STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017289	A. BUILDING: _____ B. WING _____	R-C 10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF NAKOMA	4327 NAKOMA RD MADISON, WI 53711

(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 From 10/11/2023 to 10/13/2023, Surveyors conducted 3 complaint investigations and an enforcement verification visit at Oak Park Place of Nakoma, a CBRF located in Madison, WI. Nine deficiencies were identified. Five deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) YMPK11, dated 12/07/2020, SOD 2HW013, dated 11/22/2022, SOD 2HW014, dated 05/16/2023 and SOD D0TF11, dated 06/20/2023. One of 3 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed. Census: 28	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's legal representative and/or resident's physician were notified of an incident to the resident.	N 169		

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

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N 169	Continued From page 1 On 10/07/2023, Resident 10 and Resident 11 experienced unwitnessed falls in their rooms. Resident 10 nor Resident 11's legal representatives were notified of these falls at the time of the incident. FINDINGS INCLUDE: The facility provides care to the following client groups: terminally ill, advanced aged, irreversible dementia and Alzheimer's. On 10/10/2023, the Department received a complaint related to resident safety at facility. On 10/11/2023, Surveyor arrived at facility for a complaint investigation. On 10/11/2023 at 9:30 AM, Surveyor discussed facility fall protocols with Assistant DON L. Assistant DON L stated when a resident falls staff have been instructed to call for a nurse, complete a fall packet, notify primary care provider and/or hospice provider. On 10/11/2023 at 9:35 AM, Surveyor spoke with Caregiver M about resident falls. Caregiver M stated s/he was monitoring Resident 10 and Resident 11. Caregiver M stated Resident 10 and Resident 11 had fallen over the past weekend. EXAMPLE 1: On 10/11/2023, Surveyor reviewed Resident 10's facility record. Resident 10 was admitted to the facility on 09/06/2023. Resident 10 has an activated care power of attorney. On 10/11/2023, Surveyor reviewed Resident 10's fall record. On 10/07/2023 at 5:00 PM, Assistant	N 169		

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N 169	Continued From page 2	N 169		

DON L documented that Resident 10 had suffered an unwitnessed fall. Assistant DON L documented Resident 10 was found prone on the floor in front of his/her wheelchair, and that s/he did not suffer any injury at that time. Under the subsection, "Agencies/People Notified," it states that Resident 10's physician was notified of the fall on 10/08/2023 at 4:10 AM and Family Member N was notified of the fall on 10/08/2023 at 04:15 AM.

On 10/11/2023 at 10:20 AM, Surveyor spoke with Family Member N over the phone. Family Member N stated that Resident 10 suffered a fall at approximately 5:00 PM on Saturday (10/07/2023) and s/he was not notified of the fall until 4:00 AM on Sunday (10/08/2023).

EXAMPLE 2:

On 10/11/2023, Surveyor reviewed Resident 11's facility record. Resident 11 was admitted to the facility on 12/17/2020. Family Member O is listed as Resident 11's activated power of attorney.

On 10/11/2023, Surveyor reviewed Resident 11's fall record. On 10/07/2023 at 4:25 PM, Assistant DON L documented the following, "Resident discovered on knees next to bed." Assistant DON L documented that Resident 11 did not appear to suffer an acute injury. Under the subsection, "Agencies/People Notified," it states that Resident 11's physician was notified of the fall on 10/08/2023 at 4:10 AM.

On 10/11/2023 at 11:10 AM, Surveyor spoke with Family Member O over the phone. Family Member O stated they were not notified of Resident 11's fall on 10/07/2023. Stated this was the first they were hearing about Resident 11

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N 169	Continued From page 3 having a fall over the weekend. INTERVIEW: On 10/11/2023 at 1:00 PM, Surveyor discussed the above concerns with Regional Nurse A, Administrator K and Assistant DON L. Regional Nurse A, Administrator K and Assistant DON L acknowledged that Resident 10's legal representative and physician were not notified of Resident 10's fall within an acceptable time frame. Regional Nurse A, Administrator K and Assistant DON L acknowledged that Resident 11's legal representative was not notified of Resident 11's fall on 10/07/2023.	N 169		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the facility and its operation complied with all laws governing the CBRF. Findings include: From 10/11/2023 to 10/13/2023, Surveyors conducted 3 complaint investigations and a verification visit. As a result of the survey, the following concerns were identified: Special Orders:	N 196		

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N 196	Continued From page 4 On 07/17/2023, the provider received Statement of Deficiency (SOD) 2HW014, which included a "Notice and Order" letter, from the Department that stated the following: "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS ... 1. Pursuant to Wis. Stat. § 50.03(5g)(b)3. and (b)6., effective immediately, the licensee will comply with requirements specified by Wis. Admin. Code § DHS 83.36(1)(a), and shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. The facility will develop (or review/revise) written procedures to ensure: Staffing patterns will be sufficient to meet the personal care needs of residents, to ensure needed supervision, to provide needed services (e.g., toileting, bathing, medication management, interventions to prevent falls, personal cares, meals), and to facilitate a safe evacuation of the building in the event of an emergency. ... When a resident or residents (as a group) require the assistance of two or more staff members to address care and service needs, to provide supervision, or to evacuate the building in an emergency, the licensee will ensure sufficient, qualified staff members are on duty, present and available to assist residents at all times. ... A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request ... AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements. All operational and resident records required as	N 196		

