STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 11/14/2025, Surveyor conducted a standard survey and 1 complaint investigation and on 11/26/2025, Surveyor conducted a 2nd complaint investigation at Hamilton Park Place. Eight deficiencies were identified. Seven of the 8 deficiencies were repeat violations. See Statement Of Deficiency (SOD) SZPT11 dated 03/09/2020, WHTX11 dated 05/25/2022, WHTX12 dated 12/12/2022, WTHX13 dated 05/09/2023, WHTX14 dated 09/27/2023, WHTX15 dated 03/21/2024, WHTX16 dated 07/12/2024, and WHTX17 dated 11/06/2024. One complaint was substantiated. Census: 25	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. From 03/09/2020 to 12/10/2025, the provider did not comply with all the laws governing the CBRF as evidenced by 45 deficiencies identified, 22 of the 45 deficiencies were repeat deficiencies, Special Orders were issued by the Department	N 196		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 196	Continued From page 1	N 196		

with 6 Statement Of Deficiencies (SODs), and 5 complaints were substantiated.

This is a repeat deficiency. See Statement Of Deficiency (SOD) WHTX14 dated 09/27/2023.

Findings include:

The facility is licensed as a Class CNA able to serve up to 29 residents within the client groups of advanced age, physically disabled, and irreversible dementia/Alzheimer's.

Example 1- SOD SZPT11, dated 03/09/2020:
On 03/09/2020, a standard survey and 1 complaint investigation were conducted resulting in 7 deficiencies identified in Statement Of Deficiency (SOD) SZPT11, dated 03/09/2020:
N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation
N0277 DHS 83.25 Continuing Education
N0381 DHS 83.35(1)(a) Preadmission And Ongoing Assessments
N0407 DHS 83.37(1)(h) Scheduled Psychotropic Medication
N0416 DHS 83.37(2)(e) Other Administration Given Or Delegated By RN
N0525 DHS 83.47(2)(d) Fire Drills
N0526 DHS 83.47(2)(e) Other Evacuation Drills

Example 2- SOD WHTX11, dated 05/25/2022:
On 05/25/2022, a standard survey and 1 complaint investigation were conducted. As a result of the survey, the complaint was substantiated and 8 deficiencies including 2 repeat deficiencies were identified in SOD WHTX11, dated 05/25/2022:
N0243 DHS 83.21(1)-(3) All Employee Training
N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication

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N 196	Continued From page 2 N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes, N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0431 DHS 83.38(1)(g) Health Monitoring N 0526 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills N0546 DHS 83.48(4)(f) Smoke Detector in Non-Resident Living Areas Special Orders issued 08/21/2022 with SOD WHTX11, dated 05/25/2022 stated, " ...Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall comply with requirements as specified by Wis. Admin. Code § DHS 83.38(1)(g). That is, the licensee shall monitor the physical, mental, and oral health of residents; and make arrangements for services unless otherwise arranged for by the resident. The licensee will develop (or review/revise) written procedures and provide staff training for all managers and caregivers to address how the provider will: - assess risk factors contributing to skin integrity concerns including pressure injuries, - implement pressure injury prevention and treatment, - monitor and document changes in a resident's health, - notify the physician, notify the resident's legal representative or family, notify the care manager (if any) when a resident experiences a change in health status or medical emergency, - ensure timely medical assessments and emergency medical care, - review and revise individualized service plans annually or when there is a change in a resident's needs, abilities or physical or mental condition, and - implement standards of practice for medical	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

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N 196	Continued From page 3 records to ensure each resident's record is accurate, current, and complete ..." Example 3- SOD WHTX12, dated 12/12/2022: On 12/12/2022, 1 verification visit and 1 complaint investigation were conducted. As a result of the survey, 3 deficiencies including 2 repeat deficiencies were identified in SOD WHTX12, dated 12/12/2022: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0450 DHS 83.41(2)(c) Nutrition: Menus Example 4- SOD WHTX13, dated 05/09/2023: On 05/09/2023, 1 verification visit was conducted. As a result of the survey, 3 deficiencies including 2 repeat deficiencies were identified in SOD WHTX13, dated 05/09/2023: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0415 DHS 83.37(2)(d) Documentation Of Medication Administration SPECIAL ORDERS issued 07/13/2023 with SOD WHTX13 stated, " ...Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., effective immediately, the licensee will comply with the requirements specified by Wis. Admin. Code § DHS 83.32(3)(h) and ensure each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by a practitioner ...Diabetes Management, to include standards of practice for the assessment, care planning, and provision of services for residents with diabetes ..."	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 196	Continued From page 4 Example 5- SOD L5VC11, dated 07/13/2023: On 07/13/2023, 1 complaint investigation was conducted. As a result of the survey, the complaint was substantiated and 1 deficiency was identified in SOD L5VC11, dated 07/13/2023: N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs Example 6- SOD WHTX14, dated 09/27/2023: On 09/27/2023, 1 verification was conducted. As a result of the survey, 4 deficiencies including 3 repeat deficiencies were identified in SOD WHTX14, dated 09/27/2023: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0415 DHS 83.37(2)(d) Documentation Of Medication Administration SPECIAL ORDERS issued 12/11/2023 with SOD WHTX14 stated, " ...1. Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., effective immediately, the licensee shall comply with the requirements specified by Wis. Admin. Code § DHS 83.14(2)(a) and ensure that the CBRF and its operation comply with this chapter and with all other laws governing the CBRF and its operation. The licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency (SOD) WHTZ14. The licensee's corrective measures, at a minimum, shall include the development (or review) of written procedures and staff training (as appropriate) to address: Medication Management: including how the facility will document medication orders,	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

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N 196	Continued From page 5	N 196		

medication administration, missed/refused doses; and ensure residents receive medications at the intervals and dosages prescribed ...Diabetes Management: Including standards of practice for the assessment, care planning, and provision of services for residents with diabetes ..."

Example 7- SOD WHTX15, dated 03/21/2024:
On 03/21/2024, a standard survey and 1 verification visit were conducted. As a result of the survey, 5 deficiencies including 2 repeat deficiencies were identified in SOD WHTX15, dated 03/21/2024:
N0219 DHS83.17(1) Licensee Conduct Caregiver Background Check,
N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication
N0408 DHS 83.37(1)(i) PRN Psychotropic Medication
N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented
Z0010 50.065(2)(bb) Determine Final Disposition Of Charge

SPECIAL ORDERS issued 04/19/2024 with SOD WHTX15 stated,
" ...1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall provide medication administration appropriate to the resident's needs and ensure each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. In consultation with a registered nurse (RN), the licensee shall develop and implement corrective measures for the deficiencies issued under Wis. Admin. Code §§ DHS 83.32(3)(h) and 83.37(1)(i) as identified in Statement of Deficiency (SOD) WHTX15. The RN will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 83, Wis.

