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 _____	R-C 01/16/2025

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 01/16/2025, Surveyor conducted a verification visit and three complaint investigations at Oak Park Place of Oak Creek, a Community-Based Residential Facility (CBRF) in Oak Creek, WI. Nine deficiencies identified. Six of the 9 deficiencies are repeat deficiencies. Three of 3 complaints unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 62	{N 000}		
N 283	83.26(1) Documentation of required employee training The CBRF shall maintain documentation of all employee training under s. DHS 83.21 and task specific training under s. DHS 83.22 and shall include the name of the employee, the name of the instructor, the dates of training, a description of the course content, and the length of the training. This Rule is not met as evidenced by: Based on record review and interview the provider did not maintain documentation of all employee training for 1 of 2 employees reviewed. Caregiver N did not have documentation of training in recognizing, preventing, managing, and responding to challenging behaviors within 90 days after starting employment. Findings include: The provider is licensed as a class CNA	N 283		

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

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N 283	Continued From page 1 (non-ambulatory) CBRF (community-based residential facility) able to serve up to 90 residents advanced aged and irreversible dementia/Alzheimer's. On 01/16/2025, at approximately 10:00 AM, Surveyor reviewed employee records and identified the following: Recognizing, Preventing, Managing and Responding to Challenging Behaviors Caregiver N was hired on 07/30/2024. Caregiver N's record did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 01/16/2025, at 11:30 AM, Surveyor interviewed Director of Housing (DOH) C and Director of Healthcare Services N. DOH C stated s/he had Caregiver N completed the training but s/he did not document it so s/he did not have evidence of the training.	N 283		
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 residents received all prescribed medications in the dosage and at	N 352		

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N 352	Continued From page 2 intervals prescribed by a practitioner for 1 of 1 resident (Resident 11) reviewed. Resident 11 did not receive 3 consecutive doses of insulin. Findings include: On 01/16/2025, Surveyor reviewed Resident 11's record. Resident 11 was admitted on 01/29/2024, with diagnoses including vascular dementia, unspecified severity, without behavioral disturbance, hypothyroidism, type 2 diabetes with diabetic chronic kidney disease, type 2 diabetes with hyperglycemia, hyperlipidemia, and hyperkalemia. The following was identified: -Individual Service Plan (ISP), dated 12/17/2024, stated, "Resident is unable to self-administer the following medications...Resident will receive medications safely and as prescribed...Medications will be administered by licensed or certified team members." -Active Orders As of 01/31/2024, identified Resident 11 was prescribed Lantus Subcutaneous Solution 100 Unit/Milliliters (insulin glargine), inject 18 unit subcutaneously at bedtime for diabetes. Resident 11's December 2024 (date range 12/01/2024 through 12/31/2024) Medication Administration Records (MARs) identified the following: -Lantus Subcutaneous Solution 100 Unit/Milliliters (insulin glargine), inject 18 unit subcutaneously at bedtime for diabetes. The medication was not available on 12/13/2024, 12/14/2024 and 12/15/2024. Resident 11 missed 3 consecutive doses of insulin.	N 352		

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N 352	Continued From page 3 Resident 11's progress notes stated the following: -12/13/2024 stated: "nun [sic] in the cart or fridge for me to give any" -12/14/2024 stated: "[Resident 11] wouldn't wake up for me to give [him/her] meds, [s/he] kept saying no [s/he] wants to sleep, nurse was called about that and insulin being out." -12/15/2024 stated: "[Resident 11] has nun [sic] in the cart or the fridge to give and the nurse is aware" On 01/16/2025, at 1:00 PM, Surveyor interviewed Director of Housing C (DOH C) and Director of Healthcare Services M (DHS M). DOH C stated s/he knew there was an issue before with the pharmacy not sending the insulin, but s/he was not sure if that was the reason. DOH C stated if the documentation from staff administering the medication stated there was no insulin, then Resident 11 most likely did not receive his/her insulin that day.	N 352		
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.	N 381		

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N 381	Continued From page 4	N 381		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not assess a resident's needs, abilities and physical and mental condition when there was a change for Resident 11.

Resident 11 was not assessed for a physical and cognitive decline when s/he became unresponsive and was sent out to the hospital. Resident 11 had a stay in a rehabilitation (rehab) facility, but the power of attorney (POA) requested for Resident 11 to be sent back to the facility. The provider then issued a 30-day discharge notice.

This is a repeat deficiency. See Statement of Deficiency (SOD) 92LE12, dated 04/11/2023.

Findings include:

The provider is licensed as a class CNA (non-ambulatory) CBRF able to serve up to 90 residents within the client groups of irreversible dementia/Alzheimer's and advanced age.

