STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016397	A. BUILDING: _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF GREEN BAY	421 ERIE RD GREEN BAY, WI 54311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 05/01/2024 with information gathered through 05/02/2024, Surveyors conducted a standard survey, 4 complaint investigations and 1 self report review at Oak Park Place in Green Bay. Four (4) of 4 complaints were unsubstantiated. As a result of the survey, 2 deficiencies were identified. Census: 50	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess each resident's needs, abilities and physical and mental condition before admitting the person or when there was a change in condition for 1 of 1 residents (Resident 1) reviewed. Resident 1 had an enabler bar on his/her bed. Resident 1's closed record did not contain an	N 381		

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

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N 381	Continued From page 1 assessment for the use of an enabler bar. Findings Include: On 01/27/2024, the Department received a self-report indicating on 01/24/2024 Resident 1 was found with his/her neck between enabler bar and mattress with a pillow behind his/her head, and against mattress. Resident 1's lower right side of body was on the floor next to bed with blankets covering his/her body. On 01/24/2024, Resident 1 was pronounced dead by the medical examiner. On 05/01/2024, Surveyors made an onsite visit to the facility. Surveyor requested Resident 1's closed record. On 05/01/2024 at approximately 1:30 PM, Surveyor reviewed Resident 1's closed record. Resident 1 admitted to the facility on 02/03/2020 with diagnoses to include hypothyroidism, hypercholesterolemia, Alzheimer's Late Onset, hypertension and chronic kidney disease. Resident 1 had an unwitnessed fall on 11/08/2023 where s/he fractured his/her hip and was admitted to a facility for rehabilitation services. Resident 1 readmitted back to the facility on 12/06/2023. A comprehensive assessment was completed on 12/06/2023 and under mobility needs, it indicated Resident 1 required assistance of 1-2 staff and gait belt for all transfers, and the use of a walker or wheelchair for ambulation. The assessment indicated Resident 1 does not require an assistive device to transfer to bed, chair or toilet. Under bed mobility, the assessment also reflects Resident 1 requires a one-person physical assist to move to and from a lying position, side to side and/or position body while in bed. The assessment indicates Resident	N 381		

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N 381	Continued From page 2 1 did not utilize a supportive device with restraining qualities. Resident 1's most recent individual service plan (ISP) dated 02/03/2024 indicated Resident 1 was a risk for falls, had advanced cognitive impairment, was a 1-assist and gait belt for transfers, an elopement risk and had incontinence. Additionally, the ISP indicated Resident 1 needed staff assistance for dressing, bathing, oral care, medication management, laundry and housekeeping. There was a section on the ISP which identified Resident 1 as a fall risk. Under this section, there was an intervention which stated, "Enabler bar on bed to promote proper bed positioning." A progress note dated 01/24/2024 stated, "Staff entered resident apartment at approximately 0650 and found resident positioned with neck between enabler bar and mattress with pillow behind head and against mattress. Resident lower right side of body on floor next to bed with blankets covering body. Right upper body hanging from enabler bar off floor and against bed. Resident unresponsive with absent vitals and no signs of life. DHCS [sic] updated at 0700 and instructed staff to dispatch EMS. EMS dispatched and instructed staff not to move body. POA updated at 0703. EMS arrived at approximately 0715. EMS confirmed asystole and absent vital signs. EMS notified GBPD [Green Bay Police Department]. GBPD arrived to facility at 0728. Medical examiner's office notified by 911 dispatched at 0725. [Medical Examiner A] arrived at 0740 for examination and investigation. ME pronounced time of death at 0754. Per ME impression of enabler bar noted to resident neck with no apparent bruising or any other injury noted. Per ME a Natural event may have	N 381		

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N 381	Continued From page 3 occurred to cause death prior to body sliding from bed. Per ME Rigor mortis had not set in and resident death could have occurred 1-3 hours prior to being found..." On 05/01/2024 at approximately 1:52 PM, Surveyor interviewed Caregiver B who confirmed Resident 1 utilized an enabler bar in bed to reposition his/herself. On 05/01/2024 at 2:50 PM, Surveyor requested an assessment for the use of the enabler bar for Resident 1 from Director of Nursing (DON) C. DON C verified s/he did not assess Resident 1 for the enabler bar as this was something the family provided and s/he has "had it for years." DON C explained the enabler bar was not attached to Resident 1's bed and described it as a "U-shaped" device that slid underneath his/her mattress. DON C reported they did not have an assessment tool for this prior to this incident, but that has since changed. When Surveyor asked about the date on the ISP as it was after Resident 1 passed away, DON C confirmed the date of 02/03/2024 was the date s/he closed Resident 1's record. On 05/02/2024 at 4:00 PM, Surveyors interviewed DON C who confirmed Resident 1 was not assessed to have an enabler bar. DON C stated, "An assessment was never available prior to this. I never thought an enabler bar was a restraint." DON C reported training will be provided to staff and the system has been updated with the new assessment.	N 381		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall	N 489		

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N 489	Continued From page 4	N 489		

make reasonable attempts to keep all rooms free from odors.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 1 of 1 resident rooms were free from odors. Resident 2's room contained a strong smell of urine.

Findings include:

On 05/01/2024 at approximately 10:05 AM, Surveyor toured the facility accompanied by Director of Housing D and observed a strong smell of urine outside Resident 2's room. The smell was very noticeable and penetrated the air past several resident rooms located near the identified room. Director of Housing D acknowledged Surveyor's observation and identified Resident 2 struggles with incontinence and will defecate on the floor of his/her room as well as various other parts of the facility. Director of Housing D reported staff are aware and the areas are cleaned as needed.

Surveyor and Director of Housing D knocked and entered Resident 2's room where the odor of urine appeared even stronger. Surveyor observed there was a thin layer of carpeting in Resident 2's room. Resident 2 was sleeping in a chair and was covered in a blanket. Resident 2 also had a visitor.

On 05/01/2024 at 10:25 AM, Surveyor interviewed Family E who verified Resident 2 has trouble finding the bathroom and "drops them wherever [s/he] is." Family E pointed down to a spot on the carpet near the door where Surveyor was standing. Surveyor observed a large wet spot on the carpet adjacent to the trim on the floor.

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N 489	Continued From page 5 Family E reported Resident 2 urinated on the floor sometime this morning and s/he has not gotten around to informing the staff yet. When Surveyor asked if the smell bothered him/her, Family E stated, "That is why I open the window" and proceeded to point to the open window. Director of Housing D confirmed s/he would have it cleaned right away. On 05/01/2024 at 10:50 AM, Surveyor along with Director of Housing D went back to Resident 2's room after the spot had been cleaned. Surveyor observed the spot near the door appeared to have been cleaned; however, there was still a strong odor of urine. On 05/01/2024 at 10:55 AM, Surveyor interviewed Director of Housing D who acknowledged s/he could still smell a strong odor of urine odor in Resident 2's room.	N 489		