STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017017	A. BUILDING: _____ B. WING _____	C 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF JANESVILLE	700 MYRTLE WAY JANESVILLE, WI 53545

(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 07/16/2025, the Bureau of Assisted Living, completed two complaint investigations at Oak Place of Janesville, a CBRF, located in Janesville. Three deficiencies were identified, one of which is a repeat violation from Statement of Deficiency (SOD) ENKL11, dated 02/21/2020, SOD ENKL12, dated 02/10/2021, SOD 657X13, dated 11/03/2022, SOD 657X14, dated 05/09/2023, SOD 657X16, dated 01/18/2024 and SOD Z7JQ11, dated 05/23/2024. The complaints were substantiated. Census: 42	N 000		
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 2 of 2 residents reviewed received all medications in the dosage and at intervals prescribed by a practitioner. Resident 1 did not receive his/her apixaban 2.5 mg tablet, furosemide 40 mg tablet, or oxycodone 10 mg tablet, as prescribed. Resident 2 did not receive his/her Enalapril	N 352		

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

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Maleate 2.5 mg prescribed for hypertension, Spironolactone 25 mg prescribed for hypertension, Metoprolol Succinate ER 25mg prescribed for hypertension and Omeprazole 20 mg prescribed for gastro-esophageal reflux disease.

This is a repeat deficiency. See Statement of Deficiencies (SOD) ENKL11, dated 02/21/2020, SOD ENKL12, dated 02/10/2021, SOD 657X13, dated 11/03/2022, SOD 657X14, dated 05/09/2023, SOD 657X16, dated 01/18/2024, and SOD Z7JQ11, dated 05/23/2024.

Findings include:

On 07/16/2025, Surveyors conducted a complaint investigation regarding medication errors. Surveyors reviewed Resident 1 and Resident 2's records, which identified the following concerns:

Example 1 - Resident 1:

Resident 1 was admitted on 07/29/2021. Resident 1's physician orders included the following:

-Apixaban Tablet 2.5 MG: Take 1 tablet by mouth two times a day related to UNSPECIFIED ATRIAL FIBRILLATION
-Furosemide Tablet 40 MG: Give 1 tablet by mouth one time a day for CHF.
-Oxycodone HCL Tablet 10 MG: Give 1 tablet by mouth one time a day related to CHRONIC PAIN SYNDROME. May have additional 2 doses per 24 hours.

Resident 1's medication administration record (MAR) and progress notes, dated 06/01/2025 - 07/16/2025, documented the following 8

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N 352	Continued From page 2 occurrences as medication not administered: "06/15/2025- 09:51 AM- Furosemide Tablet 40 MG- Med n/a 06/30/2025- 12:19 PM- Oxycodone HCL Tablet 10 MG- Pharm notified 07/01/2025- 12:55 PM- Oxycodone HCL Tablet 10 MG- Writer contacted [doctor] to send over new order to [pharmacy] 07/05/2025- 9:44 AM- Apixaban Tablet 2.5 MG- Not yet delivered, pharm notified 07/05/2025- 7:25 PM- Apixaban Tablet 2.5 MG- Needs ordered 07/06/2025- 9:32 AM- Apixaban Tablet 2.5 MG- Pending delivery 07/15/2025- 8:34 AM- Furosemide Tablet 40 MG- Pharmacy notified 07/16/2025- 9:23 AM- Furosemide Tablet 40 MG- Pharmacy notified" On 07/16/2025 at approximately 12:30 PM, Surveyor interviewed Administrator A and Regional Nurse B regarding Resident 1's medications. Regional Nurse B stated the Apixaban and Furosemide should come automatically from pharmacy with the cycle medications. S/he stated the Oxycodone would not be a cycle fill medication, and would require a new script with each fill, but that the pharmacy should trigger the refill request to the provider when it is needed. Administrator A and Regional Nurse B agreed there could be a variety of reasons the medications were not on site, but they would follow up to determine cause and to prevent future lapses in medication administration. Example 2 - Resident 2: Resident 2 admitted to the provider's facility on	N 352		

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N 352	Continued From page 3 05/07/2025. Resident 2's physician orders included the following medications: - Docusate Sodium Capsule 100 mg (Start Date: 05/01/2025) - Enalapril Maleate 2.5 mg (Start Date: 05/01/2025) - Furosemide tablet 40 mg (Start Date: 05/01/2025) - Metformin HCl 500 mg (Start Date: 05/01/2025) - Omeprazole 20mg (Start Date: 05/01/2025) - Spironolactone 25 mg (Start Date: 05/01/2025) - Warfarin Sodium 2.5 mg (Start Date: 05/01/2025) -Warfarin Sodium 5mg (Start Date: 05/01/2025) Resident 2's Medication Administration Record (MAR), dated 05/01/2025 through 06/30/2025 documented Resident 2's Enalapril Maleate, Spironolactone, Metoprolol Succinate ER, and Omeprazole were not available from 05/17/2025 through 06/01/2025. The facility's records included documentation of a medication error/investigation. The documentation stated that on 05/31/2025 the facility was notified by the [Resident Family] Resident 2 had not been receiving several medications. The facility stated an investigation was immediately initiated. The investigation indicated the pharmacy did not have insurance on file. The pharmacy was contacted several times regarding the medication issues and kept denying due to insurance. The family is aware that Resident 2 does not have prescription drug coverage. Resident 2 did have a credit card on file with the pharmacy. The unavailable medications were delivered to the facility on 06/01/2025.	N 352		

