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 05/22/2026

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 05/13/2026 with information gathered through 05/22/2026, Surveyor conducted two complaint investigations, standard survey and verification visit for SOD ZWH713, dated 01/16/2025 at Oak Park Place of Oak Creek, a Community-Based Residential Facility (CBRF) in Oak Creek, WI. Nine deficiencies were identified. Four of the 9 violations are repeat violations, See Statement of Deficiency (SOD) 8I4W11, dated 01/11/2022, SOD 92LE11, dated 05/06/2022, SOD 92LE12, dated 04/11/2023, SOD ZWH712, dated 08/01/2024 and SOD ZWH713, dated 01/16/2025. Two of 2 complaints substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 71	{N 000}		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the department within 3 working days of a serious injury requiring hospitalization for 1 of 1 resident (Resident 17) reviewed. Resident 17 had a fall on 03/17/2026,	N 165		

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

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N 165	Continued From page 1	N 165		

resulting in a left L2-L4 transverse process fracture (a break in the small bony pieces on the left side of lower vertebrae in the lower back) which required hospitalization.

This is a repeat deficiency. See Statement of Deficiency 92LE11, dated 05/06/2022.

Findings include:

On 04/23/2026, the Department received a complaint expressing concerns regarding this facility providing incorrect information regarding the circumstances of resident fall as well as the seriousness of the fall.

On 05/13/2026, Surveyor reviewed the provider's self-report history in the department's electronic file for the facility and identified the following:

-On 03/25/2026, the Department received a self-report from the facility, submitted by Director of Housing C, reporting the following: Date of Incident: 03/20/2026. Reason for report: Hospitalization for fall. Resident involved: Resident 17. Incident description: "March 17th approximately 7:30 pm [Resident 17] reported to staff that [s/he] had a fall earlier in the day around 12:00 pm [sic]. [Resident 17] reported [s/he] had fallen in [his/her] bathroom and hit the toilet. [Resident 17] was able to get [him/herself] up. [Resident 17] stated [s/he] was now having pain and requested Tylenol. Tylenol was given and [power of attorney] was notified. 8:30 pm [sic] [power of attorney] arrived and transported [Resident 17] to [emergency department]. All notifications made. Incident outcome: March 18th hospital notified community resident had been admitted for UTI (urinary tract infection) and currently has a indwelling catheter. March 20th

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[Resident 17] returned to the community transported by family. After Visit Summary provided to staff by [power of attorney]. Community reviewed diagnosis which stated left L2-L4 transverse process fracture; weakness s/p (after) fall, UTI; post renal AKI-improving (acute kidney injury)."

On 05/13/2026 through 05/22/2026, Surveyor reviewed Resident 17's record and identified the following:

-Resident 17 was admitted to the facility on 12/20/2024.

-Resident 17 had an activated healthcare power of attorney.

-Resident 17's Incident report, dated 03/17/2026 at 7:30 PM, written by Licensed Practical Nurse Q, documented the following: Date of fall: 03/17/2026. "Incident Description: [Resident 17] reported to staff that [s/he] had a fall earlier in the day at around 12:00 PM. [Resident 17] reported [s/he] had fallen in [his/her] bathroom and hit the toilet. [S/he] was able to get [his/herself] up. [Resident 17] stated [s/he] was now [7:30 PM] having pain and requested Tylenol. Tylenol was given and POA was notified."

-Resident 17's Patient Discharge Summary, dated 03/20/2026, documented the following:

"Date of admit: 03/17/2026. Date of discharge: 03/20/2026. Reason for hospitalization: Fall. Diagnosis: Left L2-L4 Transverse process fracture."