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N 196	Continued From page 5 evidence of compliance with applicable rules will be available to department representatives upon request." On 10/11/2023 at approximately 10:00 a.m., Surveyor requested documentation of the provider's follow up to the 07/17/2023 Special Orders from Regional Nurse A. On 10/11/2023 at approximately 1:00 p.m., Regional Nurse A stated s/he was trying to find the "Notice and Order" letter. Regional Nurse A then checked the email of the department's electronic statement of deficiency contact and confirmed the letter had been received. Regional Nurse A stated the provider had done a lot of work revolving around staffing and that s/he would follow up with Surveyor regarding the procedures. On 10/12/2023 at approximately 12:15 p.m., Surveyor received a revised "Adequate Staffing" policy, revision date 10/12/2023. The revision date indicated the policy was revised greater than 45 days after the "Notice and Order" letter, after an incident on 10/08/2023 when the facility was inadequately staffed resulting in concerns brought to management's attention and after Surveyors onsite visit. Repeat Deficiencies: - Staff not receiving department approved trainings was an identified deficiency for the 3rd time in 1 year. - Residents not receiving their medications as prescribed was an identified deficiency for the 2nd time in 3 years. - Lack of adequate staff was an identified deficiency for the 2nd time in 5 months.	N 196		

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N 196	Continued From page 6 - Documentation of medication administration was an identified deficiency for the 2nd time in 4 months. - Medication availability was an identified deficiency for the 3rd time in 1 year. On 10/11/2023 at approximately 1:00 p.m., Surveyor reviewed all identified concerns with Regional Nurse A, Administrator K and Assistant DON L. Assistant DON L stated the facility would ensure all trainings were completed. Regional Nurse A stated management was working on staffing patterns and s/he made note of all concerns involving medications. Cross Reference: N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0432 DHS 83.38(1)(h) Medication Administration	N 196		
{N 239}	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting	{N 239}		

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{N 239}	Continued From page 7 employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees reviewed obtained all department approved training as required. Caregiver I and Caregiver J did not have training in fire safety or first aid and choking within 90 days after starting employment. This is a repeat deficiency. See Statement of Deficiency (SOD) 2HW013, dated 11/22/2022 and 2HW014, dated 05/16/2023. Findings include: On 10/11/2023 at approximately 10:00 a.m., Surveyor conducted a review of 3 employees to verify compliance with department approved training requirements. Surveyor requested training records from Regional Nurse A for Caregiver I and Caregiver J.	{N 239}		

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{N 239}	Continued From page 8 Fire Safety The records for Caregiver I, hired 06/21/2023 and Caregiver J, hired 06/27/2023 did not contain evidence of training or evidence of meeting an exemption for fire safety. On 10/11/2023, at approximately 12:00 p.m., Surveyor interviewed Assistant DON L. Assistant DON L confirmed the provider did not have evidence Caregiver I or Caregiver J completed or met an exemption for fire safety training. On 10/11/2023 at approximately 12:30 p.m., Surveyor verified neither Caregiver I, nor Caregiver J were on the Community-Based Care and Treatment training registry for fire safety. First Aid and Choking The records for Caregiver I, hired 06/21/2023 and Caregiver J, hired 06/27/2023 did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 10/11/2023, at approximately 12:00 p.m., Surveyor interviewed Assistant DON L. Assistant DON L confirmed the provider did not have evidence Caregiver I or Caregiver J completed or met an exemption for first aid and choking training. On 10/11/2023 at approximately 12:30 p.m., Surveyor verified neither Caregiver I, nor Caregiver J were on the Community-Based Care and Treatment training registry for first aid and choking. On 10/11/2023 at approximately 1:00 p.m., Surveyor reviewed concern with Regional Nurse A, Administrator K and Assistant DON L that 2 of 3 caregivers reviewed did not have department	{N 239}		

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{N 239}	Continued From page 9 approved trainings completed within 90 days of hire. Regional Nurse A took note of Surveyor's concern. Cross Reference: N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake	{N 239}		
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 observation, record review and interview, the provider did not ensure 1 of 3 residents reviewed received all prescribed medications in the dosage and at intervals prescribed by the practitioner. Resident 5 did not receive all his/her medications as prescribed by his/her physician due to lack of medication availability and staffing patterns. This was a repeat deficiency. See Statement of Deficiency (SOD) YMPK11, dated 12/07/2020. Findings include: On 10/11/2023, Surveyors conducted a complaint investigation alleging that residents did not receive their medications as prescribed. Example 1 - Medication Availability	N 352		

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N 352	Continued From page 10 On 10/11/2023 at approximately 7:30 a.m., Surveyor interviewed Caregiver B, who was responsible for passing medications that day. Caregiver B stated there were times s/he was unable to administer medications because they were unavailable. On 10/11/2023 at approximately 7:40 a.m., Surveyor interviewed Caregiver M, who was responsible for passing medications at times. Caregiver M stated medications took forever to arrive from pharmacy, so there were times residents did not receive their prescribed medications because they were unavailable. On 10/11/2023 at approximately 10:40 a.m., Surveyor and Caregiver B reviewed Resident 5's physician orders, medication administration record (MAR) for October 2023 and medications available in the medication cart. The following medications were not available in the medication cart for administration: - Donepezil Hcl 23 mg (Start Date: 06/21/2021) - Give 1 tablet daily for Parkinson's disease: The MAR indicated this medication had not been administered from 10/01/2023 to 10/11/2023. - Mirtazapine 45 mg (Start Date: 06/21/2021) - Give 1 tablet daily for depression. The MAR indicated this medication had not been administered 10/07/2023 to 10/11/2023. - Docusate Sodium (Start Date: 06/21/2021) - Give 1 capsule 2 times daily for constipation. The MAR documented this medication had not been administered on 10/09/2023 PM and 10/11/2023 AM. Caregiver B stated this medication had been unavailable for approximately 2 weeks, so documentation of administration for the past 2 weeks must have been an error. - Polyethyl Glycol Eye Drops (Start Date:	N 352		

