

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/29/2026
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on interview and record review the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 2 residents (R33) reviewed for accidents out of a sample of 17 Residents. R33 received a laceration (that required 10 stitches) during a transfer that was done with 1 assist and R33 required 2 assist. This is evidenced by: The Facility's Policy and Procedure entitled Safe Lifting and Movement of Residents dated July 2017 documents in part: .3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. R33 was admitted to the facility on [DATE] with the following diagnoses: wedge compression fracture of third lumbar vertebra, restless leg syndrome, unspecified diastolic (congestive) heart failure, localized edema, cognitive communication deficit, difficulty in walking not elsewhere specified, need for assistance with personal care, and repeated falls. R33's comprehensive Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/8/26, documents R33 is cognitively intact, with a Brief Interview of Mental Status (BIMS) score of 13 out of 15. R33's care plan documents in part: .Focus: Decreased ability to perform ADL's (Activities of Daily Living) related to compression fractures in lumbar spine/TLSO (thoracolumbosacral orthosis (back brace)) present. Transfer: ext (extensive) 2a (assist), 2WW (wheeled walker). Intervention implemented: 4/28/26. R33's progress notes documents in part: 6/21/26 21:30 (9:30 PM) Laceration to left lower leg U shaped with muscle and fatty tissue exposed. R33 was in wife's room sitting in her recliner. Was 2120 (9:20pm) and wife wanted to go to bed R33 was restless and was trying to get out of recliner. Call light on for staff [sic] get him into wheelchair to transport him to his room. CNA G (Certified Nursing Assistant) came into room. Said she would get him into bed. CNA G got resident. stood up no gait belt wife said R33's foot got caught behind small wheel in back of foot pedal. R33 was placed in wheelchair and screamed. Call to room blood on floor lifted his pj bottoms and R33 had laceration R33's NP (Nurse Practitioner) called sent R33 to ER (emergency room) after 911 called called [sic] 6/22/26 06:07 (6:07 AM) Following an investigation of the incident, it was determined that the (CNA) instructed R33 that she would assist him in transferring to a wheelchair and accompany him back to his room since he was in his wife's room at the time. R33 was informed that she would return with a second staff member to provide additional assistance. However, he expressed that he would not wait and would transfer himself. At that moment, CNA G made the decision to assist R33 herself, as she believed that leaving the room to obtain a second staff member posed a greater risk of potential falls compared to the risks associated with assisting R33 alone. Following the incident, further education and training were provided to the CNA G to address the situation appropriately. [sic] Surveyor reviewed the Facility's investigation of the incident. The (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525728
		If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	incident documents, in part: .R33 is care planned for 2 persons assist with transfers. R33 had attempted unsuccessfully to self-transfer from the recliner to his wheelchair. R33 put on the call light for assistance. When CNA G responded to the call light, CNA G explained to R33 that CNA G cannot transfer him safely on her own, CNA G will need to get a second staff to assist with transferring him. R33 said to CNA G that he is not waiting for her to get someone and will self-transfer. CNA G was not able to leave the room to get a second person to assist her with the transfer. R33 was at risk for falling if he self-transferred. CNA G made the decision to assist R33 to the wheelchair without the second person. In the process, R33 had sustained a laceration to his leg. Laceration measured 12 cm (centimeters), required 10 stitches. Investigation summary: R33 was in spouse's room. Spouse asked him to go back to his room so that she could go to sleep .CNA G had locked the brakes on the wheelchair and guided him to the wheelchair. As R33 got to the wheelchair, his foot got caught behind the small wheel in the back of the foot pedal. R33 sustained a laceration to his leg. CNA G sat him down on the wheelchair and yelled out for assistance. RN H (Registered Nurse) came to assist CNA G. RN H assessed resident and notified R33's NP (Nurse Practitioner). R33 was sent to the ER (Emergency Room) to be evaluated and treated for the laceration. R33 received stitches and was returned to the facility. CNA G's statement from Facility's investigation documents the following: R33 was in his wife's room. R33 call light was on, I went into the room. R33 was sitting in the recliner; he was trying to get up. I asked how I can help him, he said that he wanted to go back to his room so that his wife can sleep. I explained to him that I can help him, however, I need to get