On 01/16/2025, Surveyor reviewed Resident 11's record and identified the following:
-Resident 11 was admitted to the provider on 01/29/2024 with diagnoses including vascular dementia, unspecified severity, without behavioral disturbance, hypothyroidism, type 2 diabetes with diabetic chronic kidney disease, type 2 diabetes with hyperglycemia, hyperlipidemia, and hyperkalemia.
-There was no assessment in Resident 11's record identifying Resident 11's condition upon request to come back to the facility after a change in condition.

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N 381	Continued From page 5 On 01/16/2025 at approximately 11:00 AM, Surveyor reviewed an incident report, dated 12/26/2024 at 8:40 PM, which stated Resident 11 had a change in condition and was non-responsive, "[Caregiver] was coming into [Resident 11's] room to pass [his/her] 8:00PM meds. When [caregiver] came into [his/her] room, [s/he] was unresponsive. [His/her eye was half way open and [s/he] was gargling on [his/her] spit. [S/he] could hear caregiver call [his/her] name but couldn't talk." On 01/16/2025 at approximately 11:30 AM, Surveyor reviewed Resident 11's progress notes and stated the following: -"12/30/2024 at 9:39 AM, Social worker at hospital called to update, resident will be going to rehab due to change in physical condition. Is currently a Hoyer-2 person assist compared to [his/her] baseline of SBA (stand by assist)." -"12/31/2024 at 11:04 AM, Informed that [Resident 11] has given up and will not walk or do anything. Writer informed [him/her] that [Resident 11] needs to be back at baseline to come back to facility and cannot be in lift status. Encouraged [him/her] to talk about trying therapy otherwise [Resident 11] will not be coming back to [facility]." -"01/04/2025 at 3:48PM, call received from [family member] who stated that rehab is a "dump" and wants to bring [Resident 11] back ASAP (as soon as possible). Writer informed [family member] that there is a process including orders, medications, assessment and making sure we can meet [Resident 11's] needs. [Family member] threatened to just bring [him/her] back. Writer stated facility would then immediately send resident to the hospital and issue a permanent discharge order. Writer to call on Monday for	N 381		

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N 381	Continued From page 6	N 381		

update."
-"01/06/2025 at 11:51 AM, Spoke with [rehab facility] and updated that resident is a hoyer[sic] lift and max assist with all ADL's (activities of daily living). Writer informed [him/her] that [facility] would not be able to meet [Resident 11's] need and would call [family member] back to inform [him/her]."
-"01/06/2025 at 7:39 PM, Spoke with [(POA)], and due to not being able to meet [Resident 11's] needs, [facility] will not be able to accept [him/her] back into the facility as [s/he] is more skilled appropriate. Gave the names of 3 SNF's (skilled nursing facilities) to [his/her] home and also gave [him/her] some info on what Hospice provides and that [s/he] would need to be evaluated by Hospice first."
-"01/08/2025 at 4:42 PM, 3 way call with Director of sales and Oasis rep for resident. Wanted to know why [facility] would not take [Resident 11] back because POA (power of attorney) stated [s/he] is the same as [s/he] was a month ago. Writer stated what [his/her] current level was and [facility] could not meet [his/her] needs and what [facility] currently are with lifts in the facility."

On 01/16/2025, Surveyor reviewed a 30-day discharge notice sent to Resident 11's POA dated 01/13/2025. The 30-day discharge stated the following:
-"This letter is to notify you of Oak Park Place's decision to discharge [Resident 11], involuntarily within 30 days. REASON FOR DISCHARGE: Determining factors for this decision are [Resident 11's] identified care needs to address [his/her] medical complexities including but not limited to: dependent care status for most activities of daily living (ADLs), bedbound/non-ambulatory status, and inability to participate in rehabilitative efforts. Despite the

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efforts of Oak Park Place to manage these issues within the scope of care for a Community-Based Residential Facilities, it has been determined that [Resident 11] requires a higher level of care. You have been advised that moving [Resident 11] back to Oak Park Place is not in [his/her] best interest due to [his/her] exceeding the level care of a CBRF. [Resident 11] will be discharged from this facility on 02/13/2025."
-"Discharge or Transfer: Reason for involuntary discharge. The CBRF may involuntarily discharge a resident except for the following: A.) Medical care that is required that the CBRF cannot provide. B.) Care is required that is beyond the CBRF's license classification."
-"Oak Park Place will assist you and your family in locating a reasonably appropriate alternate placement and will be working with you to prepare for an orderly discharge. Involuntary Discharge from the facility does not prevent any collection efforts for any amounts owed and not timely paid."

