interactions, but FM E frequently closes the door. NHA A indicated the facility did not implement a plan or any interventions to ensure R1 is kept safe and free from further abuse. NHA A indicated the facility did not report nor do a thorough investigation into this incident. The facility did not implement their written policies and procedures that prohibit and prevent abuse, neglect, and exploitation for R1.

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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 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. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the appropriate agencies for 1 of 1 abuse allegations involving a resident (R1).On 10/22/25, an allegation of verbal abuse toward R1 from a family member was reported to the facility and the facility did not report the allegation of abuse.This is evidenced by:The facility's policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/21, includes: Residents have the right to be free from abuse. This includes but is not limited to freedom from .verbal. abuse. 1. Protect residents from abuse.by anyone including, but not necessarily limited to: f. family members; 2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents; 8. Identify and investigate all possible incidents of abuse. 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations. The facility's policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 9/22, includes: All reports of resident abuse.are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. 1. If resident abuse.is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. R1 admitted to the facility on [DATE]. R1's BIMS (Brief Interview for Mental Status) completed on 10/17/25 has a score of 13, indicating R1 is cognitively intact. On 10/29/25 at 12:30 PM, Surveyor interviewed R4. R4 indicated she had been discharged home and was no longer at the facility. R4 explained on 10/22/25, she heard FM E (Family Member) in R1's room. R4 stated FM E was screaming and using profanity toward R1. R4 indicated it seemed FM E was mad and yelling at R1. R4 had a visitor in her room at the time, RV D (Resident's Visitor). R4 stated hearing the interaction between FM E and R1 was scary and sickening. R4 stated It tore me up to hear the way R1 was being treated. R4 indicated she reported the abuse to SS C (Social Services).On 10/29/25 at 12:35 PM, Surveyor interviewed RV D regarding the interaction between FM E and R1. RV D indicated she was visiting R4 when she heard screaming next door. RV D indicated she left R4's room and was standing outside of R1's room. RV D indicated she saw FM E standing at the foot of R1's bed screaming and yelling. RV D indicated FM E had a hanger in her hand and while she was yelling at R1, FM E threw the hanger across the floor and the hanger hit the wall. RV D stated nobody should be treated that way and she was furious that someone would treat another person like that. RV D stated That's abuse. It was awful. It's elder abuse. I'm glad she not at home with her. RV D indicated SS C came into R4's room and asked about the incident. RV D indicated she told SS C what happened.On 10/29/25 at 10:28 AM, Surveyor interviewed SS C (Social Services) regarding R1 and FM E (Family Member). SS C stated on 10/22/25, R4 and RV D reported the incident to her. SS C stated FM E was yelling and swearing at R1 and FM E threw a hanger against the wall in R1's room. SS C stated she reported this to the previous NHA (Nursing Home Administrator), NHA F. SS C stated she did not talk to R1 regarding the incident because FM E is R1's activated power of attorney and FM E instructed the staff they cannot speak to R1 without FM E being present. SS C indicated FM E visits daily. SS C indicated FM E will go into R1's room and shut the door and when FM E comes out, she appears frustrated. SS C indicated she feels the incident on 10/22/25 is considered abuse and that is why she reported it to NHA F. SS C indicated she is not aware of any plan or interventions the facility has put in place to keep R1 safe and free from further abuse. On 10/29/25 at 10:48, Surveyor interviewed NHA A (Nursing Home Administrator) regarding R1 and FM E. NHA A indicated the interaction on 10/22/25 between R1 and FM E could be considered abuse. NHA A indicated the facility has not interviewed R1 because FM E is R1's activated power of attorney and has to be present for staff to talk with R1. NHA A indicated staff want the residents to be safe and staff are encouraged to report and document any incidents. NHA A indicated staff try to monitor the interactions, but FM E frequently closes the door. NHA A indicated the facility did not implement a plan or any interventions to ensure R1 is kept safe and free from further abuse. NHA A indicated the facility did not report the allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported to the administrator and other officials in accordance with State law through established procedures for 1 of 3 residents (R1) reviewed for abuse.On 10/22/25, an allegation of verbal abuse toward R1 from a family member was reported to the facility and the facility did not thoroughly investigate the allegation of abuse.This is evidenced by:The facility's policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/21, includes: Residents have the right to be free from abuse. This includes but is not limited to freedom from .verbal.abuse. 1. Protect residents from abuse.by anyone including, but not necessarily limited to: f. family members; 2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents; 8. Identify and investigate all possible incidents of abuse. 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations.The facility's policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 9/22, includes: All reports of resident abuse.are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations. 5. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. 7. The individual conducting the investigation as a minimum: d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident. l. documents the investigation completely and thoroughly. Witness statements are obtained in writing, signed and dated.R1 admitted to the facility on [DATE].R1's BIMS (Brief Interview for Mental Status) completed on 10/17/25 has a score of 13, indicating R1 is cognitively intact.On 10/29/25 at 12:30 PM, Surveyor interviewed R4. R4 indicated she had been discharged home and was no longer at the facility. R4 explained on 10/22/25, she heard FM E (Family Member) in R1's room. R4 stated FM E was screaming and using profanity toward R1. R4 indicated it seemed FM E was mad and yelling at R1. R4 had a visitor in her room at the time, RV D (Resident's Visitor). R4 stated hearing the interaction between FM E and R1 was scary and sickening. R4 stated It tore me up to hear the way R1 was being treated. R4 indicated she reported the abuse to SS C (Social Services).On 10/29/25 at 12:35 PM, Surveyor interviewed RV D regarding the interaction between FM E and R1. RV D indicated she was visiting R4 when she heard screaming next door. RV D indicated she left R4's room and was standing outside of R1's room. RV D indicated she saw FM E standing at the foot of R1's bed screaming and yelling. RV D indicated FM E had a hanger in her hand and while she was yelling at R1, FM E threw the hanger across the floor and the hanger hit the wall. RV D stated nobody should be treated that way and she was furious that someone would treat another person like that. RV D stated That's abuse. It was awful. It's elder abuse. I'm glad she not at home with her. RV D indicated SS C came into R4's room and asked about the incident. RV D indicated she told SS C what happened.On 10/29/25 at 10:28 AM, Surveyor interviewed SS C (Social Services) regarding R1 and FM E (Family Member). SS C stated on 10/22/25, R4 and RV D reported the incident to her. SS C stated FM E was yelling and swearing at R1 and FM E threw a hanger against the wall in R1's room. SS C stated she reported this to the previous NHA (Nursing Home Administrator), NHA F. SS C stated she did not talk to R1 regarding the incident because FM E is R1's activated power of attorney and FM E instructed the staff they cannot speak to R1 without FM E being present. SS C indicated FM E visits daily. SS C indicated FM E will go into R1's room and shut the door and when FM E comes out, she appears frustrated. SS C indicated she feels the incident on 10/22/25 is considered abuse and that is why she reported it to NHA F. SS C indicated she is not aware of any plan or interventions the facility has put in place to keep R1 safe and free from further abuse.On 10/29/25 at 10:48, Surveyor interviewed NHA A (Nursing Home Administrator) regarding R1 and FM E. NHA A indicated the interaction on 10/22/25 between R1 and FM E could be considered abuse. NHA A indicated the facility has not interviewed R1 because FM E is R1's activated power of attorney and has to be present for staff to talk with R1. NHA A indicated staff want the residents to be safe and staff are encouraged to report and document any incidents. NHA A indicated staff try to monitor the interactions, but FM E frequently closes the door. NHA A indicated the facility did not implement a plan or any interventions to ensure R1 is kept safe and free from further abuse. NHA A indicated the facility did not