another staff member to help me transfer him. R33 said that he can't wait for another person, he wants to go. R33 said that he would get himself off up [sic] and in his wheelchair. I told him that its not safe for him to do that. I said to him again that let me get someone to help me transfer him so that he can be transferred safely. He wouldn't wait and I couldn't leave him. I was afraid, he may fall if he tries to get himself up. I made the judgement call to transfer R33 myself, its less of a risk that to leave the room and have him fall trying to get up and get into his wheelchair. I saw that he was struggling to stand so I asked him to put his arm around my shoulder so that he doesn't fall. He got to the wheelchair, and I noticed his foot was stuck behind the wheel. I sat him down in the wheelchair and helped fix his leg and I noticed blood on his pants, I called out to the nurse to come in to help. RN H came into room and looked at his leg and saw that he had a cut. I kept pressure on his leg while supplies were obtained to secure the wound. The wheelchair was moved out of the room and put away for maintenance to inspect. A different wheelchair was used to transfer him to his room. [sic] Surveyor reviewed the Facility's Disciplinary Action Form, dated 6/26/26, for CNA G, the staff that transferred R33 independently when R33 sustained a laceration requiring stitches. The form documents, in part: .Description of Infraction: Employee, in good faith, made error in discretion when she transferred a two person assist resident by herself from the recliner to the wheelchair. The incident resulted in bodily injury. Corrective Action: Employee is expected to reactivate pendant call to alert additional staff for assistance with two persons transfers. On 6/22/26 the Facility recognized the deficient practice and immediately implemented a corrective action plan as evidenced by:- All necessary notifications were made 6/21/26-6/22/26- Investigation initiated 6/22/26- R33's wheelchair was inspected by maintenance 6/22/26- CNA G received education on resident transfers and completed a skills checklist on resident transfers 6/22/26- Interviewed other staff 6/22/26- Interviewed other residents, no concerns noted 6/22/26- R33 had a Trauma History Evaluation completed 6/22/26- R33 had a Mood assessment completed (PHQ9) completed 6/22/26- R33 had a new BIMS completed= 12, 6/22/26- All wheelchairs were inspected 6/23/26- CNA G's personnel file was reviewed to include; CNA registry verified, background check, and orientation from hire 6/23/26- DON B (Director of (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Nursing) verified transfer status from the resident responses to each corresponding resident care plan 6/23/26.- All Nursing staff were provided education on transfer status 6/26/26- CNA G received disciplinary coaching 6/26/26 On 7/28/26 at 11:51 AM, Surveyor interviewed CNA C. Surveyor asked CNA C where you can verify a residents transfer status, CNA C said on the kardex, in the computer. Surveyor asked CNA C if a resident is a 2 assist to transfer, are you required to use 2 assist, CNA C stated yes. Surveyor asked CNA C if a resident is a 2 assist but is attempting to self-transfer, what is your best course of action, CNA C explained they'd try to talk to them, put call light on, holler if they know someone is in hall. Surveyor asked CNA C if they received any education on transfers recently, CNA C stated yes. On 7/28/26 at 12:36 PM, Surveyor interviewed CNA D. Surveyor asked CNA D where you can verify a residents transfer status, CNA D said on the kardex, labeled transfer. Surveyor asked CNA D if a resident is a 2 assist to transfer, are you required to use 2 assist, CNA D stated yes. Surveyor asked CNA D if a resident is a 2 assist but is attempting to self-transfer, what is your best course of action, CNA D explained they'd try to re-direct resident, look for help but keeping an eye on them. Surveyor asked CNA D if they received any education on transfers recently, CNA D stated yes. On 7/28/26 at 2:39 PM, Surveyor interviewed CNA E. Surveyor asked CNA E where can you verify a residents transfer status, CNA E said on the Kardex. Surveyor asked CNA E if a resident is a 2 assist to transfer, are you required to use 2 assist, CNA E stated yes. Surveyor asked CNA E if a resident is a 2 assist but is attempting to self-transfer, what is your best course of action, CNA E explained they'd try to report to nurse, if resident is determined that they need help right now, yell for help. Surveyor asked CNA E if they received any education on transfers recently, CNA E stated yes. On 7/28/26 at 3:30 PM, Surveyor interviewed DON B. Surveyor asked if CNA G should have transferred R33 with 2a, DON B stated yes however, R33 was attempting to get up on his own and she made the decision to stay with R33 and assist versus leaving him to fall and potentially be hurt worse. CNA G did not follow R33's care plan for 2 assist for transfers, and transferred R33 by herself, resulting in a laceration to R33's leg which required stitches.		