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	01/11/2025

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

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview and record review, the facility failed to ensure a hospital transfer was documented in the medical record and appropriate information was communicated to the receiving hospital for 1 of 1 resident (R1) of eight sample residents. Findings include: Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with diagnoses that included T-cell lymphoma (a rare type of cancer), skin cancer, and diabetes. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 10/29/24 revealed that R1 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R1 was cognitively intact and had no skin issues. Review of the Communication with Physician (non-COC-change of condition), dated 11/18/24 and located in the Progress Notes tab of the EMR, revealed [R1] continues to have generalized weakness and is failure to thrive . The physician feels that there is no more we can do for [R1] here aside from the suggestion of hospice. [R1] is not eating or drinking well, his skin is worsening .The physician suggest which (sic) is to get [R1] to the hospital for diagnostic and lab testing and from there [Name] (clinic) could send a helicopter to take him to Rochester, MN as this would be the best way for [R1] to comfortably travel this distance in his current condition . Review of the discharge-return anticipated MDS located in the MDS tab of the EMR with an ARD of 11/18/24 revealed, R1 had the following documented pressure ulcers: One Stage 4 pressure ulcer (full thickness tissue loss extending to the muscle, tendon, or bone) to the sacrum, one unstageable pressure ulcer to the scrotum (full-thickness pressure injuries in which the base (of the ulcer) is obscured by necrotic tissue (dead cells) and one deep tissue injury (a soft tissue injury) to his heels. Review of a Nursing Progress Note, dated 11/19/24 and located in the Progress Notes tab of the EMR, revealed .Received call from [Name] clinic informing writer that resident was admitted to [Name of Clinic] with Septic Shock [a life-threatening condition that happens when your blood pressure drops to a dangerously low level after an infection] . (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the SNF/NF [skilled nursing facility/nursing facility] to Hospital Transfer Form, provided by the Regional Clinical Nurse, dated 11/18/24, revealed the following information to the receiving hospital was left blank regarding R1's condition upon discharge: 1. Who was notified of the transfer and if they were aware of the clinical condition. 2. Respiratory status. 3. Skin/wound care. 4. Rehabilitation Therapy. In addition, the Transfer Form did not contain information that was to be sent with R1 to the hospital to include: 1. A face sheet (includes R1 demographic information). 2. Personal Belongings identified on the resident. 3. Current medication list. 4. Advanced Directive (living will or power of attorney). 5. Advanced Care Orders (code status). 6. Most recent History and Physical. 7. Any recent hospital discharges. 8. Recent MD/NP orders. 9. Flow sheets to include diabetic and wound care. 10. Relevant x-ray results. During an interview on 01/11/25 at 12:17 PM, the Regional Clinical Nurse stated, The transfer form to the hospital was not completely filled out including the wounds. My expectation would be that the entire form was filled out when a resident was transferred to the hospital.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observations, interviews, record review, and review of the facility procedure, the facility failed to ensure activities of daily living (ADLs) were provided according to the plan of care for 1 of 3 residents (R5) of 8 sampled residents. Findings include: Review of the facility's procedure titled, Bath Tub/Shower, dated 2001, revealed The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Review of R5's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed, R5 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive and a need for personal care. Review of the Five-day PPS (Prospective Payment System-a Medicare reimbursement) located in the Minimum Data Set (MDS) assessment tab with an Assessment Reference Date (ARD) of 01/11/25 revealed R5 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated she was moderately impaired in cognition. Review of the Activities of Daily Living Care Plan, dated 01/02/25 and located in the Care Plan tab of the EMR, revealed The resident has an ADL self-care performance deficit r/t [related to] dx [diagnosis] of LE [left extremity] cellulitis [a bacterial skin infection.] Approaches included but not limited to: Bathing/Showering: The resident requires extensive one person assistance for bathing/showering bi-weekly and as necessary. In addition, Personal Hygiene: The resident requires limited one person assistance with personal hygiene and oral care. Dressing: The resident requires extensive one