STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017017	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF JANESVILLE	700 MYRTLE WAY JANESVILLE, WI 53545

(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 12/04/2024, The bureau of assisted living Southern regional office conducted 3 complaint investigations and a self-report review at Oak Park Place a CBRF located in Janesville, WI. As a result of this survey, 3 violations of DHS Chapter 83 were issued. 2 complaints were substantiated. 1 complaint was unsubstantiated. Census: 51	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure Resident 1 was provided prompt and adequate treatment that was appropriate to meet Resident 1's needs. On 11/15/2024 after lunch, staff assessed that Resident 1's left hand appeared to be red and blistered. Staff reported Resident 1's hand injury to Nurse C and Nurse G. Nurse C and Nurse G assessed Resident 1's hand and took photos of the injury (Picture 1). Resident 1 was not provided pain medication, first aid treatment or transport to an emergency medical facility.	N 353		

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

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N 353	Continued From page 1 On 11/18/2024, Caregiver E observed Resident 1's left hand was red and blistered. Caregiver E observed Resident 1 to be in pain from his/her left-hand injury. Caregiver E called local emergency medical services (EMS) to assist Resident 1. EMS transported Resident 1 to an emergency room. Resident 1 was diagnosed with 2nd degree burns to the left hand. Resident 1's left hand required debridement surgery. This is a repeat violation of statement of deficiency (SOD) ENKL11 dated 02/21/2020. FINDINGS INCLUDE: The facility cares for the following client groups: irreversible dementia & Alzheimer's. On 11/21/2024, The Department received a self-report. The self-report documented Resident 1 had obtained a burn injury. Administrator A documented the following, "[Resident 1] (Memory Care Resident) sustained what appears to be a burn injury to [his/her] left hand. It is unclear of the date and time this burn occurred. Based upon the current known timeline, [his/her] hand began to show blisters during the lunch service 11/15/2024. Nursing was contacted to assess and evaluate [his/her] hand. [His/Her] physician and POA was notified on 11/15/2024 On 11/16/2024 [his/her] POA was contacted again by the [Caregiver H] with a description on how [his/her] hand is presenting.[His/Her] POA then advised that [s/he] would reach out to the physician to see what [s/he] thinks. On Monday 11/18/2024 [Local Police Department] was notified and came to the facility regarding [Resident 1]. The nursing staff escorted them up to the unit... [Resident 1] was sent out to [Local Emergency Room] via 911 on 11/18/2024. [S/he] returned that same night with a	N 353		

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diagnosis of a partial thickness burn of [his/her] hand including fingers according to the [Hospital] after visit summary. [His/Her] hand was debrided and dressed with xeroform gauze and triple antibiotic ointment. It is confirmd (sic.) that [s/he] sustained an injury to [his/her] left hand. The facility has not been able to determine how this occurred as of right now. The facility has ruled out that the injury occurred from hot water, hot food, a hot lamp in the room or from the stove in the Memory Care Activity room. The investigation included record review, review of camera footage, environment checks, and staff interviews."

On 12/02/2024, the Department received a complaint regarding resident safety.

On 12/03/2024, Surveyor arrived at facility for a complaint investigation.

On 12/03/2024, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 03/11/2021. Resident 1 had an activated power of attorney. Resident 1 was diagnosed but not limited to: vascular dementia, Pick's disease, major depressive disorder, and obsessive-compulsive disorder.

On 12/03/2024, Surveyor reviewed Resident 1's individualized service plan (ISP). Resident 1's ISP was signed on 05/13/2024. Resident 1 required a 4 wheeled wheelchair for mobility. Resident 1 suffered from expressive aphasia (difficulty with verbal communication). Resident 1 required staff to help set up meals and remind him/her of appropriate silverware to utilize.