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N 352	Continued From page 11 06/21/2023) - Instill 1 drop in both eyes 2 times daily. The MAR documented this medication had not been administered on 10/07/2023 AM, 10/08/2023 AM, 10/08/2023 PM and 10/09/2023 AM. Caregiver M stated this medication had been unavailable since the medication cart was audited on 10/05/2023, so documentation of administration since that date must have been an error. On 10/11/2023 at approximately 11:00 a.m., Surveyor reviewed Resident 5's progress notes, dated 09/01/2023 to 10/11/2023. Progress notes did not include documentation of attempts or barriers to obtain medications from pharmacy. On 10/11/2023 at approximately 1:00 p.m., Surveyor reviewed scheduled medications that were unavailable to Resident 5 for administration with Regional Nurse A, Administrator K and Assistant DON L. Assistant DON L stated the provider had some difficulty obtaining Carbidopa-Levodopa from the pharmacy, but did not comment on difficulty receiving the above unavailable medications. Example 2 - Carbidopa Levodopa Intervals On 10/11/2023 at approximately 7:40 a.m., Surveyor interviewed Caregiver M. Caregiver M stated s/he wasn't always able to complete medication administration within the prescribed intervals because s/he was frequently interrupted to provide cares. On 10/11/2023 at approximately 11:00 a.m., Surveyor reviewed Resident 5's medication administration record (MAR), dated 09/01/2023 to 10/11/2023. Resident 5's physician orders included:	N 352		

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N 352	Continued From page 12 Carbidopa-Levodopa 25-100 mg (Start Date: 06/21/2021) - Give 2 tablets by mouth at 6:00 a.m. Carbidopa-Levodopa 25-100 mg (Start Date: 06/21/2021) - Give 2 tablets by mouth at 9:00 a.m. Carbidopa-Levodopa 25-100 mg (Start Date: 06/21/2021) - Give 2 tablets by mouth at 12:00 p.m. Carbidopa-Levodopa 25-100 mg (Start Date: 06/21/2021) - Give 2 tablets by mouth at 3:00 p.m. Carbidopa-Levodopa 50-100 mg (Start Date: 09/08/2021) - Give 2 tablets by mouth at 7:00 p.m. Resident 5's MAR documented the following occurrences when Resident 5's Carbidopa Levodopa was not administered within the prescribed interval: - 09/01/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 8:10 a.m. - 09/02/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered 9:08 a.m. The 3:00 p.m. Carbidopa-Levodopa was administered at 4:08 p.m. - 09/03/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 9:14 a.m. - 09/04/2023 9:00 a.m. Carbidopa-Levodopa was administered at 10:39 a.m. - 09/05/2023 6:00 a.m. Carbidopa-Levodopa was administered at 7:50 a.m. The 9:00 a.m. Carbidopa-Levodopa was then administered at 8:02 a.m. - 09/06/2023 6:00 a.m. Carbidopa-Levodopa was administered at 8:48 a.m. The 9:00 a.m.	N 352		

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N 352	Continued From page 13 Carbidopa-Levodopa was then administered at 8:49 a.m. - 09/07/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 8:39 a.m. - 09/08/2023 6:00 a.m. Carbidopa-Levodopa was administered at 8:45 a.m. The 9:00 a.m. Carbidopa-Levodopa was then administered at 8:51 a.m. The 3:00 p.m. Carbidopa-Levodopa was administered at 4:16 p.m. - 09/09/2023 6:00 a.m. Carbidopa-Levodopa was administered at 7:29 a.m. The 3:00 p.m. Carbidopa-Levodopa was administered at 4:12 p.m. -09/11/2023 6:00 a.m. Carbidopa-Levodopa was administered at 7:41 a.m. The 9:00 a.m. Carbidopa-Levodopa was then administered at 8:07 a.m. - 09/13/2023 6:00 a.m. Carbidopa-Levodopa was administered at 7:51 a.m. The 9:00 a.m. Carbidopa-Levodopa was administered at 10:10 a.m. - 09/14/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 8:31 a.m. - 09/15/2023 6:00 a.m. 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 9:14 a.m. - 09/16/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 12:00 p.m. The 12:00 p.m. Carbidopa-Levodopa was administered at 1:01 p.m. - 09/17/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 9:05 a.m. - 09/18/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 9:40 a.m. - 09/19/2023 6:00 a.m. Carbidopa-Levodopa was administered at 7:44 a.m. The 9:00 a.m.	N 352		

