

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER Oak Park Place of Janesville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434</p> <p>Based on interview and record review, the facility did not ensure a thorough investigation of abuse was completed for 4 of 5 Residents (R1, R2, R3, and R4) reviewed for abuse.</p> <p>On 4/17/25, the facility became aware of an injury of unknown origin (IUO) for R1. The facility did not complete a thorough investigation regarding this IUO.</p> <p>On 2/17/25, R2 notified the facility of staff being rough with cares and feels she is being neglected. The facility did not complete a thorough investigation for R2's concerns.</p> <p>On 1/29/25, R3 had a verbal altercation with her family member. The facility did not thoroughly investigate this altercation.</p> <p>R4 verbalized staff did not provide desired care the facility did not complete a thorough investigation.</p> <p>This is evidenced by:</p> <p>The facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, states, in part: Policy: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from . verbal, mental, sexual or physical abuse . Policy Interpretation and Implementation The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff; b. other residents; c. consultants; d. volunteers; e. staff from other agencies; f. family members . i. visitors; and/or j. any other individual . 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements .</p> <p>The facility policy titled, Abuse Policy, dated 6/18/18, states, in part: . 10. The facility will identify and investigate all suspicion of or allegation of abuse (such as suspicious bruising of residents); review the occurrence and identify patterns and trends that may constitute abuse and that will be used to determine the direction of the investigation .</p> <p>Example 1:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R1 was admitted to the facility on [DATE], with diagnoses that include, in part: cerebral infarction (stroke), difficulty in walking, cognitive communication deficit, type 2 diabetes, essential tremor, congestive heart failure, and muscle weakness.</p> <p>R1's most recent Quarterly Minimum Data Set (MDS), with Assessment Reference Date of 1/9/25, states that R1 has a BIMS (Brief Interview for Mental Status) of 5 out of 15, indicating that R1 is severely cognitively impaired.</p> <p>R1's Physician Orders indicate, in part:</p> <p>Aricept (Medication that improves nerve cell function) Tablet 5 MG (Donepezil HCl) Give 1 tablet by mouth at bedtime for Aphasia (Difficulty comprehending or formulating language following damage to the brain). Start Date: 3/27/25.</p> <p>Appointment: Neurology. Date: 4/8/25. Time: 1:00 PM .</p> <p>(Of note: R1 did not have a physician order for a urinary catheter).</p> <p>R1's Comprehensive Care Plan indicates, in part:</p> <p>Focus: R1 has impaired visual function r/t (related to) age related vision loss. She wears glasses and wears appropriately, able to maneuver environment. Date Initiated: 3/14/25.</p> <p>Interventions/Tasks</p> <p>Ensure appropriate visual aids (glasses) are available to support participation in ADL's (Activities of Daily Living). Date Initiated: 3/14/25.</p> <p>On 4/3/25, a document titled, Skin Observation Weekly - V 2 was made effective. This document states, no new skin concerns. No wounds, lacerations, tears, or bruising noted on this document.</p> <p>On 4/8/25 at 12:36 PM, a Progress Note is written that states, in part: Pt (patient) was picked up by [Facility Name] transport to take to her 1:00pm appointment . Leaving in good condition.</p> <p>On 4/8/25 at 1:46 PM, a document titled, After Visit Summary was printed from a Neurology appointment. This document indicates the resident was seen for a Hospital Follow-up.</p> <p>On 4/8/25 at 2:32 PM, a Progress Note is written that states, in part: Pt returned with [Facility Name] transport driver in good condition. Received AVS (After Visit Summary) .</p> <p>Surveyor provided with a document titled, Driver Daily Ride Manifest for Appointments, dated 4/8/25, that indicates R1 left the facility at 12:30 PM for her Neurology Appointment. Drop Off time is indicated to be 12:40 PM. The document does not indicate when R1 was picked up from her appointment, however R1's AVS was printed at 1:46 PM. R1 is then documented to be dropped off at 3:00 PM</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>(Of note: Surveyor utilized a program to estimate the drive time from the facility to the clinic office, which was estimated to take 10 minutes. This time is reflected in the document with a leave time of 12:30 PM and a drop off time of 12:40 PM. However, R1's AVS was printed at 1:46 PM. (AVS is a document printed just prior to a patient leaving an appointment and contains a summary of the appointment). Drop off time for this resident is indicated to be 3:00 PM. Utilizing a pick-up time of 2:00 PM, this is a transport time difference of 50 minutes between the transport to the facility and transport back to the facility.