STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011449	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE AUTUMN LANE	702 JUPITER DRIVE MADISON, WI 53718

(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 01/16/2025, Surveyors conducted a standard survey at Oak Park Place Autumn Lane, a CBRF in Madison. Two deficiencies were identified. One deficiency is a repeat deficiency - See Statement of Deficiency (SOD) N4VE11, dated 05/15/2020. Census: 31	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 observation, record review and interview, the provider did not ensure 1 of 3 residents reviewed received their medications as prescribed. Resident 1 did not receive his/her Dorzolamide Hcl-Timolol and Brimonidine Tartrate eye drops as prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) N4VE11, dated 05/15/2020. Findings include: On 01/16/2025 at approximately 10:50 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 01/26/2023. Resident 1's physician orders included the following:	N 352		

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

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N 352	Continued From page 1 - Dorzolamide Hcl-Timolol Ophthalmic Solution (Start Date: 01/25/2023) - Instill 1 drop in both eyes 2 times daily for eye health. - Brimonidine Tartrate Ophthalmic Solution .2% (Start Date: 01/25/2023 / DC Date: 12/13/2024) - Instill 1 drop in both eyes 3 times daily. Resident 1's Medication Administration Record (MAR), dated 08/01/2024 to 01/16/2025, included the following concerns: Example 1 - Brimonidine Tartrate: On 01/16/2025 at approximately 10:50 a.m., Surveyor reviewed Resident 1's MAR, dated 08/17/2024 to 12/13/2024, which documented 223 missed administrations of Brimonidine Tartrate eye drops. Follow up progress notes documented the medication was unavailable during missed administrations. On 01/17/2025 at approximately 11:15 a.m., Surveyor interviewed Nurse A. Nurse A explained s/he noticed the eye drops were not available when s/he began auditing charts (date of audit not mentioned) and was working to get the eye drops discontinued. Nurse A then provided documentation indicating the facility had reached out to family in hopes of discontinuing the eye drops on 09/13/2024 and had reached out to the eye doctor requesting a discontinuation order on 12/11/2024. Nurse A provided a discontinuation order for the Brimonidine Tartrate Ophthalmic Solution, dated 12/13/2024. Example 2 - Dorzolamide Hcl-Timolol: On 01/17/2025 at approximately 12:00 p.m., Surveyor interviewed Pharmacy D, an individual	N 352		

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N 352	Continued From page 2 with the provider's pharmacy. Pharmacy D confirmed the pharmacy provided Resident 1's medications. Pharmacy D stated the pharmacy had last filled Resident 1's Dorzolamide Hcl-Timolol on 10/28/2024, which was a 50-day supply. Pharmacy D stated the pharmacy had no record of a refill being requested from the provider. On 01/17/2025 at approximately 12:10 p.m., Surveyor reviewed Resident 1's MAR, dated 10/29/2024 to 01/16/2025, which documented 8 missed administrations of Dorzolamide Hcl-Timolol eye drops (Dates included: 12/18/2024, 12/20/2024, 12/22/2024, 12/30/2024, 01/05/2025, 01/09/2025, 01/10/2025, 01/15/2025). Follow up progress notes documented the medication was unavailable during missed administrations. On 01/17/2024 at approximately 12:15 p.m., Surveyor reviewed the provider's medication cart with Caregiver B. Caregiver B confirmed the provider did not have Dorzolamide Hcl-Timolol available to Resident 1. On 01/17/2025 at approximately 12:30 p.m., Surveyor discussed concern with Nurse A and Executive Director C that Resident 1 had missed 9 administrations of Dorzolamide Hcl-Timolol eye drops. Nurse A acknowledged Surveyor's observation and stated s/he would follow up with pharmacy. Cross Reference: N0415 83.37(2)(d) Documentation of Medication Administration	N 352		
N 415	83.37(2)(d) Documentation of medication administration.	N 415		

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N 415	Continued From page 3 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 1 of 3 residents reviewed had accurate documentation of his/her medication administration. Resident 1's medication administration record (MAR) documented administration of his/her Dorzolamide Hcl-Timolol and Brimonidine Tartrate eye drops when the medications weren't available for administration. Findings include: On 01/16/2025 at approximately 10:50 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 01/26/2023. Resident 1's physician orders included the following: - Brimonidine Tartrate Ophthalmic Solution .2% (Start Date: 01/25/2023 / DC Date: 12/13/2024) - Instill 1 drop in both eyes 3 times daily. - Dorzolamide Hcl-Timolol Ophthalmic Solution (Start Date: 01/25/2023) - Instill 1 drop in both	N 415		

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N 415	Continued From page 4	N 415		

eyes 2 times daily for eye health.

