STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110198	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD VILLAGE TABOR OAKS	6175 MINERAL POINT RD MADISON, WI 53705

(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 06/27/2023, Surveyor conducted a complaint investigation at Oakwood Village Tabor Oaks. Complaint was substantiated. 2 deficiencies were identified. Census 58	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 Resident 1 received all prescribed medications in the right dosage and at intervals prescribed by a practitioner. Resident 1 received the incorrect dose of their blood pressure medication for 66 days before the error was caught by pharmacy staff. Findings include: On 06/27/2023 at approximately 9:40 AM, Surveyor interviewed Resident 1 who alleged s/he was being administered a double dose of blood pressure medications and as a result was felt dizzy and light headed. Resident 1 stated the pharmacy caught the medication error and explained to him/her that it would take a little	N 352		

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

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N 352	Continued From page 1	N 352		

while for the higher levels of the medication to work its way out of their system. Additionally, Resident 1 was not receiving prescribed pain medications until about a month ago. Resident 1 stated that when s/he does not get pain medication per orders, they start having pain and have to take a PRN medication that makes him/her drowsy.

On 06/27/2023 at approximately 10:30 AM, Surveyor reviewed Resident 1's facility file and reviewed a medication error report dated 05/25/2023. The report documented that from 03/25/2023 until 05/25/2023, Resident 1 received 50 MG of metoprolol (blood pressure medication) in the PM instead of the prescribed 25 mg of metoprolol. The report also indicated Resident 1 was given 100 mg of metoprolol instead of the prescribed 50 mg in the AM. Resident 1 was given double the prescribed dosage of metoprolol for 66 days.

On 06/27/2023 at approximately 10:40 AM, Surveyor reviewed the facility's grievance forms. A grievance form dated 06/12/2023, stated there was a medication error made on 05/31/2023, in which Resident 1 did not receive their scheduled pain medication, oxycotin.

On 06/27/2023 at approximately 12:06 PM, Surveyor interviewed Administrator A who confirmed the facility needs to put a better medication system in place for auditing medications being transcribed to the medication administration records. Administrator A admitted a facility issue but explained that there is a performance improvement plan in place to correct concerns. Administrator A stated caregivers should be doing the 5 rights of medication administration and working with the RN for

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N 352	Continued From page 2 oversight.	N 352		
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: Based on record review and interview the provider did not ensure required documentation of medication administration for Resident 1 was completed. Findings include: On 06/29/2023 at approximately 10:30 AM, Surveyor reviewed Resident 1's MAR and noted the following: Resident 1's MAR dated 03/01/2023 to 03/31/2023, was missing documentation for levothyroxine, melatonin, metoprolol, mirtazapine, nortriptyline, lidocaine patch, acetaminophen, and oxytocin. There were 35 times that the medications were not signed off as administered but were administered.	N 415		

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N 415	Continued From page 3 Resident 1's MAR dated 04/01/2023 to 04/30/2023, was missing documentation for levothyroxine, melatonin, metoprolol, mirtazapine, nortriptyline, lidocaine patch, acetaminophen, and oxytocin. There were 38 times that the medications were not signed off as administered but were administered. Resident 1's MAR dated 05/01/2023 to 05/31/2023, was missing documentation for levothyroxine, melatonin, metoprolol, mirtazapine, nortriptyline, lidocaine patch, acetaminophen, and oxytocin. There were 48 times that the medications were not signed off as administered but were administered. Resident 1's MAR dated 06/01/2023 to 06/30/2023, was missing documentation for levothyroxine, melatonin, metoprolol, mirtazapine, nortriptyline, lidocaine patch, acetaminophen, and oxytocin. There were 40 times that the medications were not signed off as administered but were administered. On 06/27/2023 at approximately 11:00 AM, Surveyor audited the medication cart and concluded the medications for Resident 1 matched what should have been left for the month of June 2023 with no remaining meds in the bubble packs indicative of medication administration without required documentation. On 06/27/2023 at approximately 12:06 PM, Surveyor interviewed Administrator A who stated after internally auditing the medication cart it became apparent that the facility needs to put a better system in place to audit medications and records. Administrator A admitted that there is an issue but they are place working on a plan to	N 415		

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N 415	Continued From page 4 correct the concerns.	N 415		