Wisconsin Department of Health Services

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 _____	R-C 04/22/2026

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 04/22/2026, Surveyors conducted a verification visit and 2 complaint investigations at Oak Park Place Janesville, a CBRF in Janesville. As a result of this survey, 3 violations of Chapter DHS 83 were issued. Two of 5 violations were repeat. See Statement of Deficiency (SOD), ENKL12, dated 02/10/2021, SOD 657X15, dated 08/31/2023, SOD 657X16, dated 01/18/2024, 3DZM12, dated 05/13/2025 and V1E712, dated 10/30/2025. Three (3) deficiencies from previous statement of deficiency (SOD) # V1E712, dated 10/30/2025 were substantially corrected. One complaint was substantiated. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed. Census: 48	{N 000}		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their	{N 389}		

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

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{N 389}	Continued From page 1 involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure an individual service plan (ISP) was updated when there was a change in condition or need. Resident 7's ISP was not updated to transfer needs. This is a repeat violation. See Statement of Deficiency (SOD) ENKL12, dated 02/10/2021, SOD 657X15, dated 08/31/2023, SOD 657X16, dated 01/18/2024, 3DZM12, dated 05/13/2025 and V1E712, dated 10/30/2025. Findings include: On 04/22/2026 at approximately 10:00 a.m., Surveyor reviewed Resident 7's record. S/he was admitted to the facility on 02/11/2023, with multiple sclerosis. The ISP, dated 08/08/2025, documented the following for transfer needs for Resident 7: -Performance deficit in transferring r/t evolving MS, "Transfer: [Resident 7] requires assist of 1 staff with easy stand. [Resident 7] requires easy stand and assist of 1 for transfers." On 04/22/2026 at approximately 10:30 a.m., Surveyor interviewed Caregiver E. Caregiver E stated that Resident 7 was using the Hoyer now since the accident. Caregiver E stated that 2 staff assist Resident 7 now and that Resident 7 just had a hospital bed delivered to make transfers	{N 389}		

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{N 389}	Continued From page 2 and bathing easier until Resident 7's injury was healed. On 04/22/2026 at approximately 10:45 a.m., Surveyor observed Resident 7 in the hair salon. Resident 7 was being transferred with the Hoyer and 2 staff assisting from the salon hair chair to the his/her wheelchair. On 04/22/2026 at approximately 10:55 a.m., Surveyor interviewed Resident 7. Resident 7 stated that since s/he had vertebra fractures from the van accident in March 2026, s/he had to use the Hoyer. Resident 7 stated that 2 staff assisted him/her. On 04/22/2026 at approximately 1:00 p.m., Surveyor shared the concern of Resident 7's ISP being updated to indicate the transfer needs for Resident 7. Executive Director A Executive Director A acknowledged that Resident 7's ISP was not updated to state that Resident 7 was using the Hoyer and 2 staff assist since the accident where Resident 7 had a vertebrae fracture. Executive Director A stated that the facility will continue to work on updating the ISP's.	{N 389}		
{N 414}	83.37(2)(c) Medication administration not supervised Medication administration not supervised by a registered nurse, practitioner or pharmacist. When medication administration is not supervised by a registered nurse, practitioner or pharmacist, the CBRF shall arrange for a pharmacist to package and label a resident ' s prescription medications in unit dose. Medications available over-the-counter may be excluded from unit dose packaging requirements,	{N 414}		

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{N 414}	Continued From page 3 unless the physician specifies unit dose. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure medication administration not supervised by a registered nurse, practitioner, or pharmacist was packaged and labeled in unit dose. The provider had bottles of medications that were for multiple residents. Resident 8 had 4 medications being administered from a prescription bottle. Resident 9 had 7 medications being administered from a prescription bottle. This is a repeat deficiency. See statement of deficiency (SOD) V1E712, dated 10/30/2025. Findings include: On 04/22/2026 at approximately 10:05 AM, Surveyor observed the medication storage cart. Upon inspection completed with Caregiver E, Surveyor identified prescription bottles in the medication cart belonging to Resident 8 and Resident 9. Surveyor observed 4 bottles, with Resident 8's name, of the following medications: Ezetimibe tabs 10 mg, Furosemide 40 mg, Carvedilol 6.25 mg, and Finasteride 5 mg. Surveyor observed 7 bottles with Resident 9's name, of the following medications: Ibuprofen 200 mg, Megestrol Acetate 40 mg, Cyanocobalamin 1000 mcg tablet, Isosorbide mononitrate 30 mg tablet, Metoprolol tartrate 50 mg, Docusate 100 mg capsules, and Vitamin D3 25 mcg tablets.	{N 414}		