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N 196	Continued From page 6 Stat. ch. 50) and knowledge of the client groups served by Hamilton Park Place. Consultation will include the development (or review) of written procedures to address: Medication Management and Administration, including how the provider will: - Implement standards of practice for insulin management ... - Monitor and document the rationale for use, detailed description of the behavior, and effectiveness of the use of PRN psychotropic medications as a behavioral intervention.." Example 8- SOD WHTX16, dated 07/12/2024: On 07/12/2024, 1 verification visit and 3 complaint investigations were conducted. As a result of the survey, 2 complaints were substantiated and 4 deficiencies including 3 repeat deficiencies were identified in SOD WHTX16, dated 07/12/2024: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0388 DHS 83.35(3)(c)Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0408 DHS 83.37(1)(i) PRN Psychotropic Medication SPECIAL ORDERS issued 08/26/2024 with SOD WHTX16 stated, "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Hamilton Park Place: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide legal representative and case manager (if any) of Resident 9,	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 196	Continued From page 7 Resident 10, Resident 11, Resident 12, and Resident 13 with a copy of Statement of Deficiency WHTX16 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #1. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request." Example 9- SOD WHTX17, dated 11/06/2024: On 11/06/2024, 1 verification visit and 3 complaint investigations were conducted. As a result of the survey, 1 complaint was substantiated and 1 deficiency, a repeat deficiency was identified in SOD WHTX17, dated 11/06/2024: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication SPECIAL ORDERS issued 02/11/2025 with SOD WHTX17 stated " ...1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall ensure each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by the practitioner. The resident has the right to refuse medication unless the medication is court ordered. WITHIN 45 DAYS of receipt of this notice, the licensee will develop and implement corrective measures to address the medication administration deficiency identified in Statement of Deficiency WHTX17. All managers and resident care staff with responsibilities for medication administration and management will receive training regarding the provider's corrective measures..."	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 196	Continued From page 8 Example 10- SOD 56CN11, dated 12/10/2025 (this survey): On 11/14/2025, 1 complaint investigation and a standard survey were conducted, and on 11/26/2025 1 complaint investigation was conducted. As a result of the survey, 1 complaint was substantiated and 8 deficiencies, including 7 repeat deficiencies were identified in SOD 56CN11, dated 12/10/2025: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check N0277 DHS 83.25 Continuing Education N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0381 DHS 83.35(1)(a) Preadmission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0408 DHS 83.37(1)(i) PRN Psychotropic Medication On 11/26/2025 at 12:50 PM, Surveyor discussed concerns regarding the CBRF's noncompliance, focusing on resident's right to receive medication with Executive Director A and Resident Care Director B (who joined discussion via telephone at 1:27 PM). Executive Director A stated their former RN was not as capable as they thought. Executive Director A stated the recent addition of the LPN position and an intense 4-hour RN delegation class held by the RN consultant has been a huge improvement. Cross Reference: N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

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N 196	Continued From page 9 N0277 DHS 83.25 Continuing Education N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0381 DHS 83.35(1)(a) Preadmission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0408 DHS 83.37(1)(i) PRN Psychotropic Medication	N 196		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure caregiver background checks were conducted at the time of hire and every 4 years thereafter for each employee. A caregiver background check was not conducted	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

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HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

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N 219	Continued From page 10 for Caregiver G at time of his/her hire, and Caregiver H's 4 year background check was conducted late. This is a repeat violation. See Statement Of Deficiency (SOD) WHTX15 dated 03/21/2024. Findings include: A complete caregiver background check includes a background information disclosure form (BID), Department of Justice (DOJ) record, a Governmental Findings Report (previously "IBIS letter). On 11/11/2025, Surveyor reviewed Caregiver G's and Caregiver H's employee records. Example 1- Caregiver G Caregiver G was hired 04/22/2025. The record did not contain a caregiver background check. Example 2- Caregiver H Caregiver H was hired 09/01/2021. The record did not contain a 4-year background check. On 11/11/2025, Executive Director A provided Surveyor with a DOJ and Governmental Findings Report dated 11/11/2025 (4 years, 2 months and 10 days after hire date) for Caregiver H. On 11/11/2025 at 4:21 PM, Surveyor discussed concern regarding lack of Caregiver G's initial background check and Caregiver H's late 4 year background check with Executive Director A and Resident Health Director B. Executive Director A stated s/he had completed Caregiver G's background check at time of hire but did not have record of it and locked him/herself out of the portal while trying to look it up on 11/11/2025.	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 219	Continued From page 11 Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 219		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the administrator and resident care staff completed at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: standard precautions; client group related training; medications; resident rights; prevention and reporting of abuse, neglect and misappropriation; fire safety and emergency procedures, including first aid. Executive Director A (facility administrator) had	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

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N 277	Continued From page 12	N 277		

not completed required continuing education requirements for 2024.

This is a repeat violation. See Statement of Deficiency (SOD) SZPT11, dated 03/09/2020.

Findings include:

On 11/11/2025, Surveyor reviewed the staff roster. Based on all staff's positions and hire dates, Surveyor only requested Executive Director A's 2024 continuing education.

On 11/11/2025, Surveyor interviewed Executive Director A who stated s/he was the facility administrator and in November 2024, when the previous management company left, s/he lost a lot of access to his/her training records. Executive Director A provided Surveyor with copies of staff in-service attendance sheets and explained although s/he had not signed the attendance sheets, s/he had attended the in-services.

Inservice attendance sheets included:
03/13/2024- Elder Abuse (length of in-service not listed)
05/23/2024- Medication Administration (length of in-service not listed)
07/18/2024- Proper Documentation in Electronic Medical Record (1.5 hours)
08/21/2024- Resident Rights (1.5 hours)
11/26/2024- Dietary (length of in-service not listed)

No training in standard precautions, client groups, fire safety and emergency procedures including first aid was included with the 2024 in-service training.

Cross Reference:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 277	Continued From page 13 N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 277		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse screened each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis (TB). Resident 2 was screened for TB 239 days prior to admission. Findings include: On 11/11/2025, Surveyor reviewed Resident 2's record. S/he was admitted 09/29/2025.	N 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 302	Continued From page 14 The record contained a form dated 09/25/2025 stating " ...Resident must have PPD [TB skin test] with in [sic] 30 days of admission ..." Handwritten on the form was "Negative CXR [chest x-ray] on 2/25/2025". On 11/11/2025 at 4:21 PM, Surveyor discussed concern of Resident 2's TB screen not completed within 90 days prior to admission with Executive Director A and Resident Health Director B. Executive Director A stated Resident 2's doctor said it would be sufficient since it was a chest x-ray. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 302		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident right to receive all prescribed medication in the dosage and at intervals prescribed by the practitioner. From 10/01/2025-10/03/2025, Resident 3 did not receive his/her Lantus SoloStar (long-acting) insulin as ordered by the physician resulting in	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

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N 352	Continued From page 15 high blood sugar readings and hospitalization for diabetic ketoacidosis. This is a repeat deficiency. See Statement of Deficiency (SOD) WHTX11 dated 05/25/2022, WHTX12 dated 12/12/2022, WTHX13 dated 05/09/2023, WTHX14 dated 09/27/2023, WHTX15 dated 03/21/2024, WHTX16 dated 07/12/2024, and WHTX17 dated 11/06/2024. Findings include: According to drugs.com, " ...Diabetic ketoacidosis is a potentially fatal complication of diabetes that occurs when you have much less insulin than your body needs. This problem causes the blood to become acidic and the body to become dangerously dehydrated. Diabetic ketoacidosis can occur when diabetes is not treated adequately, or it can occur during times of serious sickness ...(Source: https://www.drugs.com/health-guide/diabetic-ketoacidosis.html (retrieval date 11/14/2025)). On 11/11/2025, Surveyor reviewed (former) Resident 3's record. S/he was admitted 08/22/2022. Diagnoses included type 1 diabetes mellitus with hyperglycemia. From 06/10/2025 to - 09/24/2025, physician orders included Lantus SoloStar KwikPen 100 Unit/ML inject 20 units subcutaneously every evening with supper for type I diabetes mellitus. Resident was hospitalized 09/25/2025-09/29/2025 and upon discharge from the hospital the order was changed to 17 Units every evening with supper (4:30 PM), and on 09/30/2025 the order was changed from 4:30 PM to 8:00 AM.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

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N 352	Continued From page 16	N 352		

Medication Administration Record (MAR):
The order for Lantus Solostar 100 Unit/ML inject 17 Units at 8:00 AM was not added to the MAR on 09/30/2025 and was shaded out indicating an nonactive order 10/01/2025, 10/02/2025 and 10/03/2025.
Staff documented on the MAR: 09/29/2025 at 4:30 PM, administered; 09/30/2025 at 4:30 PM, held; and 10/01/2025 at 4:30 PM, held.

Observation notes:
10/03/2025 11:45 AM- "When staff came in this morning, [Resident 3] was yelling for help. Staff went in and saw resident sitting on [his/her] walker, in front of [his/her] toilet with [his/her] head down, pants off and [his/her] Pajama [sic] top still on. Staff asked what was wrong. Resident said [s/he] felt not well and dizzy. Staff got [him/her] onto the toilet safely, got [him/her] changed and took resident to [his/her] chair to relax. Staff check [sic] [his/her] Blood Sugar [sic] levels and they were at 574. Staff gave [him/her] extra units of humalog and called [Executive Director A] and [Family Member D] to update. Staff and [Family Member D] made a decision to see how [s/he] does though [sic] the morning and to see if [his/her] blood sugar keeps going down. Staff took Blood [sic] Sugars [sic] at 6:20 AM (574) 8:06 am (488) and 10:30 am (372) ...Called [Family Member C] ...[Family Member C] stated [Resident 1] has an appointment with [his/her] Doctor [sic] on Monday ..."