person assistance to dress. During an initial observation on 01/09/25 at 1:15 PM, R5 was seated at the dining table (the noon meal was finished) with two other residents who were listening to music. R5's blue sweatshirt was covered with white flakes, had on Christmas flannel pajama pants and slippers. Her chin hair was approximately one-half inch long and was below the chin. Her lip hair was also long touching the top of her upper lip. In addition, her hair appeared greasy. R5 was asked if she was taking her showers and getting help with looking nice. R5 nodded, Yes. During a second observation on 01/10/25 at 1:06 PM, R5 was sitting at the dining table, just having finished the noon meal. R5 was wearing the same blue sweatshirt covered in white flakes, the same pajama pants and slippers. The chin and lip hairs and the greasy hair were the same as the day before. Review of the POC [point of care] Response History [CNA-certified nurse aide documentation] located in the Tasks tab of the EMR, revealed that since admission on 12/30/24, there had been no documented showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/10/25 at 1:29 PM, CNA1 stated, The showers are pre-set by someone, I don't know who though, but it is on my shower sheet. CNA1 pulled her resident list out of her pocket and stated, [R5] gets therapy showers, but I don't know if they are giving them or not. CNA1 was asked what occurred when she gave a shower to a resident. CNA1 stated, I do skin checks, wash their hair and body. I do nail care, but only after the shower. CNA1 was asked about R5's long chin and lip hair. CNA1 stated, The chin hair, I don't know when that had been addressed, I haven't shaved her though shaving is part of the shower. CNA1 further stated, I will admit that I have not given her a shower. CNA1 stated, I don't believe she has any other clothes to wear either. CNA1 was asked if she had mentioned this to the nurse or R5's family. CNA1 stated, No, I didn't know I could do that. During an interview on 01/10/25 at 1:57 PM, Occupational Therapist (OT) stated, We do have a list for the showers we give, and we share this with nursing. The residents may refuse or don't want the shower on a particular day. We try and document this when they refuse, and we try to communicate with staff. OT further stated, [R5] had a light sponge bath on 01/03/25 with therapy however, she declined any sponge bath this week. I had asked R5 about her chin and lip hair and she told me they were not a priority. We also tried to wash her hair, but she refused. Review of the OT ADL GET UPS located on a clip board inside the nursing station, revealed, On 01/06/25, [R5] preferred sponge baths, but she declined one on this day. During an interview on 01/10/25 at 2:43 PM, the Assistant Director of Nursing (ADON) was asked if she had observed R5's long chin and lip hair, clothing, and greasy hair. The ADON stated, I was not here when [R5] was admitted to the facility. The ADON then went to the dining room where R5 was seated at the table. The ADON stated, Yep, I see what you mean. The ADON was asked if R5 had enough clothes, as CNA1 explained she did not have any other clothes other than what she was wearing. The ADON stated, There is a lost and found closet, and the family should have been called to bring in additional clothing. The ADON stated, If [R5] had been refusing, we at least should have been encouraging her to take a shower. During a phone interview on 01/11/25 at 12:13 PM, the Director of Nursing (DON) stated, Staff have been educated over and over again about shower documentation. They should not be putting 'not applicable' if a resident refuses. The POC should be accurate. Cross-reference: F725: Sufficient Staffing.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for three of three residents (R3 and R1) of 8 sampled residents. The facility failed to assess and monitor R3's diuretic medication and provide supplemental medication to prevent critical laboratory values which caused R3 to be hospitalized due to the critically low blood levels. In addition, the facility failed to monitor and document R1 and R3's physician ordered weights. These failures placed the residents at increased risk of health complications and hospitalization . R3 is being cited at severity level 3 (actual harm). R1 is being cited at severity level 2 (potential for more than minimal harm). Findings include: Review of the facility's policy and procedure titled, Weighing and Measuring the Patient, dated March 2011, revealed .The purposes of this procedure are to determine the resident's weight and height to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition . Example 1 Review of R3's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R3 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included congestive heart failure. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/27/24 revealed R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R15 was cognitively intact and always continent of bowel and bladder. Review of the Special Instructions banner located across the bottom of the undated Face Sheet in the EMR, revealed .Acutely decompensated HF [heart failure-a serious medical condition that occurs when the heart can't pump blood effectively, causing a sudden or gradual worsening of heart failure symptoms] DAILY WEIGHT, LE [lower extremity] edema .Fluid restriction 2L [liters] per day . Review of the Discharge Summary, dated 11/22/24 and located in the Miscellaneous tab of the EMR revealed that R3 had been admitted to the hospital with several days of increased swelling in his lower legs which made it difficult for him to walk. He was sent to the hospital for evaluation and treatment which found that he had decompensated HF [heart failure]. R3 was discharged to the nursing facility with a physician order for Furosemide (a loop diuretic medication which cause the kidneys to excrete potassium and sodium) 40 mg twice daily. According to the National Library of Medicine dated 03/06/19 and located at doi:10.1152/ajprenal.00614. 2018 titled, Potassium-sparing effects in mice on high potassium diets, revealed .Loop diuretics, such as furosemide, are widely used to reduce fluid overload in patients and are well known for their renal K [potassium]-wasting effects that often produce hypokalemia [low potassium levels] .K wasting results from inhibition of Na [sodium] reabsorption . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	According tothe National Library of Medicine dated 5/22/23 and located at https://www.ncbi.nlm.nih.gov/books/NBK546656 /Adverse Effects: Adverse effects for loops diuretics typically occur from electrolyte imbalances secondary to the diuresis effects, which include: hyponatremia (low sodium) hypokalemia (low potassium) .Monitoring: Prescribers must be cautious when it comes to dosing to achieve diuresis. A black box warning states each loop diuretic is a potent diuretic and, at higher dosages, could lead to a profound diuresis with water and electrolyte depletion. Careful medical supervision is necessary as adjustments to these drugs should be according to the patient's needs. Electrolyte disturbances, including hyponatremia, hypokalemia . can lead to serious cardiac arrhythmias (fatal heart rhythms). Electrolytes require monitoring periodically to assess diuretic tolerance. According to Drugs.com dated 10/4/23 and found at https://www.drugs.com/sfx/furosemide-side-effects.html. Furosemide is a loop diuretic used to treat fluid retention (edema) in people with congestive heart failure . Furosemide may cause other serious side effects. Side effects signs of an electrolyte imbalance - increased thirst or urination, constipation, muscle weakness, leg cramps, numbness or tingling, feeling jittery, fluttering in your chest. Dosing Information Usual Adult Dose for Edema associated with Congestive Heart Failure: Oral: Initial dose: 20 to 80 mg orally once; may repeat with the same dose or increase by 20 or 40 mg no sooner than 6 to 8 hours after the previous dose until the desired diuretic effect has been obtained. Maintenance dose: Administer the dose that provided the desired diuretic effect once or twice a day (e.g., at 8 am and 2 pm). Comments:Edema may be most efficiently and safely mobilized by giving this drug on 2 to 4 consecutive days each week. When doses greater than 80 mg/day are given for prolonged periods of time, careful clinical observation and laboratory monitoring are particularly advisable. Furosemide works by increasing the amount of urine the body makes, which helps reduce swelling and symptoms of fluid retention and helps lower high blood pressure. Furosemide tablets are sometimes called water pills as they increase how much you urinate. Review of the November 2024 Medication Administration Record (MAR) located in the Orders tab of the EMR, revealed Furosemide 40mg [milligrams] twice daily. Start date: 11/23/24 and discontinued date of 01/07/25. It should be noted R3 was not on potassium supplementation despite being on 40 milligrams of Furosemide BID. Facility staff should have calrified orders for labratory electrolyte monitoring frequency with the physician based on R3's Furosemide dosage. It should be noted the facility was not monitoring R3's labs despite R3 receiving 40 milligrams of Furosemide BID. Progress note dated 12/11/2024 at 10:56 PM, states in part: Late entry. Note text: PC (Per Call) to (NP1), NP1 explained the symptoms patient was experiencing, fatigue, confusion, eating with a straw, urinating frequently and large amounts of incontinence when usually continent. Orders for UA and labwork were recevied. Review of the Laboratory Values, dated 12/12/24 and located in the Results tab of the EMR, revealed Sodium (Na) 118 [normal values 136-145] and Potassium (K+) 2.4 [normal values 3.5-5.1] R3 was transferred to the hospital due to the critically low lab values. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Of note, the critically low lab levels are a direct result from being on Furosemide a loop diuretic which will cause potassium and sodium to be excreted through the kidneys. Facility staff should have known the side effects of Furosemide and clarified whether R3 should have been on a potassium supplement and how frequently they should monitor labs as a result of receiving 40 milligrams of Furosemide twice a day. During a follow-up interview on 01/09/24 at 4:00 PM, the DON was asked why the blood work was done on 12/12/24. The DON stated, [R3] is on routine psychotropic medications and his CSP requires this for monitoring purposes. Actually, the bloodwork was to have been done on 12/08/24 or 12/09/24. However, the requisition was found in a pharmacy drawer, along with other orders on 12/12/24, when the bloodwork was done. Review of the Discharge Transfer Orders, dated 12/17/24 and located in the Miscellaneous tab of the EMR, revealed Stop taking Furosemide 40mg. In addition, the Discharge Transfer Order included Daily weights. Review of the December 2024 MAR located in the Orders tab of the EMR, revealed the Furosemide 40 mg twice daily continued and was not discontinued per the physician order. Review of the Physician Visit Note, dated 12/26/24 and located in the Miscellaneous tab of the EMR, revealed Heart failure .furosemide previously, discontinued in the hospital due to hyponatremia .Resume Lasix 20mg daily and check BMP [basic metabolic panel] in 1 week. During an interview on 01/09/24 at 3:01 PM, the Assistant Director of Nursing (ADON) stated, I am responsible to do admission and review the transfer orders. I will have to look into why the Lasix was not discontinued on 12/17/24, per the transfer order. During a follow-up interview on 01/09/24 at 4:00 PM, the DON stated, On 12/17/24, when [R3] was readmitted to the facility, the ADON had a personal issue going on and after she did the admission, she went home with the transfer orders so they couldn't be put into the system. When she did this, there was no second check of the orders, so the stopping of the Lasix was not found, and he continued on the Lasix 40 mg BID. The DON was asked about the Physician Note, dated 12/26/24 where he indicated that the Lasix was to be restarted at 20mg q day and why this order was not processed. The DON stated, It was missed. The physician reviewed R3's medication list on [hospital electronic medical record] which showed the discontinued Lasix. However, he did not review the facility medication list which would have shown that the Lasix had continued at 40mg twice daily. Review of the Laboratory Values, dated 01/03/25 and located in the Results tab of the EMR, revealed Sodium 132 and Potassium 2.2. The Nurse Practitioner (NP1) was notified of the critical potassium level. Review of the Nursing Progress Notes, dated 01/03/25 and located in the Progress Notes tab of the EMR, revealed .Lab with critical test results of Potassium = 2.2 (critical low). PC [per call] to NP1. Orders received to start potassium tonight, hold tomorrow [01/04/25] 0800 [8:00 AM] dose of Lasix and get a BMP on Monday 1/6/25 to reassess . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Telephone Orders located in the Miscellaneous tab of the EMR, revealed the following Physician Orders. Potassium Chloride ER [extended release] 20 MEQ [milliequivalents] give one tablet four times a day on 01/04/25 and then give 20 MEQ three times a day until 01/06/25. In addition, the order stated, BMP must be drawn on 01/06/25 and Furosemide (Lasix) 40mg twice daily. Review of the 01/06/25 Laboratory Values, dated 01/06/25 and located in the Miscellaneous tab of the EMR, revealed Sodium 134 and Potassium 2.9. Review of the current Order Summary located in the Orders tab of the EMR, revealed an 01/08/25 Physician order for Furosemide (Lasix) 40mg daily and a BMP to be drawn on 01/09/25. During an interview on 01/09/25 at 1:32 PM, R3 stated, I am feeling better now. R3 was asked if he remembered why he was sent to the hospital. R3 stated, My CHF [congestive heart failure]. R3 was asked if they were weighing him daily. R3 stated, No, I am not getting weighed every day, they miss days. Review of the Weights and Vitals tab in the EMR revealed the following dates that R3 had no documented weights, per the Physician Orders. -For November 2024: 11/23/24, 11/24/24, 11/25/24, 11/27/2. -For December 2024: 12/02/24, 12/05/24, 12/06/24, 12/07/24, 12/08/24, 12/09/24, 12/10/24, 12/11/24, 12/18/24, 12/19/24, 12/20/24, 12/25/24, 12/26/24, 12/29/24. -For January 2025: 01/01/25, 01/02/25, 01/06/25, 01/07/25, and 01/08/25. During an interview on 01/09/25 at 2:40 PM, the Director of Nursing (DON) stated, I know the CNA [Certified Nurse Aide] does them [weights] and she gives them to the nurse however, the nurse does not always finish her charting. The DON confirmed that the daily weights need to be entered into the EMR daily. Example 2 Review of R1's Admission Record located in the Profile tab of the EMR revealed R1 was admitted to the facility on [DATE] with diagnoses of T-cell lymphoma (a rare form of cancer), skin cancer, and diabetes. Review of the admission MDS located in the MDS tab of the EMR with and ARD of 10/29/24 revealed that R1 had a BIMS score of 14 out of 15 which indicated R1 was cognitively intact. Review of a Physician Order, dated 10/25/24 and located in the Orders tab of the EMR, revealed .Weight daily x 3 days, weekly x 4 weeks, then monthly . Review of the Weights and Vitals tab of the EMR revealed the following dates that weights were obtained and documented by nursing staff. 