STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Village East Health and Rehab Center	5833 American Parkway 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 12Number of residents cited:1Based on record review and interview, the facility failed to ensure resident's advanced directives were accurate and up to date in the resident's electronic medical records for 1 of 12 residents (R20) reviewed for advanced directives.R20's CPR (Cardiopulmonary Resuscitation) preference form indicated he wanted CPR attempts and R20's electronic medical record reflected he was a DNR (Do Not Resuscitate).This is evidenced by:The facility's policy titled Advance Directives, dated 9/22, includes the following: The resident has the right to formulate an advance directive. 2. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff. The director of nursing services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record and plan of care. The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident medical record and care plan.R20 admitted to the facility on [DATE].R20's Resident CPR Preference Form states in part: Yes I want cardiopulmonary resuscitation (CPR) attempts. In the even that my heart and breathing should suddenly stop, I elect to have the facility staff to apply force to my chest with their hands, thus compressing the heart (chest compressions) and breathe into my mouth, filling my lungs with air (artificial respiration). The form was signed on [DATE] by R20 and a facility RN (Registered Nurse).On [DATE] at 3:29 PM, Surveyor spoke with RN L regarding R20's advance directives. RN L indicated R20's resident CPR preference form states R20 is a full code (wants CPR) and R20's electronic medical record indicated R20 is a DNR. RN L stated this was a discrepancy and indicated the resident's CPR preference should be reflected in the resident's electronic medical record.R20's physician orders printed on [DATE] include: DNR (Do Not Resuscitate). Order date [DATE]. Discontinue on [DATE].Of note, the DNR physician order was discontinued after Surveyor made staff aware of the discrepancy between the physician order and the resident CPR preference form.On [DATE] at 3:30 PM, Surveyor interviewed LPN K (Licensed Practical Nurse) regarding residents' advance directives. LPN K indicated a resident's code status is in the electronic health record and in the resident's hard chart. LPN K indicated the hard chart and electronic health record should match.On [DATE] at 12:45 PM, Surveyor interviewed RN M regarding residents' advance directives. RN M indicated residents' code stats is in the computer and the resident's hard chart. RN M indicated both locations should match.On [DATE] at 1:17 PM, Surveyor interviewed ADON E (Assistant Director of Nursing) regarding R20's advance directive. ADON E stated she discontinued R20's DNR physician order on [DATE] because she was given updated information. ADON E indicated on [DATE], she was made aware of the discrepancy between R20's physician orders and R20's CPR preference form. On [DATE] at 1:17 PM, Surveyor interviewed DON B (Director of Nursing) regarding R20's advance directives. DON B stated that once the facility became aware on [DATE] that R20 wanted to be a full code, the staff obtaining the new advance directive should have changed the order in the computer but did not. DON B indicated the resident's CPR preference and physician orders should match and R20's did not.

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(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)

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	525692	A. Building B. Wing	07/29/2025

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to protect the residents' right to be free from verbal abuse, mental abuse, and sexual abuse by staff for 2 of 8 Residents Reviewed for abuse (R35 and R60).R35 and R35's representative (RR P) used the concerns/grievance process to voice a concern regarding unwanted touching of her vaginal area by LPN K (Licensed Practical Nurse) even after she asked him to stop.CNA O (Certified Nursing Assistant) heard RN S (Registered Nurse) yelling at R60 and intervened. CNA O observed RN S pull R60's blanket off without warning and throw it on the floor. CNA O observed RN S slam R60's room door and bathroom door. CNA O reported the allegation of verbal abuse/mental abuse to DON B (Director of Nursing).Evidenced by:Facility's policy, titled Abuse, Neglect, Misappropriation, Mistreatment, Exploitation, Preventing, Investigating, and Mandatory Reporting, updated 8/25/23, includes: . this includes but is not limited to freedom from. abuse, neglect, exploitation, involuntary seclusion, or misappropriation of resident property, corporal punishment, neglect. Residents will not be abused by anyone, including but not limited to facility staff, other residents, consultants, volunteers, agency staff, family members, legal guardians, friends, or other individuals. Definitions: Verbal abuse is using oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to: threats of harm, saying things to frighten a resident. Sexual abuse is nonconsensual sexual contact with a resident, including harassment, inappropriate touching, and assault. Mental abuse includes but is not limited to humiliation, harassment, threats of punishment, deprivation. It is the policy of the facility that each resident will be free from abuse. Abuse can include verbal, mental, sexual, or physical abuse. Example 1R35 admitted to the facility on [DATE] with a need for assistance with personal care.R35's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 7/1/25 indicates R35's cognition is intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15.R35's concern/grievance form, dated 6/26/25, includes: this writer spoke with R35 and R35's representative on 6/26/25 regarding a concern that she had expressed about her cares the previous evening. R35 had stated that LPN K had come into her room to complete her skin assessment check as part of her admission to the health and rehab center on the PM shift of 6/25/25. She stated that she was lying in bed. She stated that LPN K had put lotion on her arms and then proceeded to apply lotion to her legs and groin area. R35 stated she told LPN K that she was able to apply lotion to this area on her own. She stated that she felt uncomfortable with the cares being provided so she asked LPN K to get a female nurse or caregiver to assist her instead. She stated that LPN K told her I'm the nurse and I have to do this. R35 stated that the interaction made her feel uncomfortable and she described that while LPN K was putting lotion on her upper thighs and groin area that his fingers touched her vagina. She explained that there was nothing inserted into her vagina during the interaction. R35 reported that she feels safe at the health and rehab center. She has requested to not have LPN K or other male nurses, caregivers, or therapists assist her with peri cares. She stated she would not like to work with LPN K in the future during her rehab stay. This writer updated DON B (Director of Nursing) and ANHA F (Assistant Nursing Home Administrator) of this care concern after interviewing R35 on 6/26/25. On 7/24/25 at 9:00 AM LPN N indicated she had concerns that the facility's management is not following the abuse policy and procedures. LPN N indicated an incident occurred with R35 and LPN K. LPN N indicated R35 claimed LPN K was applying lotion to her vagina and she asked him to go get a female caregiver. LPN N indicated R35 and RR P reported this to her. LPN N indicated RR P stated to her that R35 was afraid she would get raped. LPN N indicated she was not asked to write a statement when she reported it to the management team, LPN K was never taken off of the floor and left working independently with other vulnerable residents. LPN N also indicated she did not think the facility conducted an investigation into the incident. On 7/28/25 at 9:28 AM RR P (Resident representative) indicated the LPN K was putting lotion on R35 and put it between her legs and came in contact with her labia. RR P indicated R35 asked LPN K to stop and get a female caregiver to assist her, but LPN K stated that he was the nurse and he continued to assist her. RR P indicated she and R35 reported this to the facility together and they did not understand why he was going down there when the dry skin was on her arms and legs and they did not understand why he did not stop when R35 asked him to find a female caregiver. On 7/28/25 at 10:43 AM SW G (Social Worker) indicated a concern of unwanted touching by a staff member in a private area could be an allegation of abuse. SW G indicated staff should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law though established procedures for 5 of 5 abuse investigations reviewed involving 1 of 1 sampled Residents (R1) and 4 of 4 supplemental Residents (R35, R61, R62 and R60). Facility became aware of an abuse allegation involving R1 on 12/4/24 and 7/14/25 and failed to report the allegations to the State Agency. R35 and R35’s representative (RR P) used the concerns/grievance process to voice a concern regarding unwanted touching of her vaginal area by LPN K (Licensed Practical Nurse) even after she asked him to stop. The facility failed to report R35’s allegation of sexual abuse to the state agency. CNA O (Certified Nursing Assistant) heard RN S (Registered Nurse) yelling at R60 and intervened. CNA O observed RN S pull R60’s blanket off without warning and throw it on the floor. CNA O observed RN S slam R60’s room door and bathroom door. CNA O reported the allegation of verbal abuse/mental abuse to DON B (Director of Nursing). The facility did not report the allegation of abuse to the state agency. R62’s representative used the facility’s grievance process to voice a concern of a staff member refusing to provide care for R62. The facility did not report R62’s allegation of neglect to the state agency. R61 used the facility’s grievance process to voice a concern of a staff member being very rough with her during cares. This allegation of abuse was not reported to the state agency. (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Evidenced by:The facility policy entitled “Abuse, Neglect, Misappropriation, Mistreatment, and Exploitation, Preventing, Investigating, and Mandatory Reporting Policy,” updated 8/25/2023, states, in part: …“Policy: It is the policy of Oakwood Village to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion, or misappropriation of resident property from abuse, corporal punishment, neglect, misappropriation of resident property, and exploitation… The Nursing Home Administrator or designee will report “abuse” to the state agency per State and Federal requirements… It is the policy of Oakwood Village that each resident will be free from “Abuse.”