STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017017	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF JANESVILLE	700 MYRTLE WAY JANESVILLE, WI 53545

(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 05/21/2024, the bureau of assisted living southern regional office conducted 2 complaint investigations at Oak Park Place Janesville a CBRF located in Janesville, WI. As a result of this survey, 2 violations of DHS 83 were issued 1 complaint was substantiated Census: 49	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 medications were administered in the dosage and intervals prescribed by their practitioner. On 05/01/2024, Case Manager H faxed provider a list of Resident 1's prescription medications to be administered by community based residential facility (CBRF) staff upon Resident 1's discharge from the hospital. This list included digoxin 0.125 mcg for atrial fibrillation and sertraline 50 mg for depression. On 05/03/2024 at approximately 11:00 AM, Resident 1 was admitted to the facility on hospice	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	N 352		

service. The medications listed on the 05/01/2024 fax were not at the facility.

On 5/03/2024 at approximately 5:00 PM, Hospice Nurse F faxed 3 sets of verbal orders from Doctor G. Doctor G ordered a scheduled and PRN (as needed) morphine sulfate for pain management.

Resident 1's symptoms were managed by one pharmacological intervention (alprazolam) from approximately 11:00 AM on 05/03/2024 until 8:58 PM on 05/04/2024. Resident 1's prescription medications excluding the alprazolam were not delivered to the facility until after 4:00 PM on 05/04/2024. Resident 1's digoxin and sertraline were not transcribed to the facility medication administration record (MAR) until 05/05/2024 at 7:00 AM.

On 05/05/2024 at 3:33 pm, Resident 1 passed away.

This is a repeat deficiency of statement of deficiency (SOD) #657X16 dated 01/18/2024, SOD #657X14 dated 05/09/2023, SOD #657X13 dated 11/03/2022, SOD #ENKL12 dated 02/10/2021 & SOD #ENKL11 02/21/2020.

FINDINGS INCLUDE:

On 05/17/2024, the department received a complaint related to medication administration practices at facility.

On 05/21/2024, Surveyor arrived at facility for a complaint investigation.

RECORD REVIEW & INTERVIEW:

On 05/21/2024, Surveyor reviewed Resident 1's

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N 352	Continued From page 2	N 352		

facility record. Resident 1's facility facesheet. Resident 1 was admitted to the facility on 05/03/2024. Resident 1 had an activated power of attorney. Resident 1 had a primary pharmacy listed. Resident 1 was diagnosed with but not limited to: type 2 diabetes mellitus, major depressive disorder, cardiomyopathy, chronic atrial fibrillation and constipation.

On 05/21/2024 at 11:51 AM, Surveyor spoke with Pharmacy Technician E. Pharmacy Technician E stated Resident 1 was listed in his/her system. Pharmacy Technician E stated Resident 1 was admitted to the [Facility Name] on 05/03/2024 from [Hospital Name]. Pharmacy Technician E stated on 05/03/2024 after 6:00 pm the pharmacy received an electronic order for the medication alprazolam. Pharmacy Technician E stated the cut off for receiving prescriptions to be filled the same day is 6:00 pm. Pharmacy Technician E stated the pharmacy is a 24-hour pharmacy and if an assisted living facility (ALF) calls to obtain resident prescriptions after 6:00 pm the pharmacy will fill the prescription and attempt to deliver as soon as possible. Pharmacy Technician E stated pharmacy received multiple electronic orders for Resident 1's prescription medication at approximately 12:00 PM on 05/04/2024. Pharmacy Technician E stated all of Resident 1's medications including digoxin and morphine sulfate were delivered to the facility the late afternoon on 05/04/2024.