On 05/13/2026, at approximately 6:33 PM, Surveyor interviewed Director of Housing (DOH)

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N 165	Continued From page 3 C. DOH C confirmed Resident 17 had a fall on 03/17/2026, resulting in a left L2-L4 transverse process fracture which required hospitalization. DOH C reported s/he was responsible for reporting to the Department. DOH C reported s/he was not aware Resident 17 sustained a left L2-L4 transverse process fracture until 03/20/2026 when Resident 17 returned from hospital.	N 165		
N 318	83.29(3)(a) Refunds returned within 30 days of discharge The CBRF shall return all refunds due a resident under the terms of the admission agreement within 30 days after the date of discharge. This Rule is not met as evidenced by: Based on record review, the provider did not ensure all refunds due to a resident under the terms of the admission agreement were returned within 30 days of discharge. Resident 19 moved out of the facility on 01/21/2026. On 03/02/2026, the provider mailed a check to Resident 19 or Resident 19's activated healthcare power of attorney (POA) refunding the following: Security deposit ($2011.70) and rent/care ($2896.36 for the following dates 01/22/2026-01/31/2026). According to the check stub $1,556.44 was deducted as a carpet charge. Findings include: On 04/20/2026, the Department received a complaint regarding refunds. On 05/13/2026 through 05/20/2026, Surveyor	N 318		

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N 318	Continued From page 4 reviewed Resident 19's record and identified the following: -Resident 19 was admitted to the facility on 09/03/2025. -Resident 19 had a move out date of 01/21/2026. -Resident 19 had an activated POA. -Resident 19's Residency Agreement, signed by Resident 19's POA on 09/03/2025, documented the following: "2,000 Security Deposit (Refundable) - With the exception of any loss, damage or repair needed to be made to apt (i.e. carpet, painting etc.) The cost of these repairs shall be deducted from the Security Deposit and in some cases money may be owed to [This facility] by you. The amount of this Security Deposit may not exceed the amount of one month's Monthly Fee." -Resident 19's Move In/ Move Out Checklist, dated 09/03/25, signed by Resident 19's POA and Director of Housing (DOH) C, documented the following: "Carpeting: worn in walkway slightly soiled." -An email printout dated 05/20/2026, at 8:57 AM, from facility accounts receivable to DOH C, documented the following: "Check # 006125 was mailed 03/02/2026 to Resident 19 or POA. Refund - Security Deposit $2011.70 Refund - Rent/care 1/22-1/31/2026 $2896.36 Deduct - Carpet Charge ($1556.44) Total - $3351.62"	N 318		

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N 318	Continued From page 5 On 05/20/2026, at 8:23 AM, Surveyor interviewed DOH C. DOH C confirmed that based on Resident 19's Move In/ Move Out Checklist, dated 09/03/2025 the carpeting was already worn when Resident 19 moved in on 09/03/2025. DOH C confirmed $1,556.44 was deducted as a carpet charge from Resident 19's security deposit refund of $2011.70. DOH C reported that due to the Move In/Move Out Checklist documenting the carpeting was worn Resident 19 should not have had the carpet fee deducted. DOH C reported that s/he did not know if Resident 19's Move In/Move Out Checklist was reviewed prior to the deduction of the carpet charge.	N 318		
{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 intervals prescribed by a practitioner for 1 of 1 resident (Resident 18) reviewed. Resident 18 had a total of 11 medications not administered between 04/02/2026-04/30/2026. This is a repeat deficiency. See Statement of Deficiency ZWH713, dated 01/16/2025.	{N 352}		

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{N 352}	Continued From page 6 Findings include: On 05/13/2026 through 05/22/2026, Surveyor reviewed Resident 18's record and identified the following: -Resident 18 was admitted to the facility on 12/19/2025. Resident 18's April 2026 Medication Administration Record (MAR) stated Resident 18 was prescribed the following medication: -Ursodiol Oral Tablet 500 milligram (mg) give 1 tablet by mouth two times a day for cholesterol. Resident 18's April 2026 MAR had chart code "9" which meant the medication was not available, entries on the following dates: -Ursodiol Oral Tablet 500 mg on 04/02/2026, 04/04/2026, 04/08/2026 and 04/10/2026-04/13/2026 at 7:00 AM (7 entries). -Ursodiol Oral Tablet 500 mg on 04/05/2026, 04/07/2026, 04/09/2026 and 04/30/2026 at 4:00 PM (4 entries). On 05/22/2026, at approximately 9:31 AM Surveyor interviewed Director of Housing (DOH) C. DOH C reported Resident 18 needed assistance with medication administration from staff. On 05/22/2026, at 11:19 AM, Surveyor interviewed Regional Director of Healthcare Services (RDHS) O. RDHS O reported based off April 2026 MAR code "9" indicates Resident 18 did not receive his/her medication on the	{N 352}		

