STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014395	A. BUILDING: _____ B. WING _____	R-C 01/31/2025

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OAK PARK PLACE WAUWATOSA	1621 RIVERS BEND WAUWATOSA, WI 53226

(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 01/17/2025, Surveyor completed a verification visit and 4 complaint investigations at Oak Park Place Wauwatosa. As a result, 11 of the previous 14 deficiencies were corrected, 3 deficiencies were recited, and 4 new deficiencies were identified; therefore, a total of 7 deficiencies were cited. Four of the 7 deficiencies were repeat cites. Three complaints were substantiated, 1 complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 52	{N 000}		
{N 220}	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse	{N 220}		

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

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{N 220}	Continued From page 1 indicating all employees have been screened for clinically apparent communicable disease including tuberculosis (TB), within 90 days before the start of employment for 2 of 4 caregivers reviewed (Caregiver FF, and Caregiver GG). Caregiver FF's and Caregiver GG's communicable disease screening was not signed by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse. This deficiency is being cited for a fifth time. See Statement of Deficiency (SOD) W0M011, dated 10/22/2020, SOD W0M012, dated 07/06/2021, SOD W0M014, dated 04/27/2023 and SOD W0M015, dated 05/08/2024. Findings include: On 01/17/2025, at 10:50 AM, Surveyor reviewed staff files and identified the following: Caregiver FF was hired on 11/13/2024. Caregiver FF's record contained the results of a TB test on 11/12/2024. Caregiver FF's record contained a communicable disease screening. The communicable disease screening was not signed by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse. Caregiver GG was hired on 09/24/2024. Caregiver GG's record contained the results of a TB test on 09/24/2024. Caregiver GG's record contained a communicable disease screening. The communicable disease screening was not signed by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse. On 01/17/2025, at 2:20 PM, Surveyor interviewed Director of Housing (DOH) AA. DOH AA confirmed s/he was aware of the code	{N 220}		

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{N 220}	Continued From page 2 requirement. DOH AA reported they would ensure all communicable disease screenings were signed to ensure staff were screened for communicable diseases.	{N 220}		
{N 277}	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees received continuing education in all required topics in 2024. Medical Assistant V did not receive continuing education training in prevention and reporting abuse, neglect, and misappropriation for 2024. Caregiver HH did not receive continuing education in medications. This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) W0M013, dated 10/25/2022, SOD W0M014, dated 04/27/2023 and SOD W0M015, dated 05/08/2024.	{N 277}		

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{N 277}	Continued From page 3 Findings include: On 01/17/2025, at 10:50 AM, Surveyors reviewed employee files and identified the following: Medical Assistant V was hired 09/03/19. Medical Assistant V's record did not contain evidence of continuing education training in prevention and reporting abuse, neglect and misappropriation for 2024. Several of Medical Assistant V's training documentation did not include how long the training was. Medical Assistant V's training record did not indicate the total number of continuing education hours Medical Assistant V completed. Caregiver HH was hired 03/06/2020. Caregiver HH's record did not contain evidence of continuing education training in medications for 2024. Several of Caregiver HH's training documentation did not include how long the training was. Caregiver HH's training record did not indicate the total number of continuing education hours Caregiver HH completed. On 01/17/2025, at 2:20 PM, Surveyor interviewed Director of Housing (DOH) AA. DOH AA confirmed s/he was aware of the continuing education trainings required annually. DOH AA reported s/he was aware of the missing topics and was in the process of corrections. DOH AA confirmed the training documentation should include length of time to ensure staff receive 15 hours annually.	{N 277}		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights:	N 353		

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N 353	Continued From page 4 Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 20) received prompt and adequate treatment. Resident 20 experienced a change of condition and was not medically assessed. Findings include: On 06/26/2024, the department received a complaint alleging concerns regarding pain management. On 01/17/2025, at 12:30 PM, Surveyor reviewed Resident 20's record. Resident 20 was admitted on 05/23/2023 with diagnoses including Alzheimer's disease, nonrheumatic mitral stenosis, hypertension and chronic kidney disease. A fall report dated 06/01/2024, indicated Resident 20 was found on the floor in her/his room, with swelling in the left hand. Resident 20 was sent to the emergency department. The after-visit summary (AVS), dated 06/02/2024, diagnosed Resident 20 with a closed Colles' fracture of the left radius. The AVS indicated Resident 20 should "return to the emergency department for severe pain, numbness or tingling, worsening swelling, if symptoms worsen or for any other concerns." Surveyor reviewed a fall report, dated 06/11/2024, which indicated Resident 20 missed the chair during activities and sustained a skin tear on upper left arm.	N 353		

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N 353	Continued From page 5	N 353		

Surveyor reviewed a fall report, dated 06/13/2024, which indicated staff heard a fall in Resident 20's room and found Resident 20 on the floor. The fall report stated, "Resident has fracture to left lower arm and still tries to use it when getting up or getting out of bed."