… (5) Investigations Components: The first responsibility of the facility is to assure resident safety. In the event of an allegation of abuse, neglect, mistreatment, misappropriation of resident property, and exploitation made against a staff member, visitor, contractor, and/or family member, the facility shall take immediate steps to ensure the safety of the resident(s) and prevent the risk of future or further harm. Such steps shall minimally include:*Suspension of the staff member until investigation of the allegation is complete…*Examine the resident for any signs of injury, including a physical and/or psychosocial assessment as needed.a. All reports of suspected crime and/or alleged sexual abuse will be immediately reported to local law enforcement for additional investigation…(7) Reporting and Response Components:All personnel, residents, family members, visitors, etc., are expected to report incidents of, or suspected incidents of abuse, neglect, mistreatment, misappropriation of resident property, and exploitation. Such reports must be made immediately to the Administrator and may be made without fear of retaliation from the facility or its staff…a. The facility will ensure that all allegations of abuse, including injuries of unknown source, neglect, mistreatment, misappropriation of resident property, and exploitation are reported to DQA.*For allegations of abuse or serious bodily injury, immediately, but not later than 2 hours after the allegation is made*For allegations that do not involve abuse or do not result in serious bodily injury, no later than 24 hours. Submit the Misconduct Incident Report to: Department of Health Services…” Example 1:R1 was admitted to facility on 1/02/24 and has diagnoses that include mild cognitive impairment, anxiety and depression. R1’s Concern Form, dated 12/4/24, states, in part: …“What is your concern(s) about? Care Provided.When did your concern happen? 12/2 PM shift…Investigation details: R1 states that RN D (Registered Nurse) “Threw a pill in her mouth after dinner time and told me I need to learn how to control myself.”Summary of the pertinent findings or conclusions: Staff member reports the accusation were false and investigation were done with some inconsistence.Corrective action or resolution: Education and training on customer service and medication administration relating to customer service. Dated 12/12/24.” On 7/28/25, at 10:05 AM, DON B indicated to Surveyor regarding the abuse allegations that it is what the resident says it is, and DON B believes the residents. Surveyor asked DON B, looking at the concern form dated 12/4/24 when R1 indicates nurse threw a pill in her mouth and told her she needed to learn how to control herself, could that be considered an allegation of abuse. DON B indicated yes an allegation, not abuse. DON B indicated it should have been reported along with all allegations of abuse should be reported and investigated. Example 2: (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1 was admitted to facility on 1/02/24 and has diagnoses that include mild cognitive impairment, anxiety and depression. R1’s Concern Form, dated 7/14/25, states, in part: …“What is your concern(s) about? Care Provided.When did your concern happen? On 7/14/25…How can we make this situation better for you? “I don’t want the cna (certified nursing assistant) in my room again. ” … Investigation details: AM floor nurse stated R1 mentioned that the med tech gave her the bruise. After speaking with R1, she mentioned that it was a cna that did it that morning. NOC (night) shift cna and nurse stated they had seen the bruise during shower prior to the morning R1 was explaining it happened. Stated R1 was wobbly in the shower. Stated she almost fell…” R1’s interview, undated, states: “R1 stated the cna had kept encouraging her to change her clothing on her own. R1 stated that the cna was helping her lean up from sitting to change and grabbed her hand. She said that the cna grabbing her hand to pull her up-right is what caused the bruise…” R1’s progress note, dated 7/14/25 at 10:06AM, states, in part: … “CNA stated that the resident has a bruise to her left hand. CNA also stated that “The resident says that I caused the bruise by being rough with her… Writer went and assessed a medium sized bruise to the resident’s left hand with a pain rated at a 9/10… Client stated that the med tech was the one who caused the bruise… On 7/24/25, at 1:23 PM, Surveyor interviewed DON B (Director of Nursing) and ADON E (Assistant Director of Nursing). ADON E indicated it was reported to her by a cna that there was a bruise on R1’s hand from a staff member that hurt her. ADON E indicated R1 indicated to her that R1 had a falling out with a staff member and had received this bruise. R1 informed ADON E that a cna was helping her that morning and grabbed her hand and now she has a bruise. Surveyor asked ADON E when this was reported to her and ADON E indicated 7/14/25 between 8:00AM – 9:00AM. ADON E indicated she had reported it to DON B right away. DON B then indicated to Surveyor that ADON E, ANHA (Assistant Nursing Home Administrator) and herself went to R1 right away. R1 had indicated a staff member was trying to help her and was holding her hand and gave her a bruise and then R1 also indicated someone was trying to catch her from falling in the shower. Surveyor asked DON B and ADON E if that could be an allegation of abuse and if “being rough” as was documented in R1’s progress notes could be an allegation of abuse. DON B indicated yes. Surveyor asked DON B if an allegation of abuse should be reported to state and investigated and DON B indicated yes and it had not been reported. On 7/28/25, at 10:46AM, Surveyor interviewed SW G (Social Worker) who indicated the grievance process as once a concern form is received and reviewed, the ANHA and DON B come together and make a decision whether or not to submit to the state the concern. Surveyor asked if “being rough” could be an allegation of abuse and SW G indicated yes. Surveyor asked if grabbing a resident’s hand and pulling could be an allegation of abuse and SW G indicated it could. Surveyor asked SW G if allegations of abuse should be reported to the state and investigated and SW G indicated yes. On 7/28/25, at 11:23 AM, Surveyor interviewed NHA A (Nursing Home Administrator). NHA A indicated the facility would investigate whoever is involved with the concern and then it is decided if it is reportable, or it the concern goes as a grievance. Surveyor asked if staff should follow the facility’s abuse policy and NHA A indicated yes. Example 3 R35 admitted to the facility on [DATE] with the following diagnoses: chronic obstructive pulmonary disease with exacerbation, chronic respiratory failure, and need for assistance with personal care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R35’s most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 7/1/25 indicates R35’s cognition is intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. R35’s concern/grievance form, dated 6/26/25, includes: this writer spoke with R35 and R35’s representative on 6/26/25 regarding a concern that she had expressed about her cares the previous evening… R35 had stated that LPN K (Licensed Practical Nurse) had come into her room to complete her skin assessment check as part of her admission to the health and rehab center on the PM shift of 6/25/25. She stated that she was lying in bed. She stated that LPN K had put lotion on her arms and then proceeded to apply lotion to her legs and groin area. R35 stated she told LPN K that she was able to apply lotion to this area on her own. She stated that she felt uncomfortable with the cares being provided so she asked LPN K to get a female nurse or caregiver to assist her instead. She stated that LPN K told her “I’m the nurse and I have to do this.” R35 stated that the interaction made her feel uncomfortable and she described that while LPN K was putting lotion on her upper thighs and groin area that his fingers touched her vagina. She explained that there was nothing inserted into her vagina during the interaction. R35 reported that she feels safe at the health and rehab center. She has requested to not have LPN K or other male nurses, caregivers, or therapists assist her with peri cares. She stated she would not like to work with LPN K in the future during her rehab stay. This writer updated DON B (Director of Nursing) and ANHA F (Assistant Nursing Home Administrator) of this care concern after interviewing R35 on 6/26/25… On 7/24/25 at 9:00 AM LPN N indicated she had concerns that the facility’s management is not following the abuse policy and procedures. LPN N indicated an incident occurred with R35 and LPN K. LPN N indicated R35 claimed LPN K was applying lotion to her vagina and she asked him to go get a female caregiver. LPN N indicated R35 and RR P reported this to her. LPN N indicated RR P stated to her that R35 was afraid she would get raped. LPN N indicated she was not asked to write a statement when she reported it to the management team, LPN K was never taken off of the floor and left working independently with other vulnerable residents. LPN N also indicated she did not think the facility reported the incident to the state agency or the local law enforcement. On 7/28/25 at 9:28 AM RR P (Resident representative) indicated the LPN K was putting lotion on R35 and put it between her legs and came in contact with her labia. RR P indicated R35 asked LPN K to stop and get a female caregiver to assist her, but LPN K stated that he was the nurse and he continued to assist her. RR P indicated she and R35 reported this to the facility together and they did not understand why he was going down there when the dry skin was on her arms and legs and they did not understand why he did not stop when R35 asked him to find a female caregiver. On 7/28/25 at 10:43 AM SW G (Social Worker) indicated a concern of unwanted touching by a staff member in a private area could be an allegation of abuse. SW G indicated the facility policy is that all allegations of abuse or neglect will be reported to the state agency and if there is suspicion of a crime being committed then the facility would notify the police. SW G indicated that unwanted touching in a private area could be a crime. (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

