

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525472	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2025
NAME OF PROVIDER OR SUPPLIER  Oakbrook Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  206 W Prospect St Thorp, WI 54771	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff for 1 of 32 residents (R) reviewed for abuse (R2).</p> <p>Registered Nurse (RN) C verbally abused R2 by yelling and swearing at R2 while wheeling R2 down the hallway in the wheelchair. Facility did not ensure interventions were in place to ensure verbal abuse did not occur to nonverbal, vulnerable residents.</p> <p>This is evidenced by:</p> <p>Facility's policy titled Facility policy titled: Resident Safety Abuse policy, dated 2/22, states in part, under Section titled Protocol: states in part, 2. Application (a) the policy is regarding resident safety has application in the manner in which: .v. The staff members are supervised.</p> <p>R2 was admitted to the facility on [DATE] with diagnoses that include dementia and aphasia.</p> <p>R2's most recent [NAME] Data Set (MDS) assessment dated [DATE] indicated that R2 has both short and long-term memory problems and is severely impaired cognitively.</p> <p>Facility reported incident submitted to state agency on 05/29/25 stating: Staff reported that RN C yelled at R2 well god damn it pick your feet up. Staff reported that RN C has seemed to be impatient and anxious recently. Also reporting the RN seems to appear like is in a hurry. RN C stated, I was not as nice as I should have been. RN C also admitted that sleep schedule is off and has been very tired. RN C also stated needs to ask for assistance sometimes.</p> <p>On 06/13/25 at 10:15 AM, Surveyor requested information on how the facility plans to prevent further abuse from occurring. Surveyor received a sheet of paper that stated the following:</p> <p>On 05/24/25: RN C suspended.</p> <p>On 05/28/25: RN C completed education and was able to return to work. (Of note, Surveyor was given certificates of education provided to RN C to include stress management, abuse, and dementia care. RN C returned to 2nd shift duty on this date with no evidence of increased supervision provided during the shift.)</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/29/25: Chatted with a few residents. No issues yesterday evening. (Of note, R2 is not interviewable and unable to report issues.)</p> <p>On 06/09/25: Watched RN C good interactions. (Of note: no details of what was observed or if potential residents at risk were observed.)</p> <p>On 06/12/25: Touched base with RN C, feels is doing good. There have been no other issues. Has been observed many times with positive interactions with residents. RN C completed additional education as directed.</p> <p>After reviewing the above mentioned audit notes regarding RN C, the facility did not do the following:</p> <ul style="list-style-type: none"> <li>-Audit notes did not state what residents were spoken to or what questions the residents were asked.</li> <li>-Audit notes did not state what was observed with RN C having good interactions. Facility did not state if potential residents at risk were observed.</li> <li>-Audit notes stated they touched base with RN C and feels is doing good. Facility did not show evidence that this comment would ensure residents will be free from verbal abuse.</li> <li>-Audit notes did not state specifics in detail as to how the facility will ensure abuse will not reoccur for vulnerable residents who are unable to speak for themselves.</li> </ul> <p>No resident or staff have reported any negative interactions.(Of note: undated and no further interviews conducted.)</p> <p>Facility documentation shows three staff members who were interviewed at the time of the investigation stated, [RN C] is kind of short with the residents, Just stay out of [RN C's] way she is a tornado just on a mission, and [RN C] is not always patient. Three staff members stated [RN C] is in a hurry always, I would not say she is mean, but not nice either.</p> <p>On 06/13/25 at 11:58 AM, Surveyor interviewed DON B who was unable to provide any further information as to how they are monitoring the behaviors of nonverbal residents for abuse and what the facility has in place to prevent abuse from occurring for the nonverbal residents who can't speak for themselves.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did not ensure a thorough investigation was conducted of a staff to resident verbal abuse.</p> <p>The facility did not conduct a thorough investigation to ensure other residents have not been affected by abuse or have knowledge to prevent further potential abuse by Registered Nurse (RN) C for 1 of 32 residents (R2).</p> <p>Findings include:</p> <p>Facility policy titled: Resident Safety Abuse policy, dated 2/22, states in part, under Section 9. Procedure for Investigation: a. All alleged violations will be thoroughly investigated, and all investigations are conducted by or coordinated through facility administration.m. The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>R2 was admitted to the facility on [DATE] with diagnoses that include dementia and aphasia.</p> <p>R2's most recent [NAME] Data Set (MDS) assessment dated [DATE] indicated that R2 has both short and long-term memory problems and is severely impaired cognitively.</p> <p>The facility reported incident submitted to state agency on 05/29/25 stating: Staff reported Registered Nurse (RN) C yelled at R2 Well god damn it pick your feet up. Staff reported RN C has seemed to be impatient and anxious recently. Also reporting the RN C seems to appear like she is in a hurry. RN C stated, I was not as nice as I should have been. RN C also admitted her sleep schedule is off, and she has been very tired. RN C also stated she needs to ask for assistance sometimes.</p> <p>The facility started an investigation immediately suspending RN C. The facility interviewed the staff witness and 3 additional staff members. R2 was non-interviewable, and the facility completed 3 resident interviews from the building.</p> <p>The investigation had no evidence of interviews with other residents that reside in the facility or staff to ensure they were not subjected to verbal abuse by RN C.</p> <p>On 06/13/25 at 10:15 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding the lack of interviews with other residents and staff members, NHA A stated, That's all I had written down.</p> <p>On 06/13/25 at 11:58 AM, Surveyor interviewed Director of Nursing (DON) B regarding RN C's probability of having contact with all residents in the building. DON B stated RN C could have contact with all residents in the facility during a shift.</p> <p>Surveyor interviewed DON B regarding the statements made by the 3 staff members at time of investigation, stating [RN C] is kind of short with the residents, Just stay out of [RN C's] way she is a tornado just on a mission, and [RN C] is not always patient. Three staff members stated [RN C] is in a hurry always, I would not say she is mean, but not nice either. Surveyor asked if this would be an indication to investigate further. Director of Nursing (DON) B stated, I see what you mean,</p>		