Surveyor reviewed Resident 20's medication administration record (MAR) for June 2024. On 06/06/2024, Resident 20 was prescribed oxycodone 5 milligrams (mg) to be administered every 4 hours as needed for pain. On 06/10/2024, Resident 20 was prescribed tramadol 50 mg to be administered every 6 hours as needed for pain.

Surveyor reviewed Resident 20's progress notes and identified the following:

06/10/2024 at 6:17 PM - "resident refused to shower due to pain in arm [sic] pro re nata (PRN) was given and resident went to bed" administered oxycodone

06/11/2024 at 9:36 AM - "dont [sic] want to get up" administered oxycodone

06/11/2024 at 1:44 PM - "still [complains of] pain resident is now sleeping follow-up pain scale was: 8" administered oxycodone

06/11/2024 at 7:47 PM - administered tramadol

06/12/2024 at 10:49 AM - administered oxycodone

06/12/2024 at 10:53 AM - PRN administration was ineffective; follow-up pain scale was 6

06/12/2024 at 3:12 PM - "Resident resting in bed

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N 353	Continued From page 6	N 353		

peacefully. Swelling and discoloration in left hand has improved. Resident currently wearing sling to help remind [her/him] not to bear weight on that arm. Ortho [sic] follow up next week."

06/13/2024 at 10:07 AM - "Resident had an unwitnessed fall in room this morning. Resident had a skin teat [sic] on the back of [her/his] left upper arm ..."

06/14/2024 at 7:25 AM - "When I touch [her/him] [s/he] screamed [sic]" administered oxycodone

06/14/2024 at 10:59 AM - "PRN administration was ineffective still in pain follow-up pain scale: 10"

06/14/2024 at 12:54 PM - "Writer was alerted by care staff that resident has a skin tear on [her/his] right wrist and right elbow. Writer assessed resident and cleaned wound with saline water [sic] applied triple antibiotic ointment and dressed wounds with a Band-aid ..."

06/14/2024 at 2:51 PM - "Writer spoke with Resident's [Power of Attorney] (POA) and recommended Resident be seen for uncontrolled pain and possible reinjury to [her/his] left arm. [POA] unsure of whether [s/he] wants [her/him] to go tonight or if '[s/he] can't just wait till tomorrow'. Writer stated residentis [sic] screaming out in pain, and writer recommended [s/he] be seen [as soon as possible] (ASAP). Writer is waiting on [POA] to decide."

Surveyor did not review any further documentation regarding follow up with Resident 20.

On 01/17/2024, at 2:20 PM, Surveyor interviewed

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N 353	Continued From page 7 Director of Housing (DOH) AA and Director of Nursing (DON) EE. DON EE reported Resident 20 was not sent to the hospital with increased pain due to Resident 20's POA was unsure about sending Resident 20 out. DON EE reported s/he would have contacted the doctor regarding Resident 20's increased pain. When Surveyor inquired about any further orders from Resident 20's physician or progress notes indicating Resident 20's physician was contacted, DON EE reported s/he would send them to Surveyor. When Surveyor inquired about what further interventions were DON EE reported after the 2nd fall, Resident 20 received more supervision. DON EE reported after the 3rd fall there were no new interventions put into place. DON EE reported Resident 20 was placed on hospice services soon after the falls. On 01/17/2025, at 4:54 PM, DON EE emailed Surveyor and reported s/he was unable to locate the requested documentation.	N 353		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.	N 386		

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N 386	Continued From page 8	N 386		

This Rule is not met as evidenced by:
Based on record review, observation, and interview, the provider did not develop a comprehensive individual service plan (ISP) for 1 of 2 residents (Resident 23). Resident 23 had an elopement, and her/his ISP did not identify her/his elopement risk. Resident 23's bathroom was in need of cleaning, and her/his ISP did not identify the assistance Resident 23 required for housekeeping.

This is a repeat deficiency. See Statement of Deficiency (SOD) W0M013, dated 10/25/2022.

