| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0015983 | A. BUILDING: _____ B. WING _____ | C 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OAK PARK PLACE OF MENASHA | 2205 MIDWAY ROAD MENASHA, WI 54952 |

| (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<br><br>On 11/13/2025, with information gathered through 11/18/2025, Surveyor conducted a standard survey and 2 complaint investigations at Oak Park Place of Menasha.<br><br>One of 2 complaints were substantiated.<br><br>As a result of the survey, 1 deficiency was issued.<br><br>Census: 39 | N 000 | | |
| N 388 | 83.35(3)(c) Implement, follow the individual service plan<br><br>Implementation. The CBRF shall implement and follow the individual service plan as written.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not implement and follow the individual service plan (ISP) for 1 of 1 (Resident 1) residents reviewed.<br><br>Resident 1's ISP indicated to provide 1 hour safety checks. Staff did not conduct the 1 hour checks between 11:00pm and 5:00am on 09/01/2025, 09/02/2025, 09/13/2025, 09/14/2025, 09/21/2025, 09/22/2025, 09/23/2025 and 09/24/2025. On 09/14/2025 at 4:50am, Resident 1 had a fall which resulted in injuries to hand, face and right knee.<br><br>Findings Include:<br><br>On 10/23/2025, the department received a complaint regarding falls.<br><br>On 11/13/2025, Surveyor conducted an onsite visit to the facility. A sample of residents was | N 388 | | |

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

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| OAK PARK PLACE OF MENASHA | 2205 MIDWAY ROAD MENASHA, WI 54952 |

| (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 388 | Continued From page 1 | N 388 | | |

selected including the closed record of Resident 1. Resident 1 was admitted to the facility on 04/14/2025 with diagnoses to include dementia, depression, bipolar disorder and anxiety. Resident 1 passed away on 09/28/2025. Resident 1's most recent ISP with an initiation date of 04/21/2025 indicated Resident 1 was a fall risk due to cognitive deficit. Interventions listed on the ISP included: At each safety check, remind Resident 1 to use call pendant for any assistance; chair and bed alarm in place and on; encourage participation in activities, encourage Resident 1 to stay in common areas.

Surveyor reviewed Resident 1's September 2025 MAR (Medication Administration Record). Resident 1 was noted to have "Hourly safety checks every hour" starting 06/19/2025. Surveyor noted no hourly checks were documented at the following times:
-09/01/2025 at 11pm
-09/02/2025 at 12am, 1am, 2am, 3am, 4am and 5am
-09/13/2025 at 11pm
-09/14/2025 at 12am, 1am, 2am, 3am, 4am and 5am
-09/21/2025 at 10pm and 11pm
-09/22/2025 at 12am, 1am, 2am, 3am, 4am and 5am
-09/23/2025 at 11pm
-09/24/2025 at 12am, 1am, 2am, 3am, 4am and 5am

Surveyor reviewed Resident 1's fall report and noted the following:
-09/14/2025 at 4:50am "Staff rounded corner near nurses' station to see [Resident 1] on the ground. Chair pad alarm was going off for a bit more than 2 minutes...scratches were noted to knuckles on right hand, top of left eyebrow, on

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OAK PARK PLACE OF MENASHA** | **2205 MIDWAY ROAD MENASHA, WI 54952** |

| (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 |
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| N 388 | Continued From page 2<br>nose, right knee. Small abrasion to [right] side of forehead..." The report noted hospice was notified and Resident 1 did not go out to the hospital.<br><br>On 11/17/2025 at approximately 2:00 PM, Surveyor interviewed Director of Health Care Services A. Director of Health Care Services A verified the missing documentation related to one hour safety checks on the above days. | N 388 | | |