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 12/09/2024

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 On 12/09/2024, Surveyor conducted 2 complaint investigations at Oak Park Place in Menasha. One (1) of 2 complaints were substantiated. As a result of the survey, 1 deficiency was issued. Census: 45	N 000		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the ISP (Individual Service Plan) was followed for 1 of 1 (Resident 1) residents reviewed. Resident 1's ISP indicated Resident 1 was a 2 assist with hoyer lift for transfers. During a transfer of Resident 1, Caregiver A operated the hoyer lift alone. Caregiver A indicated during the transfer the hoyer lift descended rapidly, resulting in Resident 1 feeling like s/he had fallen, however, Resident 1 did not fall. Resident 1 reported to staff increased pain after the incident and was sent out to the hospital. Resident 1 was discovered to have a left hip fracture. Findings Include: On 10/17/2024, the Department received a complaint regarding falls. On 12/09/2024, Surveyor conducted an onsite visit to the facility and requested Resident 1's	N 388		

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

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N 388	Continued From page 1 resident record. Resident 1 was admitted to the facility on 03/31/2021 with diagnoses to include hyperlipidemia, hypothyroidism and chronic kidney disease. Resident 1 was discharged from the facility on 11/11/2024. A facility incident report dated 08/07/2024 stated, "Resident stated [s/he] fell in [his/her] bedroom near [his/her] bed. Resident said [s/he] was trying to put [his/her] sweater on and when [s/he] turned around by [his/her] walker [s/he] somehow landed on [his/her] left side on the floor. Resident did say [s/he] did not hit [his/her] head at all. Resident stated [s/he] hurt [his/her] wrist a little. Resident stated [s/he] got [his/her] own self off from the floor by grabbing on to [his/her] bed...Writer also contacted POA[Power of Attorney] and notified ADOHCS [Assistant Director of Healthcare Services] regarding resident's unwitnessed fall in [his/her] bedroom. Resident and POA refused the need to be sent to ER [Emergency Room]. Family stated they would bring to hospital if pain did not improve in the morning. POA did transport to hospital the next morning for evaluation. Found to have hip fx [fracture], reported to DHS [Department of Health Services] per requirements." Per a physician's note dated 08/19/2024, Resident 1 was hospitalized from 08/08/2024 through 08/13/2024 for left hip fracture. Resident 1 was too high risk for surgical intervention, therefore Orthopedics requested OT (Occupational Therapy) and PT (Physical Therapy) and Resident 1 was transferred to a local skilled nursing facility for therapies. On 08/27/2024, Resident 1 returned to the CBRF	N 388		

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N 388	Continued From page 2 (Community Based Resident Facility). Resident 1's ISP was updated on 08/28/2024 to reflect Resident 1 required assist of 2 staff with hoyer lift for transfers. On 09/24/2024 at 7:25AM, a facility progress note stated, "Staff went to get [Resident 1] up for the day and [s/he] started to cry. [S/he] stated that [his/her] left leg and hip hurt. [S/he] stated that [s/he] had fallen last night. Stated that it was same staff that always works 2nd shift. [S/he] said [s/he] did apologize to [him/her], stating it was [his/her] fault. [Resident 1] was in a lot of pain, with just a touch. Called our nurse, [his/her] family and sent [him/her] to hospital." A facility self report dated 09/25/2024 stated, "On the morning of 9/24/24, [Caregiver A] notified DHCS [Director of Healthcare Services] and ADHCS that resident was complaining of significant pain to [his/her] left hip. [Caregiver A] called [Resident 1's POA], to inform [him/her] and was given consent to call EMS [Emergency Medical Services] for evaluation. Resident reported to [Caregiver A] that [s/he] had a fall the night before. On-call nurse had not been notified of a fall on 9/23/24 so an investigation was immediately started. Caregiver involved was suspended immediately pending investigation." The report continued to state, "Resident was transported to hospital for evaluation and was found to have an acute hip fracture, involving the same hip [s/he] had broken 1-2 months prior. [S/he] was admitted to the hospital. Interview was conducted with several staff members. NOC [night] shift staff reported that resident slept through entire night with no complaints of pain and did not push pendant for assistance...Interview was conducted with PM caregiver revealed that caregiver had transferred	N 388		

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N 388	Continued From page 3	N 388		

resident via manual hoyer lift by [him/herself]. Caregiver reported that while lowering resident to [his/her] bed, the hoyer lift descended quickly causing resident to think that [s/he] fell. Staff member reassured resident that [s/he] did not fall, was not on the ground, and was still in the hoyer sling. Staff member did apologize to resident and stated it was [his/her] fault that the hoyer lowered so quickly. Staff member also mentione[sic] that resident had been complaining of increased pain just prior to the transfer occurring. It is noted that [s/he] did complete a session of PT and OT earlier that day. Resident was given [his/her] scheduled bedtime pain medication. [S/he] did not call again for additional PRNs [as needed] as [s/he] often does if having unmanaged pain. The situation was communicated to family and lead RN [Registered Nurse] in the ER via phone." The facility report stated, "Staff member was suspended immediately pending investigation. Upon completion of investigation, staff member's employment was terminated immediately related to neglect to follow care plan which clearly states that hoyer lift must be used with two staff for resident safety. Hoyer retraining to be completed with all care staff within 7 business days of date of report. Staff member involved will be reported to Caregiver Misconduct related to this incident. Adult protective services were notified of situation and did discuss at the facility the situation and were provided information regarding incident and actions taken. It is unclear at this time if resident will return to facility when able to."

On 12/09/2024 at 10:40 AM, Surveyor interviewed Director of Housing B. Director of Housing B verified the above self report as being accurate. Director of Housing B also provided Surveyor with the Misconduct Information Report showing the facility did report Caregiver A to the

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N 388	Continued From page 4 Office of Caregiver Quality. Director of Housing B stated even though the investigation showed Resident 1 didn't fall from the hoyer lift, Caregiver A was terminated due to not following facility policy related to having 2 caregivers assist Resident 1 during the hoyer lift transfer. Director of Housing B stated they did re-educate staff on the need to have 2 staff for all hoyer lift transfers and the facility policy associated with the directive. Director of Housing B stated s/he did not have any written documentation indicating what the training detailed nor a sign-in sheet of the staff trained but stated, "I know we trained staff right after the incident and then again at our October in-service."	N 388		