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N 352	Continued From page 14 Carbidopa-Levodopa was administered 8:31 a.m. - 09/20/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 10:54 a.m. The 12:00 p.m. Carbidopa-Levodopa was administered at 2:10 p.m. - 09/21/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 8:37 a.m. - 09/22/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 9:46 a.m. The 12:00 p.m. Carbidopa-Levodopa was administered at 1:50 p.m. - 09/23/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 8:36 a.m. - 09/24/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 8:41 a.m. - 09/25/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 10:23 a.m. The 12:00 p.m. Carbidopa-Levodopa was then administered at 12:38 p.m. - 09/26/2023 6:00 a.m. Carbidopa-Levodopa was administered at 7:31 a.m. The 9:00 a.m. Carbidopa-Levodopa was administered at 8:45 a.m. The 12:00 p.m. Carbidopa-Levodopa was administered at 2:24 p.m. - 09/27/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 10:14 a.m. The 12:00 p.m. Carbidopa-Levodopa was then administered at 12:36 p.m. - 09/28/2023 6:00 a.m. Carbidopa-Levodopa was administered at 7:38 a.m. The 9:00 a.m. Carbidopa-Levodopa was then administered at 8:07 a.m. The 12:00 p.m. Carbidopa-Levodopa was then administered at 11:17 a.m. - 09/29/2023 6:00 a.m. Carbidopa-Levodopa was administered at 8:38 a.m. The 9:00 a.m. Carbidopa-Levodopa was then administered at 8:37 a.m.	N 352		

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N 352	Continued From page 15 - 09/30/2023 6:00 a.m. Carbidopa-Levodopa was administered at 8:00 a.m. The 9:00 a.m. Carbidopa-Levodopa was then administered at 8:06 a.m. - 10/01/2023 6:00 a.m. Carbidopa-Levodopa was administered at 9:51 a.m. The 9:00 a.m. Carbidopa-Levodopa was administered at 9:42 a.m. - 10/02/2023 6:00 a.m. Carbidopa-Levodopa was administered at 7:56 a.m. - 10/03/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 11:00 a.m. The 12:00 p.m. Carbidopa-Levodopa was administered at 12:15 p.m. - 10/04/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 10:37 a.m. The 12:00 p.m. Carbidopa-Levodopa was administered at 2:10 p.m. - 10/05/2023 6:00 a.m. Carbidopa-Levodopa was administered at 7:34 a.m. The 9:00 a.m. Carbidopa-Levodopa was administered at 8:20 a.m. - 10/06/2023 6:00 a.m. Carbidopa-Levodopa was administered at 10:31 a.m. The 9:00 a.m. Carbidopa-Levodopa was administered at 10:32 a.m. - 10/07/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 8:50 a.m. The 12:00 p.m. Carbidopa-Levodopa was administered at 1:11 p.m. - 10/08/2023 6:00 a.m. Carbidopa-Levodopa was administered at 9:26 a.m. The 9:00 a.m. Carbidopa-Levodopa was administered at 9:27 a.m. The 12:00 p.m. was administered at 1:03 p.m. The 7:00 p.m. Carbidopa-Levodopa was administered on 10/09/2023 at 4:47 a.m. - 10/09/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 10:28 a.m. as well. The 12:00 p.m. Carbidopa-Levodopa was administered at 1:53	N 352		

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p.m.
- 10/10/2023 6:00 a.m. and 9:00 a.m. Carbidopa-Levodopa were administered at 9:14 a.m. The 12:00 p.m. Carbidopa-Levodopa was administered at 1:57 p.m.
- 10/11/2023 6:00 a.m. Carbidopa-Levodopa was administered at 8:47 a.m. The 9:00 a.m. Carbidopa-Levodopa was administered at 8:48 a.m.

On 10/13/2023 at approximately 7:45 a.m., Surveyor interviewed Regional Nurse A regarding Resident 5's medications not being administered in prescribed intervals and occurrences of 2 doses administered at the same time. Regional Nurse A replied, "That would not be my expectation." Regional Nurse A stated the provider began auditing medications following Surveyor's visit on 10/11/2023 and began caregiver education.

Example 3 - Oxycodone Intervals

On 10/11/2023 at approximately 11:00 a.m., Surveyor reviewed Resident 5's medication administration record (MAR), dated 09/01/2023 to 10/11/2023. Resident 5's physician orders included:

Oxycodone 5 mg (Start Date: 08/31/2023) - Give 1 tablet at 7:00 a.m.
Oxycodone 5 mg (Start Date: 08/31/2023) - Give 1 tablet at 12:00 p.m.
Oxycodone 5 mg (Start Date: 08/31/2023) - Give 1 tablet at 4:00 p.m.
Oxycodone 5 mg (Start Date: 08/31/2023) - Give 1 tablet at 7:00 p.m.