On 12/03/2024, Surveyor reviewed Resident 1's observation notes from 11/01/2024 to 12/04/2024:
-On 11/15/2024 at 3:58 PM, Nurse C documented

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the following, "This writer was called to memory care unit to look at residents left hand. Resident had intact yellow fluid filled blisters on left pinky finger, ring finger, and middle finger. Pictures were taken and sent to provider and message for [Family Member I]."
-On 11/19/2024 at 2:18 PM, Nurse C documented the following, "call was placed with [Doctor L] this day at 11:50 to inform of ER visit and need for treatment to left hand. And order for home health to come in and do daily dressing changes. Dressing was changed this day as ordered by ER doctor d/t drainage."

On 12/03/2024, Surveyor reviewed Resident 1's hospital record. On 11/18/2024 at 8:23 PM, Doctor K documented Resident 1 underwent a debridement (removal of dead tissue) from a second degree burn injury to the left hand. Post-procedure Resident 1's surgical site was covered with a non-adherent dressing and triple antibiotic.- Surveyor reviewed Resident 1's 11/18/2024 emergency room after visit summary. Resident 1 was diagnosed with "Partial thickness burn of hand including fingers...". Resident 1 was prescribed Oxycodone for pain management post-discharge from the hospital.

On 12/03/2024, Surveyor reviewed Resident 1's November 2024 medication administration record. From 11/15/2024 to 11/18/2024, Resident 1 had an order for the following PRN (as needed) pain medications: Acetaminophen (Tylenol) 325 mg to be given every 6 hours as needed for pain. Zero, administrations of PRN pain medication was administered from 11/15/2024 to 11/18/2024.

On 12/03/2024 at 10:15 AM, Surveyor discussed Resident 1's facility records with Nurse C, Nurse B and Regional Nurse D. Nurse C and Nurse B

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stated all of Resident 1's facility assessments from 11/01/2024 to 12/04/2024 were documented in his/her observation notes. Nurse C and Nurse B acknowledged observation notes did not contain a comprehensive assessment for injury of unknown origin on 11/15/2024. Nurse C and Nurse B acknowledged Resident 1 was not documented as assessed on 11/16/2024, 11/17/2024 and 11/18/2024. Nurse B reported s/he did not feel the injuries assessed on 11/15/2024 were second degree burns, but instead assessed (picture 1) as cellulitis of the left hand. Nurse B reported facility had communicated with Family Member I and Resident 1's primary care provider from 11/15/2024 to 11/18/2024. Nurse B acknowledged Resident 1 had not be administered his/her PRN pain medication from 11/15/2024 to 11/18/2024. Nurse B reported Resident 1 was not expressing signs of pain to warrant the administration of PRN pain medication before Resident 1's surgical debridement on 11/18/2024. Nurse B reported Caregiver E was a 'sassy staff.' Nurse B described not supporting Caregiver E's decision to obtain EMS for Resident 1 on 11/18/2024. Nurse B described a social media website which posts emergency calls heard over the 911-scanner in the community and stated many previous staff had commented on the situation described above. Nurse C, Nurse B and Regional Nurse C acknowledged Resident 1 was not provided a comprehensive assessment, emergency treatment, pain management or surgical intervention from the development of the second degree burns on 11/15/2024 to when Caregiver E summoned EMS on 11/18/2024.

On 12/06/2024, Surveyor reviewed a social media post on the Facebook page titled, "608 Public Safety." On 11/18/2024, the following post was

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made, "3:01 PM- [Facility Name] Memory Care- 2nd degree burns on hands- Facility not helping."

