STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525472	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakbrook Health and Rehabilitation	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections which has the potential to affect all 39 residents.-R44 has open wounds with no Enhanced Barrier Precautions (EBP) in place.-RN I returned to work too soon after illness.-Inappropriate hand washing/gloving during cares (R2).Example 1 The facility protocol titled, Infection Prevention and Control Program, last revised 01/26, reads in part: During an infectious disease outbreak, facility staff along the with medical director will follow prevailing infectious disease protocol at the time-as directed by local or state health agencies or the Centers for Disease Control and Prevention (CDC).Enhanced Barrier Precautions (EBP) are applied for a group of CDC-targeted.for any long-term residents with wounds or indwelling medical devices.Antibiotic prescribing will include documentation of the dose, duration (start date, end date, and planned days of therapy) .for every course of antibiotics. Facility policy titled, Standard and Transmission-Based Precautions, last revised 02/24, reads in part: Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a contaminated body site like the perineal area to a clean body site like the face).Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of resident organisms that employs targeted gown and glove use during high contact resident care activities. They are indicated for residents with.wounds or indwelling devices. R44 was admitted to the facility on [DATE]. R44's care plan includes in part: Problem of potential for impaired skin integrity with approach of perform weekly skin assessment on scheduled bath/shower day and as needed. Weekly wound measurements to be performed by wound care nurse (01/16/26). R44's care plan includes in part: Problem of impairment of skin integrity-ulcer present to left lateral calf with an approach of change bandages as ordered (01/28/26), which was added after Surveyors entered the facility for survey. On 01/27/26 at 2:13 PM, Surveyor interviewed R44. R44 stated when R44 admitted to the facility, R44's skin was intact but did have a history of pressure ulcers and other wounds. R44 stated now there was an open area to the left lower leg that was currently draining. Surveyor observed no EBP signage or PPE present for R44's room. On 01/28/26 at 2:33 PM, Surveyor interviewed Certified Nursing Assistant (CNA) G. CNA G stated CNAs know which residents require precautions because of the signs on/near the resident's door and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the Personal Protective Equipment (PPE) hanging on the door. CNA G stated the nurses, nurse managers, or Director of Nursing (DON) are the staff responsible for hanging the PPE and signs. On 01/28/26 at 2:40 PM, Surveyor interviewed Registered Nurse (RN) H. RN H stated after assessing a resident for precautions, RN H would hang signs outside the door if warranted. RN H stated it would be appropriate for EBP if a resident had wounds, catheters, and infections such as upper COVID or Clostridium Difficile (C-Diff). RN H stated the Infection Control Nurse would let nurses know if they find it is warranted first and let nursing know. On 01/29/26 at 7:03 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated it would be appropriate to place a resident on EBP for lines that enter into a resident's body, tube feeding, Foley catheter, and open wounds. Surveyor spoke with DON B regarding R44's open wounds and no EBP in place. DON B acknowledged. Example 2 The CDC online article titled, Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, dated 03/18/2024, reads in part: Healthcare Personnel (HCP) with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and at least 24 hours have passed since last fever without the use of fever-reducing medications, and Symptoms (e.g., cough, shortness of breath) have improved. Either a Nucleic acid amplification test (NAAT) (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later. Test-based strategy: HCP who are symptomatic could return to work after the following criteria are met: resolution of fever without the use of fever-reducing medications, and improvement in symptoms (e.g., cough, shortness of breath), and results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT. HCP who are not symptomatic could return to work after the following criteria are met: results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT. Surveyor reviewed the infection line list for residents and staff. RN I's name appears on the line list. The line list indicates RN I was positive for Influenza and had a date of