Resident 5's MAR documented the following occurrences when Resident 5's Oxycodone was

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N 352	Continued From page 17 not administered within the prescribed interval: - 09/01/2023 7:00 a.m. Oxycodone was administered at 8:17 a.m. - 09/02/2023 7:00 a.m. Oxycodone was administered at 9:06 a.m. - 09/03/2023 7:00 a.m. Oxycodone was administered at 9:16 a.m. - 09/04/2023 7:00 a.m. Oxycodone was administered at 10:41 a.m. - 09/05/2023 4:00 p.m. Oxycodone was administered at 5:31 p.m. - 09/06/2023 7:00 a.m. Oxycodone was administered at 8:52 a.m. - 09/07/2023 7:00 a.m. Oxycodone was administered at 8:51 a.m. - 09/08/2023 7:00 a.m. Oxycodone was administered at 8:53 a.m. - 09/12/2023 7:00 a.m. Oxycodone was administered at 10:15 a.m. The 4:00 p.m. Oxycodone was administered at 5:53 p.m. The 7:00 p.m. Oxycodone was then administered at 6:15 p.m. - 09/14/2023 7:00 a.m. Oxycodone was administered at 8:34 a.m. - 09/15/2023 7:00 a.m. Oxycodone was administered at 9:16 a.m. - 09/16/2023 7:00 a.m. Oxycodone was administered at 12:02 p.m. The 12:00 p.m. Oxycodone was then administered at 1:02 p.m. - 09/17/2023 7:00 a.m. Oxycodone was administered at 9:08 a.m. - 09/18/2023 7:00 a.m. Oxycodone was administered at 9:44 a.m. - 09/20/2023 7:00 a.m. Oxycodone was administered at 10:55 a.m. The 12:00 p.m. Oxycodone was administered at 2:11 p.m. - 09/21/2023 7:00 a.m. Oxycodone was administered at 8:40 a.m. - 09/22/2023 7:00 a.m. Oxycodone was	N 352		

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administered at 9:47 a.m. The 12:00 p.m. Oxycodone was administered at 1:50 p.m.
- 09/23/2023 7:00 a.m. Oxycodone was administered at 8:40 a.m.
- 09/24/2023 7:00 a.m. Oxycodone was administered at 8:43 a.m.
- 09/25/2023 7:00 a.m. Oxycodone was administered at 10:24 a.m.
- 09/27/2023 7:00 a.m. Oxycodone was administered at 10:15 a.m.
- 09/29/2023 7:00 a.m. Oxycodone was administered at 8:42 a.m.
- 10/01/2023 7:00 a.m. Oxycodone was administered at 9:53 a.m.
- 10/03/2023 7:00 a.m. Oxycodone was administered at 11:02 a.m. The 12:00 p.m. Oxycodone was administered at 1:16 p.m.
- 10/04/2023 7:00 a.m. Oxycodone was administered at 10:38 a.m.
- 10/06/2023 7:00 a.m. 7:00 a.m. Oxycodone was administered at 10:34 a.m.
- 10/07/2023 7:00 a.m. Oxycodone was administered at 8:55 a.m. The 12:00 p.m. Oxycodone was administered at 1:10 p.m.
- 10/08/2023 7:00 a.m. Oxycodone was administered at 9:35 a.m. The 7:00 p.m. Oxycodone was administered on 10/09/2023 at 4:48 a.m.
- 10/09/2023 7:00 a.m. Oxycodone was administered at 10:29 a.m. The 12:00 p.m. Oxycodone was administered at 1:57 p.m.
- 10/10/2023 7:00 a.m. Oxycodone was administered at 9:16 a.m. The 12:00 p.m. Oxycodone was administered at 1:58 p.m. The 4:00 p.m. Oxycodone was administered at 5:59 p.m.
- 10/11/2023 7:00 a.m. Oxycodone was administered at 8:53 a.m.

On 10/13/2023 at approximately 7:45 a.m.,

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N 352	Continued From page 19 Surveyor interviewed Regional Nurse A regarding Resident 5's medications not being administered in prescribed intervals. Regional Nurse A replied, "That would not be my expectation." Regional Nurse A stated the provider began auditing medications following Surveyor's visit on 10/11/2023 and began caregiver education. Cross Reference: N0396 DHS 83.36(1) Adequate Staff To Meet Resident Needs N0415 DHS 83.37(2)(d) Documentation Of Medication Administration	N 352		
{N 396}	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the facility was adequately staffed to meet resident needs. During the overnight of 10/07/2023 to 10/08/2023, the facility was staffed with 1 caregiver. Residents did not receive incontinence cares, personal care assistance requested and/or repositioning due to lack of staff. Resident 5 did not receive his/her medications within the prescribed timeframe due to staffing patterns. This was a repeat deficiency. See Statement of Deficiency (SOD) 2HW014, dated 05/16/2023. Findings include:	{N 396}		

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{N 396}	Continued From page 20 On 10/11/2023, Surveyors conducted a complaint investigation alleging that the facility was staffed with only 1 caregiver during the overnight of 10/07/2023 to 10/08/2023 and that residents did not receive their medications in the prescribed intervals due to staffing patterns. Example 1 - Overnight of 10/07/2023 to 10/08/2023: On 10/11/2023 at approximately 7:40 a.m., Surveyor interviewed Caregiver M. Caregiver M stated staffing was always a struggle at the facility. Caregiver M stated the facility frequently had call-ins resulting in short-staffing or management would schedule employees not fully trained "so there were bodies here, but not really able to do the work." Caregiver M stated s/he worked following a night when Caregiver J was the only caregiver present to care for the entire facility. Caregiver M stated s/he received no report from Caregiver J when s/he came on shift. Caregiver M stated as s/he began completing morning cares for residents and found residents "so incontinent there were puddles." Caregiver M identified 10 residents that required complete bed changes due to their incontinence. On 10/11/2023 at approximately 10:00 a.m., Surveyor reviewed the staffing schedule for 10/07/2023 and 10/08/2023. On 10/08/2023 the night shift schedule shows that Caregiver J worked the first-floor memory care unit and that Caregiver P scheduled to work the third-floor assisted living unit had been called off. On 10/11/2023 at approximately 11:50 a.m., Surveyor interviewed Resident 9. Resident 9 admitted to the provider's facility on 09/12/2023.	{N 396}		