On 01/16/2025 at 12:00 PM, Surveyor interviewed Director of Housing C (DOH C) and Director Healthcare Services M (DHS M). DHS M stated s/he was in contact with the family and rehabilitation facility about Resident 11's status. DHS M stated Resident 11 was no longer able to ambulate with his/her walker and s/he required a Hoyer lift for transfers, needed assistance with feeding and full cares. Surveyor requested assessment from DHS M to show Resident 11's status change. DHS M stated s/he did not complete the assessment but s/he had gathered information from the rehabilitation facility to determine Resident 11 could not come back. DOH C stated s/he gave the 30-day notice to Resident 11 based on the clinical information DHS M received from the rehabilitation facility.

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N 381	Continued From page 8 DOH C stated s/he did not do an assessment on Resident 11 either. Surveyor asked if there were other residents who utilized a Hoyer lift. DHS M identified 6 other residents who used a Hoyer lift at the facility.	N 381		
{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 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 1 of 2 residents' (Resident 11) Individual Service Plans (ISPs) were signed by the resident or resident's legal representative acknowledging their involvement in, understanding of, and agreement with the resident's ISP. Resident 11's current ISP dated 12/17/2024 was not signed by the resident or resident's legal representative. This is a repeat deficiency. See Statement of Deficiency (SOD) 92LE12, dated 04/11/2023, and SOD ZWH712, dated 08/01/2024.	{N 389}		

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{N 389}	Continued From page 9 Findings include: On 01/16/2025, at 11:00 AM, Surveyor reviewed Resident 11's record and identified the following: -Resident 11 was admitted to the facility on 01/29/2024. Resident 11's record indicated Resident 11 had a Power of Attorney (POA). Resident 11's ISP, dated 12/17/2024, was not signed. On 01/16/2025, at 11:30 AM, Surveyors interviewed Director of Housing (DOH) C and Director of Healthcare Services M (DHS) M. DHS M stated s/he did not get Resident 11's POA to sign off on his/her ISP because s/he was out of town. DHS M stated s/he went over the information on the ISP dated 12/17/2024 with Resident 11's sibling, who is his/her secondary POA. Surveyor asked if Resident 11's sibling signed off on the 12/17/2024 ISP. DHS M stated no s/he did not have a signed ISP for 12/17/2024 for Resident 11.	{N 389}		
{N 406}	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF	{N 406}		

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{N 406}	Continued From page 10 shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on staff interview and observation, the provider did not ensure that when medications were unused or discontinued, the remaining medications were destroyed or disposed of within 30 days for 5 of 5 residents (Resident 12, Resident 13, Resident 14, Resident 15, and Resident 16). This is a repeat deficiency. See Statement of Deficiency ZWH712, dated 08/01/2024. Findings include: On 01/16/2025, at 9:40 AM, Surveyor observed the medication room. Surveyor observed the following discontinued medications for each resident in his/her punch cards: Resident 12 -Sodium chloride 1 gram (G) tablet, take two tablets by mouth (38 pills), dated 10/29/2024. -Potassium chloride (CL) ER (extended release) 20 MEQ (milliequivalent) tablet, give 2 tablets by mouth once daily (9 pills), dated 11/12/2024. -Vitamin B-12 500 microgram (MCG) tablet, give	{N 406}		

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{N 406}	Continued From page 11 2 tables by mouth once daily (4 pills), dated 11/12/2024. -Multivitamin, give 1 tablet by mouth once daily (2 pills), dated 11/12/2024. -Lisinopril 5 milligram (mg) tablet, give 1 tablet by mouth every morning (2 pills), dated 11/12/2024. -Furosemide 40 mg tablet, give 1 tablet by mouth twice daily (1 pill), dated 11/12/2024. -Amlodipine 5 mg tablet, give 1 tablet by mouth every morning (2 pills), dated 11/12/2024. Resident 13 -Aspirin 81 mg chewable tablet, give 1 tablet by mouth every morning (23 pills), dated 11/03/2024. Resident 14 -Potassium CL ER MEQ tablet, give 1 tablet three times daily (29 pills), dated 10/04/2024. Resident 15 -Preservision Areds Softgel, give 1 capsule by mouth twice daily (30 pills), dated 10/04/2024. Resident 16 -Tamsulosin hydrochloride (HCL) 0.4 mg capsule, give 1 capsule by mouth at bedtime (3 pills), dated 07/06/2024. -Donepezil 5 mg tablet, give 1 tablet by mouth at bedtime (4 pills), dated 07/06/2024. On 01/014/2025, at approximately 9:45 AM, Surveyor interviewed Director of Healthcare Services M (DHS M). DHS M stated the facility policy is to destroy discontinued or unused medications immediately. DHS M stated typically third shift will destroy the medications or his/her assistant would. DHS M stated his/her assistant was currently on vacation and had not worked for 2 weeks so that could be why the medications were not destroyed.	{N 406}		