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Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/28/25 at 11:22 AM NHA A (Nursing Home Administrator) indicated when staff receive an allegation of abuse the management team will conduct some initial interviews to see if abuse really occurred. NHA A indicated then the facility will report if necessary. NHA A indicated the facility policy is that all allegations of abuse or neglect are to be reported to the state agency within 2 hours but not to exceed 24 hours. NHA A indicated all allegations means all allegations, not just the substantiated allegations. NHA A indicated unwanted touching of a person in their private area could be sexual abuse. NHA A indicated when a resident asks staff to stop they should stop. NHA A reviewed R35’s grievance and stated, “Given the initial information this could be an allegation of abuse and would require report to the state agency.” On 7/28/25 at 1:12 PM RN Q indicated a concern related to a staff member touching a resident in a private area when they did not want to be is an allegation of abuse. RN Q indicated when a resident asks for another caregiver, staff should stop and get another caregiver. On 7/28/25 at 3:25 PM LPN K indicated while he was completing an initial skin assessment and applying lotion to R35’s body she asked him to get a female caregiver. LPN K indicated this was R35’s first day/night in the facility. LPN K indicated at one point during his assessment, R35 said she doesn’t feel comfortable with LPN K and asked him to get a female nurse. LPN K indicated he told R35 that he is the only nurse on this floor and continued to finish his assessment and apply lotion to resident. LPN K indicated R35 stated she had to use the bathroom. LPN K assisted R35 to a seated position on her bed when another male CNA walked into the room. LPN K indicated he did not tell the second male caregiver that R35 requested a female to assist her. LPN K indicated the second male CNA and LPN K assisted R35 into the bathroom. Then LPN K indicated he left the room and the male CNA finished assisting R35. LPN K indicated he should have stopped when R35 asked for a female caregiver and he should have gotten a female CNA to assist R35 to the bathroom. LPN K indicated CNAs can apply lotion and there were female CNAs working at the time of the incident. LPN K indicated he did not report to management that R35 told him she was uncomfortable and requested a female nurse. LPN K indicated it could be intimidating to R35 that 2 male caregivers were in the room after she verbalized she was uncomfortable and requested a female caregiver during her assessment. On 7/28/25 at 4:21 PM DON B and ADON E indicated they were unaware when LPN K did not stop providing cares when R35 stated she was uncomfortable, a second male caregiver entered R35’s room so two male caregivers were present. DON B and ADON E indicated this could have been intimidating to R35. (It is important to note facility staff indicated a complaint voiced regarding a staff member touching a resident in a private area when she has asked them to stop is an allegation of sexual abuse and the facility provided no evidence of this allegation of sexual abuse being reported to the state agency.) Example 4 R60 admitted to the facility on [DATE] with the following diagnoses: need for assistance with personal care, cerebral infarction, unsteady on feet, and mild cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R60’s concern/grievance form, dated 6/21/25, includes: person submitting concern: CNA O (Certified Nursing Assistant)… ADON E (Assistant Director of Nursing) obtained verbal statement at time of incident from CNA O and RN S. CNA O concerned RN S raised her voice at R60. R60 was yelling out, staff unable to calm R60. RN S admits to yelling… No harm to R60 reported. RN S admits to raising voice at R60… On 7/24/25 at 9:00 AM LPN N indicated she had concerns that the facility’s management is not following the abuse policy and procedures. LPN N indicated CNA O called DON B (Director of Nursing) in the middle of the night to report RN S verbally abused R60 and DON B did not report this to the state agency and did not remove RN S from the floor to protect R60 and other residents. On 7/24/25 at 1:18 PM CNA O stated, “I observed verbal abuse. It was a little busy at night. I had a call light or two on. I saw R60’s call light on and I was trying to get down to her. I heard the wall shake as RN S slammed the door shut. She then slammed the bathroom door too. I knocked and opened the door. RN S was shouting and screaming at R60.” CNA O indicated RN S was saying to R60, “Get up out of this bed,” and she was using a loud voice of authority. CNA O stated, “She took the blanket from the patient, threw it on the floor, and spilled her water. The patient was calling out for help. We were only 45 minutes into our shift. We just started. I don’t know why she was so worked up. I asked her if she needed help. The patient looked panicked. I told RN S I need you to leave the room three times. The third time, I told her to leave, I said you are abusing the patient and I need you to leave right now. I will assist the patient.” CNA O indicated RN S continued to work through the shift and was not removed from patient care pending an investigation. CNA O indicated this incident was not reported, was not investigated, and she does not understand why the facility does not follow the abuse policy. On 7/24/25 at 1:43 PM ADON E and DON B indicated they take turns being on call for the health and rehab center. ADON E indicated around midnight she received a call from CNA O who reported RN S raised her voice at a resident and looked frazzled so CNA O had to take over cares. ADON E indicated CNA O reported that RN S lost her patience, yelled at R60, and she asked RN S to leave. ADON E indicated then she called and spoke with RN S who stated that she used a loud, stern voice but R60 was safe. ADON E indicated R60 has some cognitive impairment and was not able to recall the incident. DON B indicated RN S was not removed from the floor pending an investigation and that statements were not collected by other staff or residents regarding this incident. DON B indicated RN S continued to work with residents and the allegation of verbal abuse was not reported to the state agency. DON B and ADON E indicated a staff member raising her voice at a resident, yelling at a resident, intimidating a resident, or using a loud stern voice with a resident could be an allegation of abuse and should be reported to the state agency within 2 hours. On 7/28/25 at 10:43 AM SW G (Social Worker) indicated a concern of a staff yelling at a resident could be an allegation of abuse. SW G indicated the facility policy is that all allegations of abuse or neglect will be reported to the state agency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/28/25 at 11:22 AM NHA A (Nursing Home Administrator) indicated when staff receive an allegation of abuse the management team will conduct some initial interviews to see if abuse really occurred. NHA A indicated then the facility will report if necessary. NHA A indicated the facility policy is that all allegations of abuse or neglect are to be reported to the state agency within 2 hours but not to exceed 24 hours. NHA A indicated all allegations means all allegations, not just the substantiated allegations. NHA A indicated a concern of a staff member yelling at a resident, pulling a blanket off and throwing it on the floor, and slamming doors could an allegation of abuse. On 7/28/25 at 1:12 PM RN Q indicated a concern related to a staff member yelling at a resident, using a loud and stern voice, slamming doors, and taking a blanket off a resident and throwing it on the floor is an allegation of abuse. (It is important to note facility staff indicate a complaint voiced regarding a staff member yelling at, pulling a blanket off without notice and tossing it to the floor, slamming resident doors, and/or intimidating a resident could be an allegation of abuse and the facility provided no evidence of this allegation of verbal/mental abuse being reported to the state agency.) Example 5 R62 admitted to the facility on [DATE] with the following diagnoses: need for assistance with personal care, generalized anxiety disorder, type 2 diabetes mellitus, polyneuropathy, and acute kidney failure. R62’s grievance/concern form, dated 4/14/25, includes: (R62’s representative named) reported that the day he admitted he asked (LPN K) after 3:00 PM to please help move him from the wheelchair to the edge of the bed so he could stretch his legs. He had been in the wheelchair since he left the hospital at noon. (LPN K) responded that he was the nurse and this was not his role. On 7/24/25 at 1:43 PM DON B and ADON E indicated a concern of a staff member refusing to assist a resident is an allegation of neglect and should be reported to the state agency within 2 hours of becoming aware. On 7/28/25 at 10:43 AM SW G (Social Worker) indicated a concern of a staff member refusing services could be an allegation of neglect. SW G indicated the facility policy is that all allegations of abuse or neglect will be reported to the state agency. On 7/28/25 at 11:22 AM NHA A (Nursing Home Administrator) indicated when staff receive an allegation of abuse the management team will conduct some initial interviews to see if abuse really occurred. NHA A indicated then the facility will report if necessary. NHA A indicated the facility policy is that all allegations of abuse or neglect are to be reported to the state agency within 2 hours but not to exceed 24 hours. NHA A indicated all allegations means all allegations, not just the substantiated allegations. NHA A indicated a concern of a staff member refusing goods or services could be an allegation of neglect. On 7/28/25 at 1:12 PM RN Q indicated a concern related to a staff member refusing to assist a resident could be neglect. (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(It is important to note facility staff indicate a complaint voiced regarding a staff member refusing to provide care could be an allegation of neglect and the facility provided no evidence of R62’s allegation of neglect being reported to the state agency.) Example 6 R61 admitted to the facility on [DATE] with the following diagnoses: congestive heart failure, chronic obstructive pulmonary disease with acute exacerbation, emphysema, and need for assistance with personal care. R61’s grievance/concern form, dated 1/14/25, includes: R61 states (Certified Nursing Assistant named) was very rough with her during evening cares. On 7/24/25 at 1:43 PM DON B and ADON E indicated a concerns of a staff member being very rough during cares could be an allegation of neglect and should be reported to the state agency. DON B indicated the facility policy is that all allegations of abuse and/or neglect are reported to the state agency within 2 hours of becoming aware. On 7/28/25 at 10:43 AM SW G (Social Worker) indicated a concern of a staff member being very rough during cares could be an allegation of abuse. SW G indicated the facility policy is that all allegations of abuse or neglect will be reported to the state agency. On 7/28/25 at 11:22 AM NHA A (Nursing Home Administrator) indicated when staff receive an allegation of abuse the management team will conduct some initial interviews to see if abuse really occurred. NHA A indicated then the facility will report if necessary. NHA A indicated the facility policy is that all allegations of abuse or neglect are to be reported to the state agency within 2 hours but not to exceed 24 hours. NHA A indicated all allegations means all allegations, not just the substantiated allegations. NHA A indicated a concern of a staff member being very rough during cares could be an allegation of abuse and he would want to know more information about the word rough. On 7/28/25 at 1:12 PM RN Q indicated a concern related to a staff member being very rough during cares is an allegation of abuse. (It is important to note facility staff indicate a complaint voiced regarding a staff member being very rough while providing cares could be an allegation of abuse and the facility provided no evidence of R61’s allegation of abuse being reported to the state agency.)