illness onset of 01/01/26. Symptoms listed include runny nose and sneezing. The line list indicates a rapid COVID test was performed and was positive. The line list indicates symptoms starting on 01/01/26 and ending on 01/05/26. One negative COVID test was performed on 01/08/26. RN I returned to work on 01/09/26 without the second negative test 48 hours after the first. On 01/29/26 at 7:03 AM, Surveyor interviewed DON B with Chief Nursing Officer (CNO) F present. DON B stated the date of onset of symptoms is day 0. DON B stated if the staff member is negative for COVID, they can return 24 hours after symptom free for 24 hours with no medication. CNO F stated if a staff member is positive for COVID, test them in on day 5-7 and if negative, they can return on day 8. CNO F stated they do not always have the staff come in for 2 tests 48 hours apart as most of them live further away and it is not always easy getting them to come to the facility for 1 test. On 01/29/26 at 9:47 AM, Surveyor interviewed DON B. Surveyor viewed guidelines on CDC website (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with DON B, pointing out where 2 negative antigen tests were required before staff return to work after a positive COVID test. DON B stated DON B would update Surveyor if DON B found any other information to dispute this information. No further information was provided to Surveyor at this time. On 02/02/26, Nursing Home Administrator (NHA) A submitted additional information to Surveyor. A new line list was submitted with the date of illness onset changed to 01/01/26. A print timecard dialog indicated RN I worked from 5:58 AM to 10:05 AM and 10:33 AM to 3:31 PM on 01/01/26. The timecard indicates RN I worked from 5:57 AM to 6:18 AM on 01/02/26 which does not correlate with a positive test on 01/01/26. Example 3 Facility's policy titled Standard and Transmission-Based Precautions revised date of 02/24 read in part, Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (i.e. when moving from a contaminated body site like the perineal area to a clean body site like the face). f. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces. On 01/28/2026 at 9:10 AM, Surveyor observed Certified Nursing Assistant (CNA) C and CNA J provide R2 with personal care. R2 is on enhanced barrier precautions. CNA C applied a gown and gloves and entered R2's room. CNA C gathered R2's clothes. CNA C placed a clean washcloth in the bottom of the sink and ran water over the washcloth. CNA C did not use a basin in the sink for washing R2. CNA C took the washcloth from the bottom of the sink and applied bar soap to the washcloth. CNA C washed R2's peri area with the contaminated washcloth. CNA C and CNA J rolled R2 to the left, and CNA C used the same washcloth and washed buttocks and anal area. CNA C did not rinse the peri area and buttocks. CNA C dried the buttocks and applied a clean brief. CNA C did not remove gloves and continued to provide care to R2. CNA C placed a clean washcloth in the bottom of the sink and ran water over the washcloth. CNA C put bar soap on the washcloth and washed R2's right hand and applied hand brace. Surveyor observed R2's hand brace appeared to be soiled on the palm portion of the brace. CNA C and CNA J transferred R2 to wheelchair using the Hoyer lift. While transferring, R2's left hand held onto the Hoyer lift cross bar. Surveyor observed the protective cover of the Hoyer lift cross bar appeared to be soiled. CNA C, with the same contaminated gloved hands, wet a toothette and squeezed the toothette with contaminated gloved hands and gave the toothette to R2 to cleanse mouth. CNA C, with the same contaminated gloved hands, got another toothette and squeezed the toothette with the same contaminated gloved hands. CNA C placed a washcloth in bottom of the sink and let the water run over the washcloth. CNA C, with the same contaminated gloves, took the wet washcloth and washed R2's face. CNA J wiped the Hoyer lift with sanitizing wipes and did not cleanse the protective cover of the cross bar. Surveyor interviewed CNA C and CNA J asking when R2's hand brace is cleaned. CNA C and CNA J did not know when the brace was to be cleaned. Surveyor asked if the cover of the cross bar gets cleaned or laundered. CNA J stated it looks a little dirty and did not know if there is a replacement or when the protective cover gets cleaned. On 01/29/2026 at 11:20 AM, Surveyor interviewed Director of Nursing (DON) B about expectation during personal cares for R2. Surveyor reviewed with DON B of the observation with CNA C providing R2 personal cares. DON B stated this is not the expectation of care being provided. Education will be provided for staff. DON B stated a basin should have been used and the washcloths not put in the sink. After washing the peri area with bar soap, the area should have been rinsed. Gloves should be changed. Toothette should not have been touched with the contaminated gloved hands.