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{N 396}	Continued From page 21 Resident 9 stated there had been 3 to 4 times when s/he called for assistance during the night and no one came within 30 minute or so. Resident 9 stated due to no assistance arriving s/he had soiled him/herself twice and ambulated to the bathroom independently. Resident 9 stated once s/he arrived to the toilet s/he was unable to transfer him/herself off the toilet and had to wait approximately 40 minutes for assistance. Resident 9's individual service plan (ISP), dated 09/12/2023, indicated that s/he required assistance of 1 for transfers and should be encouraged to call for assistance when needed for ambulation to the bathroom. Example 2 - Medication Administration Within Prescribed Interval: On 10/11/2023 at approximately 7:30 a.m., Surveyor interviewed Caregiver B. Caregiver B stated s/he wasn't always able to complete medication administration within prescribed intervals because s/he was often pulled to assist with resident cares and/or s/he would be assigned to train new employees while also trying to complete medication administration. On 10/11/2023 at approximately 7:40 a.m., Surveyor interviewed Caregiver M. Caregiver M stated s/he wasn't always able to complete medication administration within the prescribed intervals because s/he was frequently interrupted to provide cares. On 10/11/2023 at approximately 11:00 a.m., Surveyor reviewed Resident 5's medication administration record (MAR), dated 09/01/2023 to 10/11/2023, and physician orders, which documented the following:	{N 396}		

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{N 396}	Continued From page 22 Carbidopa-Levodopa: Resident 5's physician orders included: Carbidopa-Levodopa 25-100 mg (Start Date: 06/21/2021) - Give 2 tablets by mouth at 6:00 a.m. Carbidopa-Levodopa 25-100 mg (Start Date: 06/21/2021) - Give 2 tablets by mouth at 9:00 a.m. Carbidopa-Levodopa 25-100 mg (Start Date: 06/21/2021) - Give 2 tablets by mouth at 12:00 p.m. Carbidopa-Levodopa 25-100 mg (Start Date: 06/21/2021) - Give 2 tablets by mouth at 3:00 p.m. Carbidopa-Levodopa 50-100 mg (Start Date: 09/08/2021) - Give 2 tablets by mouth at 7:00 p.m. Resident 5's MAR documented 11 occurrences when Caregiver M administered Resident 5's Carbidopa-Levodopa outside the prescribed interval and 36 occurrences when Caregiver B administered Resident 5's Carbidopa-Levodopa outside the prescribed interval. Oxycodone: Resident 5's physician orders included: Oxycodone 5 mg (Start Date: 08/31/2023) - Give 1 tablet at 7:00 a.m. Oxycodone 5 mg (Start Date: 08/31/2023) - Give 1 tablet at 12:00 p.m. Oxycodone 5 mg (Start Date: 08/31/2023) - Give 1 tablet at 4:00 p.m. Oxycodone 5 mg (Start Date: 08/31/2023) - Give 1 tablet at 7:00 p.m.	{N 396}		

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{N 396}	Continued From page 23 Resident 5's MAR documented 20 occurrences when Caregiver M administered Resident 5's Oxycodone outside the prescribed interval and 35 occurrences when Caregiver B administered Resident 5's Oxycodone outside the prescribed interval. On 10/13/2023 at approximately 7:45 a.m., Surveyor interviewed Regional Nurse A regarding Resident 5's medications not being administered in prescribed intervals. Regional Nurse A replied, "That would not be my expectation." Regional Nurse A stated the provider began auditing medications following Surveyor's visit on 10/11/2023 and began caregiver education. RECORD REVIEW: On 10/11/2023, Surveyor reviewed the staffing schedule for 10/07/2023 and 10/08/2023. On 10/08/2023 the night shift schedule shows that Caregiver J worked the first-floor memory care unit and that Caregiver P scheduled to work the third-floor assisted living unit had been called off. On 10/12/2023, Surveyor reviewed a grievance initiated by Resident 9. Resident 9 reported extended wait times for staff assistance on the night shift. The call light report documents that on 10/08/2023 Resident 9 called out at 1:53 AM. The call was answered 43 minutes later. Administrator K documented that in response to Resident 9's concerns. The facility updated their staffing policy on 10/12/2023. Attached to the grievance form was a policy titled, "Adequate Staffing." The policy states that it was revised on 10/12/2023 and states the following, "Current Minimal Staffing levels 10/23...Nocs (night shift) 1 med passer one (sic.) pca (personal care assistant) or 2 pca...Scheduler to have an on-call night person scheduled...".	{N 396}		