Surveyor's review of Resident 1's MAR, observations and interviews identified the following concerns:

Example 1 - Brimonidine Tartrate:

On 01/16/2025 at approximately 10:50 a.m., Surveyor reviewed Resident 1's MAR. Resident 1's MAR, dated 08/17/2024 to 12/17/2024, documented 223 missed administrations and 116 administrations of Brimonidine Tartrate Ophthalmic Solution. Follow up progress notes documented the medication was unavailable during missed administrations.

On 01/16/2025 at approximately 11:15 a.m., Surveyor interviewed Nurse A. Surveyor shared observation that Resident 1's MAR documented his/her Brimonidine Tartrate Ophthalmic Solution as unavailable during 1 medication pass, available the next and then back to unavailable frequently throughout the MARs. Nurse A acknowledged Surveyor's observation and stated, "Yeah, I've been trying to get [caregivers] to stop documenting [eye drops] as administered." Nurse A explained s/he noticed the eye drops were not available when s/he began auditing charts (date of audit not mentioned) and was working to get the eye drops discontinued. Nurse A then provided documentation indicating the facility had reached out to family in hopes of discontinuing the eye drops on 09/13/2024 and had reached out to the eye doctor requesting a discontinuation order on 12/11/2024. Nurse A provided Surveyor with a discontinuation order for the Brimonidine Tartrate eye drops, dated 12/13/2024.

On 01/16/2025 at approximately 12:00 p.m.,

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N 415	Continued From page 5 Surveyor interviewed Pharmacy D, an individual with the provider's pharmacy. Pharmacy D confirmed the pharmacy provided Resident 1's medications and stated Resident 1's most recent delivery of Brimonidine Tartrate eye drops was a 17-day supply on 02/16/2024, which would have been depleted by 03/05/2024 if administered as prescribed, indicating the eye drops were not available from 08/17/2024 to 12/17/2024, when caregivers documented the medication as administered 116 times. Example 2 - Dorzolamide Hcl-Timolol: On 01/16/2025 at approximately 12:00 p.m., Surveyor interviewed Pharmacy D. Pharmacy D confirmed the pharmacy provided Resident 1's medications. Pharmacy D stated the pharmacy had last filled Resident 1's Dorzolamide Hcl-Timolol on 10/28/2024, which was a 50-day supply. Pharmacy D stated the pharmacy had no record of a refill being requested from the provider. On 01/16/2025 at approximately 12:10 p.m., Surveyor reviewed Resident 1's MAR, dated 10/28/2024 to 01/16/2025. The MAR documented Resident 1's Dorzolamide Hcl-Timolol was unavailable for administration on 10/29/2024 in the AM, but available for administration 10/29/2024 PM. From 10/29/2024 PM to 12/19/2024, the MAR documented 50 doses administered, which would have depleted the 10/28/2024 refill provided by pharmacy. The MAR continued to document the medication as administered 44 times from 12/19/2024 to 01/17/2025 when the medication would not have been available. From 12/19/2024 to 01/17/2025, 7 missed doses were documented with follow up progress notes indicated the medication was	N 415		

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N 415	Continued From page 6 unavailable. On 01/16/2025 at approximately 12:15 p.m., Surveyor reviewed the provider's medication cart with Caregiver B. Caregiver B confirmed the provider did not have Dorzolamide Hcl-Timolol available to Resident 1. On 01/16/2025 at approximately 12:30 p.m., Surveyor discussed concern with Nurse A and Executive Director C that based on documentation, observation of the medication cart and interview with the pharmacy, Resident 1's eye drops had been documented as administered when they were not available for administration. Nurse A and Executive Director C agreed with Surveyor's observation and stated they would follow up. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications	N 415		