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N 000	Initial Comments On 09/25/2025 to 10/22/2025, Surveyor conducted a complaint investigation at Oak Park Place Baraboo Autumn Lane. One deficiency was identified. The complaint was substantiated. Census: 34	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 follow the resident's Individual Service Plan (ISP) for 1 of 1 resident reviewed. Resident 1 was on hospice services, utilized a wheelchair for mobility and was declining rapidly in July 2025. On 07/10/2025, facility staff refused to assist Hospice Nurse D use a Hoyer lift or transfer Resident 1 another method while onsite, and Resident 1 experienced negative outcome by remaining in their wheelchair (WC) while ill and leaning forward in his/her WC, vomiting, spitting on the floor. The provider's common area recliners were occupied by other residents and staff refused to assist Resident 1 to his/her bed because they stated the provider is a "no lift" facility. Resident 1 remained in his/her WC while experiencing the above symptoms from after dinner (approximately 5:45 PM) until Hospice Nurse H came in at approximately 7:50 PM.	N 388		

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

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N 388	Continued From page 1 Findings include: On 08/06/2025, the Department received a complaint alleging concerns the provider staff refused to assist hospice staff with a transfer. On 09/25/2025, Surveyor conducted a complaint investigation and identified the following: The provider is licensed as a class CNA (non-ambulatory) to serve up to 34 residents in the following client groups: irreversible dementia/Alzheimer's and advanced age. The provider's program statement documented: "Facility Client Group: ...These are all individuals who can no longer function independently in their own home, but do not require the services of a nursing home or 24-hour skilled nursing care. Program Goals: ...To provide adequate supervision and health monitoring, supportive services and leisure time activities in order to assist residents in successfully completing activities of daily living and enjoying a dignified, quality lifestyle. Program Services:..24-hours awake staff to remind and assist residents with personal care, including weekly shower, shampoo, routine nail care, toileting, and dressing. Special Needs/Interventions of those with a terminal illness, including referral to hospice services, provision of pain management to ensure comfort and supportive care to family members. Supplemental Services are available for an additional fee based upon the individual needs of each resident. These services include: ...Short-term one-on-one staff supervision of individuals exhibiting behaviors requiring continuous supervision. Mobility assistance.	N 388		

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N 388	Continued From page 2 Behavioral assistance." Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 06/06/2024 with a diagnosis of dementia. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) dated 06/13/2025 documented: "Fall Risk: Broda chair ordered and delivered (related to) RT [Resident 1] not able to sit safely upright in a standard wheelchair (date initiated 07/11/2025), encourage [Resident 1] to stay in common areas to promote more supervision. [Legal Representative C] agrees to keep [Resident 1] in common area to help prevent injuries (date initiated 07/11/2025). Transfers: [Resident 1] requires assist of 1 (date initiated 06/09/2025). Bed Mobility: [Resident 1] will allow staff to stand-pivot transfer or utilize Hoyer as needed. [Resident 1] sleeps in common area recliner so staff have very frequent safety checks. [Legal Representative C] aware that [Resident 1] does not sleep in [his/her] bed any longer R/T poor safety awareness and terminal restlessness (date initiated 07/11/2025)." Resident 1's incident reports documented: "-07/10/2025 at 1400: Resident was on floor when staff came to check on resident because the bed/chair alarm was going off. Resident was already on the floor. [Resident 1] was found sitting on [his/her] buttocks. Resident had shoes on, resident was very restless. Resident unable to give description. Two staff members guided resident in their wheelchair with gait belt. Staff took vitals and called nurse. MD faxed. Hospice made aware and dispatched nurse." Resident 1's hospice records documented: -"07/10/2025 completed by [Hospice Nurse D]: [Hospice Nurse D] Call placed to [Legal	N 388		

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Representative C], APOA at 1702 pm. Reason for call: Notification of unwitnessed patient fall w/o and facility request for SN visit for c/o chronic anxiety, restlessness. [Legal Representative C] stated [s/he] was notified of patients fall.

