

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  11/10/2025
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)
F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review, and facility document and policy review, the facility failed to protect Resident #3's right to be free from repetitive verbal and mental abuse perpetrated by another resident (Resident #1). Specifically, Resident #1 yelled at their roommate, Resident #3, to shut up, shut their mouth, or stop talking on multiple occasions. This deficient practice affected 1 of 13 sampled residents. Findings included: A facility policy titled, Resident Safety Abuse Policy, revised 02/2022, specified, Residents have the right to be free from abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, visitors, friends, or other individuals. The policy also indicated, b. Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability, and e. Mental Abuse includes but is not limited to humiliation, harassment, and threats of punishment or deprivation. A Face Sheet revealed the facility admitted Resident #1 on 06/25/2025 and readmitted the resident to the facility on [DATE]. According to the Face Sheet, the resident had a medical history that included diagnoses of unspecified dementia with other behavioral disturbance and generalized anxiety disorder. A Face Sheet for Resident #1's 07/24/2025 readmission revealed the resident was discharged from the facility on 09/03/2025. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/02/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #1 exhibited verbal behavioral symptoms directed toward others during one to three days of the seven-day assessment look-back period that significantly disrupted care or the living environment for others at the facility. A Face Sheet indicated the facility admitted Resident #3 on 10/12/2022. According to the Face Sheet, the resident had a medical history that included a diagnosis of other symptoms and signs involving cognitive functions and awareness. An annual MDS, with an ARD of 07/25/2025, revealed Resident #3 had a BIMS score of 6, which indicated the resident had severe cognitive impairment. Resident #3's Care Plan included a problem area, dated 09/24/2025, that indicated the resident had a potential for alteration in thought processes. Interventions instructed staff to approach the resident in a quiet calm manner, dated 07/31/2025. Review of Resident #1's and Resident #3's medical records revealed they were roommates during Resident #1's stay at the facility. Resident #1's progress notes revealed an entry dated 08/12/2025 at 11:12 PM that indicated Resident #1 began yelling that they wanted a roommate, because they were scared. The note indicated a certified nursing assistant (CNA) positioned Resident #1's roommate (Resident #3) in the doorway of their room so Resident #1 could see them, but Resident #1 began yelling at their roommate, Get out of here. The note indicated the CNA removed the roommate, and Resident #1 stated they did not want the roommate in their room because the roommate talked all night. Resident #1's progress notes revealed an entry dated 08/13/2025 at 5:52 AM that indicated Resident #1 yelled out several times at [his/her] roommate to 'shut up' and was reminded that it was not nice to yell at their roommate. The facility's 24-Hour Report Sheet, dated 08/13/2025, indicated Resident #1 was yelling at their roommate. Resident #1's progress notes revealed an entry dated 08/17/2025 at 11:13 PM that indicated Resident #1 became loud and disruptive at bedtime, yelling and screaming out to their roommate to Shut up and Shut your mouth. Resident #1's progress notes revealed an entry dated 08/22/2025 at 5:33 AM that indicated Resident #1 continued to yell Shut up at their roommate because the roommate was talking. The note indicated Resident #1 did not like their roommate talking and continued to yell out. Resident #1's progress notes revealed an entry dated 08/22/2025 at 9:39 PM that indicated Resident #1 was continuously using the call light and complained of their roommate talking in their sleep. According to the note, Resident #1's roommate was quietly talking in their sleep, and Resident #1 was angry that their roommate did not stop talking. The facility's 24-Hour Report Sheet, dated 08/22/2025, indicated Resident #1 was yelling at their roommate. Resident #1's progress notes revealed an entry dated 08/26/2025 at 6:38 AM that indicated Resident #1 yelled at their roommate throughout the shift, Shut up and Stop talking. The note indicated Resident #1 was educated that it was not appropriate to yell at people and that others were trying to sleep. The note indicated Resident #1 stated, I don't care, I can't sleep with [the roommate] talking. The note indicated that staff had not heard the roommate talking. The facility's 24-Hour Report Sheet, dated 08/26/2025, indicated Resident #1 was yelling at their roommate, who was not talking. Resident #1's</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review, and facility