

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015335	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/07/2026
NAME OF PROVIDER OR SUPPLIER HAMILTON PARK PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 HAMILTON STREET PORTAGE, WI 53901		
(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 08/06/2026, Surveyor conducted 1 verification visit and 2 complaint investigations at Hamilton Park Place. Two deficiencies were identified. One of 2 deficiencies was a repeat violation. See Statement Of Deficiency (SOD): WHTX11, dated 05/25/2022; WHTX12, dated 12/12/2022; WHTX13, dated 05/09/2023; WHTX14 dated 09/27/2024; WHTX15 dated 03/21/2024, WHTX16 dated 07/12/2024, WHTX17 dated 11/06/2024, and 56CN11 dated 12/10/2025. One complaint was substantiated and 1 was unsubstantiated. The 1 deficiency identified in SOD 56CN13 dated 04/29/2026 was substantially corrected. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 24	{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 all prescribed medications	N 352		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 352	Continued From page 1 were administered in the dosages and intervals prescribed by the physician. Resident 14's 06/09/2026 8:00 PM and 06/10/2026 8:00 AM physician ordered medications were not administered. This is a repeat violation. See Statement Of Deficiency (SOD): WHTX11, dated 05/25/2022; WHTX12, dated 12/12/2022; WHTX13, dated 05/09/2023; WHTX14 dated 09/27/2024; WHTX15 dated 03/21/2024, WHTX16 dated 07/12/2024, WHTX17 dated 11/06/2024, 56CN11 dated 12/10/2025. Findings include: On 06/10/2026, the Department received a complaint alleging medications were not administered as ordered by the physician. On 08/06/2026, Surveyor reviewed Resident 14's record. S/he was admitted 06/09/2026, and had a guardian of person and finances. Diagnoses included: encephalopathy; type 2 diabetes mellitus; chronic kidney disease; essential hypertension; peripheral vascular disease; attention deficit hyperactivity disorder; hypertension; and peripheral vascular disease. Hospital Discharge Summary dated 06/09/2026 (received by facility from hospital 06/09/2026 at 10:32 AM) listed scheduled medication physician orders including time of day to be administered: acetaminophen 500 MG 2 tablets 3 times daily (morning, noon and bedtime) Aspirin Adult Low Dose 81 MG 1 tablet in AM (morning) atorvastatin 20 MG 1 tablet once daily (morning) baclofen 10 MG 1 tablet 3 times daily (morning, noon and bedtime)	N 352		

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N 352	Continued From page 2 duloxetine 30 MG 2 capsules once daily (morning) estradiol 0.01% vaginal cream place 1 syringe vaginally 3 times weekly Monday Wednesday and Friday (morning) Florajen (acidophilus probiotic) 1 capsule twice daily before meals (morning and evening) furosemide 20 MG 1 tablet daily (morning) lisinopril 20 MG 1 tablet daily (morning) metoprolol succinate 50 MG 1 tablet twice daily (morning and bedtime) mirabegron [Mybetriq] ER 25 MG 1 tablet daily (morning) nitrofurantoin 100 MG 1 capsule (bedtime) omeprazole 20 MG 1 capsule daily (morning) potassium chloride 10 MEQ 1 capsule twice daily (morning and bedtime) sodium bicarbonate 650 MG twice daily (morning and bedtime) ticagrelor 90 MG 1 tablet twice daily (morning and bedtime) vitamin D12 1.25 MG 1 tablet once weekly on Wednesday Xarelto 2.5 MG (generic: rivaroxaban) 1 tablet twice daily (morning and bedtime) Email from Pharmacy Billing Coordinator (PBC) V dated 06/09/2026 at 12:29 PM to Administrator Q, Former RN V, former Assistant Administrator R, and other pharmacy staff: " ...Subject: New Admit [wrong resident name] ...[Wrong resident name] has quite the med list and unfortunately, many of [his/her] meds are being denied as refill-too-soon with no insurance overrides available. Below is a list of meds, next fill dates and costs for [name of pharmacy] to fill ... Atorvastatin 20mg ... Furosemide 20mg ... Mybetriq ER 25mg ... Omeprazole DR 20mg ...	N 352			