Comprehensive assessment completed secondary to reported unwitnessed fall w/o injury. Facility staff called triage to report patient w/ unwitnessed fall at approx 1400. No reported injuries with assessment. Facility staff requesting SN visit assessment secondary to noting patient w/ continued symptoms of increased anxiety and restlessness which staff are unable to address w/ non-pharmacological diversion activities and redirection attempts....Noted behaviors of anxiety and restlessness included patient w/ repeated actions of attempting to get up and down from WC or chairs w/o staff assistance. If staff are present and attempt to redirect patient away from attempts to stand, patient becomes angered, yelling out, and physically aggressive, to include slapping, pinching, scratching and on occasion biting...Writer inquired to patient's sleep status. [Caregiver F] reports sleep pattern is poor w/ patient not sleeping through night w/ frequently waking at around 0300 am, then showing restless activity of trying to get up frequently w/o assistance and when sitting in chair, patient frequently leans to the left while seated and resists attempts to reposition to upright position...Writer inquired to changes to patient status, none reported by [Caregiver E] and [Caregiver F]. Writer attempted to complete physical assessment following conversation w/ staff, patient still eating dinner meal. Writer notified staff that physical assessment would be completed following meal. When patient completed dinner meal, writer required nurse assistance to transfer patient to room as patient

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is unable to lift feet on command. When transferred to room w/ assistance from [Caregiver F] writer offered to prepare patient for bed following assessment to bed. Per [Caregiver F], patient is not put to bed during evening shift but is to return to common area for visual monitoring due to patients fall prevention care plan. Writer did not transfer patient to bed and completed assessment in WC. No observed discomfort w/ assessment. Contusion noted to left anterior forearm, otherwise no s/s pain or injury noted. Patient nonverbal to questions on comfort. Writer returned patient to common area by walking WC backwards.

Writer returned patient to common area per [Caregiver F's] request and updated [him/her] to patient's return. [Caregiver F] acknowledged writers statement and left area to administer medication to residents. Patient continued to lean towards left side...Writer approached by caretaker that patient is leaning more to the left in [his/her] WC and had vomited, [s/he] requested writer assess patient. On arrival to common area, patient had turned WC from [his/her] previous placement and was leaning to the left and bent forward in chair. Writer observed that patient had expectorated a quarter sized purulent appearing phlegm beside WC. Staff reported that patient was refusing to be sat upright and was not responding to verbal communication. Writer observed patient was alert but was uncommunicative and refused to sit upright for writer as well. Writer explained to caregiver that floor med passer [Caregiver F] had indicated patient's leaning was baseline behavior and that [s/he] was not exhibiting new actions, writer also stated that the phlegm is not concerning as the previous assessment did not show signs of congestion or URI infection. Caregiver stated that

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the patient does not lean forward or in the awkward position. Writer inquired what staff would like writer to do. Staff did not provide answer. Writer offered to return patient to bed or a recliner if one was available (which at that moment, was not as both recliners to common area were occupied) as symptoms of leaning could indicate fatigue. Caregiver angrily stated 'two people cannot put [him/her] to bed if [s/he's] like this. We are a no lift facility'. Writer acknowledged statement and inquired how staff address transferring patients when sudden weakness or changes occur where a patient is unable to assist. Staff stated by Hoyer lift or EZ stand. Writer inquired if Hoyer lift available and offered to assist with transfer of patient w/ device. Again, the caregiver angrily stated, 'not without an order'. Writer acknowledged statement and stated that an order would be obtained but that the staff would need to sit one on one with patient if concerns for fall are present. The caregiver angrily stated, 'we don't have staffing to be one on one'. Writer stated a call would need to be made to get the Hoyer lift and broda chair ordered and that writer would return when completed.

Writer obtained order for Hoyer lft and broda chair from primary hospice provider on call. After obtaining order and then speaking with [Hospice Provider G] PM resource supervisor, writer was approached by angry caregiver to state while writer was speaking to supervisor that the facility has a no lift policy. Writer again acknowledged caregiver statement and informed caregiver that Hoyer lift order had been placed and that patient could now be transferred to bed or recliner with Hoyer lift. Writer ended conversation with supervisor and found patient is same position. Patients nose had begun to run clear thin mucous

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and signs that the patient had spit several times to floor were observed. Writer replaced [Caregiver F] in sitting in front of patient and again attempted to assist patient to an upright position, but patient continued to resist. Writer stated to [Caregiver F] that Hoyer lift and Broda chair order had been obtained and that writer would fax order as soon as possible and requested staff obtain a Hoyer lift to assist writer in returning patient to bed. [Caregiver F] acknowledged writers statement and left area. Writer awaited staff return for greater than 10 minutes. Writer then placed second call to [Hospice Provider G] PM supervisor, at that time the angered caregiver, [Caregiver F], [Caregiver E], returned to writer and patient's side. The angry caregiver stated " We called our director for the facility and [s/he] has asked that you leave. We will take care of the patient. Writer asked how they were planning to move the patient as the Hoyer lift was not present and they had expressly stated it was against policy to move patient w/ lift assist. The angry caregiver stated we will use four people to move patient. You can leave." Writer requested to speak to [Director of Health Services B], while waiting for staff to place call. Writer spoke to [Hospice Provider G] supervisor who advised writer offer a secondary [Hospice Provider G] RN to come in writers place to assist with transfer. Staff provided phone with [Director of Health Services B]. [Director of Health Services B] stated that writer had made staff angry with demands to lift patient when the facility has a no lift policy and that writer requesting this was risking injury to staff. Writer offered apologies for the miscommunication and tensions with staff and attempted to clarify that writer had asked for assistance to transfer patient from WC to bed and had not demanded they lift patient against policy and that a Hoyer lift and broda chair had