10/03/2025 9:15 PM - "...Staff went to take [his/her]blood sugar before dinner and it was 503 ...[Family Member C] came and took resident to the ER at 530 [sic] pm. [Family Member D] called at about 8 [sic] pm to let staff know that resident is being admitted ...When staff called, ER staff stated that [s/he] was admitted for Diabetic [sic]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 352	Continued From page 17	N 352		

Ketoacidosis [sic] and would be there for atleast [sic] 2 days ..."

10/04/2025 9:00 PM "Residents [family member] called the facility and let staff know [Resident 3] will not be discharged tonight or tomorrow for sure."

On 11/11/2025 at approximately 9:30 AM, Surveyor interviewed Executive Director A who stated Resident 3 was not administered his/her Lantus SoloStar 100 Units/ML 17 Units of insulin because the physician changed the order from 4:30 PM to 8:00 AM and the facility's med tech did not click the pharmacy link in the electronic MAR, resulting in the order not being activated and Resident 3 was subsequently hospitalized. Executive Director A stated s/he self-reported the incident to the Department.

On 11/11/2025 at 4:21 PM, Surveyor discussed concern of Resident 3's medication not administered as ordered by the physician with Executive Director A and Resident Health Director B. Resident Health Director B stated it was a staff error and retraining was provided by a RN consultant.

On 11/11/2025, Surveyor reviewed the self-report on file with the Department. " ...On Oct. 3rd residents [sic] blood sugar had been elevated throughout the day. [Family members] were updated as well as MD. At approximately 5:30p.m. [sic] resident was brought into ER by [his/her family member] due to high blood sugar reading of 503 before dinner. [S/he] was then admitted for Diabetic [sic] Ketoacidosis [sic] ...On 10/06/2025 it was discovered by administrator the resident had received an order on 9/30/25 from MD to stop giving Lantus at 4:30 p.m. and to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 352	Continued From page 18 begin giving it at 8a.m. [sic] P.M. Staff held the 4:30 does [sic] per doctor order. Staff followed the order to not give the pm [sic] dose on 9/30/25 resulting in resident not receiving any dose on 9/30/25. The new order was not checked in to start the 8am [sic] dose. This resulted in the resident not receiving [his/her] dose of Lantus on 09/30, 10/1, 10/2 and 10/3 ...RN Consultant scheduled a Health Monitoring Inservice related to Diabetes [sic] on 10/14/25. Director is conducting a retraining of medication check in procedure with team members ..." On 11/14/2025 at 11:32 AM, Surveyor interviewed Family Member D who stated staff missed a couple of doses of Resident 3's Lantis SoloStar insulin due to staff's confusion regarding an order change. Family Member D stated Resident 3's blood sugars spiked into the 500's resulting in hospitalization for several days. Family Member D stated Resident 3 did not return to Hamilton Park Place and instead was admitted to a different CBRF. Hospital record received from hospital via fax on 11/25/2025 at 12:13 PM: Hospital Discharge Summary dated 10/13/2025: " ...Patient is a [age and gender] who was readmitted to [name of hospital] for DKA and hypovolemic shock. [S/he] had been hospitalized one week prior for a severe [skin and soft tissue infection] of [his/her] right neck and face. [S/he] recovered well from that illness and was discharged back to [his/her] assisted living facility. Following discharge [s/he] had some labile blood sugars. This led to changes in [his/her] insulin regimen that ultimately caused DKA and hypovolemic shock. On presentation she had borderline low blood pressure 105/52, tachycardia 100 with remainder of vitals within normal limits.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 352	Continued From page 19 On presentation blood glucose 430 ...Initially the patient was admitted to the ICU under the DKA protocol. The patient had refractory hypotension after volume resuscitation and therefore was also started on Levophed. Over 2 days [s/he] had rapid recovery and was able to be taken off Levophed in the DKA protocol. However, on hospital day 3, [s/he] developed acute respiratory failure with hypoxia from aspiration pneumonitis and iatrogenic hypervolemia. [S/he] was started on antibiotics and diuretics and [his/her] respiratory status improved to baseline. On hospital day 11, [s/he] was able to be discharged to typically [sic] assisted living facility ..." On 11/26/2025 at 9:04 AM, Surveyor interviewed Pharmacist I who stated the pharmacy enters physician orders in the electronic system then the system sends a message to the facility. Pharmacist I stated facility staff then electronically accept the change and then system rewrites the order in the facility's system. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 352		
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	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

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N 381	Continued From page 20 the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on observation, record review and interview the provider did not ensure all resident's needs were assessed when there was a change in needs, abilities, or condition. Resident 1's and Resident 4's assessments did not include description of medical symptom or condition warranting use of side rails, alternative interventions to side rails tried and reason(s) why alternative interventions were not successful. Resident 1's and Resident 4's individual service plans (ISP) did not identify need for side rails or when side rails should be in up position, describe trials of less restrictive interventions, include education provided to resident and/or resident's legal representative regarding risks of side rail use or plans to reduce side rail use and monitor bed, mattress and side rails for safety. This is a repeat deficiency. See Statement Of Deficiency SZPT11 dated 03/09/2020. Findings include: According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 381	Continued From page 21 patient assessment...2. Because individuals may differ in their sleeping and nighttime habits, creation of a safe bed environment that takes into account patients' medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team...3. Use of bed rails should be based on patients assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patients' assessed needs. 5. Bed rail use for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use. 6. The process of reducing and/or eliminating existing use of bed rails should be undertaken incrementally using an individualized, systematic, and documented approach... Bed Rail Safety Guidelines If it is determined that bed rails are required and that other environmental or treatment considerations may not meet the individual patient's assessed	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 381	Continued From page 22 needs, or have been tried and were unsuccessful in meeting the patient's assessed needs, then close attention must be given to the design of the rails and the relationship between rails and other parts of the bed. 1. The bars within the bed rails should be closely spaced to prevent a patient's head from passing through the openings and becoming entrapped. 2. The mattress to bed rail interface should prevent an individual from falling between the mattress and bed rails and possibly smothering. 3. Care should be taken that the mattress does not shrink over time or after cleaning. Such shrinkage increases the potential space between the rails and the mattress. 4. Check for compression of the mattress' outside perimeter. Easily compressed perimeters can increase the gaps between the mattress and the bed rail. 5. Ensure that the mattress is appropriately sized for the selected bed frame, as not all beds and mattresses are interchangeable. 6. The space between the bed rails and the mattress and the headboard and the mattress should be filled either by an added firm inlay or a mattress that creates an interface with the bed rail that prevents an individual from falling between the mattress and bed rails. 7. Latches securing bed rails should be stable so that the bed rails will not fall when shaken. 8. Older bed rail designs that have tapered or winged ends are not appropriate for use with patients assessed to be at risk for entrapment. Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings 11 9. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items (See Appendix 1: Glossary) should be ongoing. " (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings"	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 381	Continued From page 23	N 381		

https://www.fda.gov/media/88765/download (retrieval date 11/12/2025)).

Example 1- Resident 1
On 11/11/2025 at 2:35 PM, Surveyor observed Resident 1 awake and lying on his/her bed with ¼ bilateral siderails in the up position.

On 11/11/2025, Surveyor reviewed Resident 1's record. S/he was admitted 09/29/2025. Diagnoses included vascular dementia, unspecified severity, with agitation.

Assessment dated 09/22/2025 (summarized):
In the area of Walking/Ambulation- independent with mobility, ambulates and transfers independently.
In the area of Fall Risk - low risk for falls
In the area of Physical Disabilities - independent with repositioning
The assessment did not identify use of or need for siderails.

ISP dated 09/29/2025 (summarized):
The ISP did not address siderails.

Hospice Care Plan dated 10/01/2025 (received from Executive Director A on 11/11/2025) (summarized):
The Hospice Care Plan did not address siderails.