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N 352	Continued From page 3 Pot Chl Er 10meq ... Ticagrelor 90mg ... Xarelto 2.5mg ... At the very least, the resident must bring in [his/her] existing supply of Mybetriq and Xarelto ...Lastly, we will need a financial POA name and address to route [his/her] invoice to. Please confirm that [s/he] will be bringing in the Mybetriq, Xarelto, and possibly the Atorvastatin and Potassium Chloride ..." On 06/09/2026 at 2:47 PM, PBC V emailed a reply (to his/her own 06/09/2026 12:29 PM email) Administrator Q, Former RN V, former Assistant Administrator R, and other pharmacy staff stating, "Correction ...this is for [Resident 14 name] ..." On 06/09/2026 at 7:20 PM, pharmacy delivered the following scheduled medications as evidenced by a "Packing Slip Proof of Delivery" (dated 06/09/2026 at 7:20 PM): acetaminophen 500 MG (morning, noon and bedtime medication) acidophilus probiotic/Florajen (morning and evening medication) aspirin 81 MG (morning medication) baclofen 10 MG (morning, noon and bedtime medication) duloxetine 60 MG (morning medication) lisinopril 20 MG (morning medication) metoprolol 50 MG (morning and bedtime medication) sodium bicarbonate 650 MG (morning and bedtime medication) On 06/10/2026 at 6:41 PM, pharmacy delivered the following medications as evidenced by "Packing Slip Proof of Delivery" (dated 06/10/2026 at 6:41 PM): atorvastatin 20 MG (morning medication)	N 352		

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N 352	Continued From page 4 furosemide 20 MG (morning medication) Myrbetriq ER 25 MG (morning medication) nitrofurantoin 100 MG (bedtime medication) omeprazole DR 20 MG (morning medication) potassium chloride ER 10 MEQ (morning and bedtime medication) Ticagrelor 90 MG (morning and bedtime medication) Xarelto 2.5 MG (morning and bedtime medication) On 08/06/2026, Surveyor compared the Resident 14's June 2026 medication administration record (MAR) to Pharmacy Packing Slip for medications delivered 6/09/2026 at 7:20 PM and Pharmacy Check In History. Staff did not document administration of the following medications on: acetaminophen 500 MG- 06/09/2026 8:00 PM or 06/10/2026 8:00 AM acidophilus probiotic/Florajen- 06/09/2026 8:00 PM or 06/10/2026 8:00 AM (checked in by Assistant Administrator T on 06/10/2026) aspirin 81 MG- 06/10/2026 8:00 AM (checked in by Assistant Administrator T on 06/10/2026) baclofen 10 MG- 06/09/2026 8:00 PM or 06/10/2026 8:00 AM duloxetine 60 MG- 06/10/2026 8:00 AM (checked in by Assistant Administrator T on 06/10/2026) estradiol vaginal cream 0.1 MG/GM lisinopril 20 MG-06/10/2026 8:00 AM (checked in by Assistant Administrator T on 06/10/2026) metoprolol 50 MG- 06/09/2026 8:00 PM or 06/10/2026 8:00 AM sodium bicarbonate 650 MG-06/09/2026 8:00 PM or 06/10/2026 8:00 AM On 08/06/2026, Surveyor compared the medications listed in PBC V's email dated 06/09/2026 at 12:29 PM to medications listed on 06/10/2026 6:41 PM packing slip, noting the	N 352		