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{N 352}	Continued From page 7 above-mentioned dates. On 05/22/2026, at 1:39 PM, Surveyor interviewed DOH C. Surveyor asked DOH C the following question via email: "When a medication is not in the medication cart, what is the procedure?" On 05/22/2026, at 3:46 PM, Surveyor received a email from DOH C stating the following: "Our procedure is to: "-Check the cart to make sure it is not in the wrong area of the cart. "-Check the med rooms to see if it was delivered and put on the cart. "-If not found to document "9" unavailable and document what we did to re-fill. "-Fax request form to pharmacy. "-Then inform [Licensed Practical Nurse Q] and me in writing."	{N 352}		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.	N 387		

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N 387	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident and/or the resident's legal representative, as appropriate, were involved in developing the individual service plan (ISP) and signed the plan acknowledging their involvement in, understanding of, and agreement with the plan for 1 of 1 resident (Resident 17). Findings include: On 05/13/2026, Surveyor reviewed Resident 17's record and identified the following: -Resident 17 was admitted on 12/20/2024. -Resident 17 had an activated healthcare power of attorney (POA). -Resident 17's ISP, dated 04/23/2026, was not signed by his/her POA. On 05/22/2026, at approximately 9:31 AM, Surveyor interviewed Director of Housing (DOH) C. DOH C confirmed Resident 17's ISP, dated 04/23/2026, was not signed or dated by his/her POA. DOH C reported s/he requested Resident 17's POA to come to the facility to sign Resident 17's ISP and POA did not come to facility to sign ISP.	N 387		
{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	{N 499}		

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{N 499}	Continued From page 9 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 1 of 1 location observed. Cleaning compound was stored in the memory care dining room. This is a repeat deficiency. See Statement of Deficiency (SOD) 8I4W11, dated 01/11/2022, SOD ZWH712, dated 08/01/2024 and ZWH713, dated 01/16/2025. Findings include: On 05/13/2026, at 6:20 PM, Surveyor toured the facility with Director of Housing (DOH) C and observed the following: -The memory care dining room in the unsecured lower cabinet was a 32 ounce bottle of Clorox Urine Remover. Surveyor observed residents moving freely throughout the facility during the survey. On 05/13/2026, at 6:20 PM, Surveyor interviewed DOH C. DOH C confirmed the above-mentioned cleaning compound was not securely stored. DOH C reported cleaning compounds and toxic substances should be securely stored at all times. DOH C reported s/he did not know why the cleaning compound was not securely stored.	{N 499}		
{N 526}	83.47(2)(e) Other evacuation drills.	{N 526}		

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{N 526}	Continued From page 10 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 2025. This is a repeat deficiency. See Statement of Deficiency (SOD) 92LE12, dated 04/11/2023, SOD 8I4W11, dated 01/11/2022, SOD ZWH712, dated 08/01/2024 and SOD ZWH713, dated 01/16/2025. Findings include: On 05/13/2026, at approximately 12:03 PM, Surveyor reviewed safety records. Surveyor did not locate any documentation indicating other emergency or disaster evacuation drills were conducted in 2025. On 05/13/2026, at 2:51 PM, Surveyor interviewed Director of Maintenance (DOM) P. DOM P reported s/he was not aware of this requirement of other emergency or disaster evacuation drills. DOM P reported it was an oversight on his/her end.	{N 526}		
N 527	83.47(2)(f) Horizontal evacuation. Horizontal evacuation. The CBRF shall have approval from the department before including horizontal evacuation in the emergency and disaster plan. CBRFs using horizontal	N 527		

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evacuation shall document the total evacuation time of the fire zone evacuated.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure they received Department approval prior to implementing horizontal evacuation in their emergency plan. The provider utilized horizontal evacuation without approval.