On 11/11/2025 at 3:06 PM, Surveyor interviewed Executive Director A who stated hospice informed facility staff Resident 1's family requested the siderails and hospice put siderails on bed. Executive Director A stated s/he did not explain to hospice that a siderail assessment needed to be completed. Executive Director A stated Resident 1 was able to independently reposition from lying to sitting/sitting to lying and transfer in and out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 381	Continued From page 24	N 381		

bed. Executive Director A stated s/he would speak with family and hospice about the side rails.

On 11/11/2025 at 4:21 PM, Surveyor discussed concern of siderails with Executive Director A and Resident Health Director B. Resident Health Director B stated Resident 1 transferred in and out of bed independently and did not need side rails.

Example 2- Resident 4
On 11/20/2025, Surveyor returned to facility to conduct a complaint investigation.

On 11/20/2025 at 10:35 AM while interviewing Resident 4 in his/her room, Surveyor observed a 1/4 siderail on Resident 4's bed. The siderail was attached to the room side of the bed in the up position. When Surveyor checked side rails stability by shaking it, it swayed approximately 5" from the mattress side of the rail to the room side of the rail. Surveyor observed an approximate 4" gap between the mattress and the rail. Resident 4 stated the siderail was used to prevent falling out of bed and for repositioning in bed. Resident 4 stated s/he fell out of bed prior to his/her admission and the side rail was on the bed since s/he was admitted.

On 11/20/2025, Surveyor reviewed Resident 4's record. S/he was admitted 05/07/2025. Diagnoses included: vascular dementia, unspecified severity; cerebral infarction (stroke); and cervical disc disorder with myelopathy (spinal cord damage due to severe compression), unspecified cervical region.

Assessment dated 05/06/2025 (summarized):
In the area of Walking/Ambulation- 1 assist with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 381	Continued From page 25	N 381		

gait belt and verbal assist, hands-on assist with getting up, walker use, sitting/lying down.
In the area of Fall Risk - Not at risk for falls
In the area of Physical Disabilities - 2 assist with positioning in bed, wheelchair, and standing

Assessment dated 06/18/2025 (summarized):
In the area of Walking/Ambulation- No changes
In the area of Fall Risk - No changes
In the area of Physical Disabilities - No changes

Assessment dated 11/17/2025 (summarized):
In the area of Walking/Ambulation- No changes
In the area of Fall Risk - No changes
In the area of Physical Disabilities - No changes

ISP, not signed or dated (summarized):
The ISP did not address siderails.

On 11/26/2025, Surveyor discussed concern regarding Resident 4's siderail with Executive Director A and Resident Health Director B. Executive Director A stated s/he did not know a side rail was on the Resident 4's bed. Executive Director A summoned Caregiver K into discussion. Caregiver K stated Resident 4 often slept in his/her recliner but when s/he did sleep in bed the side rail was kept in up position for Resident 4 to grab onto. Executive Director A stated s/he would have it removed immediately "because it's unsafe."

Cross Reference:
N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws
N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 26	N 389		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation record review and interview, the provider did not ensure the individual service plan (ISP) was updated when there was a change in resident's needs for 3 of 3 residents reviewed. Resident 1's ISP did not address falls, behaviors, hospice services, or use of wander guard bracelet. Resident 2's ISP did not identify risk for falls, use of fall mat, bed alarm, or Broda chair, and contained conflicting information regarding skin integrity, family contacts, and toileting needs. Resident 4's ISPs did not: 1. accurately reflect activities of daily living (ADL) care needs, 2. identify staff interventions related to physical disabilities and behaviors effecting incontinence and urinal use/toileting, and inappropriate sexual	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 27	N 389		

comments and gestures toward staff; and without reviewing the ISP with Resident 4's Power of Attorney for Health Care agent (Family Member J) or managed care organization the provider removed Resident 4's urinal from his/her room on 09/27/2025. The provider issued an involuntary discharge notice on 11/20/2025 due to increased ADL care needs and behaviors.

This is a repeat deficiency. See Statement Of Deficiency (SOD) WHTX11, dated 05/25/2022, and SOD WHTX16 dated 07/12/2024.

Findings include:

Example 1 - Resident 1
On 11/11/2025 at 2:35 PM, Surveyor observed Resident 1 wearing a wander guard bracelet on ankle and a black brace on his/her left wrist.

On 1/11/2025, Surveyor reviewed Resident 1's record. S/he was admitted 09/29/2025. Diagnoses included vascular dementia, unspecified severity, with agitation.

Observation notes dated 09/29/2025-11/11/2025 (summarized):
09/29/2025- Admitted, will have wander guard bracelet on ankle.
09/30/2025- 6:00 AM, incident report created for unwitnessed fall. 11:15 AM, complained of wrist and hand pain, taken for x-rays. Diagnosed with closed fracture of distal ends of left radius and ulna. Needs rest, elevation of wrist and ice if needed.
10/01/2025- Removed his/her wrist brace
10/02/2025- 5:15 AM, wandering looking for family. Agitated after lunch, lorazepam administered.
10/03/2025- 5:15 AM, walked down hall and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 28	N 389		

passed laundry room, redirected back to room.
10/04/2025- 5:00 AM, Resident was up, asked staff about leaving, wanted to call family to come get him/her, redirected to room then wandered toward door. Resident was anxious and wanting to leave, as needed (PRN) lorazepam was administered.
10/05/2025- 3:30 PM, sitting to left side of bed on floor facing bathroom, half-dollar sized skin tear right elbow bleeding quite a bit. At 9:30 PM, PRN haloperidol administered due to resident very anxious and wanting to elope off property. Resident taking wrist brace off, too tired to sit in chair.
10/06/2025- Returned from MD appointment with wrist splint to be worn at all times, and instructions to not to force him/her to put it back on if s/he removes it.
10/07/2025- Refused dinner.
10/08/2025- 5:30 AM- Approximately 1:30 AM resident rang asking for a snack, assisted to bathroom and provided snack, went back to sleep shortly after, 10:15 AM, new order for wound care to right elbow twice weekly and PRN, to be performed by facility nurse/staff if soiled/heavy drainage and hospice nurse to complete wound care weekly and PRN until healed.
10/09/2025- PRN morphine with 8:00 AM medications for wrist pain, this seems to help him/her stay relaxed and not want to elope as often. 9:30 PM, PRN lorazepam administered due to anxiety and anger stating s/he was going to elope off property.
10/14/20245- Pleasantly confused.
10/17/2025- 5:45 AM, going into peer's rooms looking for a bathroom. Reminded him/her where his/her bathroom was.
10/19/2025- 4:30 AM, wandered to nurse's station without walker. Went out to church with family.
10/21/2025- 5:30 AM, restless, agitated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 29	N 389		

wandering halls searching for family and stating s/he did not belong at facility. PRN lorazepam administered.
10/23/2025- During the night walked down hall looking for bathroom. Refused dinner.
10/24/25- 5:15 AM, walked to front entrance asking where everyone was, assisted back to room.
10/28/2025- Came out of room approximately 3:00 AM asking where bathroom was. Assisted to room and bathroom. Stated this was not his/her home and asked how to leave. Called family member who talked to resident who then went back to bed and fell asleep.
10/30/2025- Resident went to kitchen at 2:00 AM for breakfast, redirected back to room.
11/07/2025- Resident came out of room at 1:00 AM for breakfast, redirected back to room.

Physician orders included: haloperidol 0.5 MG 1 tablet twice daily as needed for anxiety/agitation (start date 09/30/2025), and lorazepam 0.5 MG 1 tablet every 4 hours as needed for anxiety/restlessness/agitation (start date 10/02/2025).

October 2025 Medication Administration Record (MAR):
Staff documented administration of PRN haloperidol and PRN lorazepam-
10/02/2025 12:34 PM- lorazepam due to agitation
10/03/2025 10:53 PM- lorazepam due to restlessness and anxiety
10/04/2025 8:14 AM- haloperidol due to irritation and removing wrist brace
10/05/2025 6:43 PM- haloperidol due to agitation, messing with call button and bandage, and wanting to go home.
10/05/2025 9:54 PM- lorazepam due to restlessness and agitation, trying to elope off

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 30	N 389		

property, very agitated calling staff names and pacing in the front room.
10/06/2025 7:38 AM- haloperidol due to agitation and aggressiveness with staff when morning cares and medication administration attempted.
10/09/2025 4:53 PM- lorazepam due to agitation when wanting to leave.
10/21/2025 12:56 AM- due to anxiety, restlessness, and wandering halls wanting to leave.
Staff documented on the October MAR that each dose of PRN haloperidol and PRN lorazepam administered during October 2025 was given for intended use according to the ISP.