10/30/24: 183.6 and 10/26/24: 181.0. R1 had been discharged to the hospital on 11/18/24. Are R1 missed roughly 4 scheduled weights according to physician orders. R1 missed 2 daily weights and 2 weekly weights. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/09/25 at 2:40 PM the DON stated I know the CNA (Certified Nursing Assistant) does them [weights] and then gives them to the nurse however, the nurse does not always finish her charting. The nurses may put them on the daily assignment sheet, but my expectation is they are documented as having been done in the EMR. Cross-reference: F725: Sufficient Staffing.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview and record review the facility failed to consistently assess and monitor pressure ulcers and wounds. In addition, the facility failed to inform the provider upon admission and when wound care was refused for 1 of 2 residents (R4) reviewed for wounds out of 8 sampled residents. Findings include: Review of the facility's policy and procedure titled, Wound Care, dated October 2010, revealed . DOCUMENTATION .The following information should be recorded in the resident's medical record .The type of wound care given .The date and time the wound care was given .The position in which the resident was placed .The name and title of the individual performing the wound care .Any change in the resident's condition .All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound .How the resident tolerated the procedure .Any problems or complaints made by the resident related to the procedure .If the resident refused the treatment and the reason(s) why .The signature and titled of the person recording the data .REPORTING .Notify the supervisor if the resident refuses the wound care .Report other information in accordance with facility policy and professional standards of practice . Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R4 was admitted to the facility on [DATE] with diagnoses that included pressure ulcers, a scalp burn, colon cancer, and osteomyelitis (a bone infection) of the left ankle and foot. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 12/25/24 revealed R4 had a Brief Interview of Mental Status (BIMS) score that was staff assessed as moderately independent. In addition, R4 had one stage 3 pressure ulcer, one deep-tissue injury and a scalp wound due to a burn he sustained at home and was administered intravenous antibiotics daily during the observation period. Review of the Nursing Admission Form, dated 12/20/24 and located in the Assessments tab of the EMR, revealed documentation of R4's wound and skin issues. However, there were no measurements or assessments of the wounds documented. Review of the admission Physician Orders located in the Orders tab of the EMR, revealed: -Wound Care to Shallow Leg Ulcers (LEFT): cleanse w/ normal saline. Change 3x weekly & PRN [as needed]. Cover with Mepilex/foam dressing. Dated 12/21/24. -Wound Care to Lateral LEFT Foot: change dressing 3x/weekly & PRN. Flush with normal saline. Exufiber AG onto wounds. Cover with Mepilex/foam dressing. Dated 12/21/24. -Wound Care to Scalp: BID flush w/ normal saline. Apply Silvadene onto some dampened gauze (use saline to dampen). Cover surface with ABD pad(s). May use silicone tape or cohesive wrap to hold dressing in place. Two times per day. Dated: 12/21/24. (continued on next page)

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	525728	A. Building B. Wing	01/11/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ceftriaxone (an antibiotic medication given intravenously) 2 grams one time a day for Diabetic Foot Infection for 14 days. Start Date: 12/21/24 End Date: 01/04/24. Review of a Health Status Note, dated 12/20/24 and located in the Progress Notes tab of the EMR, revealed Resident will not allow staff to change wound dressings. Resident stated, 'If they aren't bleeding, they do not need to be changed.' LPN [Licensed Practical Nurse] educated resident that wound dressings need to be changed PRN [as needed] especially when they are soiled and leaking. The resident stated, 'I don't care, it's not needed.' LPN attempted another time to change wound dressings and resident still refused dressing changes Will continue to monitor and educate. The Health Status Note did not show documentation that the provider was notified of R4's continued refusal to have wound dressings changed. Review of the Nursing Progress Note, dated 12/21/24 and located in the Progress