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 02/20/2025

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 02/20/2025, Surveyor conducted a complaint investigation at Oak Park Place of Nakoma. Five (5) deficieincies were identified. The complaint was substantiated. Census: 23	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate Resident 1's injury on 12/28/2025 that was not observed by any person. Findings include: On 02/20/2025, at approximately 8:45 a.m., Surveyor conducted a complaint investigation. Surveyor requested to review the closed record of Resident 1 including progress notes, incident reports, and any assessments that were completed for Resident 1 from December 2024 to January 2025. Resident 1 was admitted to the provider on 10/10/2023 with diagnoses including osteoarthritis, hypertension, and paroxysmal atrial fibrillation. Resident 1's ISP, dated	N 161		

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 02/20/2025

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 161	Continued From page 1	N 161		

05/10/2024, documents that Resident 1 is on hospice services for further decline in functional status, pain, high fall risk due to impaired mobility and transferred with a sit to stand.

Surveyor reviewed hospice notes that documented,
12/28/2025, "unwitnessed fall. co (complain of) cervical neck pain. doesn't[sic] want to move neck. good cms to hands dual hand grasps"
12/29/2025, "Check in with facility [caregiver] who reports that patient was sent to ED (emergency department) this AM due to 'extreme' pain. Unclear location of characteristics of pain. Patient was calling out during turns and cares when getting [him/her] up in the AM. Patient had fall yesterday with new cervical neck pain noted..."

At 11:06 a.m., Surveyor noted s/he did not receive any progress notes or incident reports for Resident 1 and requested any documentation regarding the provider's investigation into Resident 1's injury on 12/28/2025 or 12/29/2025 that was not observed by any person. HR Manager B stated that there was no documentation in Resident 1's record of any progress notes or incident reports from December 2024 to January 2025.

At approximately 11:30 a.m., Surveyor shared the above concerns with HR Manager B and Regional Nurse A. Regional Nurse A stated s/he understood the concern and did not have any questions.

On 02/25/2025 at 6:12 p.m., Surveyor interviewed Power of Attorney D. Power of Attorney D stated s/he was made aware that Resident 1 fell or slipped from his/her recliner on 12/28/2025. The provider noted that the fall was unwitnessed so

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 02/20/2025

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 161	Continued From page 2 time Resident 1 fell or how long s/he was on the ground was unknown. At some time in the morning, a caregiver discovered Resident 1 on the floor and then Resident 1 was put back into his/her recliner. That afternoon, hospice came to evaluate Resident 1, at that time, s/he was in the recliner and couldn't move his/her neck.	N 161		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify Resident 1's legal representative when s/he experienced a change in his/her physical condition on 12/29/2025. Findings include: On 02/20/2025, at approximately 8:45 a.m., Surveyor conducted a complaint investigation. Surveyor requested to review the closed record of Resident 1 including progress notes and any assessments that were completed for Resident 1 from December 2024 to January 2025.	N 169		

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 02/20/2025

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 169	Continued From page 3	N 169		

Resident 1 was admitted to the provider on 10/10/2023 with diagnoses including osteoarthritis, hypertension, and paroxysmal atrial fibrillation.

Surveyor reviewed hospice notes that documented,
12/28/2025, "unwitnessed fall. co (complain of) cervical neck pain. doesn't[sic] want to move neck. good cms to hands dual hand grasps"
12/29/2025, "Check in with facility [caregiver] who reports that patient was sent to ED (emergency department) this AM due to 'extreme' pain. Unclear location of characteristics of pain. Patient was calling out during turns and cares when getting [him/her] up in the AM. Patient had fall yesterday with new cervical neck pain noted. Patient was given morphine X1 dose yesterday with good effect. Pain noted this AM, no meds given. Neither [hospice] nor AHCPOA (activated health care power of attorney) were notified of decision to go to ED. Patient seen in [hospital] ED and imaging preformed - CT of head, neck, and pelvis obtained with no evidence of injury. Patient discharged with no new orders."

At 11:06 a.m., Surveyor noted s/he did not receive any progress notes for Resident 1 and requested any documentation regarding the provider notifying Resident 1's health care power of attorney of his/her change in condition on 12/29/2025 when the provider sent Resident 1 to the emergency room. HR Manager B stated that there was no documentation in Resident 1's record of any progress notes or incident reports from December 2024 to January 2025.