Incident Report dated 09/30/2025 (summarized): Resident stated s/he had previously fallen and hurt his/her wrist. On 09/30/2025, family member reported resident fell the night before (09/29/2025) in his/her bathroom, s/he did not think it was a big deal to report it. Family took resident to urgent care where s/he was treated for fractured left wrist.

Fall Risk Evaluation dated 09/30/2025, signed and dated by Resident Health Director B (summarized): On 09/29/2025 fell in bathroom while family visiting. Interventions- educated on use of call light, plan in place to encourage resident to come out for activities and stay in common areas to reduce time spent away from others. " ...Has the care plan been updated to reflect current fall risk evaluation? Yes ..."

Hospice Care Plan dated 10/01/2025 (received from Executive Director A on 11/11/2025):
" ...ANXIETY AND AGITATION/RESTLESSNESS WILL BE REDUCED/CONTROLLED. SN [SKILLED NURSING] TO INSTRUCT PATIENT/CAREGIVER ON SIGNS AND

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 31 SYMPTOMS, CAUSES, ALLEVIATING FACTORS AND TREATMENT REGIMEN FOR BEHAVIORS ...PATIENT TO HAVE DECREASED PAIN TO [LEFT] WRIST FRACTURES SN- ICE WRIST, ELEVATE ON PILLOW AT HEART LEVEL, WEAR SPLINT AT ALL TIMES ...SN TO INSTRUCT PATIENT/CAREGIVER ON SIGNS AND SYMPTOMS, CAUSES AND ALLEVIATING FACTORS FOR PAIN AND USE OF MEDICATIONS FOR PAIN, SUCH AS ACETAMINOPHEN ...ON 9/29 [SIC] A FALL ON 9/29-9/30 [SIC] RESULTED IN CLOSED FRACTURES OF THE DISTAL LEFT RADIUS AND DISTAL LEFT ULNA ...PATIENT HAS BECOME MORE AGITATED. PROVIDED STAFF WITH A LIST OF LIKES/DISLIKES AND SUBJECTS THAT MAY HELP WITH REDIRECTION ...NO WOUNDS PRESENT-NOTED BRUISING AND SWELLING TO [LEFT] WRIST AND HAND ..." The hospice Care Plan dated 01/01/2025 did not specify signs, symptoms, causes, alleviating factors or treatment regimen for behaviors; start/stop dates or how often and how long to ice and elevate left wrist; signs, symptoms, causes and alleviating factors for pain management; dislikes and subjects that may help with redirection during behaviors; or address risk of skin integrity/wound care. ISP dated 09/29/2025 (summarized): In the area of Skin Care- Skin in good condition, will maintain current skin condition on an ongoing basis until next review. In the area of Pain History and Management: Resident is free of pain, will remain free of pain until next review. In the area of Attitude: Displays a positive attitude, will maintain positive level of attitude on	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 32	N 389		

an ongoing basis until next review.
The 09/29/2025 ISP did not address or identify detailed interventions for falls (including those identified in Fall Risk Evaluation dated 09/30/2025), skin, behaviors, insomnia or wander guard bracelet.

Example 2- Resident 2
On 11/11/2025 at 4:16 PM, Surveyor observed Resident 2 in his/her room sitting in a Broda chair, a bed alarm on his/her bed and fall mat on floor next to his/her bed.

On 11/11/2025, Surveyor reviewed Resident 2's record. S/he was admitted 12/01/2023. Diagnoses included anxiety. Resident shared a room with his/her family member.

Observation notes dated 09/01/2025-11/11/2025 (summarized):
09/02/2025 8:45 AM- New spot upper right buttock cheek, approximately 1 cm in diameter, no drainage, purple in color.
09/09/2025 4:45 AM- Small open sore on right buttock.
09/14/2025 10:00 AM- Found on floor between bed and recliner.
09/15/2025 5:15 AM- Cream applied to sores on buttocks.
09/15/2025 10:00 AM- Notified staff of sore on right butt check, and right side of foot.
09/23/2025 8:15 AM- Often leaning to one side, Broda chair ordered.
09/24/2025 5:30 AM- Blister on right side of lower buttock where cheek meets thigh, size of dime.
09/26/2025 3:45 PM- Fell out of recliner, on floor in front of bed lying on right side with head facing foot of bed and feet under bed, elbow bleeding and bump on right side of forehead.
10/07/2025 7:00 PM- On floor with back against

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 33	N 389		

bed sitting upright.
10/08/2025 5:45 AM- Assisted into Broda chair
10/15/2025 4:30 PM- All fall interventions at this time have been exacerbated, is on high frequency checks, fall matt in place, toileting schedule, Broda chair and bed alarm implemented.
10/16/2025 2:15 PM- Broda chair, EZ stand for transfers, frequent checks, toileting schedule, bed alarm, resident is placed in sight of staff often, fall mat.
10/21/2025 4:15 PM- All safety interventions continue to assure s/he is free from falls, toileting schedule, every 2-hour checks, bed alarm and floor mat.
11/02/2025 9:55 PM- Penny sized round skin tear on right elbow.

Hospice care plan dated 10/09/2025 (received from Executive Director A on 11/11/2025):
In the area of Fall Prevention- "Educate/reinforce facility staff on keeping call light within reach of patient."
In the area of Ambulation- "Assist patient with wheelchair."
In the area of Goals- " ...Patient and Caregiver will demonstrate decreased fall risk as evidenced by Decreased [sic] falls ...Fall risk interventions will remain in place to decrease potential for falls within the [certification] period. [Patient/family] will demonstrate an understanding of skin care techniques within the [certification] period ...Safety Measures: Fall precautions ..."
In the area of Integument Status [skin]: "Skilled Observation & Assessment of Integument Status."

The 10/09/2025 hospice care plan did not identify specific interventions for skin and fall risk interventions (other than keeping call light within

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 34 in reach and use of walker), or use of fall mat, bed alarm or Broda chair. Facility ISP dated 09/22/2025: In the area of Skin Care- "Resident skin is in good condition and team will continue to monitor and maintain the condition ...Resident will maintain good skin condition ...Team will monitor for the potential of breakdown ...Resident wishes to maintain good skin conditions [sic] and the team will monitor for skin breakdown." In the area of Positioning- " ...Requires staff assistance for repositioning every two hours to reduce the risk of pressure areas on bony prominences ...assist with repositioning resident to comfort in bed, wheelchair/device, standing or in other facility/home furniture. ...monitor skin for moisture such as sweat or incontinence. If skin is moist, staff should assist to dry skin or assist with peri care if needed ..." In the area of Family Contacts- "Resident has no family contacts ..." In the area of Family Communication- "The community team and family will maintain an open line of communication ..." In the area of Interpersonal- " ...Resident displays several interpersonal relationships with family and friends ..." The ISP listed an area of Toileting, then an area of Bowel Movement Monitoring, followed by a 2nd area of Toileting. The 1st area of toileting identified need of physical and verbal assistance with toileting with hands on assistance with undressing/dressing, washing/wiping. The 2nd area of toileting identified need for total assistance with toileting and assistance with dressing/undressing, washing/wiping. The 09/22/2025 ISP did not identify risk for falls, use of fall mat, bed alarm, or Broda chair, and	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 35	N 389		

contained conflicting information regarding skin integrity, family contacts, and toileting needs.

On 11/11/2025 at 2:40 PM, Surveyor interviewed Med Tech E who stated staff followed both the hospice care plan and the facility ISP.

On 11/11/2025 at 2:42 PM, Surveyor interviewed Caregiver F who stated s/he did not know if they followed the facility ISP or hospice care plan.

On 11/11/2025 at 2:49 PM, Surveyor interviewed Resident Health Director B who stated they merged the facility ISP and hospice care plan together.