Notes tab of the EMR, revealed Resident took his bandage off of his head and writer attempted to rebandage head and resident started to yell at writer and said he does not need a bandage on his head if it's not bleeding. Resident is refusing to use call light and attempting to self-transfer (sic) himself in his room. Review of a Nursing Progress Note, dated 12/21/24 and located in the Progress Notes tab of the EMR, revealed Has open areas largest being the top of his head, area on top of head cleansed and Medi honey applied. According to the admission Physician Orders, dated 12/20/24, for the scalp wound, Silvadene was to be applied and not Medi-honey. Review of the 12/26/24 Skin and Wound Evaluation assessment form, dated 12/26/24 and located in the Assessments tab in the EMR, revealed the Director of Nursing (DON) had measured and assessed the wounds (six days after admission). The following wounds were documented: -A deep-tissue injury, pressure located on the right medial Achillies heel of unknown duration which measured 1.8 x 2.4 cm (centimeters). -Dry, pink areas on left buttock of unknown duration. -An abrasion to a kneecap of unknown duration which measured 1.4 x 0.9 cm. -A pressure ulcer, stage 3 (full-thickness loss of tissue), left mid foot which measured 2.6 x 4.7 x 1.9 cm of unknown duration. -Burn which measured 11.6 x 11.2cm. In addition, there was no documentation on the Skin and Wound Evaluation to show that the provider had been updated on the wounds. Review of the Nursing Progress Notes did not show any additional documentation regarding the wounds. Review of the Physician Orders located in the Orders tab of the EMR revealed, Ceftriaxone 2 grams intravenously was to be continued from 01/04/25 to 01/18/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the January 2025 Treatment Administration Record (TAR) located in the Orders tab of the EMR, revealed between 01/01/25 and 01/10/25, R4 refused wound care two times, was in the hospital one time and accepted wound care two out of five opportunities. There was no documentation in the Nursing Progress Notes to show the provider had been updated and was aware of R4's refusal to have wound care performed. During an interview on 01/11/25 at 8:45 AM, the Regional Clinical Nurse was asked why there was no assessment and monitoring for R4's wounds. The Regional Nurse stated, The DON keeps a spreadsheet on wounds however, when I contacted the DON regarding her wound documentation, she did not return my call. It's safe to say, the assessment and monitoring of the wounds was not done. As for lack of Provider notification, it's safe to say that wasn't done either.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 32513 Based on interviews, record review, and document review, the facility failed to ensure sufficient nurse staffing to provide nursing and related services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 4 of 4 residents and/or representatives (R8), Family Member (FM1) FM2, and FM3 out of a census of 20 residents. Findings include: 1. Review of the Facility Assessment, provided by the Administrator, revealed the assessment was updated on 08/24/24. The total number of beds available was 35. The average daily census was 19 for short-stay residents and zero for long-term residents. The average number of residents that were admitted to the facility per day was one to two on weekdays and zero to one on the weekends. The average number of resident discharges was zero to one per day. In addition, the Facility Assessment revealed that there are six full-time Registered Nurses (RN)s, three full-time Licensed Practical Nurses (LPN)s and 25 full-time Certified Nurse Aide (CNA) positions available. Based on condition/acuity, and census the following was the number of staff necessary for care of the residents: one Nurse Manager on the first shift; one RN/LPN on each shift and on weekends/holidays; and one to three CNAs on first and second shift and one to two CNAs on the third shift. In addition, there were one to three CNAs on the weekends. 2. Review of the Nurse Staffing Schedule provided by Human Resources (HR) revealed the following staffing from 01/09/25 to 01/11/25: a. 01/09/25: First Shift (6:00 AM to 2:00 PM): one RN for eight hours and two CNAs for eight hours. One CNA, who was scheduled but called off and did not work. Second Shift (2:00 PM to 10:00 PM): One RN for four hours and one LPN for four hours. There were three CNAs for eight hours. Third Shift (10:00 PM to 6:00 AM): One LPN for eight hours, one CMT (Certified Medication Technician) and one CNA for eight hours. b. 01/10/25: First shift: one RN for eight hours; one staffing agency LPN for eight hours due to the regularly scheduled LPN having called off, and two CNAs as the third CNA did not show up for work. Second shift: One staffing agency LPN for four hours. There was no RN or LPN identified to have worked from 6:00 PM to 10:00 PM. There were two CNAs for eight hours. Third shift: No RN or LPN was identified to have worked in the skilled unit from 10:00 PM to 6:00 AM. There was one CMT for eight hours and one CNA for eight hours. c. 01/11/25: First shift: One staffing agency RN for eight hours and two CNAs for eight hours. One CNA had called off and did not work. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Second shift: One staffing agency RN for four hours, one staffing agency LPN for four hours and three CNAs for eight hours. Third shift: one staffing agency LPN for eight hours, one CMT for eight hours, and one CNA for eight hours. 3. During an observation and interview on 01/11/25 at 9:45 AM, the call light was observed to have been activated. R8 was asked why she turned on her call light. R8 stated, I need to go to the bathroom. R8 was asked if her call light was answered timely. R8 stated, No, it does take a long time, but they do work their butts off, but it does take a long time. During a continuous observation of R8's call light response time, the light was answered in 22 min. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 11/19/24 revealed R8 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated she was cognitively intact. 4. During an interview on 01/09/25 at 1:27 PM, FM1 stated, After dinner and up to around 8:00 PM, there just isn't enough staff. Sometimes it takes up to 45 minutes to get assistance to use the toilet. During an interview on 01/10/25 at 1:10 PM, FM2 was asked if there was enough staff to meet R5's needs. FM2 stated, No, there isn't. Call lights are not answered timely, and he ends up wetting himself because it's taken too long. During an interview on 01/11/25 at 9:25 AM, FM3 stated, There are so many call lights going on during the night and the CNAs are working like crazy to get them answered, but there isn't enough staff. 5. During an interview on 01/10/25 at 1:29 PM, CNA1 was asked if there were enough staff to care for the residents. CNA1 stated, No, there isn't. CNA1 further stated, We are only two CNAs today but was supposed to have three. We have to answer the call lights first, get the showers done, make sure everyone is fed, there just isn't enough time. During an interview on 01/10/25 at 2:15 PM, the Occupational Therapist (OT) was asked if she felt there was enough staff to meet the needs of the residents. The OT stated, These residents are in a state of transition from being in the hospital and their needs can be much. No, I think they could use more help. During an interview on 01/10/25 at 2:43 PM, the Assistant Director of Nursing (ADON) was asked if she felt there was enough staff to meet the needs of the residents. The ADON stated, I agree, there just isn't enough staff for the residents. During an interview on 01/11/25 at 9:54 AM, Registered Nurse 2 (RN-staffing agency) stated, I have only worked here one other time. RN2 was asked if she helped answer call lights. RN2 stated, No, I don't have time as I am too busy with passing medications and doing treatments. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/11/25 at 10:05 AM, CNA2 stated, I work in the Memory Care Unit but was pulled down to the skilled area today. CNA2 was asked how she got everything done when there were only two CNAs working. CNA2 stated, We just try and go with flow. I have a pager and when I hear the call light go off, I will try and answer it. During an interview on 01/11/25 at 10:10 AM, CNA3 was asked if she felt there was enough staff to meet the needs of the residents. CNA3 stated, We just try and make sure everyone is fed, toileted, their beds are made, and the call lights are answered, it's a lot of work. CNA3 was asked if she worked in the skilled area regularly. She stated, No, I was pulled from the Assisted Living area to work here today. During an interview on 01/10/24 at 4:00 PM, the Administrator and Regional Clinical Nurse were asked if there was enough staff to meet the residents' needs. The Administrator stated, Our staffing numbers exceed the State of Wisconsin minimum requirements. The Regional Nurse then stated, It appears that we are not utilizing the staff effectively. Cross-reference: F677: ADL's (activities of daily living) for dependent residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview and record review the facility must provide pharmaceutical services to meet the needs for 1 (R6) of 8 sampled residents. R6 did not receive his Trazadone per R6's preference and physician's orders resulting in a timing error. Review of R6's Admission Record located in the Profile tab of the EMR. revealed R6 was admitted to the facility on [DATE] with diagnoses that included a left leg fracture, Parkinson's disease, and dementia. Review of the admission MDS located in the MDS tab of the EMR with an ARD of 11/15/24 revealed R6 had a BIMS score of 13 out of 15 which indicated he was cognitively intact and was administered an antidepressant medication during the seven-day observation period. Review of the Physician Orders located in the Orders tab of the EMR revealed Trazadone (an