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	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a thorough investigation of abuse/exploitation was completed for 1 of 1 sampled Residents (R1) and 4 of 4 supplemental Residents (R35, R61, R62 and R60) reviewed for abuse. Facility became aware of an abuse allegation involving R1 on 12/4/24 and 7/14/25 and failed to complete a thorough investigation. R35 and R35’s Resident representative (RR P) used the concerns/grievance process to voice a concern regarding unwanted touching of her vaginal area by LPN K (Licensed Practical Nurse) even after she asked him to stop. The facility failed to conduct a thorough investigation of the incident. CNA O (Certified Nursing Assistant) heard RN S (Registered Nurse) yelling at R60 and intervened. CNA O observed RN S pull R60’s blanket off without warning and throw it on the floor. CNA O observed RN S slam R60’s room door and bathroom door. CNA O reported the allegation of verbal abuse/mental abuse to DON B (Director of Nursing). The facility did not conduct a thorough investigation of the incident. R62’s representative used the facility’s grievance process to voice a concern of a staff member refusing to provide care for R62. The facility did not conduct a thorough investigation of the incident. R61 used the facility’s grievance process to voice a concern of a staff member being very rough with her during cares. The facility failed to conduct a thorough investigation, including gathering statements from other staff or other residents who may have had information regarding the incident. Evidenced by: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy entitled “Abuse, Neglect, Misappropriation, Mistreatment, and Exploitation, Preventing, Investigating, and Mandatory Reporting Policy,” updated 8/25/2023, states, in part: …“Policy: It is the policy of Oakwood Village to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion, or misappropriation of resident property from abuse, corporal punishment, neglect, misappropriation of resident property, and exploitation… The Nursing Home Administrator or designee will report “abuse” to the state agency per State and Federal requirements… It is the policy of Oakwood Village that each resident will be free from “Abuse.”… The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention…1)Screening2)Training3)Prevention4)Identification5)Investigation6)Protection7)Reporting and Response… (5) Investigations Components:The first responsibility of the facility is to assure resident safety. In the event of an allegation of abuse, neglect, mistreatment, misappropriation of resident property, and exploitation made against a staff member, visitor, contractor, and/or family member, the facility shall take immediate steps to ensure the safety of the resident(s) and prevent the risk of future or further harm. Such steps shall minimally include:*Suspension of the staff member until investigation of the allegation is complete…*Examine the resident for any signs of injury, including a physical and/or psychosocial assessment as needed.a. All reports of suspected crime and/or alleged sexual abuse will be immediately reported to local law enforcement for additional investigation… (7) Reporting and Response Components:All personnel, residents, family members, visitors, etc., are expected to report incidents of, or suspected incidents of abuse, neglect, mistreatment, misappropriation of resident property, and exploitation. Such reports must be made immediately to the Administrator and may be made without fear of retaliation from the facility or its staff…a. The facility will ensure that all allegations of abuse, including injuries of unknown source, neglect, mistreatment, misappropriation of resident property, and exploitation are reported to DQA.*For allegations of abuse or serious bodily injury, immediately, but not later than 2 hours after the allegation is made*For allegations that do not involve abuse or do not result in serious bodily injury, no later than 24 hours. Submit the Misconduct Incident Report to: Department of Health Services…” Example 1:R1 was admitted to facility on 1/2/24 and has diagnoses that include mild cognitive impairment, anxiety and depression. R1’s Concern Form, dated 12/4/24, states, in part: …“What is your concern(s) about? Care Provided.When did your concern happen? 12/2 PM shift…Investigation details: R1 states that RN D (Registered Nurse) “Threw a pill in her mouth after dinner time and told me I need to learn how to control myself.”Summary of the pertinent findings or conclusions: Staff member reports the accusation were false and investigation were done with some inconsistence.Corrective action or resolution: Education and training on customer service and medication administration relating to customer service. Dated 12/12/24.”On 7/28/25, at 10:05 AM, DON B indicated to Surveyor regarding the abuse allegations that it is what the resident says it is, and DON B believes the residents. Surveyor asked DON B, looking at the concern form dated 12/4/24 when R1 indicates nurse threw a pill in her mouth and told her she needed to learn how to control herself, could that be considered an allegation of abuse. DON B indicated yes an allegation, not abuse. DON B indicated it should have been reported along with all allegations of abuse should be reported and investigated.On 7/28/25, at 11:23 AM, Surveyor interviewed NHA A (Nursing Home Administrator). NHA A indicated the facility would investigate whoever is involved with the concern and then it is decided if it is reportable, or it the concern goes as a grievance. Surveyor asked if staff should follow the facility’s abuse policy and NHA A indicated yes. R1’s incident was not thoroughly investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 2R1’s Concern Form, dated 7/14/25, states, in part: …“What is your concern(s) about? Care Provided.When did your concern happen? On 7/14/25…How can we make this situation better for you? “I don’t want the cna (certified nursing assistant) in my room again.” …Investigation details: AM floor nurse stated R1 mentioned that the med tech gave her the bruise. After speaking with R1, she mentioned that it was a cna that did it that morning. NOC (night) shift cna and nurse stated they had seen the bruise during shower prior to the morning R1 was explaining it happened. Stated R1 was wobbly in the shower. Stated she almost fell…” R1’s interview, undated, states: “R1 stated the cna had kept encouraging her to change her clothing on her own. R1 stated that the cna was helping her lean up from sitting to change and grabbed her hand. She said that the cna grabbing her hand to pull her up-right is what caused the bruise…” R1’s progress note, dated 7/14/25 at 10:06AM, states, in part: … “CNA stated that the resident has a bruise to her left hand. CNA also stated that “The resident says that I caused the bruise by being rough with her… Writer went and assessed a medium sized bruise to the resident’s left hand with a pain rated at a 9/10… Client stated that the med tech was the one who caused the bruise… On 7/24/25, at 1:23PM, Surveyor interviewed DON B (Director of Nursing) and ADON E (Assistant Director of Nursing). ADON E indicated it was reported to her by a cna that there was a bruise on R1’s hand from a staff member that hurt her. ADON E indicated R1 indicated to her that R1 had a falling out with a staff member and had received this bruise. R1 informed ADON E that a cna was helping her that morning and grabbed her hand and now she has a bruise. Surveyor asked ADON E when this was reported to her and ADON E indicated 7/14/25 between 8:00AM – 9:00AM. ADON E indicated she had reported it to DON B right away. DON B then indicated to Surveyor that ADON E, ANHA (Assistant Nursing Home Administrator) and herself went to R1 right away. R1 had indicated a staff member was trying to help her and was holding her hand and gave her a bruise and then R1 also indicated someone was trying to catch her from falling in the shower. Surveyor asked DON B and ADON E if that could be an allegation of abuse and if “being rough” as was documented in R1’s progress notes could be an allegation of abuse. DON B indicated yes. Surveyor asked DON B if an allegation of abuse should be reported to state and investigated and DON B indicated yes and it had not been reported. On 7/28/25, at 10:46AM, Surveyor interviewed SW G (Social Worker) who indicated the grievance process as once a concern form is received and reviewed, the ANHA and DON B come together and make a decision whether or not to submit to the state the concern. Surveyor asked if “being rough” could be an allegation of abuse and SW G indicated yes. Surveyor asked if grabbing a resident’s hand and pulling could be an allegation of abuse and SW G indicated it could. Surveyor asked SW G if allegations of abuse should be reported to the state and investigated and SW G indicated yes. On 7/28/25, at 11:23 AM, Surveyor interviewed NHA A (Nursing Home Administrator). NHA A indicated the facility would investigate whoever is involved with the concern and then it is decided if it is reportable, or it the concern goes as a grievance. Surveyor asked if staff should follow the facility’s abuse policy and NHA A indicated yes. R1’s incident was not thoroughly investigated. Example 3 R35 admitted to the facility on [DATE] with the following diagnoses: chronic obstructive pulmonary disease with exacerbation, chronic respiratory failure, peripheral vertigo, and need for assistance with personal care. (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R35’s most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 7/1/25 indicates R35’s cognition is intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. R35’s concern/grievance form, dated 6/26/25, includes: this writer spoke with R35 and R35’s representative on 6/26/25 regarding a concern that she had expressed about her cares the previous evening… R35 had stated that LPN K (Licensed Practical Nurse) had come into her room to complete her skin assessment check as part of her admission to the health and rehab center on the PM shift of 6/25/25. She stated that she was lying in bed. She stated that LPN K had put lotion on her arms and then proceeded to apply lotion to her legs and groin area. R35 stated she told LPN K that she was able to apply lotion to this area