On 11/11/2025 at 4:21 PM, Surveyor discussed concerns regarding Resident 2's and Resident 3's the ISP with Executive Director A and Resident Health Director B. Executive Director B stated they would update the ISP's.

Example 3- Resident 4
Summary:
The provider failed to update Resident 4's 09/22/2025 and 11/17/2025 ISPs related to incontinence and behaviors, and his/her 11/17/2025 assessment contradicted the 11/17/2025 ISP.
Resident 4's 09/22/2025 and 11/17/2025 ISPs did not address: physical condition(s) contributing to incontinence; physical ability managing urinal and sodas; behaviors related to incontinence, toileting, and spilling urine and soda; foul language, belligerence, aggressive and combative behaviors; or sexually inappropriate comments and gestures toward staff; and did not specify staff interventions regarding urinal use, incontinence, or behaviors (other than behavior tracking initiated 11/17/2025). Resident 4's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 36 11/17/2025 assessment identified s/he required setup/cues with oral care; reminders, cues and minimal assistance with grooming; and 1 assist with dressing and toileting, and when 2 staff assist was implemented due to sexually inappropriate comments and gestures and not a change in condition, the ISP identified s/he required 2 staff assist with oral cares, grooming, dressing and toileting. Resident 4's ISP was not reviewed with Family Member J or MCO staff. On 11/20/2025, the Department received a complaint alleging urinal confiscation and inappropriate 30-day discharge notice issuance without prior ISP updates and reviews. On 11/26/2025, Surveyor conducted an onsite complaint investigation. On 11/26/2025 at 10:35 AM while interviewing Resident 4 in his/her room, s/he was sitting in and reclined back in his/her recliner and appeared clean and dry. Two urinals, each approximately an inch full of urine were and an opened soda can were on the side table next to the recliner. The floor around the recliner appeared clean. Surveyor noted a faint urine odor in the bathroom and no urine odor in main part of room. Resident 4 stated a few weeks ago, facility management took his/her urinal telling him/her s/he needed to walk to the bathroom. Resident 4 stated because of his/her health condition; s/he experienced urge incontinence so would urinate before staff could answer the call light. Resident 4 stated a family member then obtained a physician order for him/her for urinal use and provided 2 urinals. Resident 4 stated s/he accidently knocked a soda can and urinal off the side table when reaching for it from his/her recliner. Resident 4 stated Executive Director A told him/her that a 30-day	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 37	N 389		

discharge would be issued.

On 11/26/2025, Surveyor reviewed Resident 4's record. S/he was admitted 05/07/2025. Diagnoses included: vascular dementia, unspecified severity; cerebral infarction (stroke); and cervical disc disorder with myelopathy (spinal cord damage due to severe compression), unspecified cervical region. His/her Power of Attorney for Health Care document was activated with Family Member J serving as agent.

According to the National Institute of Health, " ...Bladder dysfunction represents a frequent and important clinical problem in stroke patients ...The most common symptoms of bladder dysfunction following stroke are urinary incontinence, urgency, increased frequency, and difficulty voiding ..." (Source: https://pmc.ncbi.nlm.nih.gov/articles/PMC11409650 (retrieval date: 11/27/2025)).
According to Froedtert Medical College of Wisconsin, " ...Cervical Myelopathy Symptoms ...Symptoms may progress slowly or rapidly. Cervical myelopathy symptoms include: ...Autonomic symptoms, such as bowel or bladder incontinence ..." (Source: https://www.froedtert.com/spinecare/cervical-myelopathy (retrieval date: 11/27/2025)).

Observation notes (summarized):
Regarding urinal use, incontinence and toileting-
09/17/2025- Urinal removed from Resident 4's room, and s/he was without a urinal until Family Member J brought 2 on 11/14/2025.
09/17/2025 11:30 AM (by therapy)- Resident 4 expressed displeasure with administration due to eliminating urinal as patient does not properly complete self-care skill of voiding while in recliner. Resident agreeable to using call light for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 38	N 389		

assistance to bathroom.
09/17/2025 11:54 AM- Per Resident Health Director, urinals are no longer in resident's room. Resident needs to use call light and will be walked to bathroom with assistance, gait belt and walker, per physical therapy. Staff to encourage him/her to walk to/from meals also.
09/17/2025 8:30 PM- More incontinence and urinating in brief due to not wanting to get up and use bathroom.
09/30/2025 1:30 PM- Resident would not properly position body to urinate in toilet, causing urination on floor. Resident stated, "This is what they want me to do."
10/04/2025 5:00 AM- Used call light a few times throughout night to be changed.
10/30/2025 8:45 AM- Per therapy, resident can transfer to toilet with 1 person assist and should be encouraged to do so. When encouraged to ambulate, resident becomes verbally aggressive. Continues to make inappropriate sexual remarks toward female staff during peri care.
From 05/07/2025 - 11/26/2025, Resident experienced urine incontinence, accepted toileting and used the urinal as evidenced by:
From 05/07/2025-09/17/2025, staff documented urine incontinence on 9 days, toileted on 5 days, and urinal emptied on 33 days; from 09/17/2025-11/14/2025, staff documented urine incontinence on 15 days and toileted on 24 days; from 11/14/2025-11/26/2025, staff documented urine incontinence on 4 days, toileted on 2 days and emptied urinal on 5 days.

Observation notes continued (summarized);
Regarding mood and behaviors-
05/25/2025 8:15 PM- Resident told staff s/he was angry and wanted to kill someone for waking him/her up at 4:30 AM.
06/19/2025 5:15 PM- While passing Resident 4 in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 39	N 389		

the dining room with another resident in a wheelchair, Resident 4 muttered a profane name, not sure if directed to other resident or staff person.
10/30/2025 1:30 PM- Resident used profanity and stated administrator was fake during open house. Resident stated s/he was upset due to being rushed out of dining room before finishing lunch and coffee.
11/03/2025 1:30 PM- Writer witnessed resident spilling soda on floor of room, when asked if writer could assist resident, s/he stated housekeeping could clean it up. Housekeeper stated s/he mopped resident's floor multiple times a day due to urine and soda with specialty enzyme cleaner.
11/11/2025 1:45 PM- Resident made inappropriate sexual comment towards staff.
11/16/2025 1:00 PM (by Lead Caregiver K)- During cares, Resident 4 put his/her hand on Lead Caregiver K's head and made an inappropriate sexual comment. Lead Caregiver K verbally redirected resident.
11/17/2025 1:15 PM- Executive Director A and Resident Health Director B met with resident regarding sexual remarks made to an employee, explained it is not appropriate and will not be tolerated.
11/19/2025 2:45 PM- Management requiring 2 staff present while in resident's room due to sexual remarks.
11/23/2025 8:45 PM - While 2 staff were in resident's room during cares, resident made inappropriate sexual comment.
11/25/2025 5:30 AM - refusing to use call light for assistance to bathroom, urine on floor cleaned up.

Comparison of assessments and ISP (summarized):

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 40 Resident 4's record contained 3 comprehensive assessments: "Admission Assessment" (dated 05/06/2025); "30 Day Assessment", dated 06/18/2025); and "Other Assessment: Updated ISP" (dated 11/17/2025), and an ISP dated 11/17/2025. (Note: Surveyor received ISP dated 09/22/2025 via email from Family Member J on 12/10/2025 at 10:07 AM.) In the area of Oral Care: Assessments- 05/06/2025- Set-up and occasional reminders/cues 06/18/2025- No changes 11/17/2025- No changes ISPs- 09/22/2025- occasional reminders/cues and minimal monitoring (number of staff not indicated) 11/7/2025- 2 staff to monitor during oral care In the area of Dressing Assessments- 05/06/2025- Full assistance of 1 staff 06/18/2025- No change except added assistance with TED stockings/tubi grips (compression stockings) 11/17/2025- No changes ISPs- 09/22/2025- Full assist (with number of staff not identified) 11/17/2025- Total assist of 2 staff TED stockings/tubi grips were not addressed on ISP In the area of Grooming: Assessments- 05/06/2025- Reminders, cues and minimal assistance 06/18/2025- No changes 11/17/2025- No changes	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 41 ISPs- 09/22/2025- Grooming not addressed on ISP 11/17/2025- 2 staff assist for grooming, verbally cue or prompt to complete grooming In the area of Toileting: Assessments- 05/06/2025- Requires regular assistance in managing bowel and bladder care toilet every 2 hours, full assist of 1 staff, total assistance including physical and verbal assistance with toileting needs 06/18/2025- No changes 11/17/2025- No changes ISPs- 09/22/2025- Total assist (number of staff not indicated) 11/17/2025- Total assist of 2 staff for toileting. The ISP did not identify use of urinal, resident's physical difficulties with independent urinal use, or staff interventions with urinal. In the area of Mental Health: Self-Concepts- Assessments- 05/06/2025- Light monitoring of self-concept and occasional reassurance 06/18/2025- No changes 11/17/2025- Substantial assistance with reinforcing positive self-concepts ISP- 09/22/2025 ISP- Light monitoring and assistance to maintain healthy self-concept 11/17/2025-ISP- Monitor and redirect negative self-concepts, reinforce positive self-concepts Maturation- Assessments- 05/06/2025- Independent, displays appropriate emotions	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

