STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525728	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Park Place of Janesville	700 Myrtle Way Janesville, WI 53545

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review, the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 1 of 3 residents (R1) reviewed for falls. R1 has a history of multiple falls. Facility staff did not implement appropriate fall interventions and provide adequate supervision. R1 had a fall that resulted in a displaced right inferior pubic ramus fracture (a break in part of the pelvis). Evidenced by: The facility's policy titled, Falls Policy and Prevention Program dated 6/29/21, states in part; .all residents will receive adequate supervision, assistance, and assistive devices to aid in the prevention of falls . R1 was admitted to the facility on [DATE] with diagnoses including pneumonia, need for assistance with personal care, difficulty in walking, dysphasia, cognitive communication deficit, dementia, major depressive disorder, anxiety disorder, muscle weakness, and altered mental status. R1's most recent MDS (Minimum Data Set) dated 3/19/24, states that R1 has a BIMS (Brief Interview of Mental Status) of 00 out of 15 indicating R1 is severely cognitively impaired. R1's MDS dated [DATE], also states .Bowel and Bladder section H, frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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NAME OF PROVIDER OR SUPPLIER Oak Park Place of Janesville		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Myrtle Way Janesville, WI 53545	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Comprehensive Care Plan states, in part; .Toilet use: The resident requires ext. (extensive) 2A (assistance of 2 staff) for toileting: SPT (stand pivot transfer) wc (wheelchair), grab bar. Do not leave unattended on toilet revision on: 4/4/24 .Resident is at HIGH risk for falls r/t (related to) generalized weakness, recent COVID illness, poor safety awareness, cognitive deficits, frequent falls prior to admission, deconditioning, and need for assistance with ADLs (activities of daily living), and toileting. Date Initiated: 3/15/24. Resident will not sustain serious injury through the review date. Date Initiated 3/15/24. Interventions/Tasks: HIGH FALL RISK date initiated 3/15/24. All staff to monitor that the resident is wearing appropriate footwear or non-skid socks when ambulating or mobilizing in w/c (wheelchair) 3/14/24. Anticipate and meet resident's needs as much as possible to prevent unsafe self-initiation 3/14/24. Assess/observe regularly for a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; personal items within reach 3/14/24. Be sure call light is within reach and encourage the resident to use it for assistance as needed 3/14/24. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs 3/14/24. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility 3/14/24. Ensure resident has his hearing aids in and/or utilizes his pocket talker device 3/21/24. Follow facility fall protocol if a fall occurs 3/14/24. PT evaluate and treat as ordered or PRN 3/14/24. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes 3/15/24. Upon admission, resident was placed in a room close to the nurse's station for increased monitoring and visualization d/t poor safety awareness and knowledge of h/o (history of) prior falls 3/14/24. Gripper socks on at all times 3/15/24. Low bed 3/14/24. Anti-roll back device on w/c 3/20/24. Encourage to come to common areas while awake 3/15/24. Bed against wall for spatial awareness 3/14/24. Resident had fall: 3/14/24 RCA (Root Cause Analysis): Failed self-transfer attempt. Intervention: Keep wheelchair at bed side with brakes on, so if he wants to get up, he can do so safely. 3/14/24 RCA: new environment, new admission to SNF w/dementia dx (diagnosis) and recent delirium: Intervention signs up in room as visual cues/reminders to use call light and await staff assistance to decrease risk of falls & falls with injury. 3/15/24 RCA: Failed self-transfer attempt intervention: keep bed at knee height. 3/17/24 RCA failed self-transfer. Intervention: anti-roll back locking device added to w/c. 3/19/24 RCA: Failed self-transfer. Intervention: Encourage to participate in activities of interest. Have activity meet with resident to discuss. 3/19/24 RCA: Failed self-transfer. Intervention: Continue with previous interventions. 3/19/24 RCA: Failed self-transfer. Intervention: Beveled matt landing strip. 3/24/24 RCA: Failed self-transfer. Intervention: 1:1 supervision at all times . R1 had eight falls from 3/14/24 - 3/24/24. Fall Reports state, in part: .Date 3/14/24 16:15 .Nursing description: Pt (patient) was found on the floor with his head up against the bedside dresser and bleeding from his scalp in two places. He was laying on his left side. Resident description: Resident unable to give description. Description: was able to safely get patient off the floor with a Hoyer. Wound was cleaned and steri strips were placed on the small wounds .Injury Type: Laceration .top of scalp .Environmental factors: Other. Physiological factors: confused, gait imbalance, impaired memory, recent illness, weakness. Situation factors: admitted within last 72h (72 hours), ambulating without assist .No witnesses found. It is important to note, Advanced Practice Nurse Prescriber was notified of fall, note states, in part; 3/14/24 staff did notify me of fall day of admission. Fall occurred around 4:15pm. Profound dementia pt and is ambulatory and tried to toilet self. Is on 2 blood thinners and likely hit his head .Intervention added keep wheelchair at bed side with brakes on, so if he wants to get up, he can do so safely. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Date 3/14/24 20:35 .Nursing description: Patient found on floor by CNA (Certified Nursing Assistant), self-transfer attempt to bed and fell . Resident description: Resident unable to give description. Description: Neuro checks WNL (Within Normal Limits), RN, DON in room to assist with transfer back to bed via Hoyer after assessing mobility. Injury type: No injuries observed at time of incident. Environmental factors: blank. Physiological factors: confused, gait imbalance. Situation factors: admitted within last 72hr, ambulating without assist. No witnesses found. Intervention added, signs up in room as visual cues/reminders to use call light and await staff assistance to decrease risk of falls and falls w/injury (with injury). **It is important to note, R1's most recent MDS indicates R1 has a BIMS score of 00. Date 3/15/24 10:31 .Nursing description: Patient was found in his room laying on the floor by his bed with a skin tear on his left elbow. Unable to determine if he hit his head or not. Difficult to communicate with resident due to hearing loss and garbled speech. Resident description: No description given. Description: Lifted off the floor with 2A with the Hoyer lift and placed back into bed. Was subsequently sent to hospital via ambulance to be evaluated after this being his 3rd fall in less than 24 hours per primary. Injury type: skin tear left elbow. Environmental factors: None. Physiological factors: confused, impaired memory, weakness. Situation factors: admitted within last 72hr, ambulating without assist. No witnesses found. Intervention added, Keep bed at knee height. **It is important to note, low bed is still an active intervention as well. Date 3/17/24 14:25 .Nursing description: Patient was found on the floor near the bathroom laying on his back after he was heard yelling for help. Has a 2-inch cut to the back of his head that was bleeding a little bit. Patient is very hard of hearing, so it was difficult to find out what he was doing. Resident description: Unknown. Description: Patient was checked for injuries and only the cut to the back of his head was noted. Hoyer lifted to his bed and then was sent to hospital via ambulance to be checked out further. Injury type: No injuries observed at time of incident. Environmental factors: None. Physiological factors: confused, gait imbalance, weakness. Situation factors: ambulating without assist. No witnesses found. Intervention added, Anti-roll back locking device added to w/c. **It is important to note despite resident being found near bathroom, no intervention regarding toileting schedule was discussed/added to care plan. Date 3/19/24 11:05 .Nursing description: Pt was found on the floor in the middle of his room. His head was near the bathroom and feet towards his window. He was laying on his right side. Resident could not explain what happened. Did deny pain when asked. Used a Hoyer to get pt into a wheelchair. Pt had a small 1-inch laceration to his right eyebrow at the far end by side of face. Resident description: Resident unable to give description. Injury type: laceration face. Environmental factors: None. Physiological factors: confused, gait imbalance, impaired memory, weakness. Situation factors: ambulating without assist. No witnesses found. Intervention added, encourage to participate in activities of interest. Have activity meet with resident to discuss. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Date 3/19/24 13:12 .Nursing description: Pt yelled for help. RN found pt lying on his stomach on the floor in the bathroom. His head was towards the bathroom door and his feet were near the shower. His depend was in its appropriate place but his pants were down around his ankles. No urine on the floor. He denied any pain or being hurt. RN and another staff member rolled him over to his back to be able to assess him better. Resident description: Resident unable to give description. Injury type: No injuries observed at time of incident. Environmental factors: Blank. Physiological factors: confused, gait imbalance, impaired memory, weakness. Situation factors: ambulating without assist. No witnesses found. Intervention added, Continue with previous interventions. **It is important to note despite resident being found in bathroom, no intervention regarding toileting schedule was discussed/added to care plan. Date 3/19/24 21:43 .Nursing description: CNA notified this nurse of resident on floor at 21:43. Resident found lying supine on floor next to bed with a pillow under him. Resident description: Resident unable to give description. Description: assessed for injury, no