</p> <p>(Of note: This time difference was not noted in the facility's investigation).</p> <p>R1's Medication Administration Record indicates in April 2025, R1's pain ranged from 0-3 until 4/10/25. On this date, R1 reports pain of 10 out of 10, 6 out of 10, and 6 out of 10.</p> <p>(Of note: This information does not appear in the facility's investigation).</p> <p>On 4/10/25 at 17:45 (5:45 PM), an ED (Emergency Department) Nursing Note is written that states, Pure wick applied per request of patient.</p> <p>(Of note: A pure wick is an external urinary device that allows patients to urinate without getting out of bed. No part of this device is inserted into the patient.)</p> <p>On 4/11/25, a Hospitalist Note is written by a Nurse Practitioner that states, in part: .Labial (external structures of female genitalia) bruising with vaginal tears - Noted with straight cath (catheter) 4/11. Patient denies sexual activity or abuse. Discussed with aHCPOA (Activated Healthcare Power of Attorney), declined SANE (Sexual Assault Nurse Examiner) exam or further intervention. Social work to notify APS (Adult Protective Services) of concerns .</p> <p>(Of note: Records indicate these injuries were observed prior to any external device insertion by hospital staff. Additionally, R1 did not have orders for a urinary catheter at the facility.)</p> <p>The facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, was initially sent to the State Survey Agency on 4/17/25 at 2:43 PM. This document notes that R1 is alleged to have an injury of unknown source, that was discovered while R1 was admitted to the hospital. The injury was reported to the facility on [DATE] by a police officer investigating the concern. NHA A (Nursing Home Administrator) reported to the State Survey Agency and initiated an investigation following notification. Under the section titled, EXPLAIN what steps the entity took upon learning of the incident to protect the affected person(s) and others from further potential misconduct ., it states, in part: The Director of nursing has initiated education regarding catheterization catheter care. Abuse could not be substantiated. [Resident Name] was admitted to the hospital on 04/10/2025 and injury was not noted by the hospital until 04/11/2025. This is not a criminal investigation, and no concerns have been brought to the attention of the facility by the resident or her family . This document indicates the report was submitted by NHA A on 4/21/25 at 1:49 PM.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/23/25, Surveyor reviewed the facility's investigation file for R1's injury of unknown origin. A document titled, Investigative Summary, is included in the file that describes the facility's notification of the injury, police case number, and the overall summary of the investigation. Also included were staff interviews from nursing, dietary, therapy, and maintenance employees, including DR D (Driver). DR D confirms he transported R1 to her appointment on 4/8/25, and reports the transport was without incident and was a very brief trip, and that he denies misconduct of any type with R1. The education included in the file was on Catheter Care which included a sign-in sheet including six CNA's (Certified Nursing Assistants) and one RN (Registered Nurse). Two documents titled, Catheter Care Competency Check-Off were reviewed, and were found to be signed and dated by staff but not filled out as to whether staff passed or failed each skill check.</p> <p>On 4/23/25, Surveyor requested all documentation related to resident skin checks following the report of an injury of unknown origin. Surveyor was provided with documentation for six residents out of a census of 22 on 4/23/24. Of the six residents, three were completed on 4/17/24, three were completed on 4/18/24, and R6's skin check was not completed until 4/20/24. Surveyor also notes R6 has a BIMS of 3 out of 10, which indicates severe cognitive impairment.