At approximately 11:30 a.m., Surveyor shared the above concerns with HR Manager B and Regional Nurse A. Regional Nurse A stated s/he

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 02/20/2025

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 169	Continued From page 4 understood the concern and did not have any questions. On 02/25/2025 at 6:12 p.m., Surveyor interviewed Power of Attorney D. Power of Attorney D stated that s/he was made aware of a fall on 12/28/2025 and that a hospice nurse had come that day after Resident 1 had fallen and checked over Resident 1. The hospice nurse consulted with the hospice medical doctor and thought it would be more stressful on Resident 1 to send him/her to the hospital and noted there was no medical need for Resident 1 to be sent out. Hospice and Power of Attorney D agreed that Resident 1 did not need to be sent to the hospital after the incident on 12/28/2025 and Resident 1 responded well to prn pain medication for the neck pain. Power of Attorney D stated that s/he found out that the provider had sent Resident 1 to the hospital on 12/29/2025 via a local first responder and s/he was surprised because that is not what was decided upon for Resident 1's treatment and s/he was not notified of the change.	N 169		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health,	N 383		

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 02/20/2025

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 383	Continued From page 5 including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess Resident 1 after s/he was found on the ground and did not assess Resident 1's pain and/or change in condition before sending him/her to the hospital. Findings include: On 02/20/2025, at approximately 8:45 a.m., Surveyor conducted a complaint investigation. Surveyor requested to review the closed record of Resident 1 including, progress notes, incident reports, medical discharge summaries, and any assessments that were completed for Resident 1 from December 2024 to January 2025. Resident 1 was admitted to the provider on 10/10/2023 with diagnoses including	N 383		

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 02/20/2025

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 383	Continued From page 6	N 383		

osteoarthritis, hypertension, and paroxysmal atrial fibrillation. Resident 1's ISP, dated 05/10/2024, documents that Resident 1 is on hospice services for further decline in functional status, pain, skin issues, and impaired nutrition/hydration which includes a terminal diagnosis.

Surveyor reviewed hospice notes that documented,
12/28/2025, "unwitnessed fall. co (complain of) cervical neck pain. doesn't[sic] want to move neck. good cms to hands dual hand grasps"
12/29/2025, "Check in with facility [caregiver] who reports that patient was sent to ED (emergency department) this AM due to 'extreme' pain. Unclear location of characteristics of pain. Patient was calling out during turns and cares when getting [him/her] up in the AM. Patient had fall yesterday with new cervical neck pain noted. Patient was given morphine X1 dose yesterday with good effect. Pain noted this AM, no meds given. Neither [hospice] nor AHCPOA (activated health care power of attorney) were notified of decision to go to ED. Patient seen in [hospital] ED and imaging preformed - CT of head, neck, and pelvis obtained with no evidence of injury. Patient discharged with no new orders."

At 11:06 a.m., Surveyor noted s/he did not receive any progress notes or incident reports for Resident 1 and requested any documentation regarding the provider's decision to send Resident 1 to the hospital on 12/29/2025. HR Manager B stated that there was no documentation in Resident 1's record of any progress notes, assessments or incident reports from December 2024 to January 2025.

At approximately 11:30 a.m., Surveyor shared the

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 02/20/2025

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 383	Continued From page 7	N 383		

above concerns with HR Manager B and Regional Nurse A. Regional Nurse A stated s/he understood the concern and did not have any questions.

On 02/25/2025 at 6:12 p.m., Surveyor interviewed Power of Attorney D. Power of Attorney D stated that there was little information other than Resident 1 was found on the ground on 12/28/2024. S/he also stated was no obvious need to sent Resident 1 to the hospital on 12/29/2025. S/he stated that the hospice nurse had come the day prior when Resident 1 had fallen and checked over Resident 1 and consulted with the hospice medical doctor and thought it would be more stressful on Resident 1 to send him/her to the hospital and noted there was no medical need for Resident 1 to be sent out. Hospice and Power of Attorney D agreed that Resident 1 did not need to be sent to the hospital after the fall and responded well to prn pain medication for the neck pain. Power of Attorney D stated that s/he found out that Resident 1 was sent to the hospital through a local first responder and s/he was surprised because s/he was not made aware of a change in condition of Resident 1 and that the facility had not given Resident 1 his/her prn pain medication if the provider had thought s/he was in pain, which had been effective the day before.

The provider did not assess Resident 1's physical health after s/he was found on the ground on 12/28/2024. The provider did not assess a potential change in condition or the presence of pain in Resident 1 on 12/29/2025 before sending him/her to the emergency room.