on her own. She stated that she felt uncomfortable with the cares being provided so she asked LPN K to get a female nurse or caregiver to assist her instead. She stated that LPN K told her “I’m the nurse and I have to do this.” R35 stated that the interaction made her feel uncomfortable and she described that while LPN K was putting lotion on her upper thighs and groin area that his fingers touched her vagina. She explained that there was nothing inserted into her vagina during the interaction. R35 reported that she feels safe at the health and rehab center. She has requested to not have LPN K or other male nurses, caregivers, or therapists assist her with peri cares. She stated she would not like to work with LPN K in the future during her rehab stay. This writer updated DON B (Director of Nursing) and ANHA F (Assistant Nursing Home Administrator) of this care concern after interviewing R35 on 6/26/25… On 7/24/25 at 9:00 AM LPN N indicated she had concerns that the facility’s management is not following the abuse policy and procedures. LPN N indicated an incident occurred with R35 and LPN K. LPN N indicated R35 claimed LPN K was applying lotion to her vagina and she asked him to go get a female caregiver. LPN N indicated R35 and RR P reported this to her. LPN N indicated RR P stated to her that R35 was afraid she would get raped. LPN N indicated she was not asked to write a statement when she reported it to the management team, LPN K was never taken off of the floor and left working independently with other vulnerable residents. LPN N also indicated she did not think the facility conducted an investigation into the incident. On 7/28/25 at 9:28 AM RR P (Resident representative) indicated the LPN K was putting lotion on R35 and put it between her legs and came in contact with her labia. RR P indicated R35 asked LPN K to stop and get a female caregiver to assist her, but LPN K stated that he was the nurse and he continued to assist her. RR P indicated she and R35 reported this to the facility together and they did not understand why he was going down there when the dry skin was on her arms and legs and they did not understand why he did not stop when R35 asked him to find a female caregiver. On 7/28/25 at 10:43 AM SW G (Social Worker) indicated a concern of unwanted touching by a staff member in a private area could be an allegation of abuse. SW G indicated staff should stop when a resident asks them to stop. SW G indicated the facility policy is that all allegations of abuse or neglect will be thoroughly investigated. SW G indicated no other residents were interviewed regarding the incident and no other staff members who were working this day were interviewed regarding the incident. SW G indicated LPN K was not pulled from working with residents pending an investigation. On 7/28/25 at 11:22 AM NHA A (Nursing Home Administrator) indicated the facility is to conduct a thorough investigation for all allegations of abuse and neglect. NHA A indicated a thorough investigation will contain interviews by staff and residents who may have knowledge related to allegation. (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/28/25 at 3:25 PM LPN K indicated while he was completing an initial skin assessment and applying lotion to R35’s body she asked him to get a female caregiver. LPN K indicated this was R35’s first day/night in the facility. LPN K indicated at one point during his assessment, R35 said she doesn’t feel comfortable with LPN K and asked him to get a female nurse. LPN K indicated he told R35 that he is the only nurse on this floor and continued to finish his assessment and apply lotion to resident. LPN K indicated R35 stated she had to use the bathroom. LPN K assisted R35 to a seated position on her bed when another male CNA walked into the room. LPN K indicated he did not tell the second male caregiver that R35 requested a female to assist her. LPN K indicated the second male CNA and LPN K assisted R35 into the bathroom. Then LPN K indicated he left the room and the male CNA finished assisting R35. LPN K indicated he should have stopped when R35 asked for a female caregiver and he should have gotten a female CNA to assist R35 to the bathroom. LPN K indicated CNAs can apply lotion and there were female CNAs working at the time of the incident. LPN K indicated he did not report to management that R35 told him she was uncomfortable and requested a female nurse. LPN K indicated it could be intimidating to R35 that 2 male caregivers were in the room after she verbalized she was uncomfortable and requested a female caregiver during her assessment. On 7/28/25 at 4:21 PM DON B and ADON E indicated they were unaware when LPN K did not stop providing cares when R35 stated she was uncomfortable, a second male caregiver entered R35’s room so two male caregivers were present. DON B and ADON E indicated this could have been intimidating to R35. (It is important to note facility staff indicated a complaint voiced regarding a staff member touching a resident in a private area when she has asked them to stop is an allegation of sexual abuse and the facility provided no evidence of a thorough investigation being completed including interviews by other residents and other staff. It is important to note the facility did not remove LPN K from working with residents pending an investigation.) Example 4 R60 admitted to the facility on [DATE] with the following diagnoses: need for assistance with personal care, cerebral infarction, unsteady on feet, and mild cognitive impairment. R60’s concern/grievance form, dated 6/21/25, includes: person submitting concern: CNA O… ADON E (Assistant Director of Nursing) obtained verbal statement at time of incident from CNA O and RN S. CNA O concerned RN S raised her voice at R60. R60 was yelling out, staff unable to calm R60. RN S admits to yelling… No harm to R60 reported. RN S admits to raising voice at R60… On 7/24/25 at 9:00 AM LPN N (Licensed Practical Nurse) indicated she had concerns that the facility’s management is not following the abuse policy and procedures. LPN N indicated CNA O called DON B (Director of Nursing) in the middle of the night to report RN S verbally abused R60 and DON B did not remove RN S from the floor to protect R60 and other residents. (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/25 at 1:18 PM CNA O (Certified Nursing Assistant) stated, “I observed verbal abuse. It was a little busy at night. I had a call light or two on. I saw R60’s call light on and I was trying to get down to her. I heard the wall shake as RN S slammed the door shut. She then slammed the bathroom door too. I knocked and opened the door. RN S was shouting and screaming at R60.” CNA O indicated RN S was saying to R60. “Get up out of this bed,” and she was using a loud voice of authority. CNA O stated, “She took the blanket from the patient, threw it on the floor, and spilled her water. The patient was calling out for help. We were only 45 minutes into our shift. We just started. I asked her if she needed help. The patient looked panicked. I told RN S ‘I need you to leave the room’ three times. The third time, I told her to leave, I said you are abusing the patient and I need you to leave right now. I will assist the patient.” CNA O indicated RN S continued to work through the shift and was not removed from patient care pending an investigation. CNA O indicated she was not asked to write a statement regarding the incident. CNA O indicated this incident was not investigated and she does not understand why the facility does not follow the abuse policy. On 7/24/25 at 1:43 PM ADON E (Assistant Director of Nursing) and DON B indicated they take turns being on call for the health and rehab center. ADON E indicated around midnight she received a call from CNA O who reported RN S raised her voice at a resident and looked frazzled so CNA O had to take over cares. ADON E indicated CNA O reported that RN S lost her patience, yelled at R60, and she asked RN S to leave. ADON E indicated then she called and spoke with RN S who stated that she used a loud, stern voice but R60 was safe. ADON E indicated R60 has some cognitive impairment and was not able to recall the incident. DON B indicated RN S was not removed from the floor pending an investigation and that statements were not collected by other staff or residents regarding this incident. DON B indicated RN S continued to work with residents. ADON E and DON B indicated the facility’s policy is that all allegations of abuse and/or neglect are thoroughly investigated. ADON E indicated she was unsure what makes a thorough investigation. On 7/28/25 at 10:43 AM SW G (Social Worker) indicated a concern of a staff yelling at a resident could be an allegation of abuse. SW G indicated the facility policy is that all allegations of abuse or neglect will be thoroughly investigated. SW G indicated no other residents or staff were interviewed regarding the incident. On 7/28/25 at 11:22 AM NHA A (Nursing Home Administrator) indicated the facility policy is that all allegations of abuse or neglect are to be thoroughly investigated. NHA A indicated a concern of a staff member yelling at a resident, pulling a blanket off and throwing it on the floor, and slamming doors could an allegation of abuse. (It is important to note facility staff indicate a complaint voiced regarding a staff member yelling at, pulling a blanket off without notice and tossing it to the floor, slamming resident doors, and/or intimidating a resident could be an allegation of abuse and the facility provided no evidence of this allegation being thoroughly investigated. It is also important to note RN S was not removed from working with residents pending an investigation.) Example 5 R62 admitted to the facility on [DATE] with the following diagnoses: need for assistance with personal care, generalized anxiety disorder, type 2 diabetes mellitus, polyneuropathy, and acute kidney failure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R62’s grievance/concern form, dated 4/14/25, includes: (R62’s representative named) reported that the day he admitted he asked (LPN K (Licensed Practical Nurse)) after 3:00 PM to please help move him from the wheelchair to the edge of the bed so he could stretch his legs. He had been in the wheelchair since he left the hospital at noon. (LPN K) responded that he was the nurse, and this was