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	05/14/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident received the necessary care and services in accordance with professional standards of practice to meet each resident's physical needs for 1 of 5 sampled residents (R1).R1's surgical dressing was not monitored or assessed. R1's surgical wound was not care planned.This is evidenced by:The facility's policy Acute Condition Changes - Clinical Protocol, dated 3/18, includes: 5. The physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complications. 1. The staff will monitor and document the resident/patient's progress and responses to treatment.The facility's policy Charting and Documentation, dated 7/17, includes: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. 2. The following information is to be documented in the resident medical record: a. Objective observations; c. Treatments or services performed. 7. Documentation of procedures and treatments will include care-specific details, including: c. the assessment data.R1 admitted to the facility on [DATE] with a diagnosis of pain in left hip after a fall at home. R1 was sent to the emergency room for an evaluation of pain in his left hip on 3/17/26. R1 was hospitalized until 3/23/26.R1 was readmitted to the facility on [DATE] with diagnosis of fracture of left hip.R1's hospital discharge instructions, dated [DATE], includes: Procedure: ORIF (Open Reduction and Internal Fixation, a surgical intervention to fix R1's left hip fracture) 3/18/26. Leave Dressing on - Keep it clean, dry and intact until clinic visit.R1's Admit/Readmit Screener, dated 3/23/36, includes: C. Skin Integrity site: left external hip. Type: Surgical Incision. Comments: Left surgical hip incision covered with grey hydrocolloid dressing.R1's physician orders, printed 5/14/26, does not have an order for R1's left hip surgical site until 4/20/26.On 4/20/26, R1's physician order states monitor left hip dressing each shift for drainage, shadowing, rolling or pealing [sic] edges.Of note, R1's hospital discharge orders to Leave Dressing on - Keep it clean, dry and intact until clinic visit was not entered into R1's physician orders.R1's comprehensive care plan, printed 5/14/26, does not address R1's left hip surgical site until 4/20/26.R1's March Treatment Administration Record (TAR) does not address R1's left hip surgical site.R1's April TAR does not address R1's left hip surgical site until 4/20/26.On 4/20/26, R1's TAR includes monitor left hip dressing each shift for drainage, shadowing, rolling or pealing [sic] edges.R1's nurse progress notes do not include an assessment or monitoring of R1's left hip surgical site.On 5/14/26 at 10:07 AM, Surveyor interviewed RN N (Registered Nurse). RN N indicated wound care and dressing orders should be entered into the resident's physician orders and would show up on the TAR. RN N indicated if a resident had an order to leave the dressing intact, a nurse would assess for swelling, redness, signs of infection and assess around the wound. RN N indicated the nurse would document the assessment in a progress note.On 5/14/26 at 10:13 AM, Surveyor interviewed RN O (Registered Nurse). RN O indicated wound care orders are placed on the resident's TAR. RN O indicated if a resident had an order to keep the dressing in place, the nurse would assess for infection and monitor the dressing.On 5/14/26 at 10:18 AM, Surveyor interviewed RN F (Registered Nurse). RN (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F indicated the nurse should be monitoring R1's left hip surgical site dressing every shift. RN F indicated the nurse should enter a progress note into R1's medical record detailing the assessment. RN F indicated a resident's care plan should reflect treatments that are ordered. RN F indicated R1's care plan should have been updated.On 5/14/26 at 1:26 PM, Surveyor interviewed DON B (Director of Nursing) regarding R1's left hip surgical site and dressing. DON B indicated R1's hospital discharge order to Leave Dressing on - Keep it clean, dry and intact until clinic visit should have been entered into R1's physician orders. DON B indicated the order should have been on R1's TAR. DON B indicated the nurses should have been monitoring the site daily, if not every shift, and should have documented the findings in R1's medical record. DON B indicated R1's care plan should have been updated to reflect R1's left hip surgical site.