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 02/20/2025

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 388	Continued From page 8	N 388		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not follow Resident 1's individual service plan (ISP) in regards to the coordination of care with hospice. This is a repeat deficiency. See Statement of Deficiency 2HW012, issued 6/06/2022. Findings include: On 02/20/2025, at approximately 8:45 a.m., Surveyor conducted a complaint investigation. Surveyor requested to review the closed record of Resident 1 including their ISP, progress notes, incident reports, medical discharge summaries, and any assessments that were completed for Resident 1 from December 2024 to January 2025. Resident 1 was admitted to the provider on 10/10/2023 with diagnoses including osteoarthritis, hypertension, and paroxysmal atrial fibrillation. Resident 1's ISP, dated 05/10/2024, documents that Resident 1 is on hospice services for further decline in functional status, pain, skin issues, and impaired nutrition/hydration which includes a terminal diagnosis. The ISP states to, "coordinate hospice and and routine care with the hospice team." Surveyor reviewed hospice notes that documented, 12/28/2025, "unwitnessed fall. co (complain of)	N 388		

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 02/20/2025

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 388	Continued From page 9	N 388		

cervical neck pain. doesn't[sic] want to move neck. good cms to hands dual hand grasps" 12/29/2025, "Check in with facility [caregiver] who reports that patient was sent to ED (emergency department) this AM due to 'extreme' pain. Unclear location of characteristics of pain. Patient was calling out during turns and cares when getting [him/her] up in the AM. Patient had fall yesterday with new cervical neck pain noted. Patient was given morphine X1 dose yesterday with good effect. Pain noted this AM, no meds given. Neither [hospice] nor AHCPOA (activated health care power of attorney) were notified of decision to go to ED. Patient seen in [hospital] ED and imaging preformed - CT of head, neck, and pelvis obtained with no evidence of injury. Patient discharged with no new orders."

At 11:06 a.m., Surveyor noted s/he did not receive any progress notes or incident reports for Resident 1 and requested any documentation regarding the provider's decision to send Resident 1 to the hospital on 12/29/2025. HR Manager B stated that there was no documentation in Resident 1's record of any progress notes or incident reports from December 2024 to January 2025.

At approximately 11:30 a.m., Surveyor shared the above concerns with HR Manager B and Regional Nurse A. Regional Nurse A stated s/he understood the concern and did not have any questions.

On 02/25/2025 at 6:12 p.m., Surveyor interviewed Power of Attorney D. Power of Attorney D stated that there was no obvious need to sent Resident 1 to the hospital on 12/29/2025. S/he stated that the hospice nurse had come the day prior when Resident 1 had fallen and checked over Resident

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 02/20/2025

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 388	Continued From page 10 1 and consulted with the hospice medical doctor and thought it would be more stressful on Resident 1 to send him/her to the hospital and noted there was no medical need for Resident 1 to be sent out. Hospice and Power of Attorney D agreed that Resident 1 did not need to be sent to the hospital after the fall and responded well to prn pain medication for the neck pain. Power of Attorney D stated that s/he found out that Resident 1 was sent to the hospital through a local first responder and s/he was surprised because that is not what was decided upon by Resident 1's hospice team or Power of Attorney.	N 388		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of	N 454		

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 02/20/2025

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 454	Continued From page 11 sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released.	N 454		

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 02/20/2025

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 454	Continued From page 12	N 454		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not maintain Resident 1's record in regards to significant incidents including an unwitnessed fall and an emergency room evaluation.

Findings include:

On 02/20/2025, at approximately 8:45 a.m., Surveyor conducted a complaint investigation. Surveyor requested to review the closed record of Resident 1 including their ISP, progress notes, incident reports, medical discharge summaries, and any assessments that were completed for Resident 1 from December 2024 to January 2025.

Resident 1 was admitted to the provider on 10/10/2023 with diagnoses including osteoarthritis, hypertension, and paroxysmal atrial fibrillation.

Surveyor reviewed hospice notes that documented,
12/28/2025, "unwitnessed fall. co (complain of) cervical neck pain. doesn't[sic] want to move neck. good cms to hands dual hand grasps"
12/29/2025, "Check in with facility [caregiver] who reports that patient was sent to ED (emergency department) this AM due to 'extreme' pain. Unclear location of characteristics of pain. Patient was calling out during turns and cares when getting [him/her] up in the AM. Patient had fall yesterday with new cervical neck pain noted. Patient was given morphine X1 dose yesterday with good effect. Pain noted this AM, no meds given. Neither [hospice] nor AHCPOA (activated

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 02/20/2025

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 454	Continued From page 13	N 454		

health care power of attorney) were notified of decision to go to ED. Patient seen in [hospital] ED and imaging preformed - CT of head, neck, and pelvis obtained with no evidence of injury. Patient discharged with no new orders."

At 11:06 a.m., Surveyor noted s/he did not receive any progress notes, incident reports, or hospital discharge summaries for Resident 1. HR Manager B stated s/he had talked with Regional Nurse A and that they were aware of the fall on 12/28/2025 and they see in ECP (electronic charting system) that Resident 1 was sent to the hospital on 12/29/2025, however, there was no documentation of any progress notes, incident reports, or hospital discharge summaries from December 2024 to January 2025 in Resident 1's closed record.

At approximately 11:30 a.m., Surveyor shared the above concerns with HR Manager B and Regional Nurse A. Regional Nurse A stated s/he understood the concern and did not have any questions.