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been ordered to assist with patient needs per policy, but staff had refused writers request to assist with transfer following order retrieval. [Director of Health Services B] did not acknowledge writers attempts at clarification of conversations between staff and writer or [Director of Health Services B] mishearing of order of care and observations on patient status. [Director of Health Services B] then informed writer that [s/he] had contacted [Legal Representative C] that the patient does not need a higher level of care as [s/he] stated this writer had stated to caregivers. Writer again attempted to clarify inaccuracies of writers statements. Writer offered that an alternate [Hospice Provider G] RN would arrive to assist staff and patient. [Director of Health Services B] declined offer, however during conversation, [Hospice Nurse H] arrived and staff began working with RN. Writer concluded conversation with [Director of Health Services B] and after relinquishing care to [Hospice Nurse H], writer left unit."

Completed by Hospice Nurse H at 1950: "Focused visit performed d/t: decline, Relieving [Hospice Nurse D]. Writer attempted calling with ETA. Symptoms/needs addressed and recommendations: Pt. in WC leaning heavily to left side. Unable to be corrected. Staff report that this is new. Pt. does sometimes lean but usually is correctable not like this. Writer assisted staff in helping pt. back into her room. Writer performed Stroke assessment on pt. No slurring of speech. Pt. denied pain and headaches. no facial drooping. Strength in bilateral extremities equal and strong. Writer aided staff in moving pt. onto her bed in order to put a brief on pt. During initial transfer to bed pt. was unable to stand at all. Needed to be supported by facility staff. During pt. transfer back to chair pt. able to stand on

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move with assistance and a gait belt per baseline. Pt. still leaning heavily in WC. Writer aided facility staff in transferring pt. into chair in common area. Staff report that pt. is a frequent faller and moves around a lot and has been sleeping in chair in common area for a while. Pt. appeared comfortable at visit end. Staff report that pt. was walking with walker a couple weeks ago and is now in a WC. Writer educated that leaning and increased weakness is likely decline, disease process, and fatigue. Writer educated on benefits of broda chair for pt. [Hospice Nurse D] ordered a Hoyer and a broda chair for pt. due to leaning and weakness. Writer updated facility staff on this. Staff had no further questions. Writer educated to call [hospice] with any questions or concerns. Educated staff to pass on to day shift importance of charting pt. BM. Staff v/u."

Interviews:

On 08/07/2025 at 2:07 PM, Surveyor interviewed Legal Representative C. Legal Representative C reported on 07/10/2025, Resident 1 fell out of his/her chair and Hospice Nurse D responded to the facility. Legal Representative C reported Hospice Nurse D attempted to move Resident 1 to his/her bed and that staff was uncooperative and wouldn't assist in lifting. Legal Representative C reported Hospice Nurse D was eventually asked to leave by Director of Health Services via phone. Legal Representative C stated s/he was made aware of this when Director of Health Services B called me to advise the same. Legal Representative C stated kicking Hospice Nurse D out of the facility because s/he was trying to help Resident 1 sparked my concerns.

On 09/25/2025 at 10:05 AM, Surveyor interviewed Director of Health Services B.

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N 388	Continued From page 9 Director of Health Services B reported Legal Representative C discharged Resident 1 abruptly in late July and then reported concerns to Baraboo Police Department that we were neglecting Resident 1. Director of Health Services B stated a detective came to the facility in August, spoke to staff and I. Director of Health Services B reported police were sent records via email. Director of Health Services B stated a concern Legal Representative C had was that a hospice RN wanted help from staff to transfer Resident 1 from wheelchair to bed in July. Director of Health Services B stated on this day, Resident 1 could not bear weight, and we are a no lift facility, so my staff said "no, we can use the Hoyer lift." Director of Health Services B reported the hospice nurse became belligerent and was yelling at my staff to help with the transfer. Director of Health Services B stated staff called me and I explained our policy to the nurse. Director of Health Services B noted the hospice nurse continued to be hostile over the phone, so I asked him/her to leave. On 10/01/2025 at 9:36 AM, Surveyor interviewed Caregiver F via phone. Caregiver F confirmed s/he worked the evening of 07/10/2025 and was the assigned med passer for Resident 1's living area. Caregiver F reported at the beginning of his/her shift, s/he was told that Resident 1 had a fall earlier and a hospice nurse would be out to assess. Caregiver F stated Hospice Nurse D arrived while Resident 1 was eating dinner and s/he suggested to wait until after Resident 1 was done eating to assess. Caregiver F noted Hospice Nurse D was not happy about this. Caregiver F reported Hospice Nurse D assessed Resident 1 in his/her wheelchair and said there was nothing wrong with him/her. Caregiver F reported there was 3 staff on shift including him/herself and Hospice Nurse D was sitting next	N 388		