On 12/06/2024, Surveyor reviewed adult protective service (APS) investigative report regarding Resident 1's second degree burns. On 11/18/2024, Social Worker Q documented the following statement, "[Caregiver E] worked directly with [Resident 1] on Sunday 11/17/24 and noticed that [Resident 1] had severe second degree burns all over [his/her] fingers on one hand. Burns are large and bubbled up on top/bottom of hand. CBRF staff could not tell [Caregiver E] how consumer hurt [himself/herself] but have not sent [Resident 1] out to the hospital for evaluation. [Nurse C] looked at the burns per [Caregiver E's] request but did not treat burns in any way. Burns are unclean, uncovered, and [Resident 1] is in noticeable amount of pain ... [Caregiver E] proceeded to call 911 and confirmed that [Resident 1] has been transported to [Local Emergency Room] in the evening of 11/18/24 d/t severity of burns ...[Caregiver E] stated coworkers/director know [s/he] contacted ADRC/911 and staff are talking about terminating [his/her] employment ...". On 11/20/2024, Investigator M documented the following, "11/19/24 Writer spoke with [Family Member I]. [S/he] has been ill and unable to visit. [S/he] said that [s/he] saw photos on My Chart. [S/he] had received a call from [Facility] on Saturday (11/16/2024). They thought that it was cellulitis and [Resident 3] was crying and asked for direction...They let things wait until Monday (11/18/2024) after a call to [Doctor L] for antibiotics. On Monday, the fire department was called and informed [him/her] that it was actually a burn. [S/he] has blisters and not cellulitis...11/20/24 Writer and [Supervisor N] met with [Nurse B], [Nurse C], [Administrator A] ...

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[Resident 1] was diagnosed at the clinic with second degree burns...They said they sent photos to [Doctor L], and they did not feel that [Resident 1] was in pain. Since there is a second degree burn and it has been debrided, [Resident 1] is now in pain."

On 12/06/2024, Surveyor reviewed Police report regarding Resident 1's burn injuries. On 11/19/2024 at 3:28 PM, Officer P documented the following, "On 11/18/24 at approximately 3:00 pm, officers responded to [Facility Name] for a welfare check. [Resident 1] was transported to [Emergency Room] ...ARRIVAL ON SCENE ... I arrived on scene and made contact with the front desk employee who was able to escort myself and [Officer N] to the Memory Care Unit where [Resident 1] was staying. As I entered the Memory Care Unit I made contact with [Nurse C]. I took [Nurse C] aside to receive a statement from [him/her] as to where [Resident 1] received [his/her] injuries...[Nurse C] is the RN in charge of the Memory Care Unit at [Facility Name]...[Nurse C] was aware of the burns on Friday 11/15 and knew that there were pictures taken of the burns. [Nurse C] confirmed that staff attempted to make contact with the on-call physician regarding the burns, however have not heard back. [Nurse C] also mentioned staff attempted to make contact with [Resident 1's] power of attorney however also received no answer then. [Nurse C] admitted that no staff there is trained to take care of the wounds or cover them up so the wounds were left open over the weekend. As of Monday 11/18, [Nurse C] has not heard anything back from the power of attorney or the on call physician regarding the injuries...[Nurse C] heard that the injuries were possibly caused by hot oatmeal however could not confirm. I challenged [Nurse C] further as to why EMS was not contacted since

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N 353	Continued From page 7 [s/he] was not receiving any answers from power of attorney or the physician however [s/he] stated that medical decisions have to go through them first. I further challenged [Nurse C] due to the current state of [Resident 1's] injuries that emergency medical professionals should have been contacted due to the risk of infection and the pain caused by it...[Nurse C] made comments towards the training of [his/her] staff saying that they can work at McDonald's one day and here the next and that they aren't trained for situations like this...". CROSS REFERENCE: N0415 DHS Chapter 83.37(2)(d) Documentation Of Medication Administration	N 353		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not initial Resident 1's medication administration record (MAR) at the time of	N 415		

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medication administration nor Resident 1's need/effectiveness for any PRN (as needed) medication.

On 11/18/2024, Resident 1 was sent to an emergency room. Resident 1 was diagnosed with 2nd degree burns to the left hand. Resident 1 underwent debridement surgery (removal of dead tissue) of the left hand. Doctor K ordered for Resident 1 to take the schedule II narcotic Oxycodone 2.5 mg every 6 hours (up to 4 times daily) as needed for pain post discharge. Resident 1 was discharged back to facility that evening.

From 11/19/2024 to 11/20/2024, Resident 1's November 2024 MAR had zero administrations of Oxycodone 2.5 mg administered for pain documented.