Findings include:

On 01/17/2025, at 12:30 PM, Surveyor reviewed Resident 23's record. Resident 23 was admitted on 11/29/2024 with a diagnosis of dementia. Resident 23's ISP, dated 11/29/2024, indicated the following:

- "Focus: Resident has a self care performance deficit in dressing
Goal: Resident will manage current level of function in dressing
Interventions: Allow sufficient time for dressing and undressing. Provide resident with ques [sic] and reminders for dressing and undressing"

- "Focus: Resident has a self care performance deficit in grooming and oral care
Goal: Resident will manage current level of function in oral care and grooming
Interventions: Resident requires prompting, queuing [sic] and reminders for oral hygiene and

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N 386	Continued From page 9 grooming" - "Focus: The resident is unable to self-administer the following medications ALL Goal: The resident will receive medications safely and as prescribed Interventions: Medications will be administered by licensed or certified team members" - "Focus: The resident uses psychotropic medications Goal: The resident will be free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipations/impaction or cognitive/behavioral impairment. Interventions: Administer psychotropic medications as ordered by physician. Observe for and report to nurse any side effects and effectiveness. If medication is not effective, notify the nurse." - Resident 23's ISP did not include any information regarding Resident 23's elopement risk or need for assistance with cleaning. Resident 23's comprehensive assessment, dated 11/29/2024, indicated Resident 23 required the following assistance: - Resident 23 required assistance with monitoring of nutritional supplements - Resident 23 required assistance with showering and bathing tasks 1 time a week. - Resident 23 utilized a walker for ambulation. - Resident 23 required assistance with housekeeping including daily trash pickup and	N 386		

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N 386	Continued From page 10 bed making. - Resident 23 required laundry services weekly - Resident 23 was a risk for elopement. Surveyor reviewed a self-report, dated 01/08/2025. The self-report indicated Resident 23 eloped from the facility and was returned by the police department. On 01/17/2025, at 11:50 AM, Surveyor observed Resident 23's bathroom. Resident 23's toilet seat was up, and the underside of the seat had brownish debris splattered on it. The toilet bowl contained a yellowish, brownish ring around the bowl. On 01/17/2025, at 2:20 PM, Surveyor interviewed Director of Housing (DOH) AA and Director of Nursing (DON) EE. DON EE reported s/he completed most of the assessments and ISPs, but at times a nurse from another facility will complete them. Surveyor relayed concerns regarding the ISP not containing all the information where Resident 23 required assistance. DOH AA and DON EE confirmed the ISPs were to contain all the required documentation. DON EE reported s/he was not the one who completed Resident 23's ISP but would ensure all ISPs were current and contained correct information.	N 386		
{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	{N 389}		

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{N 389}	Continued From page 11 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 involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's individual service plan (ISP) was updated when there was a change in resident's needs, abilities or physical or mental condition for 1 of 1 resident (Resident 20). Resident 20 had a fall, which resulted in an injury. Resident 20 had 2 more falls, and the ISP did not identify the new interventions. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) W0M013, dated 10/25/2022, and SOD W0M015, dated 05/08/2024. Findings include: On 01/17/2025, at 12:30 PM, Surveyor reviewed Resident 20's record. Resident 20 was admitted on 05/23/2023 with diagnoses including Alzheimer's disease, chronic kidney disease, hypertension and nonrheumatic mitral stenosis. A fall report, dated 06/01/2024, indicated Resident 20 was found on the floor in her/his room, with swelling in the left hand. Resident 20 was sent to the emergency department. The after-visit summary (AVS), dated 06/02/2024, diagnosed	{N 389}		

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{N 389}	Continued From page 12 Resident 20 with a closed Colles' fracture of the left radius. Surveyor reviewed a fall report, dated 06/11/2024, which indicated Resident 20 missed the chair during activities and sustained a skin tear on upper left arm. Surveyor reviewed a fall report, dated 06/13/2024, which indicated staff heard a fall in Resident 20's room and found Resident 20 on the floor. The fall report stated, "Resident has fracture to left lower arm and still tries to use it when getting up or getting out of bed." Surveyor reviewed Resident 20's ISP, dated 05/22/2023, which indicated Resident was at risk for falls. The intervention listed was "Remind resident to use call device pendant, pull cord, call light for assistance as needed." Resident 20's ISP was not updated to include the falls on 06/01/2024, 06/11/2024, and 06/13/2024. On 01/17/2025, at 2:20 PM, Surveyor interviewed Director of Housing (DOH) AA and Director of Nursing (DON) EE. Surveyor inquired what fall interventions were in place with Resident 20. DON EE reported Resident 20 was ambulatory and independent. DON EE reported Resident 20's bed was already in a lowered position as it was standard. DON EE reported Resident 20 was unable to utilize the call pendant. DON EE reported after the 2nd fall, Resident 20 received more supervision. DON EE reported after the 3rd fall there were no new interventions put into place. DON EE and DOH AA confirmed all fall interventions should be in the ISP.	{N 389}		
N 426	83.38(1)(b) Supervision.	N 426		