On 05/21/2024 at 12:40 PM, Surveyor interviewed Facility Nurse C. Facility Nurse C stated s/he was the unit manager. Facility Nurse C stated s/he remembered Resident 1. Facility Nurse C stated Resident 1 was admitted to the facility on 05/03/2024 at approximately 11:00 AM. Facility Nurse C stated Resident 1 was agitated

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	0017017	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF JANESVILLE	700 MYRTLE WAY JANESVILLE, WI 53545

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N 352	Continued From page 3 upon arrival to facility. Facility Nurse C stated Resident 1 was trying to pull out his/her urinary catheter. Facility Nurse C stated Resident 1 was the first resident s/he had admitted from the hospital with [Hospice Name]. Facility Nurse C stated s/he had been told the hospice provider oversaw resident medications. Facility Nurse C stated facility did not have Resident 1's prescription medications at facility upon his/her arrival. Facility Nurse C stated s/he faxed the hospital discharge list to pharmacy. Facility Nurse C stated at approximately 2:00 PM, pharmacy called Facility Nurse C and stated they did not have Resident 1 in their computer system. Facility Nurse C stated s/he had different medication lists for Resident 1 and asked Hospice Nurse F what list of medications was the correct list for Resident 1. Hospice Nurse F stated s/he would obtain verbal orders from hospice provider (Doctor G) to discontinue Resident 1's medications; and comfort medications ordered. Facility Nurse C stated Hospice Nurse F faxed Doctor G verbal orders for Resident 1's medications to a pharmacy that was not open. Facility Nurse C stated Hospice Nurse F told him/her Doctor G verbalized Resident 1 needed his/her Xanax (alprazolam). Hospice Nurse F obtained 5 tablets of Xanax from a commercial pharmacy. Surveyor requested all communications related to Resident 1's discharge from Facility Nurse C. On 05/21/2024 at 1:10 PM, Surveyor interviewed Case Manager H. Case Manager H stated s/he worked at [Hospital Name]. Case Manager H stated s/he was Resident 1's discharge planner. Case Manager H stated s/he faxed a list of Resident 1's discharge medications on 05/01/2024. Case Manager H stated s/he had been notified Resident 1 did not receive his/her	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017017	A. BUILDING: _____ B. WING _____	C 05/23/2024

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N 352	Continued From page 4	N 352		

medications while at the facility. Case Manager H stated s/he followed up with Administrator A and Facility Nurse C after Resident 1's passing on 05/05/2024. Case Manager H stated Administrator A and Facility Nurse C did not take accountability for the medication errors, but attempted to place the blame on Resident 1's hospice provider.

On 05/21/2024, Surveyor reviewed a faxed from [Hospital Name]. The fax is dated 05/01/2024 and is labeled to be a 3-page document. Under the subsection titled, "Medication Administration," the following is documented, "I authorize CBRF staff, who have met the requirements of HFS 83 for medication administration, to administer medications as prescribed to the resident. Staff positions may include Director of Operations, Director of Housing, Area Manager, CNA, Resident Assistant, and other in certain circumstances....Please List All Medications...Digoxin 125 mcg once daily for atrial fibrillation, Zoloft (sertraline) 50 mg at bedtime for depression, Trazadone 50 mg at bedtime for depression, Lasix (furosemide) 20 mg once daily PRN (as needed) for edema, bisacodyl suppository10 mg once daily PRN for constipation, Acetaminophen 650 mg Q4 hours PRN for pain, milk of magnesia once daily PRN for constipation and triple antibiotic cream to be applied up to 3 times daily for skin abrasions...I certify that this patient's medical condition(s) and related need(s) are essentially as indicated above and that placement in a Community Based Residential Facility (CBRF) is appropriate... [Doctor J]...05/01/2024."