On 12/09/2024, Administrator A notified Surveyor via email that facility had their own supply of Oxycodone 2.5 mg to administer to Resident 1 and staff had documented the administration on Resident 1's narcotic count. Surveyor reviewed Resident 1's narcotic count for Oxycodone 2.5 mg and found Resident 1 was administered the PRN pain medication once daily on 11/19/2024, 11/20/2024 and 11/21/2024. Zero, documentation of PRN effectiveness was documented on the narcotic count.

FINDINGS INCLUDE:

On 12/02/2024, the Department received a complaint regarding resident safety.

On 12/03/2024, Surveyor arrived at facility for a complaint investigation.

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N 415	Continued From page 9 On 12/03/2024, Surveyor reviewed Resident 1's facility record Resident 1 was admitted to the facility on 03/11/2021. Resident 1 had an activated power of attorney. Resident 1 was diagnosed but not limited to: vascular dementia, Pick's disease, major depressive disorder and obsessive-compulsive disorder. On 12/03/2024, Surveyor reviewed Resident 1's individualized service plan (ISP). Resident 1's ISP was signed on 05/13/2024. Resident 1 suffered from expressive aphasia (difficulty with verbal communication). Resident 1's medications were to be administered by facility staff. On 12/03/2024, Surveyor reviewed Resident 1's hospital record. On 11/18/2024 at 8:23 PM, Doctor K documented Resident 1 underwent a debridement (removal of dead tissue) from a second degree burn injury to the left hand. Post-procedure Resident 1's surgical site was covered with a non-adherent dressing and triple antibiotic. Surveyor reviewed Resident 1's 11/18/2024 emergency room after visit summary. Resident 1 was diagnosed with "Partial thickness burn of hand including fingers...". Resident 1 was prescribed Oxycodone for pain management post-discharge from the hospital. On 12/03/2024, Surveyor reviewed Resident 1's November 2024 medication administration record. Resident 1's Oxycodone 2.5mg PRN script was transcribed to the facility MAR on 11/21/2024 at 7:45PM. On 12/06/2024 at 3:34 PM, Surveyor email Administrator A, Nurse B, Nurse C and Regional Nurse D. Surveyor asked if Resident 1 had been denied PRN Oxycodone 2.5 mg for pain from 11/18/2024 until 7:45 PM on 11/21/2024.	N 415		

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N 415	Continued From page 10 On 12/09/2024 at 5:21 PM, Administrator A emailed Surveyor a copy of Resident 1's Controlled Substance Log for Oxycodone 2.5 mg tablets. Administrator A sent the following message, " [Surveyor], Attached is the controlled substance administration log for [Resident 1]. It is confirmed that [s/he] received oxycodone 5mg on 11/19/2024, 11/20/2024, and 11/21/2024 ...The medication was in house and available for the staff to administer ...". On 12/09/2024, Surveyor reviewed Resident 1's narcotic count for Oxycodone 2.5 mg and found Resident 1 was administered the PRN pain medication once daily on 11/19/2024, 11/20/2024 and 11/21/2024. Zero, documentation of PRN effectiveness/Resident 1's response was documented on the narcotic count. CROSS REFERENCE: N0353 DHS Chapter 83.32(3)(i) Rights of Residents: Adequate Treatment	N 415		
Y3235	50.09(1)(f) Privacy (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to:	Y3235		

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This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure Resident 2's right to physical and emotional privacy in his/her living arrangement.

On 11/01/2024 at approximately 1:30 PM, Resident 3 wandered into Resident 2's room. Resident 3 was recorded on a camera installed in Resident 2's room. Resident 3 was recorded touching Resident 2's bed and dresser.

FINDINGS INCLUDE:

The facility cares for the following client groups: irreversible dementia & Alzheimer's.

On 11/01/2024, the Department received a complaint regarding resident care.

On 12/03/2024, Surveyor arrived at facility for a complaint investigation.

On 12/03/2024, Surveyor reviewed an email from Family Member F. The email subject was, "[Resident 3] in [Resident 2's] room," the email had been sent to Administrator A and Nurse C on 11/01/2024 at 10:36 AM. Family Member F wrote the following message, "Please keep [Resident 3] out of [Resident 2's] room. [S/he] was touching [him/her] while [s/he] was sleeping. This was at 1:30 am. Nightshift need to keep an eye on residents."