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{N 396}	Continued From page 24 On 10/12/2023, Surveyor reviewed a grievance initiated by Family Member Q on behalf of Resident 12. The grievance reports that Resident 12 waited an extended period for assistance the morning of 10/08/2023, and Resident 12 requested PRN (as needed) pain medication that was not administered. Attached to the grievance form was the call light report for the morning of 10/08/2023. On 10/08/2023, Resident 12 pressed his/her call light at 12:08 AM. The call was answered 2 hours and 51 minutes later. On 10/08/2023, Resident 12 pressed his/her call light at 3:08 AM. The call was answered 1 hour and 22 minutes later. Surveyor reviewed an email sent from Family Member Q to Administrator K on 10/09/2023. Family Member Q wrote, "[Resident 12] reported that (s/he) could get no help on the night of Saturday Oct 7. (S/he) often has insomnia and/or needs pain meds ... (s/he) pushed (his/her) alert button repeatedly and no one came. (S/he) says this started around 1:00 am. Thankfully, a second-floor staff member [Caregiver J] happened by around 3:00 am and said (s/he) would try to get someone to help get [him/her] Tylenol and find out who was staffing the 3rd floor. However, no one came after (s/he) left to help (him/her) the rest of the night." INTERVIEWS: On 10/11/2023 at 12:42 PM, Surveyors discussed the 10/07/2023 night shift schedule with Regional Nurse A and Administrator K. Administrator K confirmed Caregiver P had called in for the 10/07/2023 night shift. Administrator K stated Caregiver J worked both the first floor and third floor that shift. Administrator K stated Caregiver J was taking care of a total of 28 patients the evening of 10/07/2023. Regional Nurse A stated	{N 396}		

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s/he was not made aware that Caregiver P had called in until 10:38 PM that evening and decided Caregiver J could cover both units for the night. Regional Nurse A and Administrator K acknowledged multiple residents on the memory care unit are a 2-person transfer. Regional Nurse A and Administrator K acknowledged Resident 9 and Resident 12 filed grievances related to staffing on the night shift between 10/07/2023 and 10/08/2023.

On 10/12/2023 at 1:00 PM, Surveyor discussed the above concerns with Caregiver E. Caregiver E stated that on the night of 10/08/2023 Resident 9 had waited 45 minutes for help to the bathroom. Caregiver E stated Resident 9 fell trying to get himself/herself to the toilet. Caregiver E stated approximately 9 residents on the memory care unit had been found in clothing/linens supersaturated in urine/feces. Caregiver E stated a resident requested PRN pain medication the night of 10/08/2023; and the nurse from the neighboring SNF (skilled nursing facility) refused to administer the resident's medication. Caregiver E stated facility administrator knew Caregiver P had called in for the night and decided to have Caregiver J work both units by himself/herself.

On 10/13/2023 at 8:26 AM, Surveyor discussed the above concerns with Caregiver R. Caregiver R stated facility administrators decided Caregiver J could take care of 28 residents on 2 separate floors by himself/herself the night of 10/08/2023. Caregiver R stated there were multiple residents who require 2 staff for transfers; and some residents were on frequent checks due to not utilizing their call pendants. Caregiver R stated the morning shift following the 10/08/2023 NOC shift found many residents on the memory care unit to be soiled in urine and/or feces. Caregiver

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{N 396}	Continued From page 26 R stated a couple residents complained that they had been on their call pendants for hours. On 10/13/2023 at 9:18 AM, Surveyor discussed the above concerns with Caregiver S. Caregiver S stated s/he observed multiple residents on the memory care unit to be in clothing/linens soiled in urine/feces the morning of 10/08/2023. Caregiver S stated Caregiver J had been forced to work both units alone the night of 10/08/2023 and s/he thinks Caregiver J did the best job they could have done alone. Caregiver S stated s/he does not feel it was safe to staff both units with one staff member because a resident could fall on the first floor while the caregiver was busy working on the 3rd floor. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	{N 396}		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are	N 397		

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self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure at least one qualified resident care staff was present during the overnight of 10/07/2023 to 10/08/2023.

Findings include:

On 10/11/2023, Surveyors conducted a complaint investigation alleging that the facility was staffed with only 1 caregiver during the overnight of 10/07/2023 to 10/08/2023.

DHS Chapter 83 defines "Qualified resident care staff" as an employee who has successfully completed all of the applicable training and orientation under subch. IV.

On 10/11/2023 at approximately 7:40 a.m., Surveyor interviewed Caregiver M. Caregiver M stated s/he worked following a night when Caregiver J was the only caregiver present to care for the entire facility. Caregiver M stated s/he received no report from Caregiver J when s/he came on shift. Caregiver M stated s/he found residents "so incontinent there were puddles" while completing morning cares. Caregiver M identified 10 residents that required complete bed changes due to their incontinence.

On 10/11/2023 at approximately 9:00 a.m., Surveyor reviewed the provider's staff schedule,

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N 397	Continued From page 28 which indicated Caregiver J was the only staff member present during the overnight of 10/07/2023 to 10/08/2023. On 10/11/2023 at approximately 10:00 a.m., Surveyor reviewed Caregiver J's record. Caregiver J's record, hired 06/27/2023, had not received training in Fire Safety and First Aid and Choking. On 10/11/2023 at approximately 12:00 p.m., Assistant DON L confirmed Caregiver J had not received training or met an exemption for Fire Safety and First Aid and Choking. On 10/11/2023 at approximately 1:00 p.m., Regional Nurse A confirmed the provider had a call-in on 10/07/2023 for the overnight shift and the decision was made that Caregiver J would work the overnight shift by him/herself. Cross Reference: N0239 DHS 83.20(2)(a-d) Department Approved Training	N 397		
N 401	83.37(1)(b) Medication label permanently attached. Medications. Prescription medications shall come from a licensed pharmacy or a physician and shall have a label permanently attached to the outside of the container. Over-the-counter medications maintained in the manufacturer ' s container shall be labeled with the resident ' s name. Over-the-counter medications not maintained in the manufacturer ' s container shall be labeled by a pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 401		