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to Resident 1 in the common area. Caregiver F reported Hospice Nurse D ended up walking away from Resident 1 to chart and we observed Resident 1 leaning to the left and bent forward while sitting in his/her wheelchair. Caregiver F stated Resident 1 vomited clear, so we asked Hospice Nurse D to reassess. Caregiver F confirmed the recliners in the common area were occupied so Resident 1 had to remain in his/her wheelchair. Caregiver F stated Hospice Nurse D asked about using a Hoyer lift to transfer Resident 1 to bed and I stated we couldn't use that without an order. Caregiver F noted the facility was a "no lift facility" and Hospice Nurse D became snotty towards staff. Caregiver F confirmed Hospice Nurse D called their on-call physician and obtained an order to use the Hoyer lift. Caregiver F reported Hospice Nurse D never asked for assistance or offered to assist staff after obtaining the order. Caregiver F confirmed Resident 1's symptoms were not baseline. Caregiver F reported s/he called Director of Health Services B to discuss the situation and s/he asked Hospice Nurse D to leave for making the staff angry. Caregiver F confirmed another nurse came into to replace Hospice Nurse B. Surveyor questioned why the 3 staff working could not transfer Resident 1 to his/her bed to be more comfortable since the recliner chairs were occupied. Caregiver F stated we could have used a gait belt to transfer him/her, but the other staff were busy helping other residents. Surveyor asked if staff ever discussed a plan to transfer Resident 1 to bed after staff were done assisting other residents. Caregiver F stated "no."

On 10/01/2025 at 12:05 PM, Surveyor interviewed Caregiver E via phone. Caregiver E confirmed s/he worked the evening of 07/10/2025 and was assigned as the med passer for the 2nd

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part of memory care that Resident 1 did not live in. Caregiver E reported when s/he got involved was when s/he saw Caregiver F and Hospice Nurse D having a tense discussion. Caregiver E reported Hospice Nurse D wanted Resident 1 to lay down in his/her bed since the recliners in the common area were occupied and Resident 1 was showing non baseline symptoms. Caregiver E stated usually when hospice gives staff directives they are not willing to assist. Caregiver E stated his/her opinion was the situation was a big misunderstanding because when s/he talked to Hospice Nurse D, s/he was willing to help with the transfer. Caregiver E reported s/he remembers Caregiver F stating 2 staff was not enough bodies to transfer Resident 1, but Hospice Nurse D stated there would be 3 of us, s/he was willing to help. Caregiver E stated by this time, Caregiver F had called Director of Health Services B and Hospice Nurse D was asked to leave. Caregiver E stated s/he was unsure of the reason why Hospice Nurse D was asked to leave. Caregiver E reported when observing Resident 1 s/he was slumped to the left with his/her left hand almost touching the ground and s/he was drooling. Caregiver E confirmed the symptoms Resident 1 was displaying was not his/her baseline. Caregiver E stated another nurse relived Hospie Nurse D and staff was able to get Resident 1 transferred to bed, changed, and placed in a recliner chair in the provider's common area. Surveyor shared concern that Resident 1 had to remain in his/her wheelchair while displaying the above symptoms without being transferred. Caregiver E acknowledged the concerns and stated that 3rd staff should have been hunted down right away to assist Resident 1.

On 10/01/2025 at 3:39 PM, Surveyor interviewed Hospice Nurse H via phone. Hospice Nurse H

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confirmed s/he relieved Hospice Nurse D on the night of 07/10/2025. Hospice Nurse H reported s/he arrived to the facility at approximately 7:50 PM, and observed Resident 1 slumped to the left in his/her wheelchair. Hospice Nurse F reported Hospice Nurse D was sitting next to Resident 1. Hospice Nurse H stated after the other nurse left, staff were happy to see me and stated Hospice Nurse D was rude. Hospice Nurse H stated s/he had never known Hospice Nurse D to act rudely, so s/he was not sure what happened before s/he got there. Hospice Nurse H confirmed a miscommunication had occurred between Hospice Nurse D and facility staff. Hospice Nurse H noted Hospice Nurse D had obtained an order for a Hoyer lift and broda chair while s/he was in the building.