On 05/21/2024, Surveyor reviewed 3 sets of verbal orders from Resident 1's hospice provider. All 3 orders list Doctor G as the ordering provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017017	A. BUILDING: _____ B. WING _____	C 05/23/2024

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OAK PARK PLACE OF JANESVILLE	700 MYRTLE WAY JANESVILLE, WI 53545

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N 352	Continued From page 5 Three of 3 orders were not signed by Doctor G. 1.) The first set of orders was dated 05/03/2024 at 16:10 CDT (4:10 PM). Hospice Nurse F documented Doctor G ordered the following medications to be administered: -alprazolam 0.5 mg tablet Q1 hour PRN -alprazolam 0.5 mg ER (extended release) tablet at bedtime -hyoscyamine 0.125 mg tablet Q4 hour PRN for secretions or nausea -ibuprofen 200 mg tablet 2 times daily -morphine 7.5 mg Q1 hours PRN for pain or dyspnea -morphine 15 mg Q1 hour PRN for pain Hospice Nruse F documented Doctor G ordered the following medications be discontinued: -albuterol 90mcg inhaler -furosemide 20 mg tablet -trazodone 50 mg tablet 2.) The second set of orders was dated 05/03/2024 at 16:45 CDT (4:45PM). Hospice Nurse F documented Doctor G ordered the following therapies: -foley urinary catheter -mechanical soft diet with honey thickened liquids -oxygen therapy -medications need to be crushed in applesauce 3.) The third set of orders was dated 05/04/2024 at 10:59 CDT (10:59 AM). Hospice Nurse F documeneted Doctor G ordered the following medications to be administered: -alprazolam 0.5 mg Q4 hour PRN for anxiety -morphine 7.5 mg Q4 hours for pain Hospice Nurse F documented Doctor G discontinued alprazolam 0.5 mg ER tablet once daily at bedtime	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017017	A. BUILDING: _____ B. WING _____	C 05/23/2024

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OAK PARK PLACE OF JANESVILLE	700 MYRTLE WAY JANESVILLE, WI 53545

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N 352	Continued From page 6 On 05/21/2024, Surveyor reviewed a hospice document titled, "Medication Profile." Doctor L is listed as Resident 1's primary care physician. The following medications are listed as active as of 05/03/2024: -acetaminophen 1,000 mg Q6 hour PRN -Digoxin 125 mcg once daily -docusate sodium 100 mg once daily -sertraline 50 mg tablet -alprazolam 0.5 mg tablet Q1 hour -alprazolam 0.5 mg tablet ER at bedtime -hyoscyamine 0.125 mg Q4 hour PRN -ibuprofen 400 mg twice daily -morphine 15 mg Q1 hour PRN and morphine 7.5 mg Q1 hour. On 05/21/2024, Surveyor reviewed Resident 1's Pre-Admission Assessment. On 05/01/2024, under the subsection, "Medication Management," Facility Nurse I documented, "Digoxin Comfort Meds...". On 05/21/2024, Surveyor reviewed Resident 1's May 2024 medication administration record (MAR). Medication orders were documented as follows: 1. Alprazolam 0.5 mg ER tablet at bedtime. The order was started on 05/04/2024 at 7:00 pm. The order was discontinued on 05/05/2024 at 2:36 am. (originally ordered by Doctor G on 05/03/2024 at 4:10 PM) 2. Digoxin (sic.) tablet once daily. The order was started on 05/05/2024 at 7:00 am. The order was discontinued on 05/05/2024 at 11:28 am. (originally ordered by Doctor J on 05/01/2024) 3. Docusate Sodium Oral Capsule 100 mg once daily. The order was started on 05/05/2024 at 7:00 am. Order was discontinued on 05/05/2024 at 11:27 am. 4. Sertraline 50 mg tablet once daily. The order	N 352		

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	0017017	A. BUILDING: _____ B. WING _____	C 05/23/2024