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N 352	Continued From page 4 On 07/16/2025 at approximately 12:30 p.m., Surveyors interviewed Administrator A and Regional Nurse B. Administrator A stated the facility was aware of the medication concern with Resident 2. Administrator stated that s/he was unaware of Resident 2's medications not being available until the family notified the facility. Administrator A stated that the facility has implemented a new process with laminated cards and notification levels so that residents do not go multiple days with medications that are unavailable.	N 352		
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 observation, record review, and interview, the provider did not ensure the individual service plan (ISP) for Resident 1 was implemented and followed as written. Resident 1's ISP directed staff to ensure s/he took his/her medication while staff are present to maintain correct timing of medication doses. Resident 1 was left unsupervised with prescription medications in his/her room. Findings include: On 07/16/2025 at approximately 10:00 AM, Surveyor toured the facility. This included a tour of Resident 1's personal bedroom. A medication cup with pills was observed on the table next to his/her recliner. Additionally, there were 2 bottles of prescription eye drops on the table next to	N 388		

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N 388	Continued From page 5	N 388		

his/her bed (Timolol & Brimonidine).

On 07/16/2025 at approximately 10:00 AM, Surveyor interviewed Resident 1. Resident 1 stated the cup of pills were his/her AM medications, and that s/he didn't take them until s/he ate his/her breakfast. Surveyor observed a plate of breakfast food sitting on the table next to the pills, that had not been eaten yet. Resident 1 stated staff used to stand there until s/he took his/her pills, but they no longer did that. Resident 1 chuckled and stated s/he wouldn't pay for the medication if s/he didn't plan to take the medication.

On 07/16/2025 at approximately 12:30 PM, Surveyor interviewed Administrator A and Regional Nurse B. Both Administrator A and Regional Nurse B stated Resident 1 should receive supervision for medication administration. They were surprised to know the medicated eye drops were on Resident 1's bedside table and stated they would follow up with staff to ensure they are providing supervision for the residents who required it.

On 07/16/2025 Surveyor reviewed Resident 1's record which documented the following:

Resident 1 admitted to the provider on 07/29/2021 with diagnosis including cognitive communication deficit and lack of coordination.

Resident 1's individual service plan (ISP) stated: " ... [Resident 1] is unable to self-administer the following medication all scheduled and prn meds. [Resident 1] will receive medications safely and as prescribed. Medications will be administered at scheduled times and ensure that [Resident 1] takes them while staff are present to maintain

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N 388	Continued From page 6 correct timing of medication doses. Medications will be administered by licensed or certified team members ..."	N 388		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility's environment was clean and homelike. Findings include: On 05/23/2025, the Department received a complaint alleging the provider was not completing regular housekeeping in resident bedrooms. This complaint was investigated on 07/16/2025. On 07/16/2025 at approximately 9:30 AM, Surveyors toured the facility and observed several concerns on the memory care unit: - Four resident bedrooms with soiled/ stained/ discolored carpet - Three resident bedrooms with scratches/ gauges in the wall next to the beds - Two resident rooms with foul odor, one of which contained a laundry basket that was overflowing and contained visibly soiled linens	N 481		

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N 481	Continued From page 7 On 07/16/2025 at approximately 10:00 AM, Surveyor interviewed Resident 1. Resident 1 stated the staff don't vacuum his/her room often enough or complete full cleaning tasks such as dusting the blinds. Resident 1 stated his/her opinion was the facility needed to hire separate housekeeping staff. S/he said the caregivers are the ones who complete all of the cleaning on that unit, and that it was too much work for them, because they are always busy enough already. Resident 1 also stated sometimes days will go by before s/he can get a staff member to help put his/her clothes away. On 07/16/2025 at approximately 11:00 AM, Surveyor interviewed Administrator A. Administrator A had already been aware of housekeeping concerns. S/he stated the facility does utilize the "universal caregiver" for the CBRF. Administrator A stated rooms should be cleaned at least once weekly, and that s/he had been feeling better about housekeeping and stated there had been recent improvements. Administrator A confirmed the caregivers were also responsible for identifying if a room needed to have the carpet cleaned, but they were not responsible to completing that task. Caregiver were to notify the front desk, who then submitted a request to the maintenance department. Administrator A stated maintenance was quick to respond to resident room needs, usually completing a request within 1 day. Administrator A stated they would continue to monitor housekeeping to make continued improvements.	N 481		