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N 352	Continued From page 5 medications lists matched. Surveyor then compared medications listed on 06/10/2026 6:41 PM packing slip to June 2026 MAR. Staff did not document administration of the following medications: atorvastatin 20 MG 06/10/2026 8:00 AM furosemide 20 MG 06/10/2026 8:00 AM Myrbetriq ER 25 MG 06/10/2026 8:00 AM (checked in by Assistant Administrator T on 06/10/2026) nitrofurantoin 100 MG 06/09/2026 8:00 PM and 06/10/2026 8:00 AM (checked in by Assistant Administrator T on 06/10/2026) omeprazole DR 20 MG 06/10/2026 8:00 AM potassium chloride ER 10 MEQ 06/09/2026 8:00 PM and 06/10/2026 8:00 AM Ticagrelor 90 MG 06/09/2026 8:00 PM and 06/10/2026 8:00 AM Xarelto 2.5 MG 06/09/2026 8:00 PM and 06/10/2026 8:00 AM Preadmission Assessment completed 06/05/2026: In the area of Physical Health/Medications- "...Resident is dependent on team to administer the medications as prescribed by the physician ...Med tech will administer the medication as prescribed by the physician ...Resident wishes to receive medications as prescribed by the physician ..." Observation notes dated 06/01/2026-08/06/2026 (summarized): The first observation note was written 06/10/2026 at 5:30 AM and stated "slept [sic] in recliner.", second observation note was written 06/14/2026 at 12:30 PM regarding upcoming appointments, shower, laundry and bedding. Observation notes did not address 06/09/2026 and 06/10/2026 issues with medications or documentation that medications	N 352		

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N 352	Continued From page 6 were administered on 06/09/2026 PM or 06/10/2026 AM. On 08/06/2026 at 1:26 PM, Surveyor interviewed PBC-V who stated on 06/09/2026, facility notified pharmacy that Resident 14 was being admitted 06/09/2026 and facility sent his/her medication orders to pharmacy. PBC-V stated a lot of Resident 14's medication orders could not be filled due to "refilled too soon" meaning the insurance would not pay for them, so PBC-V sent the email on 06/09/2026 at 12:29 PM to facility to have family either provide the medications from home or pay privately for pharmacy to dispense them. PBC-V stated pharmacy staff entered physician orders into their computer system, their system transmitted the orders to the facility's electronic medical record inbox, and the facility staff accepted the orders. On 08/06/2026 at 1:45 PM, Surveyor interviewed Administrator Q and Assistant Administrator T who stated they did not check new medications into the electronic medical record until they were received at facility. Administrator Q stated they were unable to obtain medications from Resident 14's home because police had confiscated them. Administrator Q stated medication administration was only documented on the MARs. Administrator Q stated Resident 14 was admitted to facility on 06/09/2026 at approximately 3:00 PM. Assistant Administrator T stated Guardian X arrived at facility on 06/09/2026 shortly after Resident 14 was admitted. On 08/06/2026 at 3:12 PM, Surveyor interviewed Administrator Q and Assistant Administrator T. Administrator Q stated on 06/10/2026 at 4:15 PM, Assistant Administrator T called pharmacy stating Guardian X authorized filling the medications	N 352			

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N 352	Continued From page 7 listed in PBC-V's email dated 06/09/2026 12:20 PM. Administrator Q stated s/he never received the email. Surveyor reviewed PBC-V's email dated 06/09/2026 12:20 PM with Administrator Q and Assistant Administrator T. Administrator Q verified his/her email was correct on the email and stated Former RN V and former Assistant Administrator R had left employment prior to 06/09/2026. Administrator Q stated s/he or other staff were responsible for updating pharmacy with new staff contacts. On 08/06/2026 at 3:33 PM, Surveyor discussed concern of Resident 14 not receiving his/her medications as ordered with Administrator Q, Assistant Administrator T and Day Lead U. Administrator Q stated s/he forwarded the email from PBC-V dated 06/09/2026 at 12:29 PM to Assistant Administrator T. Surveyor reviewed the forwarded email from Administrator Q to Assistant Administrator T, it was dated 06/10/2026 at 12:17 PM and stated " ...There are some medications that were not sent due to insurance that they were filled to soon ..." Attached to the email was the email dated 06/09/2026 at 12:29 from PBC-V. Administrator Q stated since this situation occurred with Resident 14's admission, they decided to not admit new residents until all medications are delivered to facility. On 08/07/2026 at 9:46 AM, Surveyor interviewed Guardian X who stated s/he arrived at facility on 06/09/2026 a couple hours prior to Resident 14's admission, signed admission paperwork then left for a couple hours. Guardian X stated s/he returned to facility after Resident 14 had arrived for admission and stayed a couple of hours. Guardian X stated s/he was not told by facility staff pharmacy needed his/her financial authorization before they would fill all	N 352			