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OAK PARK PLACE OF JANESVILLE	700 MYRTLE WAY JANESVILLE, WI 53545

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N 352	Continued From page 7 was started on 05/05/2024 at 7:00 am. Order was discontinued on 05/05/2024 at 11:27 am. (originally ordered by Doctor J on 05/01/2024) 5. Ibuprofen 200 mg tablet twice daily. The order was started on 05/04/2024 at 4:00 pm. Order was discontinued on 05/05/2024 at 10:15 am. (originally ordered by Doctor G on 05/03/2024 at 4:10 PM) 6. Ibuprofen 400 mg tablet twice daily. The order was started on 05/04/2024 at 7:00 am. Order was discontinued on 05/05/2024 at 11:27 am. 7. Alprazolam 0.5 mg tablet Q4 hour scheduled. The order was started on 05/05/2024 at 4:00 am. Order was discontinued on 05/05/2024 at 12:37 am. (originally ordered by Doctor G on 05/04/2024 at 10:59 AM) 8. Morphine sulfate 15 mg tablet Q4 hour scheduled. The order was started on 05/05/2024 at 4:00 am. Order was discontinued on 05/06/2024 at 2:11 am. (originally ordered by Doctor G on 05/03/2024 at 4:10 PM) 9. Acetaminophen (sic.) 2 tablet Q6 hour PRN. The order was started on 05/04/2024 at 12:45 pm. Order was discontinued on 05/05/2024 at 11:28 am. 10. Alprazolam 0.5 mg tablet Q1 hour PRN. The order was started on 05/03/2024 at 6:30 pm. Order was discontinued on 05/05/2024 at 2:42 am. (originally ordered by Doctor G on 05/03/2024 at 4:10 PM) 11. Bisacodyl suppository 10 mg once daily PRN. The order was started on 05/02/2024 at 7:30 pm. Order was discontinued on 05/06/2024 at 9:34 am. (originally ordered by Doctor J on 05/01/2024) 14. Hyoscyamine 0.125 mg tablet Q4 hour PRN. The order was started on 05/03/2024 at 6:30 pm. Order was discontinued on 05/04/2024 at 12:56 pm. (originally ordered by Doctor G on 05/03/2024 at 4:10 PM)	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017017	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 352	Continued From page 8 15. Milk of Magnesia suspension 30ml once daily PRN. The order was started on 05/03/2024 at 6:19 pm. Order was discontinued on 05/06/2024 at 9:34 am. (Originally ordered by Doctor J on 05/01/2024) 16. Morphine sulfate 15 mg tablet Q1 hour PRN. The order was started on 05/03/2024 at 6:30 pm. Order was discontinued on 05/06/2024 at 9:34 am. (originally ordered by Doctor G on 05/03/2024 at 4:10 PM) 17. Morphine sulfate 7.5 mg tablet Q1 hour PRN. The order was started on 05/03/2024 at 6:30 pm. Order was discontinued on 05/05/2024 at 2:45 am. Is first documented as administered on 05/04/2024 at 8:58 pm. Resident 1's pain level was documented as a 5 and medication effective for pain. (originally ordered by Doctor G on 05/03/2024 at 4:10 PM) On 05/21/2024, Surveyor reviewed Resident 1's facility observation notes. The following was documented: -On 05/04/2024 at 9:52 AM, the scheduled dose of ibuprofen 400 mg was documented as "not yet delivered". -On 05/04/2024 at 1:00 PM, the following was documented, "Note Text: [Hospice Name] called, confirmed that meds were sent over to [Pharmacy Name] 5/3/24- will be here today...". -On 05/04/2024 at 3:15 PM, the scheduled dose of ibuprofen 400 mg was documented as "not available". -On 05/04/2024 at 3:21 PM, the following was documented, "Note Text: [Pharmacy Name] calls states they received everything. Meds will for sure be out tonight." -On 05/04/2024 at 8:58 PM, Morphine sulfate 7.5 mg PRN was administered for pain. -On 05/05/2024 at 3:33 PM, Resident 1 passed away.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017017	A. BUILDING: _____ B. WING _____	C 05/23/2024