not his role. On 7/24/25 at 1:43 PM ADON E (Assistant Director of Nursing) and DON B (Director of Nursing) indicated the facility’s policy is that all allegations of abuse and/or neglect are thoroughly investigated. ADON E indicated she was unsure what makes a thorough investigation. DON B indicated a concern of an RN refusing to assist a resident is an allegation of neglect. On 7/28/25 at 10:43 AM SW G (Social Worker) indicated a concern of a staff member refusing services could be an allegation of neglect. SW G indicated the facility policy is that all allegations of abuse or neglect will be reported to the state agency. (It is important to note facility staff indicate a complaint voiced regarding a staff member refusing to provide care could be an allegation of neglect and the facility provided no evidence of R62’s allegation of neglect being thoroughly investigated. It is also important to note LPN K was not removed from working with residents pending an investigation.) Example 6 R61 admitted to the facility on [DATE] with the following diagnoses: congestive heart failure, chronic obstructive pulmonary disease with acute exacerbation, emphysema, and need for assistance with personal care. R61’s grievance/concern form, dated 1/14/25, includes: R61 states (Certified Nursing Assistant named) was very rough with her during evening cares. On 7/24/25 at 1:43 PM ADON E (Assistant Director of Nursing) and DON B (Director of Nursing) indicated a concern of a staff member being very rough during cares could be an allegation of abuse. DON B and ADON E indicated the facility’s policy is that all allegations of abuse and/or neglect are thoroughly investigated. ADON E indicated she was unsure what makes a thorough investigation. On 7/28/25 at 10:43 AM SW G (Social Worker) indicated a concern of a staff member being very rough during cares could be an allegation of abuse. SW G indicated the facility policy is that all allegations of abuse or neglect will be reported to the state agency. On 7/28/25 at 11:22 AM NHA A (Nursing Home Administrator) indicated NHA A indicated a concern of a staff member being very rough during cares could be an allegation of abuse and he would want to know more information about the word rough. NHA A indicated the facility policy is that all allegations of abuse or neglect would be thoroughly investigated. On 7/28/25 at 1:12 PM RN Q (Registered Nurse) indicated a concern related to a staff member being very rough during cares is an allegation of abuse. (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

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Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(It is important to note facility staff indicate a complaint voiced regarding a staff member being very rough while providing cares could be an allegation of abuse and the facility provided no evidence of R61’s allegation of abuse being thoroughly investigated, including other resident interviews or other staff interviews.) Cross reference F609

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	525692	A. Building B. Wing	07/29/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility did not complete the PASARR Level II (Preadmission Screening and Resident Review) when it was realized that 4 of 4 Residents (R3, R40, R6, & R14) would reside in the facility for more than 30 days. R3, R40, R6, and R14 were admitted to the facility with diagnoses that included a major mental disorder and were prescribed medication to treat symptoms of a major mental disorder. R3, R40, R6, and R14 resided in the facility for more than 30 days and no evidence was provided that a PASRR Level II Screen was completed for R3, R40, R6, and R14. Evidenced by: The Preadmission Screen and Resident Review Level 1 Screen directions include, in part, the following: 42 CFR 4830128(a) requires that the resident or his/her legal representative receive a written notice (copy of this front page) if the resident is suspected of having a serious mental illness or a developmental delay, and therefore, will require a Level II Screen. You may tell the resident or his/her legal representative that the Level II Screen will determine if the resident does have a serious mental illness or developmental disability, as defined in the federal regulations, and if so, if the resident is appropriate for nursing facility placement and if the resident needs specialized services or specialized psychiatric rehabilitative services to address his/her disability needs…The following situations, which are all for short-term admissions, are the only exemptions from Level II Screening… Hospital Discharge Exemption- 30 Day Maximum If, during the short term stay, it is established that the person will be staying for a longer period of time than permitted above, the person must be referred for a Level II Screen on or before the last day of the permitted time period…” Facility policy, titled Admission, Transfer, Discharge, includes, in part: All new admissions and readmissions are screened for mental disorders, intellectual disabilities, or related disorders per the Medicaid Pre-admission Screening and Resident Review process. The facility conducts a Level 1 PASRR screen for all potential admissions, regardless of payer source, to determine if the individual meets criteria… Example 1 R3 admitted to the facility on [DATE]. Her diagnoses include Major Depressive Disorder and Anxiety Disorder. R3’s PASRR, dated 2/27/25, includes: Does the person have a major mental disorder: No… Has the person received psychotropic medications to treat symptoms or behaviors of a major mental disorder: Yes… Medication List: Mirtazapine, Buspirone… Hospital Discharge 30 day exemption: Yes… R3’s Physician Orders, dated 7/11/25, include: Buspirone HCl 5mg give one tablet by mouth every morning for mood/anxiety… Mirtazapine 15 mg give one tablet by mouth at bedtime for mood/depression. (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3 still resides in the facility on 7/24/25. It is important to note this is more than 30 days since admission. On 7/29/25 at 9:47 AM SW G and SW H indicated R3 should have had a level 2 screen completed when the facility realized she was going to be staying for longer than 30 days. On 7/29/25 at 1:03 PM ANHA F (Assistant Nursing Home Administrator) indicated there was a change of staff in the social workers department and the responsibility of the PASRR program was not picked back up by another staff member, but the facility will sweep the house and make sure all are up to date. ANHA F indicated R3’s PASRR level 2 should have been completed when she stayed in the facility for longer than 30 days. Example 2 R40 admitted to the facility on [DATE]. Her diagnoses includes: Major Depressive Disorder and Anxiety Disorder. R40’s PASRR, dated 6/18/25, includes: Does the person have a major mental disorder: Yes… Has the person received psychotropic medications to treat symptoms or behaviors of a major mental disorder: Yes… Medication List: Wellbutrin, Clonazepam… Hospital Discharge 30 day exemption: Yes… R40’s current Physician Orders, dated 7/7/25, includes: bupropion HCl give one tablet by mouth one time a day for Major Depressive Disorder… Clonazepam 0.5mg give one tablet by mouth one time a day for anxiety… R40 still resides in the facility on 7/24/25. It is important to note this is more than 30 days since admission. On 7/29/25 at 9:47 AM SW G and SW H indicated R40 should have had a level 2 screen completed when the facility realized she was going to be staying for longer than 30 days. On 7/29/25 at 1:03 PM ANHA F indicated there was a change of staff in the social workers department and the responsibility of the PASRR program was not picked back up by another staff member, but the facility will sweep the house and make sure all are up to date. ANHA F indicated R40’s PASRR level 2 should have been completed when she stayed in the facility for longer than 30 days. Example:3 R6 was admitted to the facility on [DATE] with diagnoses that include major depressive disorder. R6’s Physician Orders, dated 7/25/25, states, in part: … “-Duloxetine HCl (hydrochloride) Capsule Delayed Release Particles 20 mg (milligrams)- Give 1 capsule by mouth in the morning for depression… -Haloperidol Tablet 1 mg- Give 1 tablet by mouth every 4 hours as needed for delirium, agitation, hospice care, restlessness…” (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6’s PASRR Level I Screen was completed on 3/27/25 and indicated that R6 has a major mental disorder and is on medication to treat symptoms or behaviors of a major mental disorder. This screen also indicates that R6 is a person entering the nursing facility from the hospital for the purpose of convalescing from a medical problem for 30 days or less. R6 still resides at the facility on 7/29/25, more than the maximum 30 days exemption. Example 4: R14 was admitted to the facility on [DATE] and has diagnoses that include delirium due to known physiological condition. R14’s Physicians Orders, dated 7/11/25, state, in part: … “-Trazodone HCl Oral Tablet 100 mg- Give 1 tablet by mouth at bedtime for insomnia…” R14’s PASRR Level I Screen was completed on 12/23/24 and indicated that R14 has a major mental disorder and is on medication to treat symptoms or behaviors of a major mental disorder. Medications: Seroquel- Delirium and Trazodone- Insomnia. This screen also indicates that R14 is a person entering the nursing facility from the hospital for the purpose of convalescing from a medical problem for 30 days or less. R14 still resides at the facility on 7/29/25, more than the maximum 30 days exemption. On 7/29/25, at 9:51AM, Surveyor interviewed SW H (Social Worker) and SW G. SW H indicated R6 had Level I PASRR completed on 3/27/25 and R6 needs a Level II completed. SW G indicated the Level II should have been completed by 4/27/25. SW G indicated they had a shift in staff as the old social worker moved to assisted living and SW H was on a FMLA (Family Medical Leave Absence) and the PASRR Level II for R6 got missed along with others. On 7/29/25, at 1:00PM, Surveyor interviewed ANHA (Assistant Nursing Home Administrator) who indicated he would expect staff to follow the facility’s PASRR policy. At 1:30PM, ANHA indicated R14 should have had another PASRR completed at the end of the exemption due to the facility is to look at past and current history.