document and policy review, the facility failed to ensure a care plan was developed to address ongoing verbal behavioral symptoms directed toward others for 1 (Resident #1) of 13 sampled residents. Findings included: A facility policy titled, Resident Assessment Instrument and Person-Centered Care Planning, revised 06/2024, indicated, iii. The comprehensive care plan will be developed to ensure the resident receives the desired care and services to attain or maintain their highest practicable physical, mental and psychosocial well-being. The policy also indicated, vi. The care plan will be revised as often as necessary to ensure that it provides an accurate depiction of the care of the resident, IDT [Interdisciplinary Team] members should evaluate the appropriateness of the care plan after each quarterly, annual and significant change assessment and modify the care plan on an ongoing basis as appropriate. The policy also indicated, The care plan is an evolving document that is updated continuously as care needs change and fluctuate. A Face Sheet revealed the facility admitted Resident #1 on 06/25/2025 and readmitted the resident to the facility on [DATE]. According to the Face Sheet, the resident had a medical history that included diagnoses of unspecified dementia with other behavioral disturbance and generalized anxiety disorder. A Face Sheet for Resident #1's 07/24/2025 readmission revealed the resident was discharged from the facility on 09/03/2025. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/02/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #1 exhibited verbal behavioral symptoms directed toward others during one to three days of the seven-day assessment look-back period that significantly disrupted care or the living environment for others at the facility. Section V Care Area Assessment (CAA) Summary of the MDS revealed the Care Area of Behavioral Symptoms was checked to indicate the Care Area triggered for care plan decision making. Resident #1's progress notes revealed an entry dated 07/01/2025 at 9:36 PM that indicated Resident #1 has been yelling out for staff to call their spouse because they were lonely, the power of attorney (POA) was called, and the resident said they wanted a roommate. Resident #1's progress notes revealed an entry dated 07/26/2025 at 9:17 PM that indicated Resident #1 yelled out quite a bit during the shift to call their spouse; a family member was called and came to the facility; the spouse came to the facility; and the resident repeatedly asked when a family member would come. Resident #1's progress notes revealed an entry dated 07/27/2025 at 6:26 PM that indicated Resident #1 yelled out for staff to call their spouse, and after speaking to their spouse on the phone, Resident #1 kept yelling and upset other residents in the television (TV) room. Resident #1's progress notes revealed an entry dated 08/06/2025 at 7:32 PM that indicated Resident #1 yelled out, repeated statements, and was not easily redirected. Resident #1's progress notes revealed an entry dated 08/10/2025 at 11:37 AM that indicated Resident #1 yelled out feed me very loudly over and over, was assured someone would assist them, but continued to yell until they were fed. Resident #1's progress notes revealed an entry dated 08/12/2025 at 11:12 PM that indicated Resident #1 began yelling that they wanted a roommate, because they were scared. The note indicated a certified nursing assistant (CNA) positioned Resident #1's roommate in the doorway of their room so Resident #1 could see them, but Resident #1 began yelling at their roommate, Get out of here. The note indicated the CNA removed the roommate, and Resident #1 stated they did not want the roommate in their room because the roommate talked all night. Resident #1's progress notes revealed an entry dated 08/13/2025 at 5:52 AM that indicated Resident #1 yelled out several times at [his/her] roommate to 'shut up' and was reminded that it was not nice to yell at their roommate. Resident #1's progress notes revealed an entry dated 08/17/2025 at 11:13 PM that indicated Resident #1 became loud and disruptive at bedtime, yelling and screaming out to their roommate to Shut up and Shut your mouth. Resident #1's progress notes revealed an entry dated 08/22/2025 at 5:33 AM that indicated Resident #1 continued to yell Shut up at their roommate because the roommate was talking. The note indicated Resident #1 did not like their roommate talking and continued to yell out. Resident #1's progress notes revealed an entry dated 08/24/2025 at 09:29 AM that indicated Resident #1 was yelling, being disruptive, and interfering with other residents' abilities to sleep. The progress note revealed Resident #1 stated they did not feel well, but refused to take their medications. The progress note revealed the facility called a family member to come to the facility to manage [Resident #1's] behaviors. Resident #1's progress notes revealed an entry dated 08/26/2025 at 6:38 AM that indicated Resident #1 yelled at their roommate</p>		