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N 389	Continued From page 42 06/18/2025- 1 person assist, requires constant supervision and assistance maintaining appropriate emotions ISPs- 09/22/2025- Maturation not addressed on ISP 11/17/2025- No changes Attitude- Assessments- 05/06/2025- Occasional monitoring to reinforce positive emotions 06/18/2025- Constant monitoring and assistance with reinforcement of positive and healthy emotions. Attitude creates daily difficulties and affect living arrangement and/or companions 11/17/2025- No changes ISPs- 09/22/2025 ISP- Consistent monitoring, cues, and redirection of negative attitude. If needed contact provider (MD. psychiatrist) if attitude prevents team from providing care. Resident will receive assistance when resisting cares, etc. on an ongoing basis 11/17/2025-ISP- No changes Interaction- Assessments- 05/06/2025- Displays positive interaction with others 06/18/2025- Receives light monitoring and cues when needed, for inappropriate interactions or withdrawn from others 11/17/2025- No changes ISPs- 09/22/2025 ISP- In the area of Interpersonal- resident displays a healthy one on one interaction with other residents and staff 11/17/2025-ISP- No changes In the area of Behavior Patterns:	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 43 Destructive/Abusive behavior- Assessments- 05/06/2025- none 06/18/2025- Requires occasional verbal reminders to prevent or stop behavior and monitoring of aggression, foul language, and belligerence 11/17/2025- No changes except added exhibits sexual/inappropriate behavior ISPs- 09/22/2025 ISP- ISP did not address aggression, foul language, or belligerence 11/17/2025 ISP did not address aggression, foul language, belligerence, or sexually inappropriate behavior. In the area of Aggressive Combative Behaviors- Assessments- 05/06/2025- No signs of aggressive/combative behaviors 06/18/2025- Frequently displays aggressive/combative behaviors and receives frequent supervision and assistance as needed to avoid/alleviate aggressive and/or combative behaviors. Team will involve resident in decision making regarding activities of daily living by offering choice to diffuse behaviors 11/17/2025- No changes ISPs- 09/22/2025 ISP- The ISP did not address aggressive/combative behaviors 11/17/2025 ISP- No changes In the area of Mood and Behavior- Assessments- 05/06/2025- Check box for "behavior Tracking" was blank 06/18/2025- No changes 11/17/2025- Added behavior tracking at 5:00 AM, 1:00 PM, and 9:00 PM.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 44 for verbal aggression towards staff, vulgar name calling, and sexually inappropriate behaviors. ISPs- 09/22/2025- No behaviors addressed on ISP 11/17/2025- In the area of Behavior Tracking- Monitor behaviors and answer questions daily at 1:00 PM, 8:00 PM, and 5:00 AM On 11/26/2025, Executive Director A provided Surveyor with what s/he identified as the "behavior part of the ISP". Two areas were titled "Behavior Tracking". The 1st stated, "Monitor behaviors and answer questions." (start date 11/10/2025, no end date) (Note- Behavior tracking did not start until 11/17/2025.) The 2nd stated "Utilize when on the Behavior Call. Resident at times displays challenging behaviors. The tab "Additional Info" has two questions; 1) Team will count the number of behaviors resident has each shift and document the number and team will describe the behaviors - What triggered the behavior and the interventions provided by the team and if they were effective. "[sic] Suggestive interventions::[sic] 1. 2 [sic] 3." (start date 11/17/2025, no end date). Questions referenced in the "behavior part of the ISP" were asked and answered on a Care History dated 11/17/2025-11/26/2025 (summarized): Questions- "How many behaviors did resident have this shift? Please describe the behaviors-what triggered them, what interventions were used. Did resident urinate on floor or outside of urinal? Spill any liquids on floor? Use foul language? If yes, document description in observation note." From 11/17/2025 thru 11/20/2025 (date discharge notice issued) no behaviors were documented on the Care History.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 45 The behavior part of ISP and Care History did not identify interventions to prevent or manage behaviors. Involuntary Discharge Notice dated 11/20/2025 issued to Family Member J: "...We are issuing 30-day notice for [Resident 4] to vacate Hamilton Park Place due to the following: Level of care needed exceeds what our facility is safely able to provide. Resident's sexual advances towards employees put them in harm's way...You will need to be moved out of Hamilton Park Place by 12/20/25..." On 11/26/2025 at 12:22 PM, Surveyor interviewed Housekeeper L who stated s/he cleaned Resident 4's floor daily due to urine on floor. Housekeeper L stated Resident 4 was "shaky" and not purposefully spilling. On 11/26/2025 at 12:32 PM, Surveyor interviewed Lead Caregiver K who stated Resident 4 made an inappropriate comment and gesture toward him/her once and s/he immediately redirected Resident 4, and afterwards Resident 4 gave him/her the cold shoulder but has not made further inappropriate comments toward him/her. Lead Caregiver K stated no training was provided specific to Resident 4's behaviors. Lead Caregiver K stated 2 staff were to be present during cares due to behaviors. Lead Caregiver K stated Resident 4 accidently urinated outside of the urinal and did not fully empty bladder while reclined back in recliner. Lead Caregiver K stated Resident 4's clothes were frequently wet and s/he did not like changing, and since Resident 4 drank while reclined back s/he spilled. Caregiver L stated Resident 4 did well with toileting when urinal was unavailable to him/her. Caregiver L	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 46	N 389		

stated s/he never witnessed Resident 4 intentionally spilling drinks or urinating on floor.

On 11/26/2025 at 12:50 PM, Surveyor discussed concerns regarding Resident 4's toileting needs, behaviors, assessments and ISP with Executive Director A and Resident Care Director B (who joined discussion via telephone at 1:27 PM). Executive Director A stated Resident 4's ISP was updated in June 2025 due to cursing at other residents in the dining room, and Resident Health Director B stated Resident 4's behaviors started a few months prior to 11/26/2025 and have since become more blatant. Executive Director A stated no ISP review meeting was held with Family Member J or MCO staff because Executive Director A had a phone conversation with Family Member J in September 2025 and the MCO staff never provided a date they would be at facility.

On 11/26/2025 at 4:43 PM, Surveyor interviewed Family Member J who stated during a phone conversation with Executive Director A in September 2025, s/he was not averse to staff encouraging Resident 4 to walk to the bathroom but was not told the urinal would be confiscated. Family Member J stated s/he then suggested a 2-hour toileting schedule. Family Member J stated s/he preferred Resident 4 used the urinal due to urge incontinence while waiting for staff to answer call light to walk him/her to the bathroom.

On 12/02/2025 at 9:12 AM, Surveyor interviewed (MCO) Case Manager P who stated s/he first heard of Resident 4's behaviors in October 2025 from provider and s/he emailed provider requesting staff redirect behaviors. Case Manager P stated Resident 4's care needs had not changed during his/her stay at Hamilton Park Place, and Executive Director A declined a care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 47	N 389		

plan (ISP review) meeting stating it was not necessary as a 30-day discharge notice was being issued.