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Y3235	Continued From page 12 On 12/03/2024, Surveyor reviewed video footage attached to Family Member F's email: 1.) Video #1 - 19 second duration - Resident 3 walked from bedside table to Resident 2's bed. Resident 3 touches bed linens and surface area off camera. 2.) Video #2 -20 second duration - Resident 3 walked from the bedside table to dresser. Resident 3 touched a photo frame and article of fabric on Resident 2's dresser. On 12/03/2024, Surveyor reviewed Resident 2's facility facesheet. Resident 2 was admitted to the facility on 04/05/2019. Resident 2 had an activated power of attorney. Resident 2 received hospice services. Resident 2 was diagnosed with but not limited to: dementia and anxiety. On 12/03/2024, Surveyor reviewed Resident 2's individualized service plan (ISP) dated 07/22/2024. Resident 2's ISP documented camera usage ad follows, "Staff to ensure camera remains in place/position at all times." Resident 2 was documented as a high fall risk. Resident 2's range of movement was documented as, "[Resident 2] requires the use of a mechanical lift for all transfers with 2 assist of staff for transfers. Uses Broda chair for mobility via staff... [Resident 2] requires max assist of 2 staff to turn and re-position in bed." Resident 2 utilized an indwelling urinary foley catheter and CPAP mask during nighttime hours. On 12/03/2024, Surveyor reviewed Resident 3's facility facesheet. Resident 3's date of admission was 11/23/2021. Resident 3 had an activated power of attorney. Resident 3 was diagnosed with but not limited to: dementia, anxiety, and	Y3235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017017	A. BUILDING: _____ B. WING _____	C 12/09/2024

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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Y3235	Continued From page 13	Y3235		

syncope.

On 12/03/2024, Surveyor reviewed Resident 3's ISP. Resident 3's ISP was dated 09/03/2024. Under the focus titled, "[Resident 3] is an elopement risk/wander as evidenced by: History of leaving pervious unit...," the following interventions were documented, "Distract [Resident 3] from wandering by offering pleasant diversions, structured activities, food, conversation, television, book... [Resident 3] moved to memory care unit, d/t wandering risk." Resident 3's ISP documented him/her as a fall risk with the following intervention documented, "Monitor during NOC hours if [Resident 3] is awake to help prevent falls."

On 12/03/2024, Surveyor reviewed Resident 3's observation notes from 10/04/2024 to 11/04/2024. On 10/16/2024 at 11:18 PM, Nurse B documented the following, "Behavior meeting: Discussed behaviors today during behavior meeting. Due to increased in striking out towards other residents, for no apparent reason, (sic.) Pharmacist recommended to start [him/her] prn (as needed) Haldol scheduled at HS (nighttime) to help [him/her] sleep at night. Will update PCC with information."

On 12/03/2024 at 11:10 AM, Surveyor discussed Resident 3's observation notes with Nurse B. Nurse B reported Resident 3's care team had a monthly meeting to discussed behaviors. Nurse B stated staff had been re-directing Resident 3's from striking out towards fellow peers who were pacing in the same hallway as him/her. Nurse B denied Resident 3 had made physical contact with other residents.

On 12/03/2024 at 1:30 PM, Surveyor discussed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017017	A. BUILDING: _____ B. WING _____	C 12/09/2024

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Y3235	Continued From page 14 the above concern with Administrator A, Nurse B, Nurse C and Regional Nurse D. Administrator A, Nurse B, Nurse C and Regional Nurse D acknowledged the Resident 3's right to not be recorded had been violated. Administrator A, Nurse B, Nurse C and Regional Nurse D acknowledged Resident 2's right to a private living arrangement had been violated. Administrator A, Nurse B, Nurse C and Regional Nurse D acknowledged Resident 3 had been documented as "striking out towards fellow peers," on 10/16/2024. Administrator A, Nurse B, Nurse C and Regional Nurse D acknowledged all residents who re-sided on the memory care unit were to be provided 24-hour supervision.	Y3235		