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{N 414}	Continued From page 4 On 04/22/2026 at approximately 10:10 AM, Surveyor interviewed Caregiver E. Caregiver E stated s/he was aware medication should not be administered out of a bottle. Caregiver E stated it used to happen more but was corrected and the previous nurse was keeping an eye on it. Caregiver E stated the previous nurse had left roughly 2 months prior, and since then the issue of proper packaging has returned as the nurse supervision has been inconsistent.	{N 414}		
N 435	83.38(1)(k) Transportation. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Transportation. The CBRF shall provide or arrange for transportation when needed for medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest. CBRFs that transport residents shall develop and implement written policies addressing the safe and secure transportation of residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a plan was developed and implemented for written policies addressing the safe and secure transportation of residents. Resident 7 was injured being transported home	N 435		

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from an activity with the provider on the facility bus.

Findings include:

On 04/01/2026, the department received a complaint alleging a resident was injured during a bus ride provided by the facility.

On 04/22/2026 at approximately 10:00 a.m., Surveyor reviewed Resident 7's record. S/he was admitted to the facility on 02/11/2023, with multiple sclerosis. The record included an incident report, dated 03/11/2026 at 14:30 that indicated the following:

"-On 03/11/2026, [Resident 7] participated in an outing to [store name] with the activity staff and several other residents. Residents were transported via facility vehicle. During the ride back to the facility, the vehicle went over railroad tracks and [Resident 7] stated immediately that the bump going over the track had cause [him/her] to have back pain. [Resident 7] stated that [s/he] had sharp pain when the facility vehicle went over the railroad tracks. [Resident 7] stated that the pain continued and [s/he] requested XRAYS, due to [his/her] history of compression fracture and diagnosis of osteoporosis. Immediately upon return to the facility, [Resident 7] was examined by [facility nurse], at which time [Resident 7] stated that [s/he] was having lower back pain but declined to be sent out to the hospital. On 03/17/2026, [Resident 7] stated that [s/he] continued to have lower back pain and staff offered to send [him/her] to the [hospital], [Resident 7] stated that [s/he] would prefer to go the next morning. [Resident 7] went to [clinic] on 03/18, and imaging showed mild superior endplate compression fracture of L1-consistent

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with acute subacute fracture."

On 04/22/2026 at approximately 10:00 a.m., Surveyor interviewed Resident 10. Resident 10 stated that s/he and other residents went on a shopping trip to the store. Resident 10 stated on the way home, Activities F was driving the bus fast and went over railroad tracks. Resident 10 stated that s/he and Resident 7 were injured during this trip. Resident 10 stated that s/he has been dealing with knee and leg pain.

On 04/22/2026 at approximately 10:30 a.m., Surveyors interviewed Caregiver E. Caregiver E stated that Resident 7 was injured during a bus activity. Caregiver E stated that Resident 7 had a fracture in his/her back. Caregiver E stated that Activities F was driving the bus on the day of the incident.

On 04/22/2026 at approximately 10:55 a.m., Surveyors interviewed Resident 7. Resident 7 stated that the bus went over the railroad tracks fast and s/he hit his/her head on the top of the bus and when s/he came back down s/he felt a sharp pain in his/her back. Resident 7 stated that s/he was strapped in to his/her wheelchair and the bus. Resident 7 stated that s/he reported the incident but did not want to go to the doctor right away. Resident 7 was sent to the urgent care on 03/18/2026 for continued back pain and was diagnosed with mild superior endplate compression fracture of L1-consistent with acute subacute fracture

On 04/22/2026 at approximately 11:30 a.m., Surveyors interviewed Activities F. Activities F stated that s/he was driving the bus on 03/11/2026. Activities F stated that "I was not going fast at all." Activities F acknowledged that

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N 435	Continued From page 7 the bus did go over railroad tracks and Activities F stated that the "bus did jostle a little bit." Activities F stated that Resident 7 did complain of pain and was assessed by the nursing team. Activities F stated that the facility did run his/her driving record, and the only formal training was from another driver at the facility that showed him/her how to operate the bus. On 04/22/2026 at approximately 12:00 p.m., Surveyors reviewed transportation policy and Activities F driving record. The policy reviewed the kinds of transportation that would be provided to the residents at the facility. The policy did not include safe and secure transportation of the residents at the facility. Activities F driving record was clear for driving. On 04/22/2026 at approximately 1:00 p.m., Surveyors shared the concern of the transportation policy not including the safe and secure transportation of the residents that resulted in Resident 7 having a L1 fracture during a bus ride. Executive Director A acknowledged that the transportation policy only included the types of transport that the facility provided. Executive Director A stated that the facility would work on updating the policy.	N 435		