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	525692	A. Building B. Wing	07/29/2025

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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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This had the potential to affect all 33 residents. One staff member returned to work too soon after experiencing GI (gastrointestinal) symptoms. Five staff members on the facility’s line list did not have the date of last symptoms listed. R63 and R13, did not have accurate symptoms reflected on the line listing. Staff did not perform appropriate hand hygiene per Standards of Practice while providing catheter care to R6. This is evidenced by: The facility policy entitled Communicable/Contagious Diseases, Employee, with a revision date of December 2024, states in part:“Policy Statement: Personnel with active communicable infections may not be in contact with residents, resident-care items and equipment, or resident environments (e.g., common areas or resident rooms) until they are no longer clinically infectious or contagious. Work restrictions and return to work criteria for specific illnesses are determined by the infection preventionist based on the risk of transmission.Policy Interpretation and Implementation:1. Personnel are required to report suspected or confirmed infection with communicable or infectious diseases to their supervisor.…1. Personnel must report the following symptoms to their supervisor upon onset or prior to reporting to their scheduled shift: a. Temperature greater than 100° F; b. Nausea/vomiting; c. Head or body lice (pediculosis); d. Skin rashes, poison ivy/oak; e. Acute diarrheal illness with other symptoms (i.e. fever, abdominal cramps, bleeding, etc.) or diarrhea lasting longer than twenty-four (24) hours; f. Skin lesions or infections; and/or g. Acute upper or lower respiratory infection…. 6. Recommendations for transmission-based precautions are available at: https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/selected-infections/index.html.”According to the CDC (U.S. Centers for Disease Control and Prevention), for GI symptoms, “Exclude ill personnel from work for a minimum of 48 hours after the resolution of symptoms” (https://www.cdc.gov/infection-control/hcp/norovirus-guidelines/summary-recommendations.html#:~:text=14., FDA%20Food%20CodeExternal%20website). Example 1: Surveyor reviewed the staff line list provided by the facility and used for infection surveillance when staff members report an illness. The list reports the following information for CNA J (Certified Nursing Assistant): Last Worked: 7/18/2025 / Type of Known Infection: GI / Tested for COVID 19: 0 / Signs/Symptoms: Diarrhea / Date of Onset: 7/19/2025 / Date Form Received: 7/21/2025 / Date of F/U (Follow-Up): 7/21/2025 / Date of Last Symptoms: 7/19/2025 / Return to Work: 7/20/2025. (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/29/25 at 10:45 AM, Surveyors interviewed DON B (Director of Nursing) and IP I (Infection Preventionist) about the staff line list. Surveyors pointed out that CNA J returned to work the following day after the date of her last GI symptoms. DON B reviewed the list and said, “I see what you mean. ” DON B agreed that CNA J’s return to work date should have been 48 hours after symptoms resolved. Example 2: Surveyor reviewed the staff line list provided by the facility and used for infection surveillance when staff members report an illness. The list has 23 staff members on it from January-July 2025. The “Date of Last Symptoms” column is missing dates for five staff members:-CNA T: Last Worked: 1/8/2025 / Signs/Symptoms: Fever / Date of Onset: 1/8/2025 / Date of Last Symptoms: Blank / Return to work: 1/15/2025.-UC U (Unit Clerk): Last Worked: 2/12/2025 / Signs/Symptoms: COVID / Date of Onset: 2/12/2025 / Date of Last Symptoms: Blank / Return to work: 2/19/2025.-EFC V (Exercise and Fitness Coordinator): Last Worked: 1/21/2025 / Signs/Symptoms: COVID-19 / Date of Onset: 1/21/2025 / Date of Last Symptoms: Blank / Return to work: 1/31/2025-CNA W: Last Worked: 1/26/2025 / Signs/Symptoms: GI / Date of Onset: 2/8/2025 / Date of Last Symptoms: Blank / Return to work: Blank-CNA X: Last Worked: 7/15/2025 / Signs/Symptoms: GI / Date of Onset: 7/16/2025 / Date of Last Symptoms: Blank / Return to work: 7/27/2025 On 7/29/25 at 10:45 AM, Surveyors interviewed DON B (Director of Nursing) and IP I (Infection Preventionist) about the staff line list. Surveyors asked how proper illness tracking can be done for staff members when the line list is not filled out completely and how the administration can determine when staff members can return to work if the date of their last symptoms is missing on the tracking tool. IP I indicated this information should be on the line list. DON B agreed that all information should be filled out on the line list because this is the tracking tool they are using for surveillance purposes. Example 3: R63 was admitted to the facility on [DATE] and discharged on 6/10/25 with diagnoses that include encounter for surgical aftercare following surgery on the circulatory system, cardiogenic shock (the heart cannot pump enough blood to meet the body’s needs), and urinary tract infection. Surveyor reviewed R63’s progress notes. On 5/25/25, a UA (urinalysis) was ordered because “the resident’s urine was cloudy and smelled malodorous” and the resident “described a ‘burning sensation when urinating.’” A UA was collected on 5/26/25. Surveyor reviewed the UA and C&S (culture and sensitivity) results. Cefpodoxime Proxetil was ordered to be administered from 5/28/25-6/2/25. Surveyor reviewed the May 2025 and June 2025 line lists. The following is listed for R63 on the June 2025 line list: admit date : [DATE] / Type of Infection: UTI / Onset Date: blank / Signs/Symptoms: blank / Antibiotic Prescribed? Yes / Antibiotic Name or Medication: Ciprofloxacin / Route: Oral / Start date: 6/9/2025 / End date: blank / Precautions: blank / Organism: blank / Criteria met? blank / Facility or hospital acquired? facility / Labs: blankThe UTI detected by the UA on 5/25/25 was not on the May 2025 line list. (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

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Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/29/25 at 10:30 AM, Surveyors interviewed DON B (Director of Nursing). DON B agreed that the line list was missing information. She indicated many different people have been working on this list together since the facility’s previous infection preventionist left. DON B said the information on the line list should be complete. DON B agreed that accurate surveillance cannot be done without accurate information on the line list. Example 4 Surveyor reviewed the July 2025 line list. The following is listed for R13 on the July 2025 line list (Note: the resident’s name was misspelled): admit date : [DATE] / Type of Infection: UTI / Onset Date: 7/2/25 / Signs/Symptoms: frequency, urgency / Antibiotic Prescribed? Yes / Antibiotic Name or Medication: Cipro oral 250 / Route: oral / Start date: 7/2/25 / End date: 7/9/25 / Precautions: standard / Organism: ref / Criteria met? Yes / Facility or hospital acquired? blank / Labs: blank Surveyor reviewed the Revised McGeer Criteria for Infection Surveillance Checklist completed by the facility. The following boxes are checked under Table 2. Urinary Tract Infection (UTI) Surveillance Definitions Criteria: 1. Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate / 2. Greater than 10^5 cfu/ml of no more than 2 species of organisms in a voided urine sample. The information on the line list does not match the information on the McGeer Criteria for R13. On 7/29/25 at 10:30 AM, Surveyors interviewed DON B (Director of Nursing). DON B agreed that the line list was missing information. DON B said the information on the line list should be complete. DON B agreed that accurate surveillance cannot be done without accurate information on the line list. Example 5 The facility’s policy entitled “Handwashing/Hand Hygiene,” dated 10/2023, states, in part: … “Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation: Administrative Practices to Promote Hand Hygiene: … 2. All personnel are expected to adhere to hand hygiene policies and practices… Indications for Hand Hygiene: 1. Hand Hygiene is indicated: … g. immediately after glove removal… Applying and Removing Gloves: 5. Perform hand hygiene before applying non-sterile gloves…” (continued on next page)