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N 426	Continued From page 13 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure appropriate supervision for 1 of 1 resident (Resident 23). Resident 23 eloped from the facility when a caregiver left the floor unattended. Findings include: On 09/05/2024, and 01/06/2025, the department received 2 complaints alleging concerns regarding supervision for residents. Observation On 01/17/2025, at 11:30 AM, Surveyor toured the facility. The facility was comprised of 3 floors. The memory care was located on the 2nd floor. Record Review On 01/17/2025, at 12:30 PM, Surveyor reviewed a self-report, dated 01/08/2025. The self-report indicated at 10:45 PM, Resident 23 was exit seeking. Caregiver II was able to redirect Resident 23 back to her/his room. Caregiver II left the memory care unit to move her/his car. When	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014395	A. BUILDING: _____ B. WING _____	R-C 01/31/2025

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N 426	Continued From page 14	N 426		

Caregiver II returned to the memory care unit, the stairwell door alarm was sounding. Caregiver II went to Resident 23's bedroom and was unable to locate Resident 23 on the unit. Caregiver II contacted additional staff to assist with the search for Resident 23 and contacted the Wauwatosa police. Wauwatosa police found Resident 23 at the police station and returned Resident 23 to the facility.

Surveyor reviewed notes from the provider's investigation. On 01/08/2025 at 8:30 AM, Director of Housing (DOH) AA called Caregiver II. Caregiver II reported Resident 23 was agitated and wandering. Caregiver II reported s/he redirected Resident 23 back to her/his room and thought s/he was settled enough to leave the floor to move her/his car.

Surveyor reviewed Resident 23's record. Resident 23 was admitted on 11/29/2024 with a diagnosis of dementia. Resident 23's comprehensive assessment, dated 11/29/2024, indicated Resident 23 was a risk for elopement. The comprehensive assessment did not indicate what elopement interventions were in place for Resident 23.

On 01/31/2025, at 8:30 AM, Surveyor reviewed a Wauwatosa Police Report which indicated the following:

"01/07/2025 11:11 PM - Memory care resident walked off about 30 minutes ago..."
"01/07/2025 11:20 PM - [Subject] is at [police department] entrance."
"01/08/2025 12:10 AM - Spoke to [Caregiver II] who stated that [Resident 23] walked off in between shifts. [Resident 23] has been a resident for approximately 2 months and has alcohol

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N 426	Continued From page 15 induced dementia. [Resident 23] was located at the [police department] and stated [s/he] was uncomfortable at a party and left. [Resident 23] was transported back to [her/his] room and checked out by [fire department] due to being out in the cold and claiming to have fallen and hit [her/his] head. No need for additional assistance." The police department was approximately 0.3 miles away from the facility. The weather at 10:52 PM on 01/07/2025 was 15 degrees Fahrenheit (F). [Source: Weather Underground; https://www.wunderground.com/history/daily/us/wi/wauwatosa/KWIWAUWA16/date/2025-1-4] Interview On 01/17/2025, at 2:20 PM, Surveyor interviewed Director of Housing (DOH) AA. DOH AA reported staff were not to leave the memory unit unattended. DOH AA reported s/he was unsure how long Caregiver II was gone from the floor. DOH AA reported there were 3 staff on 3rd shift, and 1 staff was always scheduled for memory care. DOH AA reported staff have received training regarding elopement. DOH AA reported Caregiver II was not terminated due to it was her/his first offense. DOH AA reported Caregiver II received discipline and additional training.	N 426		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area.	N 499		

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N 499	Continued From page 16 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored in 3 of 3 areas. Findings include: The facility was licensed on 11/01/2013 to serve up to 75 residents in client groups of advanced aged, physically disabled, and irreversible dementia/Alzheimer's. On 01/17/2025, at approximately 11:50 AM, Surveyor toured the facility and observed the following: Memory Care spa room There was a cleaning cart located inside the spa room. The cart contained 2 bottles of Lysol bathroom cleaner, a can of Arm & Hammer deodorizing air freshener, 2 bottles of Clorox toilet bowl cleaner, a bottle of Windex, and 2 containers of Sani-Cloth germicidal wipes. The door to the spa room contained a locking mechanism which was not engaged. The cart contained a locking mechanism, which was not engaged. First Floor spa room On top of a plastic storage container, was 2 containers of Sani-Cloth germicidal wipes. There were 2 Swiffer wet jets located next to the door. The door contained a locking mechanism which was not engaged. Staff Desk There were 2 containers of Sani-Cloth germicidal wipes and a can of Arm & Hammer deodorizing air freshener.	N 499		

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N 499	Continued From page 17 Café room The café room was located near the main entrance. In a cupboard, under the sink was a bottle of Seventh Generation disinfecting spray and a container of Clorox bleach germicidal wipes. Surveyor observed residents moving freely through the facility. On 01/17/2025, at 2:20 PM, Surveyor interviewed Director of Housing (DOH) AA. DOH AA confirmed the code requirement. DOH AA reported s/he would ensure staff were ensuring all chemicals were securely stored.	N 499		