</p> <p>On 4/23/25 R 2:05 PM, Surveyor interviewed NHA A (Nursing Home Administrator) DON B(Director of Nursing), and RN C (Regional Nurse). Surveyor asked NHA A what she understood regarding R1's injury of unknown origin. NHA A indicates a police officer came to the facility and reported he was conducting a non-criminal investigation into an injury reported to the police department by the hospital. The police officer was provided with all requested documentation regarding DR D. NHA A then initiated a self-report and her investigation. Surveyor asked should skin checks be conducted on all residents following possible abuse/injury of unknown origin. DON B indicates staff does skin checks with showers, during cares, and before leaving for an appointment as well as DON B conducting weekly skin checks. DON B also indicates she went room to room on 4/17/25 to interview residents but didn't do skin evaluations on residents who are alert. Surveyor asked DON B if the alert residents should have been asked about completing a skin assessment. DON B said no, because they are alert so it would be inappropriate to ask. Surveyor asked NHA A when she would expect these skin assessments to be conducted. NHA A indicates, right away. Surveyor asked if education should have been conducted regarding abuse and injuries of unknown origin. DON B indicates that she does not believe the injury occurred in the facility after reading the report so she assumed it could be from catheter care since R1 is elderly with fragile skin. Surveyor asked DON B if she was aware that R1's neurology appointment had been cancelled prior to 4/8/25. NHA A and DON B indicate, no. Surveyor asked what the expectations are for drivers. DON B indicates she expects drivers to be competent to drive the van, secure residents in the van, and if there is some kind of issue, they should call the facility to let us know. Surveyor asked NHA A if she would expect a driver to call her if transport was going to take longer than expected. NHA A indicates, yes. Surveyor asked NHA A if drivers undergo any training from the facility. NHA indicates staff are provided with a lot of education but does not know the specifics about drivers. Surveyor asked NHA A if she would expect the drivers to have training and competency checks. NHA A indicates, yes. Surveyor asked RN C if they noticed the time differences in the transportation log from 4/8/24. RN C indicates they did not. Surveyor showed NHA A, DON B, and RN C the transportation log, and asked specifically about the 50-minute time difference in transport times. RN C proposes it may have been due to DR D having multiple appointments around that time but did not know for sure. Surveyor asked NHA A if their vans have GPS units or dash cameras. NHA A indicates, no. Surveyor asked NHA A if any contracted staff, such as agency or hospice nurses, were interviewed regarding this injury of unknown origin. NHA A indicates that one of the staff interviewed was agency staff, but no hospice nurses were interviewed.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Does the person initiating the concern feel they are being abused or neglected? If yes, notify NHA (Nursing Home Administrator) or supervisor immediately. Yes</p> <p>What was done immediately after learning of concern? Assisted pt. with current needs and filled out grievance. Brought to manager for follow up .</p> <p>What system or procedure was implemented to resolve this concern and to prevent further similar concerns? Employee was identified and terminated .</p> <p>Facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report states, in part:</p> <p>Summary of Incident:</p> <p>Allegation Type- Neglect: Intentionally withholding care, disregard of policy or care plan .</p> <p>Date Discovered: 1/30/25 .</p> <p>Brief Summary of Incident: A SNF (skilled nursing facility) resident . made an allegation of neglect regarding care provided .</p> <p>Report Submitted Date: 1/30/25 1:38:18 PM .</p> <p>The facility's Misconduct Incident Report, dated 2/6/25, states. In part: .</p> <p>Summary of Incident:</p> <p>Date Discovered: 1/30/25</p> <p>Briefly describe the incident . R4 verbalized a concern towards an agency nurse during the NOC shift 1/30/25. She was asking for pain medications. She stated the staff came and turned her call light off and did not return. R4 verbalized to the Regional Nurse she did not want that nurse taking care of her.</p> <p>Describe the effect that the incident had on the affected person . R4 was not happy with the interaction with this nurse. She did not sustain a change of condition from this interaction. Review of her MAR confirms she received her lidocaine patch and extended-release acetaminophen for pain. When Administration followed up with her she did not feel abused or neglected. She did feel that the response from the nurse was poor customer service. R4 is happy and feels that her needs are being met.</p> <p>Explain what steps the entity took upon learning of the incident to protect the affected person and others from further potential misconduct .</p> <ol style="list-style-type: none"> 1. The facility contacted clipboard agency and request the agency nurse not to return as a contracted worker at Oak Park Place Janesville. 