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the accuracy of assessment related to Minimum Data Set (MDS) for 1 of 1 resident reviewed (R1).R1 had a Preadmission Screening and Resident Review (PASARR) 1 and 2 completed, which the MDS assessment did not reflect.R1 was admitted to the facility on [DATE].Surveyor reviewed R1's health record. PASARR 1 was completed upon admission dated 03/01/24. PASARR 2 was completed on 03/13/24.Surveyor reviewed R1's MDS assessments. The annual MDS on 03/01/24 indicated R1 did not have a PASARR 1 completed. A correction was made to reflect that R1 did in fact have both PASARR 1 and 2 completed.Upon further review, the MDS assessments completed after the correction had the previous information stating R1 did not have either PASARR completed.On 01/28/26 at 2:46 PM, Surveyor interviewed Social Worker (SW) D. SW D stated PASARR level 1's are completed upon admission and if the resident will be there 30 days or less, SW D would send the information to the county. SW D stated if the resident would be there longer than 30 days, the PASARR 2 will be submitted right away. SW D stated SW D updates the MDS all the time when changes occur. Surveyor showed SW D where the MDS assessments indicated no PASARRs were completed. SW D stated SW D would look into it.On 01/28/26 at 3:05 PM, Surveyor interviewed Clinical and Quality Consultant (CQC) E. CQC E stated there may be a glitch in the system that is pulling the old information from the MDS. CQC E stated there was a nurse working at the time that may have changed the information on the MDS back to the original information, but that nurse no longer worked there. CQC E stated CQC E stated it may not help at this time, but the facility would be working on fixing the issue so it would not continue to occur.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure to follow their antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 1 of 1 resident (R36) reviewed. This is evidenced by:Facility's policy titled Infection Prevention and Control Program revised date of 08/25 documented in part. 9. Antibiotic Stewardship. A. The facility follows the current CDC guidelines for Preventing Antimicrobial Resistance among Long-Term Care Facility Residents and has adopted facility-specific protocols (i.e. see Urinary Tract Infection Protocol) for certain high antibiotic-use infections. B. Additional antibiotic use protocols and systems to monitor antibiotic use: i. Antibiotic prescribing will include documentation of the dose (including route), duration (i.e. start date, end date and planned days of therapy, and indication, which includes both rationale (i.e. prophylaxis vs therapeutic) and treatment site (i.e. respiratory tract, urinary tract) for every course of antibiotics.R36 was admitted to the facility on [DATE]. R36's current diagnoses include enterocolitis due to clostridium difficile, pneumonitis due to inhalation of food and vomit, and immune thrombocytopenic purpura.R36's physician orders documented on 01/13/26 Doxycycline Hyclate 50 mg daily for bacterial infection and Valtrex (valacyclovir HCL) 1 GM tablet dose ordered: (1 tablet) by mouth daily AM FOR: Varicella Zoster Infection Therapeutic goal: decrease vital symptoms. Note, the orders did not document an end date of use for both medications and rationale for continued use. Review of R36's hospital discharge orders documented on 01/13/26 order for doxycycline 50 mg daily for meibomian gland dysfunction. With no end date.Review of the facility's antibiotic stewardship line lists did not document R36 being prescribed antibiotics of doxycycline and Valtrex.On 01/29/2026 at 8:53 AM, Surveyor interviewed Director of Nursing (DON) B asking if R36's use of doxycycline and reason for use should be listed on the facility's antibiotic stewardship infection control line list. DON B stated anyone on an antibiotic is to be on the line list. On 01/29/2026 at 9:50 AM, Surveyor interviewed DON B asking if R36 should be listed on the antibiotic stewardship infection control line list for Valtrex and reason for use. DON B stated this must have been missed. On 01/29/2026 at 11:50 AM, Surveyor interviewed DON B about Valtrex for a stop date. DON B stated had just found the diagnosis listed for Valtrex was incorrect. Surveyor asked if the information about the end date and reasons for both antibiotics should have been verified at the time of admission. DON B stated this information should have been found out at the time of admission.