On 10/03/2025 at 12:14 PM, Surveyor conducted an exit conference and shared findings with Director of Housing A and Director of Health Services B via phone. Both staff acknowledged an understanding of the concern. Director of Health Services B reported the incident took place almost 3 months ago, so s/he could not recall all details. Director of Health Services B stated s/he was not present but did receive a call from staff that evening about how the hospice nurse was treating staff. Director of Health Services B stated it sounds like staff need to be retrained. Both staff did not provide comment on why staff did not transfer Resident 1 either by themselves or with Hospice Nurse D.

On 10/22/2025 at 2:23 PM, Surveyor interviewed Hospice Nurse D via phone. Hospice Nurse D reported s/he was called to the facility on 07/10/2025 for a fall with no injury and Resident 1 showing signs of restlessness. Hospice Nurse D reported s/he arrived to the facility at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012510	A. BUILDING: _____ B. WING _____	C 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE BARABOO AUTUMN LANE	800 WALDO STREET BARABOO, WI 53913

(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 13 approximately 5:15 PM, Resident 1 was eating dinner, so s/he had to wait approximately 30 minutes to assess Resident 1. Hospice Nurse D reported after dinner, s/he took Resident 1 to his/her room with assistance from Caregiver F. Hospice Nurse D stated s/he offered to assist Resident 1 to bed following his/her assessment, but Caregiver F stated Resident 1 is not to be put to bed during evening shift and is to return to common area for visual monitoring due to resident's fall risk. Hospice Nurse D reported s/he completed his/her assessment while Resident 1 remained in his/her wheelchair. Hospice Nurse D stated s/he did not observed any discomfort with assessment, so s/he returned Resident 1 to common area by walking WC backwards and Resident 1 dragging his/her feet. Hospice Nurse D stated s/he was charting at the facility for approximately 30 minutes, when s/he was approached by staff reporting Resident 1 vomited and was leaning forward. Hospice Nurse D reported when arriving to the common area, s/he observed Resident 1 leaning to the left and bent forward in his/her WC. Hospice Nurse D stated s/he observed a small amount of mucus beside the WC. Hospice Nurse D stated s/he told staff with Resident 1's symptoms of leaning it could indicate s/he was fatigued, so I [Hospice Nurse D] offered to assist with transferring Resident 1 to bed or a recliner. Hospice Nurse D reported Caregiver F became hostile towards him/her when offering assistance and reiterated the facility was a "no lift" facility. Hospice Nurse D reported s/he offered to obtain a hoyer lift order while onsite, so we could safely transfer Resident 1 to a more comfortable position. Hospice Nurse D confirmed s/he obtained a hoyer lift order from hospices' on-call provider and communicated this with staff. Hospice Nurse D stated while talking with his/her supervisor, s/he was approached with	N 388		

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	0012510	A. BUILDING: _____ B. WING _____	C 10/22/2025

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N 388	Continued From page 14 anger by Caregiver F explaining the facility has a "no lift" policy. Hospice Nurse D reported s/he again told staff that the hoyer lift order had been obtained and Resident 1 could now be transferred to bed or recliner with hoyer lift. Hospice Nurse D stated Caregiver F acknowledged his/her statements and left area. Hospice Nurse D reported s/he called his/her supervisor a second time and again was approached with anger from staff. Hospice Nurse D stated Caregiver F reported staff had called their director and s/he was asking Hospice Nurse D to leave. Hospice Nurse D stated s/he tried to clarify miscommunication and tensions with staff and Director of Health Services B that s/he had asked for assistance to transfer Resident 1 from WC to bed and had not demanded they lift resident against policy. Hospice Nurse D stated staff or Director of Health Services B did not acknowledge his/her attempts to clarify conversations. Hospice Nurse D confirmed s/he was asked to leave the facility by Director of Health Services B. Hospice Nurse D reported s/he did not feel comfortable leaving Resident 1 in his/her current state, so s/he offered another hospice nurse to come to the facility to defuse the tension. Hospice Nurse D stated Director of Health Services B declined the offer, but by this time, Hospice Nurse H had arrived to the facility. Hospice Nurse D reported s/he then left the facility, but felt attacked by staff and did not understand why they would not assist me [Hospice Nurse D] with transferring Resident 1.	N 388		