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N 401	Continued From page 29 did not ensure Ipratropium-Albuterol Solution.5-2.5 mg/3ml was labeled. Findings include: On 10/11/2023 at approximately 10:40 a.m., Surveyor and Caregiver B reviewed the medication cart, located on the memory care unit. Surveyor observed a pack of Ipratropium-Albuterol Solution.5-2.5 mg/3ml packets for a nebulizer. The medication did not have a label on it to indicate who the medication was intended for. Surveyor asked Caregiver B if s/he knew who the medication was prescribed for. Caregiver B stated s/he believed the medication was for Resident 5 because s/he had orders for Ipratropium-Albuterol Solution.5-2.5 mg/3ml as needed, but s/he was unable to confirm this due to lack of label.	N 401		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by:	N 415		

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Based on observation, record review and interview, the provider did not ensure the medication administration of 1 of 3 residents reviewed was accurately documented. Resident 5's medication administration record (MAR), documented medications that were not available to him/her as administered.

This was a repeat deficiency. See Statement of Deficiency (SOD) D0TF11, dated 06/20/2023.

Findings include:

On 10/11/2023 at approximately 10:40 a.m., Surveyor and Caregiver B reviewed Resident 5's physician orders, medication administration record (MAR) for October 2023 and medications available in the medication cart. The following concerns were identified:

- Polyethyl Glycol Eye Drops (Start Date: 06/21/2023) - Instill 1 drop in both eyes 2 times daily: This medication was not in the medication cart. The MAR documented this medication had not been administered on 10/07/2023 AM, 10/08/2023 AM, 10/08/2023 PM and 10/09/2023 AM. All other dates documented the medication as administered. Caregiver M stated this medication had been unavailable since the medication cart was audited on 10/05/2023, so documentation of administration since that date was an error. Caregiver B confirmed his/her documentation of the eye drops being administered on 10/11/2023 AM was an error.
- Docusate Sodium (Start Date: 06/21/2021) - Give 1 capsule 2 times daily for constipation. This medication was not in the medication cart. The MAR documented this medication had not been administered on 10/09/2023 PM and 10/11/2023 AM. All other dates documented the medication

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N 415	Continued From page 31 as administered. Caregiver B stated this medication had been unavailable for approximately 2 weeks, so documentation of administration the past 2 weeks, including his/her own documentation for 10/10/2023 AM was an error. On 10/11/2023 at approximately 1:00 p.m., Surveyor reviewed concerns regarding the documentation of medication administration with Regional Nurse A, Administrator K and Assistant DON L. DON L nodded his/her head in acknowledgment of the concern. Regional Nurse A made note of Surveyor's concern. Cross Reference: N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	N 415		
{N 432}	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the	{N 432}		

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provider did not ensure 1 of 3 residents were provided medication administration appropriate to their needs. Resident 5 had 8 as needed medications unavailable to him/her.

This is a repeat deficiency. See Statement of Deficiency (SOD) 2HW013, dated 11/22/2022 and 2HW014, dated 05/16/2023.

Findings include:

On 10/11/2023 at approximately 7:30 a.m., Surveyor interviewed Caregiver B, who was responsible for passing medications that day. Caregiver B stated there were times s/he was unable to administer medications because they were unavailable.

On 10/11/2023 at approximately 7:40 a.m., Surveyor interviewed Caregiver M, who was responsible for passing medications at times. Caregiver M stated medications took forever to arrive from pharmacy, so there were times residents did not receive their prescribed medications because they were unavailable.

On 10/11/2023 at approximately 10:40 a.m., Surveyor and Caregiver B reviewed Resident 5's physician orders, medication administration record (MAR) for October 2023 and medications available in the medication cart. The following as needed medications were unavailable for administration:

- Diabetic Tussin EX (Start Date: 06/21/2021) - Give 10 ml every 4 hours as needed for cough.
- Hydrocortisone Cream 1% (Start Date: 06/21/2021) - Apply to affected area every 24 hours as needed for itching. *Caregiver B stated this medication may have been pulled during the

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{N 432}	Continued From page 33 10/07/2023 medication cart audit because the medication was expired. - Ibuprofen 600 mg (Start Date: 12/09/2022) - Give 1 tablet every 6 hours as needed for pain. - Milk of Magnesia (Start Date: 06/21/2021) - Give 30 ml every 24 hours as needed for constipation. - Nitroglycerin .4 mg (Start Date: 06/21/2021) - Give 1 tablet as needed for chest pain. - Nystatin Powder (Start Date: 11/10/2022) - Apply to groin rash topically every 8 hours as needed. - Ondansetron Hcl 4 mg (Start Date: 06/21/2021) - Give 1 tablet every 8 hours as needed for nausea. - Polyvinyl Alcohol Solution 1.4% (Start Date: 09/08/2021) - Give 1 drop in both eyes every 4 hours as needed for dry eyes. On 10/11/2023 at approximately 1:00 p.m., Surveyor reviewed medications that were unavailable to Resident 5 for administration with Regional Nurse A, Administrator K and Assistant DON L. Administrator K stated s/he was used to having these medications in "contingency" with the affiliated skilled nursing facility.	{N 432}		