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 _____	R 06/18/2025

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 From 06/17/2025 to 06/18/2025, Surveyor conducted a verification visit at Oak Park Place Autumn Lane, a CBRF in Madison. One deficiency was identified. This is a repeat deficiency - See Statement of Deficiency (SOD) N4VE11, dated 05/15/2020 and IOO411, dated 01/16/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 29	{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 2 of 3 residents reviewed received their medications as prescribed. Resident 2 did not receive his/her Novolog 100 unit/ml as prescribed. Resident 3 did not receive his/her Vyzulta solution as prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) N4VE11, dated 05/15/2020 and IOO411, dated 01/16/2025. Findings include:	{N 352}		

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

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{N 352}	Continued From page 1 On 06/17/2025 at approximately 8:30 a.m., Surveyor reviewed resident records, provided by Nurse A, and identified the following concerns: Example 1 - Resident 2: Resident 2 was admitted to the provider's facility on 07/24/2023 with diagnoses including diabetes. Resident 2's physician orders included Novolog 100 unit/ml - Inject 3 times daily per sliding scale: If blood sugar (BS) 250-300 = 1; 301-350 = 2; if lower than 70 or greater than 350, call provider (Start Date: 11/14/2024). Resident 2's medication administration record (MAR), dated 05/17/2024 to 06/17/2025, identified the following dates when his/her BS was greater than 350, Novolog was held and the physician was not contacted: - 05/23/2025 1700 BS = 397 - 06/03/2025 1200 BS = 352 - 06/06/2025 1700 BS = 367 - 06/10/2025 1200 BS = 366 On 06/17/2025 at approximately 10:00 a.m., Surveyor reviewed concern with Nurse A and Executive Director C that Resident 2 had blood sugars greater than 350, but his/her record did not indicate the physician was notified to determine additional steps. Nurse A stated the facility would have contacted Resident 2's hospice agency for guidance. Nurse A stated s/he would reach out to Resident 2's hospice agency for documentation. On 06/17/2025 at approximately 5:00 p.m., Surveyor received hospice documentation from Nurse A. The documentation did not indicate the agency was contacted regarding the 05/23/2025, 06/03/2025, 06/06/2025 or 06/10/2025 BS that were greater than 350.	{N 352}		

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{N 352}	Continued From page 2 On 06/18/2025 at approximately 2:15 p.m., Surveyor interviewed Nurse A. Nurse A confirmed s/he was unable to provide confirmation that Resident 2's physician was informed of BS greater than 350. Nurse A stated at times when Resident 2's BS was greater than 350, hospice would instruct the provider to administer additional insulin units and/or push fluids, but s/he was unsure what occurred for the 05/23/2025, 06/03/2025, 06/06/2025 or 06/10/2025 dates. Example 2 - Resident 3: Resident 3 was admitted to the provider's facility on 02/18/2022. Resident 3's physician orders included an order for Vyzulta solution - Instill 1 drop in both eyes 1 time daily (Start Date: 02/19/2022). Resident 3's MAR, dated 05/17/2025 to 06/17/2025 indicated "Other/See Progress Note" for the Vyzulta solution on 05/22/2025, 05/24/2025, 05/25/2025 and 05/26/2025. Progress notes stated, "N/A." On 06/17/2025 at approximately 9:00 a.m., Surveyor observed the Vyzulta solution was in the provider's medication cart and labeled as opened 05/15/2025. On 06/17/2025 at approximately 9:10 a.m., Surveyor shared concern with Nurse A that Resident 3 did not receive his/her Vyzulta solution on 4 dates reviewed by Surveyor. Nurse A stated the medication was available; however, the caregiver that was passing medications on the dates the medication was not administered was unable to locate the medication due to having dyslexia. Nurse A stated s/he was working with the caregiver regarding the issue. On 06/17/2025 at 9:25 a.m., Surveyor interviewed	{N 352}		

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{N 352}	Continued From page 3 Pharmacy E, who stated Resident 3's Vyzulta solution bottle was a 25-day supply. Surveyor reviewed Resident 3's MAR, indicating the Vyzulta bottle should have been depleted on approximately 06/13/2025 with the missed doses accounted for on 05/22/2025, 05/24/2025, 05/25/2025 and 05/26/2025 (and 05/16/2025 - Date prior to Surveyor's "look back" period). On 06/17/2025 at approximately 10:00 a.m., Surveyor reviewed concern that Resident 3 did not receive his/her Vyzulta solution as prescribed based on documentation and the amount remaining from the 25-day supply. Nurse A made note of Surveyor's concern.	{N 352}		