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 _____	C 09/01/2023

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 On 08/31/2023, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation at Oak Park Place Nakoma, a CBRF located in Madison, WI. As a result of the investigation, 2 violations of Chapter DHS 83 were issued. Complaint was substantiated Census: 29	N 000		
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 to involve the resident and the resident 's legal representative, as	N 387		

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

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 _____	C 09/01/2023

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 387	Continued From page 1	N 387		

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.

On 08/31/2023, Surveyor reviewed 2/4 individualized service plans (ISPs) that were not signed by the resident or the resident's legal representative.

FINDINGS INCLUDE:

EXAMPLE 1:

On 08/31/2023, Surveyor reviewed Resident 1's facesheet. Resident 1 was admitted to the facility on 06/21/2021 and had an activated power of attorney.

On 08/31/2023. Surveyor reviewed Resident 1's individualized service plan (ISP) dated 03/23/2023. The ISP was not signed by Resident 1 or Resident 1's legal representative.

EXAMPLE 2:

On 08/31/2023, Surveyor reviewed Resident 2's facesheet. Resident 2 was admitted to the facility on 02/24/2023 and had an activated power of attorney.

On 08/31/2023. Surveyor reviewed Resident 2's individualized service plan (ISP) dated 08/23/2023. The ISP was not signed by Resident 2 or Resident 2's legal representative.

INTERVIEW:

On 08/31/2023 at 2:30 PM, Surveyor discussed

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 _____	C 09/01/2023

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 387	Continued From page 2 the above concern with Administrator A. Administrator A acknowledged that Resident 1 and Resident 2's ISP's were not signed by the resident themselves or their legal representative per requirement.	N 387		
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 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 observation, record review and interview, the provider did not ensure that at least one qualified resident care staff was present in the community based residential facility (CBRF) when one or more residents are present in the	N 397		

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 _____	C 09/01/2023

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 397	Continued From page 3	N 397		

CBRF.

On 08/13/2023, the memory care unit did not have a qualified resident care staff present from 6:00AM to 9:00AM. At the time the memory care unit had a census of 12.

FINDINGS INCLUDE:

This facility provides care to the following client groups: terminally ill, advanced aged, irreversible dementia and Alzheimer's.

On 07/24/2023, the Department received a complaint concerning adequate staffing at facility.

On 08/31/2023, Surveyor arrived at facility for a complaint investigation.

OBSERVATIONS:

08/31/2023, Surveyor toured and observed the layout of the facility. The CBRF is split between 2 floors of the building. The first floor is a locked memory care unit, and the third floor is an assisted living unit. Staff must take the stairs or an elevator to move between the units.

RECORD REVIEWS:

On 08/31/2023, Surveyor reviewed the resident roster for the memory care unit. The memory care unit had 12 residents listed as being admitted to the facility before 08/13/2023.

On 08/31/2023, Surveyor reviewed the August 2023 staff schedule. On 08/13/2023, the AM schedule listed: Caregiver B, Caregiver C and Caregiver E to work the third-floor assisted living unit, and Caregiver F, Caregiver G and Caregiver

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 _____	C 09/01/2023

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 397	Continued From page 4	N 397		

D were to work the memory care unit. On this shift, Caregiver F's name was crossed out with the words, "NO SHOW," next to it and Caregiver G's name crossed out with the words, "Called In," next to it. Next to Caregiver D's name is "9:53 AM."

On 08/31/2023, Surveyor reviewed Caregiver E's timecard for 08/13/2023. On 08/13/2023, Caregiver E clocked in at 10:48 AM and clocked out at 2:30 PM.

On 08/31/2023, Surveyor reviewed an email sent from Family Member H to Former Administrator I on 08/17/2023. Family Member H wrote the following, "Dear [Former Administrator I], I hope you're well. On Sunday morning, the memory care unit at the [Facility Name] was without staffing until a 3rd floor staff member came down after 9am. I assume you are aware of this...Regardless of a call, I would like a response in writing to share with family who witnessed this and are concerned. On 08/22/2023, Former Administrator I responded to Family Member H's email with the following, "Thank you for your email, and apologies for my getting back to you now. I sincerely did not see your email prior to today, and I apologize for that. This was a unique situation, and we apologize for it. A staff member who was scheduled was not able to contact the building, and therefore we did not know [s/he] was not reporting to work. Going forward, we will have a manager contact the building to validate that all staff are on each floor as scheduled. We have also educated staff that no floor can be unstaffed and to contact me if there is a problem with coverage. We did get, coverage for the floor promptly when we discovered the situation, and we validated that all medications were given, breakfast was served, and everyone was given

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 _____	C 09/01/2023

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 397	Continued From page 5	N 397		

care. We have not had this occur before, and the steps we are taking should prevent it from happening again...".

On 08/31/2023, Surveyor reviewed a grievance from filled out by Former Administrator I. The grievance from is date 08/22/2023 and is describing an incident which occurred on 08/13/2023. Former Administrator I documented the following, "memory care floor with no staff on Sunday, August 13 from AM shift change...Date and Time Incident Occurred: 08/13/2023 at or about 6:00 am..."

INTERVIEWS:

On 08/31/2023 at 9:12 AM, Surveyor interviewed Resident 4. Resident 4 told Surveyor the staff on duty were very nice but there just wasn't enough of them. Resident 4 told Surveyor that a few weeks ago the unit downstairs didn't have any staff all morning.

On 08/31/2023 at 9:30 AM, Surveyor interviewed Caregiver B. Caregiver B stated that 3 weekends ago. Caregiver B and Caregiver C were working the 3rd floor assisted living unit. Caregiver B stated that around 9:00 AM s/he was called to work the memory care unit. Caregiver B stated that when s/he arrived at the memory care unit s/he found the residents had not been provided morning cares or given their medications. Caregiver B stated that s/he worked on serving breakfast and cleaning up residents immediately. Caregiver B stated Caregiver D was called in from home and arrived at the unit at about 10:00 AM to pass medications. Caregiver B confirmed the NOC shift staff left and that the memory care AM staff who were scheduled to start at 6:00 AM called in. Caregiver B reported the memory care

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 _____	C 09/01/2023

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 397	Continued From page 6 unit went without a resident care staff from 6:00 AM to 9:00 AM. On 08/31/2023 at 9:45 AM, Surveyor interviewed Caregiver C. Caregiver C acknowledged that s/he was working with Caregiver B a few weekends back. Caregiver C stated s/he remembers a morning where the staff for the memory care unit did not come into work. Caregiver C confirmed that around 9:00 AM on this day Caregiver B was pulled to the memory care unit to find it had not been staffed since 6:00 AM. Caregiver C stated that low staffing is a chronic concern at facility. On 08/31/2023 at 2:30 AM, Surveyor discussed the above concerns with Administrator A. Administrator A acknowledged that on 08/13/2023 from 6:00AM to 9:00AM the memory care unit did not have a qualified resident care staff present. Administrator A acknowledged the memory care unit is a locked unit with at least 12 residents at the time of the incident.	N 397		