Findings include:

The facility is licensed to serve up to 90 residents who may be advanced aged and irreversible dementia/Alzheimer's.

On 05/13/2026, Surveyor reviewed the provider's self-report history in the department's electronic file for the facility and identified the following:

-On 08/22/2025, the Department received a self-report facility, reporting the following: "Date of Incident: 08/20/2025. Reason for report: Other. Outcome: Fire: Resident (s) temporarily relocated. Incident Description: On 08/20/2025 at 9:30 PM, caregiver entered the laundry room on the south side of memory care and saw a washing machine with smoke coming out of it. Caregiver yelled for help and the fire alarms in the facility started going off. The staff contained the smoke, made sure all the residents were safe and called 911. The Oak Creek fire department arrived in minutes and cleared the smoke. Incident Outcome: No residents were harmed. Fire department identified washer belt as cause. Washer [sic] no visible flames were noted. Action taken to ensure resident's health, safety and well-being: Residents who are ambulatory were temporarily moved behind the fire door. Hoyered residents in Broda chairs were moved to their

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N 527	Continued From page 12 bathrooms per policy so they were behind 2 doors. After the fire department cleared the area, residents were put back in their rooms. Education on not overloading washers and laundry safety provided to staff. Fire safety education was done on 06/25 and 08/20 before the fire." Surveyor did not locate a horizontal evacuation approval for this facility. On 05/22/2026 at 9:31 AM, Surveyor interviewed Director of Housing (DOH) C. DOH C confirmed that the Department had not granted approval of the horizontal evacuation procedure before it was incorporated into the facility's emergency plan. DOH C reported s/he was aware facility required approval from the Department prior to implementing horizontal evacuation in their emergency plan. DOH C reported s/he will ensure all documentation is submitted to the Department to request approval for horizontal evacuation.	N 527		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on record review and interview, the	N 535		

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N 535	Continued From page 13 provider did not ensure that CBRF (community-based residential facility) personnel tested smoke detectors at least once every other month during 2024 and 2025 to present. Findings include: The facility is licensed to serve up to 90 residents who may be advanced aged and irreversible dementia/Alzheimer's. On 05/13/2026, at approximately 12:03 PM, Surveyor reviewed all safety documentation provided by Director of Maintenance (DOM) P and was unable to find documentation to show the facility smoke detectors were tested once every other month in 2024 and 2025 to present. On 05/13/2026, at approximately 2:51 PM, Surveyor interviewed DOM P. DOM P confirmed that there was no documentation to show the facility smoke detectors were tested once every month in 2024 and 2025 to present. DOM P reported s/he was not aware of the requirement that facility personnel were required to test smoke detectors at least every other month. On 05/13/2026, at approximately 3:19 PM, Surveyor interviewed Director of Housing (DOH) C. DOH C reported s/he was not aware of the requirement that facility personnel were required to test smoke detectors at least every other month.	N 535		
N 654	83.59(4)(f) Delayed egress: department approval Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a	N 654		

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 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 654	Continued From page 14 supervised interconnected automatic fire detection system and shall comply with all of the following: To obtain department approval, the CBRF shall demonstrate that delayed egress equipment is necessary to ensure the safety of residents served by the CBRF, specifically persons at risk of elopement due to behavioral concerns, cognitive impairments or dementia, including Alzheimer ' s disease. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure approval from the Department was received for 1 of 1 delayed egress door in the facility. Findings include: On 05/13/2026, at approximately 6:11 PM, while conducting a tour of the facility with Director of Housing (DOH) C, Surveyor observed the following: -Delayed egress door in the memory care (door lead to elevator lobby). On 05/13/2026, at approximately 6:33 PM, Surveyor interviewed DOH C. DOH C confirmed the door in the memory care was equipped with delayed egress hardware. DOH C reported s/he was not aware facility needed approval from the Department for delayed egress doors. CROSS REFERENCE N 526 83.47(2)(e) - Other Evacuation Drills N 527 83.47(2)(f) - Horizontal Evacuation N 535 83.48(1)(b) - Smoke And Heat Detectors Per Nfpa 72	N 654		