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OAK PARK PLACE OF JANESVILLE	700 MYRTLE WAY JANESVILLE, WI 53545

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N 352	Continued From page 9 On 05/21/2024 at 3:17 PM. Surveyor discussed the above concerns with Nurse B. Nurse B acknowledged facility had a copy of Doctor J's prescription orders for Resident 1's from 05/01/2024 to 05/03/2024. Nurse B acknowledged facility did not coordinate a way to obtain Resident 1's medications for him/her until after Resident 1 had been admitted to the facility. Nurse B stated on 05/03/2024 Hospice Nurse F had told him/her Doctor G would discontinue all of Resident 1's medication orders but the comfort medications. Nurse B acknowledged the 3 sets of verbal orders reviewed by Surveyor were all the verbal orders the facility received from Doctor G. Nurse B acknowledged the 3 sets of verbal orders did not instruct the facility to discontinue the following medications: Digoxin 125 mcg once daily for atrial fibrillation, Zoloft (sertraline) 50 mg at bedtime for depression, bisacodyl suppository10 mg once daily PRN for constipation, Acetaminophen 650 mg Q4 hours PRN for pain, milk of magnesia once daily PRN for constipation. Nurse B acknowledged Doctor C was Resident 1's primary care provider. Nurse B acknowledged Doctor C's office faxed a list of orders on 05/04/2024 verifying Resident 1's order for Digoxin 125 mcg and sertraline 50 mg had remained active since 05/03/2024. Nurse B acknowledged Resident 1 did not receive his/her medications as prescribed from 05/03/2024 to 05/04/2024. CROSS REFERENCE N0401 DHS Chapter 83.37 (1)(b) Medication Label Permanently Attached	N 352		
N 401	83.37(1)(b) Medication label permanently attached.	N 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OAK PARK PLACE OF JANESVILLE	700 MYRTLE WAY JANESVILLE, WI 53545

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N 401	Continued From page 10 Medications. Prescription medications shall come from a licensed pharmacy or a physician and shall have a label permanently attached to the outside of the container. Over-the-counter medications maintained in the manufacturer ' s container shall be labeled with the resident ' s name. Over-the-counter medications not maintained in the manufacturer ' s container shall be labeled by a pharmacist. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure all Resident 2's prescription medication had a permanent label from a licensed pharmacy or physician attached to the container. On 05/21/2024, Surveyor observed medication cart with Facility Nurse C and Caregiver D. Surveyor observed 2 oral syringes in the narcotic drawer without prescription labels attached to them. The 2 oral syringes were in a clear plastic bag labeled in black marker as morphine sulfate. FINDINGS INCLUDE: On 05/17/2024, the department received a complaint related to medication administration practices at facility. On 05/21/2024, Surveyor arrived at facility for a complaint investigation. OBSERVATION: On 05/21/2024 at 9:55 AM, Surveyor observed the medication cart with Facility Nurse C and Caregiver D. Surveyor observed the secured narcotic storage drawer. Surveyor observed 2	N 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OAK PARK PLACE OF JANESVILLE	700 MYRTLE WAY JANESVILLE, WI 53545

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N 401	Continued From page 11 unlabeled oral syringes which were partially filled with a light blue liquid (Picture 1). The unlabeled syringes were stored in a clear Ziploc bag. The clear Ziploc bag was labeled as, "[Resident 2] Morphine Sulfate 100mg/15ml...0.25ml Q4* PRN." Facility Nurse C acknowledged Resident 2's schedule 2 narcotic did not have a pharmacy label attached to it. Facility Nurse C stated facility no longer draws oral syringes from stock bottles. Facility Nurse C stated s/he thought s/he had disposed of all oral syringes drawn from a stock bottle. RECORD REVIEW: On 05/21/2024, Surveyor reviewed Resident 2's facility facesheet. Resident 2 was admitted to the facility on 01/06/2022. On 05/21/2024, Surveyor reviewed Resident 2's proof of use record. Resident 2 originally had 5 oral syringes of morphine sulfate 100mg/15ml (0.25ml) and 3 had been recorded as administered. CROSS REFERENCE N0352 DHS Chapter 83.32 (3)(h) Right of Residents: Recieve Medication	N 401		