antidepressant medication) 50mg. Give one tablet my mouth in the evening at 1800 [6:00 PM]. Start Date: 12/28/24. Review of the Special Precautions on the banner located on the undated Face Sheet, revealed .Meds to be given between 6:30-7:00 PM d/t (due to) preference to go to bed around 7pm . During an interview on 01/10/25 at 2:25 PM, FM1 stated, He did not get medication on time last night for his Parkinson's. It was supposed to be given to him between 6:30 PM and 7:00 PM but, it was after 7:30 PM. He was sleepier this morning. FM1 was asked if she had mentioned her concerns to the staff. FM1 stated, Yes, I spoke to the Regional Nurse about it, and he stated he would take care of it. During an interview on 01/11/25 at 9:25 AM, FM1 was asked if R6's medication was given between 6:30 PM and 7:00 PM. FM1 stated, No he didn't. FM1 stated that an agency nurse was on duty last night who did not know what to do and did not give the medication until 7:15 PM. FM1 further stated, He did not even get his afternoon medications until 7:15 PM either. FM1 was asked if she had informed the Regional Nurse regarding this issue. She stated, Yes, I did. He gave me his phone number personally if there was an issue with the timing of [R6's] medications. During an interview on 01/11/25 at 10:30 AM, the Regional Clinical Nurse confirmed that R6's medications had been administered late. He stated, My expectation is the medications are to be administered, according to the special precautions banner.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interviews and record reviews, the facility failed to maintain a complete and accurate medical record for 2 (R1 and R4) of 8 sample residents. The facility failed to ensure the daily Medicare and/or Skilled Charting documentation contained skin/wound documentation for R1. In addition, the daily Medicare and/or Skilled Charting assessments were not completed daily, as required for R4. This failure placed the residents at risk of unmet care needs. Findings include: Example 1 Review of R1's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed, R1 was admitted to the facility on [DATE] with diagnoses which included T-cell Lymphoma (a rare type of cancer), skin cancer, and diabetes. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/29/24 revealed that R1 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated he was cognitively intact and had no skin issues. Review of the Skin/Wound assessments, dated 11/14/24 and located in the Skin/Wound tab in the EMR, revealed the following identified wounds and pressure ulcers. -Stage four (a full-thickness loss of tissue with exposed muscle, tendon, or bone) on the sacrum. -An unstageable pressure ulcer (a full thickness-loss of tissue with the wound bed containing necrotic tissue (dead tissue) on the scrotum. -A deep-tissue injury on the heels. Review of the daily Medicare and/or Skilled Charting documentation (a required document for all residents who have Medicare/Insurance as their primary payor source) located in the Assessments tab of the EMR, revealed no documentation regarding R1's skin/wounds on the 11/14/24, 11/15/24, 11/16/24, 11/17/24 and 11/18/24 Medicare and/or Skilled Charting forms. In addition, a review of the Nursing Progress Notes located under the Progress Notes tab of the EMR did not contain documentation regarding R1's skin or pressure wounds. During an interview on 01/10/24 at 10:36 AM, the Assistant Director of Nursing (ADON) was asked what the expectation was regarding completing the daily Medicare and/or Skilled Charting by the nursing personnel. The ADON stated, Anything out of the ordinary is to be documented on the Medicare and/or Skilled Charting or the Nursing Progress Notes. The ADON was shown the Medicare and/or Skilled Charting forms for the above dates and the lack of documentation regarding the skin/wounds. The ADON stated, I was not aware that the nurses' had not documented the wounds, they definitely should have. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2 Review of R4's Admission Record located in the Profile tab of the EMR revealed R4 was admitted to the facility on [DATE] with diagnoses that included colon cancer, stage 3 ulcers, and diabetes. Review of the admission MDS located in the MDS tab of the EMR with an ARD of 12/25/24 revealed R4 had a staff assessed BIMS of moderately independent, had one stage 3 pressure ulcer, one deep-tissue injury, and was on intravenous antibiotic therapy for a wound infection. Review of the Medicare and/or Skilled Charting located in the Assessments tab of the EMR, revealed on 12/25/24, 12/30/24, 01/04/25, 01/05/25 and 01/09/25 there was no documentation that nursing personnel had documented R4's care. During an interview on 01/10/25 at 12:20 PM, the ADON was asked what the expectation was regarding the daily Medicare and/or Skilled Charting documentation. The ADON stated, The 'Medicare and/or Skilled Charting' documentation is to be done daily and updated with any new issue the resident develops.