11/10/2025 at 12:39 PM, email from Resident Health Director B to Family Member J (received from Family Member J 11/27/2025 at 8:24 PM): " ...[Executive Director A] has spoken with [Family Member J] regarding [Resident 4] telling staff [s/he] will intentionally "Piss [him/herself]" if [s/he] doesn't have [his/her] urinal. [Resident 4] continues to be on a 2-hour toilet schedule. When [Executive Director A] spoke with [Family Member J] [s/he] told [Executive Director A] [Resident 4] has had this type of personality since [s/he] was a child. If [Resident 4] doesn't like how things are done [s/he] will retaliate. In this case [s/he] is intentionally dumping [his/her] soda's on the floor, along with urinating on the floor. The therapy group has deemed [him/her] capable to walk with one assist to and from bathroom. We do not feel it would be safe to put a commode beside [his/her] bed or chair as [s/he] may try to self transfer which would increase the risk of falls, along with continue [sic] urinating on the floor in the same manner as the urinal. Our housekeeper is currently having to mop his floor multiple times on [his/her] shift and use specialty cleaning products. Management and the owners have met and discussed these ongoing issues and agree this warrants a 30 day notice. We will be drafting the official notice and sending out by end of day tomorrow ..."

11/13/2025 at 1:53 PM, email from Family Member J to Resident Health Director B, Executive Director A and MCO staff (received from Family Member J 11/27/2025 at 8:33 PM), " ...Here are updates that should be added to [Resident 4's] Plan of Care/ISP: Toileting:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 48	N 389		

[Resident 4] has challenges with urinary incontinence secondary to effects from two strokes. [S/he] has decreased sensation of bladder fullness. When asleep, [his/her] body does not signal a need to empty the bladder. When awake, [s/he] has difficulty holding in urine when [his/her] bladder is full and when [s/he] changes position from sitting to standing. [S/he] often cannot wait long after using [his/her] call pendant for help to the bathroom. [S/he] does not want to be incontinent and wants [his/her] dignity maintained. [S/he] uses disposable briefs for protection. Interventions and approaches to address the need: [Resident 4] has hand-held urinals that allow [him/her] greater independence with urinating and helps [him/her] manage urinary urgency. Provide support with using the urinals as needed such as help with positioning/repositioning, helping with clothing management and adjusting briefs as needed, and emptying the urinals to prevent them from getting too full. [Resident 4] should be offered the option to walk to the bathroom with staff assistance for toileting. If [s/he] declines the offer, respect [his/her] choice. Offer to walk [him/her] at a different time and when toileting needs have been met ..."

11/19/2025 at 2:39 PM, email from Resident Health Director B to Family Member J (received from Family Member J 11/27/2025 at 8:37 PM): " ...Due to [Resident 4's] behaviors we can no longer send a single staff member in there, we will have to send two staff members in for safety concerns. Due to these increased behaviors and the sexual harassment of our staff [Resident 4] is no longer appropriate for our facility. We will be following up with a formal 30-day notice ..."

11/19/2025 at 4:28 PM, email from Family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 389	Continued From page 49	N 389		

Member J to Resident Health Director B, Executive Director A and MCO staff (received 11/27/2025 at 8:58 PM from Family Member J): " ...Please feel free to incorporate the following ideas into a Behavior Support Plan: [Resident 4] makes comments, jokes, or statements of a sexual nature. >if [sic] [s/he] is talking about something in the past that [s/he] saw, heard, or experienced, let it be. >if [sic] [s/he] makes comments, jokes, etc [sic], while staff are doing peri-care, offer a change of topic (likes hunting and fishing, NASCAR, Vikings, Wrestling shows, played football in HS, worked and lived in [name of city] most of [his/her] life), or tell [him/her] that you don't feel comfortable with the conversation and want to keep it all professional. Ask [him/her] kindly to avoid talking about sexual things ...first, these "increased behaviors" - what did you do about the behaviors when they first started? Where is your documentation that you took a look at the situation, consulted with [his/her] care team, spoke with me, spoke with [him/her] to gain understanding, made a behavior plan, and implemented simple interventions..."

11/24/2025 at 2:48 PM email with attached ISP from Executive Director A to Family Member J (received 11/27/2025 at 9:03 PM from Family Member J) " ...Attached is [Resident 4's] current Care Plan. Please review and reach out with any questions. We can also have a zoom meeting if you desire ..."

On 12/03/2025 at 12:45 PM, Surveyor emailed Executive Director A, Resident Health Director B, Owner N and Owner O requesting all Resident 4's ISP's since admission (except ISP dated 11/17/2025) by noon on 12/04/2025. As of 12/05/2025 at 5:00 PM, ISPs were not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

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N 389	Continued From page 50 On 12/09/2025 at 10:01 PM, Surveyor received an email from Family Member J stating (summarized) sometime between 09/22/2025 and 09/25/2025, Executive Director A emailed him/her an ISP. Family Member J stated no discussion was held regarding the ISP's contents, just a request for signature. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0381 83.35(1)(a) Preadmission And Ongoing Assessments N0408 83.37(1)(i) PRN Psychotropic Medication	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PARK PLACE	2525 HAMILTON STREET PORTAGE, WI 53901

(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 408	Continued From page 51 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure when a psychotropic medication was prescribed on an as needed (PRN) bases for a resident, the resident's individual service plan (ISP) included the rationale for use and a detailed description of the behaviors with indicated the need for administration of the PRN psychotropic medication for 1 of 2 residents reviewed. Resident 1's ISP did not include the rationale for use and detailed description of behaviors indicating need for administration of PRN haloperidol or PRN lorazepam. This is a repeat deficiency. See Statement Of Deficiency (SOD) WHTX13 dated 05/09/2023, SOD WHTX14 dated 09/27/2023, SOD WHTX15 dated 03/21/2024, and SOD WHTX16 dated 07/12/2024. Findings include: Per DHS 83.02(41) "Psychotropic medication means a prescription drug, as given in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior". On 11/11/2025, Surveyor reviewed Resident 1's record. S/he was admitted 09/29/2025. Diagnoses included vascular dementia, unspecified severity, with agitation. Physician orders included: haloperidol 0.5 MG 1 tablet twice daily as needed for anxiety/agitation (start date 09/30/2025), and lorazepam 0.5 MG 1 tablet every 4 hours as needed for anxiety/restlessness/agitation (start date	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

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N 408	Continued From page 52 10/02/2025). October 2025 Medication Administration Record (MAR): Staff documented administration of PRN haloperidol and PRN lorazepam 10/02/2025 12:34 PM- lorazepam due to agitation 10/03/2025 10:53 PM- lorazepam due to restlessness and anxiety 10/04/2025 8:14 AM- haloperidol due to irritation and removing wrist brace 10/05/2025 6:43 PM- haloperidol due to agitation, messing with call button and bandage, and wanting to go home. 10/05/2025 9:54 PM- lorazepam due to restlessness and agitation, trying to elope off property, very agitated calling staff names and pacing in the front room. 10/06/2025 7:38 AM- haloperidol due to agitation and aggressiveness with staff when morning cares and medication administration attempted. 10/09/2025 4:53 PM - lorazepam due to agitation when wanting to leave. 10/21/2025 12:56 AM - due to anxiety, restlessness, and wandering halls wanting to leave. Staff documented on the October MAR that each dose of PRN haloperidol and PRN lorazepam administered during October 2025 was given for intended use according to the ISP. Observation notes dated 09/29/2025-11/11/2025 (summarized: 10/04/2025 5:00 AM - Resident was up, asked staff about leaving, wanted to call family to come get him/her, redirected to room then wandered toward door. Resident was anxious and wanting to leave, PRN lorazepam administered. 10/09/2025 9:30 PM - PRN lorazepam administered due to resident very anxious and	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015335	A. BUILDING: _____ B. WING _____	12/10/2025

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N 408	Continued From page 53 angry stating s/he was going to elope off property. 10/21/2025 5:30 AM - restless, agitated, wandering halls searching for family and stating s/he did not belong at facility. PRN lorazepam administered. ISP dated 09/29/2025 did not identify rationale for use and a detailed description of the behaviors which indicated the need for administration of the PRN psychotropic medication. On 11/11/2025 at 4:21 PM, Surveyor discussed concern of PRN psychotropic medication not addressed on Resident 1's ISP with Executive Director A and Resident Health Director B. Resident Health Director B stated s/he would update the ISP. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 408		