

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  03/10/2026
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility did not implement policies and procedures for ensuring the reporting of physical abuse in accordance with section 1150B of the Act when an allegation of physical abuse was not reported immediately, but no later than 2 hours to the State Agency and local law enforcement in accordance with state law through established procedures for 1 of 3 residents (R) reviewed (R1). On 02/03/26, the facility was made aware of R1's allegation of abuse. The facility did not report this allegation to State Agency (SA) or to local law enforcement within 2 hours. This is evidenced by: Facility policy titled, Resident safety Abuse Policy, with reviewed date of 03/24, states in part: 8. Reporting Suspected Violations: .e. All facility staff members shall ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the administrator and the administrator will ensure reporting to other officials (including to the State Survey Agency and adult protective services where state law provides jurisdiction in long-term care facilities). 9. Procedure For Investigation: . g. An employee suspected of violation of the Resident Safety Abuse Policy or Social media Policy may be suspended pending investigation. Example 1R1 was admitted to the facility on [DATE] diagnoses of degeneration of nervous system due to alcohol, convulsions, hepatic failure, altered mental status, major depressive disorder, anxiety disorder, thiamine deficiency, and cerebrovascular disease. R1's progress notes documented on 02/03/26 at 9:38 PM stated, Grabbing staff/shouting threats at staff: pt (patient) put room light on, CNA (Certified Nursing Assistant) and this nurse responded. [R1] was sitting in [R1's] wheelchair with lower half of body/penis exposed. [R1] was asked to cover himself up. [R1] shouted, you sure you don't want some of this! This nurse put a folded blanket over exposed genitals. Pt stated things were missing out of [R1's] room but was not able to state what was missing. [R1] jumped up out of [R1's] wheelchair to standing, [R1] pushed this nurse and grabbed my left arm. I told [R1] to sit back down in [R1's] wheelchair before [R1] fell and to back up. [R1] then lunged at the CNA. [R1] was again told to back up and sit down. [R1] stood face to face to me. I told [R1] again to back up. Many dirty cups and dishes were then removed from [R1's] room. [R1] attempted to block the exit from his room and again lunged at this nurse and the CNA. [R1] was again told to back up and sit down. [R1] shouted the [R1] would get me and see that I was taken care of. Staff left [R1's] room and [R1] followed us out in to the hall. [R1] again, was face to face with me. [R1] was told to back up. [R1] shouted, call the cops! I know you already have before! 9:05 PM: [R1] came up to Nursing Station, jumped out of the wheelchair and shouted, she threatened me! she came at my throat! I want the cops called on her! She threatened me! She came at me! Multiple attempts by staff to find out what the missing items were. Shouting R1 wants cops called, (Name) Admin (Nursing Home Administrator (NHA A) was called and arrived. The facility did not contact the local law enforcement. The facility did not submit within 2 hours a Facility Reported Incident (FRI) concerning allegation of abuse to the State Agency. The FRI documented the Report submitted date of 2/4/2026 6:47:28 PM On 3/10/26 at 1:26 PM, Surveyor (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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>interviewed NHA A regarding incident. NHA A stated R1's allegation was considered abuse, and the FR1 was sent the next day. R1 was interviewed right away that night. When R1 was interviewed, R1 stated no one had hit R1. R1 likes it here, and R1 was upset about R1's shower. NHA A stated R1 will state what staff had done to R1 and in actuality this is what R1 had done to staff. NHA A stated felt this allegation did not occur and Licensed Practical Nurse (LPN) C continued to work, and local law enforcement was not called. The full investigation was completed the next day. Surveyor asked if NHA A had followed the facility's policy for reporting to SA and law enforcement within 2 hours. NHA A stated no, because the allegation did not occur. Surveyor asked how NHA A determined LPN C is not abusive to residents if the investigation was not completed until the next day on 02/04/26 when interviews with residents and staff were completed. NHA A stated the other interviews were completed on 02/04/26.</p>		