STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017746	A. BUILDING: _____ B. WING _____	C 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF OAK CREEK	**1980 W RAWSON AVE OAK CREEK, WI 53154**

(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 07/02/2025 with information gathered through 07/08/2025, Surveyor conducted two complaint investigations, at Oak Park Place of Oak Creek, a Community-Based Residential Facility (CBRF) in Oak Creek, WI. One deficiency identified. This is a repeat deficiency. See Statement of Deficiency (SOD) 92LE12, dated 04/11/2023, and SOD ZWH713, dated 01/16/2025. One of 2 complaints substantiated. Census: 70	N 000		
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 the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess 1 of 1 resident (Resident 2) reviewed when s/he had a change in his/her needs, abilities, and/or physical and mental condition. Resident 2 did not have an assessment	N 381		

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
	0017746	A. BUILDING: _____ B. WING _____	C 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF OAK CREEK	1980 W RAWSON AVE OAK CREEK, WI 53154

(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 1 completed after s/he exhibited sexually inappropriate behaviors toward other residents. This is a repeat deficiency. See Statement of Deficiency (SOD) 92LE12, dated 04/11/2023, and SOD ZWH713, dated 01/16/2025. Findings include: On 06/30/2025, the Department received a complaint with concerns regarding alleged sexual assault. On 07/02/2025, Surveyor completed a review of the Department facility self-report folder and the following was identified: -Self-Report, dated 06/25/2025, stated the following: Incident Description: On 06/20/2025, during NOC (overnight) shift, Resident 3 reported a wo/man came in and climbed in bed and touched his/her private area. Resident 3 described the wo/man to be Resident 2. Action taken to ensure resident's health, safety, and well-being: "[Resident 2] put on 1 hour checks. Daily psychosocial assessments done 6/20 through 6/23/2025 for [Resident 3]." -Self-Report, dated 06/30/2025, stated the following: Incident Description: "On 06/28/2025, at 4:45 PM, Police responded to alleged [sic] interaction between [Resident 1] and [Resident 2]." Action taken to ensure resident's health, safety, and well-being: "Residents sent out to hospital for further evaluation. Copy of report requested by facility on 7/2/25. [Resident 2] placed on 1:1 supervision." On 07/02/2025, Surveyor reviewed Resident 2's record and identified the following:	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017746	A. BUILDING: _____ B. WING _____	C 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF OAK CREEK	1980 W RAWSON AVE OAK CREEK, WI 53154

(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 2 -Resident 2 was admitted to the provider's home on 02/03/2025 with a diagnosis of dementia. -Resident 2 had an activated healthcare power of attorney. -Resident 2 incident report, dated 06/20/2025, stated the following: "[Activity Assistant B] was assisting [Resident 3] when [s/he] stated that during the night shift, a [wo/man] came in and climbed into [his/her] bed and touched [his/her] [private area]. [Resident 3] described [him/her] as a tall [wo/man] with a plaid shirt on, which described [Resident 2]. [Resident 3] stated [s/he] told the[wo/man] to stop, and [s/he] stated, "Why, I am not hurting anybody." [Resident 3] stated the [wo/man] got up and left the room after that." -Resident 2 incident report, dated 06/28/2025, stated the following: "[Certified Nursing Assistant C] called [Director of Housing (DOH) A] to report [Resident 2] locked [Resident 1] in [his/her] room... [s/he] was found unclothed on [his/her] bottom half and [Resident 1] was found fully clothed. [Resident 1] seemed confused and asked to go to the bathroom." Resident 2 reported s/he had Resident 1 engage in oral sex. Resident 2's most recent assessment was dated 01/23/2025. Resident 2's record did not contain any evidence of assessments completed for Resident 2 after either of 2 sexually inappropriate behaviors with other residents who did not consent.	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017746	A. BUILDING: _____ B. WING _____	C 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF OAK CREEK	1980 W RAWSON AVE OAK CREEK, WI 53154

(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 3 Resident 2's individualized service plan (ISP), dated 02/03/2025, stated the following: "[Resident 2] has a behavior problem r/t [related to] dementia - anger and agitation d/t [due to] new placement." Resident 2's ISP did not mention s/he exhibited inappropriate sexual behaviors. On 07/02/2025, at approximately 12:10 PM, Surveyor interviewed Director of Housing (DOH) A. DOH A stated a new assessment was not completed after Resident 2 incidents due to Director of Healthcare Services D being on vacation. DOH A confirmed Resident 2's should had been assessed after the first incident occurred on 06/20/2025 when Resident 2 showed sexual inappropriate behaviors. DOH A stated s/he was aware that this was a higher priority, but s/he was responsible for the operations of this facility.	N 381		