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{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. 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 2 of 2 locations observed. Cleaning compounds were stored in the spa room and dining room. This is a repeat deficiency. See Statement of Deficiency (SOD) 8I4W11, dated 01/11/2022 and SOD ZWH712, dated 08/01/2024. Findings include: On 01/16/2025, at 9:55 AM, Surveyor toured the facility and observed the following: -The spa room located in the center of the building on the first floor had an unsecured bottle of Clorox Fuzion cleaner disinfectant and Sani-Cloth Germicidal disposable wipes. -The memory care dining room in the lower cabinet was a bottle of Clorox Fuzion cleaner disinfectant. Surveyor observed residents moving freely throughout the facility during the survey. On 01/16/2025 at 10:00 AM, Surveyor interviewed Director of Healthcare Services M (DHS M) confirmed all toxic substances were not securely locked at all times. DHS M stated most	{N 499}		

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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 499}	Continued From page 13 chemicals are on the cleaning cart and the cleaning cart is stored in the spa room. DHS M stated the spa room is not locked and staff and residents would have access to it 24/7.	{N 499}		
{N 525}	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted quarterly and at least one drill simulated the conditions during usual sleeping hours for 1 of 1 year reviewed (2024). There was not a fire drill conducted in quarter four of 2024 and there was not a drill which simulated the conditions during sleeping hours in 2024. This is a repeat deficiency. See Statement of	{N 525}		

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{N 525}	Continued From page 14 Deficiency ZWH712, dated 08/01/2024. Findings include: On 01/16/2025, at approximately 10:30 AM, Surveyor reviewed facility fire drills for calendar year 2024 and identified the following: Fire drills were conducted on 01/31/2024, 02/21/2024, 03/20,2024, 04/19/2024, 05/16/2024, 06/28/2024, 07/18/2024, 08/22/2024. None of these fire drills were simulated conditions during usual sleeping hours or in the fourth quarter of calendar year 2024. On 01/16/2025 at 1:00 PM, Surveyor interviewed Director of Housing (DOH) C. DOH C confirmed fire drills needed to be completed every quarter and one drill should be a simulated drill with conditions during usual sleep hours. DOH C stated the maintenance director could not locate any of these drills.	{N 525}		
{N 526}	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding or other emergency or disaster drills were conducted at least semi-annually for 1 of 1 year. There were no other drills conducted in 2024. This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) 92LE12,	{N 526}		

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{N 526}	Continued From page 15 dated 04/11/2023, SOD 8I4W11, dated 01/11/2022, and SOD ZWH712, dated 08/01/2024. Finding include: On 01/16/2025, at approximately 10:30 AM, Surveyors reviewed safety records. Surveyors did not locate any documentation indicating other emergency and disaster drills were conducted in 2024. On 01/16/2025 at 1:00 PM, Surveyor interviewed Director of Housing (DOH) C. DOH C confirmed other drills needed to be completed semi-annually. DOH C stated the maintenance director could not locate any of these drills for 2024.	{N 526}		
Y3100	50.09(1)(f) RESIDENT'S RIGHTS IN CERTAIN FACILITIES (2) The department, in establishing standards for nursing homes and community based residential facilities may establish, by rule, rights in addition to those specified in sub. (1) for residents in such facilities.	Y3100		

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Y3100	Continued From page 16	Y3100		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure each resident had the right not to be recorded or filmed when electronic surveillance cameras were placed throughout the facility in common spaces. This had the potential to effect 62 of 62 residents that resided there.

Findings include:

The provider is licensed to serve up to 90 residents in the client groups irreversible dementia/Alzheimer's and advanced aged. The facility is two levels divided into two units they call "memory care" and "assisted living." The main level is the "assisted living" unit and the lower level which is a secure unit (delayed egress) is the "memory care." Each unit has a dining area, common gathering spaces and kitchenette area.

On 01/16/2025 at approximately 10:00 AM, Surveyor toured the facility. Surveyor observed cameras in the following areas:

- The entrance to the "memory care" off the elevators which pointed to the door and common sitting area.
- Common space in the "assisted living" area by the main floor bathrooms

Two cameras were observed throughout the facility, all in common spaces where residents may gather. There were no signs.

On 01/16/2025 at approximately 10:15 AM, Surveyor interviewed Director of Healthcare Services M (DHS M)about the camera surveillance system. DHS M stated s/he would have to disagree about the camera by the doors of the memory care. DHS M stated they had

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Y3100	Continued From page 17 always been there. Surveyor asked DHS M if it would be considered a common area since s/he observed couches and chairs in the area for residents and visitors to sit and commingle. DHS M stated yes residents and visitors could sit there if they wanted to.	Y3100		