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	525692	A. Building B. Wing	07/29/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R6 admitted to facility on 3/27/2025 and has diagnoses that include retention of urine and encounter for fitting and adjustment of urinary device. R6’s Physicians Orders, dated 7/25/25, states, in part: … -empty foley and record in MLs(milliliters)/provide foley cares every shift… Order Date: 3/28/2025 Start Date: 3/28/2025 -urinary catheter care every shift… Order Date: 4/16/2025 Start Date: 4/16/2025…” R6’s Care Plan, dated 6/12/2025, states, in part: … “Focus: Risk for Infection r/t (related to) chronic indwelling foley catheter… Date Initiated: 6/12/2025… Interventions: … -Manage indwelling catheter to minimize risk of infection every shift and PRN (as needed). Date Initiated: 6/22/2025 -Staff to follow standard precautions, including proper hand washing techniques, to minimize microorganism transmission. Date Initiated: 6/12/2025…” On 7/24/25, at 10:53 AM, Surveyor observed CNA C (certified nursing assistant) perform catheter care for R6. CNA C changed gloves four times while providing catheter cares without performing hand hygiene. On 7/24/25, at 11:15 AM, Surveyor interviewed CNA C and asked when hand hygiene should be performed during catheter cares. CNA C indicated before and after. Surveyor asked if hand hygiene should be performed with glove changes and CNA C indicated yes, with hand sanitizer or wash with soap and water. Surveyor asked CNA C if she had performed hand hygiene with glove changes while providing catheter care and CNA C indicated yes. Surveyor informed CNA C that it was observed four times glove changes without hand hygiene while CNA C performed catheter care. CNA C indicated she is about to perform hand hygiene now her hands are just full. On 7/24/25, at 2:40PM, Surveyor interviewed DON B (Director of Nursing) and informed DON B of observation of catheter care with CNA C with 4 glove changes with no hand hygiene. DON B indicated she would expect hand hygiene to be performed with glove changes per standard of care practice.

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	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525692	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Village East Health and Rehab Center	5833 American Parkway 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure they followed their antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 2 of 6 supplemental residents (R41 and R63) reviewed for antibiotic stewardship. A UTI (urinary tract infection) was not documented on the line list for R63. The UTI that was documented had incomplete information. The facility did not obtain a C&S (culture and sensitivity) for R63's UA (urinalysis) results or complete a McGeer Criteria checklist to indicate if UTI criteria was met.There was incorrect documentation on the line list for R41 and the facility did not show that the antibiotic was necessary. This is evidenced by:The facility policy entitled Antibiotic Stewardship - Orders for Antibiotics, with a revision date of December 2016, states in part: Policy Statement: Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program and in conjunction with the facility's general policy for medication utilization and prescribing.Policy Interpretation and Implementation:3. Appropriate indications for use of antibiotics include:a. criteria met for clinical definition of active infection or suspected sepsis; andb. pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending).5. If a resident is admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current antibiotic/anti-infective orders.The facility policy entitled, Surveillance for Infections, with a revision date of April 2025, states in part: Policy Statement: The infection preventionist conducts ongoing surveillance for healthcare-associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative symptoms.Policy Interpretation and Implementation. 3. Infections that are included in routine surveillance include those with:a. Evidence of transmissibility in a healthcare environment; b. available processes and procedures that prevent or reduce the spread of infections; c. clinically significant morbidity or mortality associated with infection (e.g., pneumonia, UTIs, C. difficile); d. pathogens associated with serious outbreaks (e.g., invasive Streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza); and e. infections that are included in reporting requirements (i.e., acute respiratory illnesses and vaccination data).McGeer revised criteria indicates the following, in part: . Table 2. Urinary Tract Infection (UTI) Surveillance Definitions .UTI without indwelling catheter. Must fulfill both 1 AND 2.1. At least one of the following signs or symptoms.- Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate.- Fever or leukocytosis, and greater than or equal to 1 of the following:- Acute costovertebral angle pain or tenderness; suprapubic pain; gross hematuria; new or marked increase in incontinence; new of marked increase in urgency; new or marked increase in frequency.- If no fever or leukocytosis, then greater than or equal to 2 of the following:- Suprapubic pain; gross hematuria; new or marked increase in incontinence; new of marked increase in urgency; new or marked increase in frequency.2. At least one of the following microbiological criteria.- Greater than 10^5 cfu/ml (colony forming unit per milliliter) of no more than 2 species of organisms in a voided urine sample.- Greater than or equal to 10^2 cfu/ml of any organism(s) in a specimen collected by an in-and-out catheter. Example 1:R63 was admitted to the facility on [DATE] and discharged on 6/10/25 with diagnoses that include encounter for surgical aftercare following surgery on the circulatory system, cardiogenic shock (the heart cannot pump enough blood to meet the body's needs), and urinary tract infection. Surveyor reviewed R63's progress notes. On 5/25/25, a UA (urinalysis) was ordered because the resident's urine was cloudy and smelled malodorous and the resident described a ‘burning sensation when urinating.' A UA was collected on 5/26/25. Surveyor reviewed the UA and C&S (culture and sensitivity) results. Cefpodoxime Proxetil was ordered to be administered from 5/28/25-6/2/25.The facility completed a Revised McGeer Criteria for Infection Surveillance Checklist dated May 28. At the bottom of the form, UTI criteria met is checked.Of note: R63's symptoms do not meet McGeers criteria.On 6/6/25, a second UA was done by the lab and results showed a continued infection. Progress notes on 6/7/25 indicate no new orders were given yet, as the doctor was waiting on sensitivity results. Ciprofloxacin HCl was ordered on 6/9/25 for five days to treat R63's UTI.Surveyor requested documentation from the facility for this UTI. The facility did not provide a Revised McGeer Criteria for Infection Surveillance Checklist for this UTI. There are no progress notes discussing any symptoms to have a second UA done. The facility provided documentation for the UA collected on 6/6/25 but did not provide documentation for the C&S results to show that R63 received the correct antibiotic for treatment On

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza and/or pneumococcal immunization; and (B) That the resident either received the influenza and/or pneumococcal immunization or did not receive the influenza and/or pneumococcal immunization due to medical contraindications or refusal. This affected 1 of 5 residents (R3) reviewed for immunizations.R3 did not sign, date, or check consent or declination for the influenza vaccination for 2024/2025 until 7/29/25.This is evidenced by:The facility policy entitled Influenza Vaccine, with a revision date of March 2022, states in part: Policy Statement: All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccines against influenza.Policy Interpretations and Implementation: 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized.2. Employees hired or residents admitted between October 1st and March 31st should be offered the vaccine within five (5) working days of the employee's job assignment or the resident's admission to the facility. 6. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record.Example 1:R3 was admitted to the facility on [DATE].R3 had documentation for the Influenza vaccine administered on 12/9/23.R3 did not have an influenza vaccine listed in her Electronic Health Record (EHR) for the last influenza season 2024/2025.On 7/28/25 at 4:15 PM, Surveyor requested influenza administration or declination documentation for the influenza vaccine for R3.On 7/29/25 at 10:50 AM, Surveyor asked DON B (Director of Nursing) about the influenza vaccine documentation for R3. DON B indicated there should be a declination form, but they were still looking for it.The facility provided an admission Immunization Assessment form with a checkmark indicating that R3 does not want the flu vaccine. R3 signed the form on 7/29/25. On 7/29/25 at approximately 12:30 PM, DON B told Surveyor that she had found the influenza vaccine declination form for R3. Surveyor reviewed the document. R3 and the staff assessing the vaccine status had both signed the form and dated it on 7/29/25.