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 12/20/2023

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 12/20/2023, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation at Oakwood Village Tabor Oaks, a CBRF located in Madison, WI. As a result of the investigation, 1 violation of Chapter DHS 83 was issued. Complaint was substantiated Census: 57	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 each resident received all their prescribed medications in the dosage and at intervals prescribed by a practitioner. From 11/02/2023 to 11/23/2023, Resident 1 missed 21 capsules prescribed by their practitioner. FINDINGS INCLUDE: On 12/05/2023, the Department received a complaint related medication administration practices at facility.	N 352		

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
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N 352	Continued From page 1 On 12/20/2023, Surveyor arrived at facility for a complaint investigation. On 12/20/2023, Surveyor reviewed Resident 1's facility record. On 12/20/2023, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 09/21/2022. On 12/20/2023, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 10/21/2022. Resident 1's ISP stated staff were to administer Resident 1's medications. On 12/20/2023, Surveyor reviewed the facility medication error report dated 11/24/2023. The medication error report stated that Resident 1 was prescribed 20 mg Nortriptyline once daily at bedtime and the Nortriptyline was to be administered in (2) 10mg capsules. Under the subsection, "NARRATIVE DESCRIPTION OF ERROR," the following is documented, "Pharmacy packaged just (1) 10mg capsule in each blister on card dated 10/20/2023." The medication error report stated that from 11/02/2023 to 11/23/2023 Resident 1 missed 21 complete dosages of Nortriptyline due to only (1) of 2 capsules being packaged in the blister pack. On 12/20/2023 at 11:00 AM, Surveyor discussed the above concern with Administrator A and Manager B. Administrator A and Manager B acknowledged that Resident 1 missed (21) 10mg capsules of his/her prescribed dosage of Nortriptyline from 11/02/2023 and 11/23/2023, and med passers were not acknowledging Resident 1's right to the correct dosage of medication during their medication passes. Administrator A and Manager B stated facility had	N 352		

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N 352	Continued From page 2 its own pharmacy which has completed its own investigation into how the incorrect dosage was dispensed into the blister pack. On 12/20/2023 at 11:30 AM, Surveyor discussed the above concern with Director of Pharmacy C. Director of Pharmacy C acknowledged the incorrect dosage was dispensed into Resident 1's blister pack of Nortriptyline dated 10/20/2023.	N 352		