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N 352	Continued From page 8 medications. Guardian X stated s/he was not aware of the issues with medication until s/he received an email from Resident 14's managed care organization the morning of 06/10/2026, after which s/he contacted the pharmacy and provided authorization to fill the medications. Guardian X stated because Resident 14's home medications were confiscated by police and Resident 14 could not bring medications from the hospital due to history of abusing medications, his/her medications needed to be obtained from the facility pharmacy. During interview, Surveyor reviewed an email forwarded to Surveyor from Guardian X on 06/24/2026 9:28 AM. The email (dated 06/10/2026 at 8:46 AM) from Guardian X to Administrator Q and Resident 14's MCO team and stated " ...I just wanted to follow up and ensure that [Resident 14's] medications have arrived at the facility? I did stop back in last night and talked to [Resident 14] for some time along with the second shift staff. Staff reported that the medications had not arrived at the facility by the time that I left (after 5pm). When I called a few minutes ago, staff again reported that [his/her] medications have not arrived. Can you clarify what is being done to address this situation?" Administrator Q replied with an email dated 06/10/2026 at 9:13 AM " ...Yes they did [sic] i [sic] didn't have your information with me last night [sic] sorry about that [sic] thank you ..." On 08/07/2026 at 11:37 AM, Surveyor interviewed Administrator Q and Assistant Administrator T. Administrator Q stated s/he did not read the email from PBC-V (dated 06/09/2026 at 12:29 PM), prior to forwarding it to Assistant Administrator T (on 06/10/2026 at 12:17 PM) because s/he was in the middle of an off-grounds assessment. Assistant Administrator T stated s/he did not read the forwarded email until later on 06/10/2026	N 352		

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N 352	Continued From page 9 because s/he did not get to his/her emails quick enough.	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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 14's legal representative signed the individual service plan (ISP) acknowledging his/her involvement in, understanding of and agreement with the plan. Findings include: On 08/06/2026 at approximately 10:00 AM, Surveyor requested Resident 14's record, including ISP with signature sheet from Administrator Q and Assistant Administrator T.	N 387		

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N 387	Continued From page 10 On 08/06/2026, Surveyor reviewed Resident 14's record. S/he was admitted 06/09/2026 with Guardian X serving as his/her legal representative for health and finances. The ISP was not signed or dated. On 08/07/2026 at 9:46 AM, Surveyor interviewed Guardian X who stated prior to 08/06/2026 s/he was not approached by facility to review and sign Resident 14's ISP, and on 08/06/2026 s/he received an email from Assistant Administrator T requesting s/he sign the ISP, attached to the email. On 8/07/2026 at 9:47 AM during interview, Surveyor received a forwarded email chain dated 08/06/2026 (beginning at 10:56 AM and ending at 3:19 PM) between Assistant Administrator T and Guardian X. The 1st email at 10:56 AM was from Assistant Administrator T to Guardian X and stated " ... [Guardian X], I am attaching [Resident 14's] Care plan, could you please sign this and return as soon as possible! State is in our building and they are requesting [Resident 14's] care plan but we cannot give it to them without it being signed ..." The 3rd email at 1:07 PM from Assistant Administrator T to Guardian X stated " ...the state lady took it anyways so the signature is not urgent at this time, so you can take a look at it and review it, let me know if you'd like me to add anything In [sic] there ..." On 08/07/2026 at 11:37 AM, Surveyor discussed concern of Resident 14's ISP not signed by his/her legal representative with Administrator Q and Assistant Administrator T. Assistant Administrator T stated s/he never fully completed	N 387		

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N 387	Continued From page 11 the ISP but they had monthly video meetings with Guardian X and s/he forgot to send the ISP to Guardian X for signature. Assistant Administrator T stated Resident 14's ISP was sent to Guardian X on 08/06/2026 for signature.	N 387		