new injury observed. Assisted off floor via 2A Hoyer. Vitals obtained and neuro assessment started. DON notified; PCP (primary care provider) faxed notification of fall. Injury type: No injuries observed at time of incident. Environmental factors: poor lighting. Physiological factors: confused, drowsy, gait imbalance, impaired memory, weakness. Situation factors: active exit seeker, improper footwear, ambulating without assist. No witnesses found. Intervention added, Beveled matt landing strip. **It is important to note there was no education/discussion regarding improper footwear despite being care planned for R1 to have gripper socks on at all times. Date 3/24/24 11:30 .Nursing description: Pt found perpendicular to his bed lying on his back on the floor mats. Head near the bed. Resident description: Pt states he was trying to get to his wheelchair and slid to the floor. He kept stating I did not fall. Injury type: no injuries observed at time of incident. Environmental factors: None. Physiological factors: confused, gait imbalance, impaired memory. Situation factors: ambulating without assist. No witnesses found. Intervention added, 1:1 supervision at all times. Patient Report x-ray, states, in part; .Date of Service 3/25/24 .Reason .Numerous falls in the last week, Pain, Bruising bilateral on buttocks and both sides of hips, Pain in left leg femur area and also in right leg in femur area .Findings .Pelvis 1 view History: history of multiple falls, pain .Impression: nondisplaced avulsion fracture lucency across the ischial bone on the right side inferiorly as noted . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/11/24 at 4:58PM, RN C (Registered Nurse) indicated R1 has had several falls since R1's admission. RN C indicated the first few falls the facility was still getting to know R1 and all notifications were made regarding R1's falls. RN C and Surveyor reviewed R1's Fall Reports. RN C indicated Fall Reports do not include a lot of information. RN C indicated all of R1's Fall Reports state, failed self-transfer. Surveyor asked RN C if failed self-transfer indicates why R1 self-transferred in the first place? RN C indicated RN C understands what Surveyor is stating and that failed self-transfer does not explain the root cause of R1's falls. RN C indicated the facility is working on the process for falls and discussion regarding the root cause of a fall. RN C indicated R1's falls on 3/14/24 at 4:15pm, 3/17/24 at 2:25pm, 3/19/24 11:05am, and 3/19/24 at 1:12pm all indicated that R1 was possibly attempting to use the bathroom. RN C indicated R1's fall interventions did not include a toileting schedule (ex: assistance to bathroom every two hours, before/after meals, etc.) or any support regarding assisting R1 to the bathroom. RN C indicated interventions and updates to R1's care plan regarding a toileting schedule could have prevented some of R1's falls. RN C indicated on 3/28/24 the facility implemented 1:1 staff support for R1. RN C indicated this was implemented after R1 was discharged from the hospital having been diagnosed with a pelvic fracture. RN C indicated, I will be implementing a toileting schedule as soon as I leave this room. On 4/11/24 at 5:15PM, RN D (Regional Registered Nurse) indicated failed self-transfer does not explain the root cause of R1's falls. RN D indicated R1's fall interventions, Educate the resident about safety reminders . and signs up in room as reminders to use call light and await staff assistance .are not ideal fall interventions for a resident with a BIMS score of 00. RN C and RN D indicated for R1's fall on 3/19/24 9:43pm improper footwear was marked as a factor and there was not any education or discussion with staff regarding this as being a factor for R1's fall despite it stating on care plan gripper socks on at all times 3/15/24. Surveyor asked RN C and RN D about the interventions, low bed 3/14/24 and keep bed at knee height 3/15/24, and asked which intervention is the correct intervention since both are on R1's care plan. RN C and RN D indicated understanding that both interventions contradict each other. On 4/11/24 at 5:46PM, DON B (Director of Nursing) indicated the facility is currently working on updating their process for falls and they have all staff training scheduled. DON B indicated the staff education for fall interventions has not yet been completed. DON B indicated DON B did not realize R1's MDS states R1 is incontinent. DON B indicated that the interventions low bed and knee-high bed contradict each other and did not realize both interventions were on care plan. DON B indicated R1 would not be able to be educated regarding safety awareness because R1 would not remember discussion/education. DON B indicated DON B would expect the intervention to align with the root cause of the fall. The facility failed to ensure there was a robust discussion around root causes for each of R1's falls. The facility failed to identify patterns, failed to educate staff when an intervention wasn't followed, and failed to reassess R1's fall interventions. R1 had eight unwitnessed falls from 3/14/24-3/24/24, one resulting in a displaced right inferior pubic ramus fracture.