2. Regional Nurse followed up with her daily for psycho-social support and she was happy with the follow up . <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Report Submitted Date: 2/6/25 9:28:21 PM.</p> <p>Of Note: There is no documentation of other residents being interviewed regarding concerns of missed medications/cares, education provided to staff, or documentation of Regional Nurse's daily follow ups with R4.</p> <p>On 4/23/25, at 2:05 PM, Surveyor interviewed RN C (Regional Nurse), NHA A (Nursing Home Administrator) and DON B (Director of Nursing) on the Facility Self Report regarding R4, dated 1/30/25. Surveyor asked RN C if he was familiar with this Facility Self Report and RN C indicated yes. Surveyor asked RN C if he felt this was a thorough investigation and RN C indicated yes. Surveyor asked RN C if other residents were interviewed regarding missed medications or cares. RN C indicated he remembers interviewing other residents but is unable to locate them. Surveyor asked RN C if education was provided to staff regarding the concern and RN C indicated yes but is unable to locate the documentation. RN C indicated the interview with the agency nurse was completed. RN C indicated the nurse interview is unable to be located as well. RN C indicates the prior NHA may have taken the documentation or placed it somewhere they are unable to locate. RN C indicated he remembered interviewing R4 and R4's family and both had no further concerns and indicated they were happy with the outcome of the investigation. Surveyor asked without the supporting documentation would this Facility Self Report be considered a thorough investigation. RN C indicated no. Surveyor asked RN C if the supporting documentation should be with the investigation and RN C indicated yes.</p> <p>49436</p> <p>Example 3</p> <p>The facility submitted a self-report to the state on 2/17/25 regarding R2.</p> <p>On 4/23/25, Surveyor requested the entire self-report regarding R2. NHA A (Nursing Home Administrator) indicated the file handed to the surveyor was the completed investigation for R2's report of neglect and rough care.</p> <p>The facility's Misconduct Incident Report, dated 2/17/25, includes the following: R2 made an allegation of general neglect. She was unable to pinpoint a specific staff member, but did feel that her needs are not being met and she feels isolated, especially during the NOC (night) shift.</p> <p>OT E's (Occupational Therapist) written statement states in whole: On 2/17/25, R2 and daughter-in-law presented concerns regarding her recent care. R2 expressed frustration with long call light wait times and rushed care when care is provided. When caregivers do not answer her call light, she feels ignored, isolated, forgotten and neglected. Stated last night she slept with a light on in her room because a caregiver forgot to turn the light off and then did not come back to check on her. Feels there needs to be more caregivers checking on her at night, so this does not happen again. States there is mistreatment by a certain caregiver, name unknown, who is not friendly, often barks orders at her, and handles her roughly during cares. This writer listened to all of R2's concerns and assisted R2 and [Daughter-in-law] to fill out a concern report for further investigation and resolution. When asked if she feels she is abused or neglected, R2 affirms she feels she is being neglected and doesn't want this to happen to others.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/23/25, Surveyor requested the report the facility submitted to the state regarding R3. Surveyor was provided a file that contained only the Misconduct Incident Report.</p> <p>The facility's Misconduct Incident Report, dated 1/29/25, states in part: Administration was contacted regarding a family member speaking loudly towards a resident. When administration came to the room the sister/POA (Power of Attorney) was speaking loudly in a negative tone towards the resident. The resident did appear in distress. The POA was escorted off the premises immediately and P.D (Police Department), Adult Protective Services, and the Regional Ombudsman were notified. The facility has begun an investigation.</p> <p>On 4/23/25 at 2:05 PM, Surveyors interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and RN C (Regional Nurse) regarding the facility's investigation of R3. Surveyor asked for documentation of an investigation, interviews of residents and staff, skin assessments, education, or training to staff on how to handle disruptive visitors. NHA A, DON B, and RN C indicated there is no documentation of the investigation, interviews, skin assessments, psychosocial assessment and stated the facility's investigation of R3's incident is not a thorough investigation.</p>		