STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525729	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Park Place of Nakoma	4327 Nakoma Rd. Madison, WI 53711

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were assessed for self-administration of medications for one of four residents (Resident (R) 6) reviewed for self-administration of medications out of 12 sample residents. Findings include:Review of the facility's policy titled, Administering Medications, last revised April 2019, revealed the policy statement, Medications are administered in a safe and timely manner, and as prescribed and Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.Review of R6's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R6 was admitted to the facility on [DATE] with diagnoses that included fibromyalgia, anxiety disorder, chronic kidney disease stage 3A, and hypertension.Review of R6's care plan, dated 12/16/25 and located under the Care Plan tab of the EMR, revealed .has demonstrated a decreased ability to perform activities of daily living (ADLs) related to impaired mobility. Interventions in place, dated 12/16/25, included .currently requires set-up assist by one staff with eating.wears glasses, and wears hearing aids. Review of R6's assessments located under the Assessments tab of the EMR, revealed that R6 was not assessed for self-administration of medications.Review of all progress notes under the Progress Notes tab in the EMR, revealed that R6 was not assessed for self-administration of medications.Review of the orders located under the orders tab of the EMR revealed no orders related to self-administration of medication. Review of the Medication Administration Record (MAR) located under the orders tab of the EMR, revealed R6 had a physician's order for Ipratropium Bromide Nasal Solution 0.06 % (Ipratropium Bromide (Nasal)) two spray in both nostrils three times a day for seasonal allergic rhinitis, start date 12/16/25.During an observation for medication administration for R6 and interview on 12/23/25 at 7:46 AM, while Registered Nurse (RN) 1 was pulling the morning medications to administer to R6, RN1 stated, I don't have the nasal spray in the cart because usually the other nurses leave the nasal spray in the resident's room because she can do it by herself. During this observation, R6 picked up the nasal spray from a white box located on top of her bedside table and administered the nasal spray in front of RN1.During an observation and interview on 12/23/25 at 8:02 AM, when asked what the white bottle was on her bedside table, R6 stated, that's my nasal spray. They leave it there because I have been using nasal spray for a long time and I can do it on my own. R6 proceeded to demonstrate how she had to hold the right nostril closed as she sprayed in the left nostril and then she demonstrated how to spray in the right nostril. During an interview on 12/23/25 at 3:50 PM, the Director of Nursing (DON) stated that when a resident was able to administer their own medications, this would be documented in the assessments tab of the EMR, it will also be care planned, and they had an Interdisciplinary Team (IDT) meeting progress note stating that the resident was able to self-administer their own medications.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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
	525729	A. Building B. Wing	12/23/2025

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Oak Park Place of Nakoma	4327 Nakoma Rd. Madison, WI 53711

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure professional standards were in place for ensuring medication administered was not borrowed from another resident for one of six residents (Resident (R) 9) reviewed for professional standards and medication administration of 12 sample residents. This failure had the potential to affect the potential for negative outcome for 26 residents currently residing in the skilled nursing floor of the facility.Findings include:Based on review of a facility reported incident submitted to the State Agency (SA) on 08/12/25 and provided by the facility, revealed that narcotic pain medication ordered for one resident was administered to another resident. The facility's investigation revealed that R9 was administered physician-ordered narcotic pain medication for R8.Evidenced by:Review of the facility's policy titled, Medication Administration, last revised on 04/19, revealed that the facility's policy statement was Medications are administered in a safe and timely manner, and as prescribed. The policy further revealed, Policy Interpretation and Implementation item number eight stated, if a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. Item number nine stated, The individual administering medication verifies the resident's identity before giving the resident His/her medications. Methods of identifying the resident include: a. checking the identification band; b. checking photograph attached to medical record; and if necessary, verifying resident identification with other facility personnel. Item number ten stated, The individual administering the medication checks the label THREE (3) ties to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. And item number 26 stated, Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the director of nursing services. Example 1Review of R8's admission Record located under the Profile tab of the electronic medical record (EMR), revealed R8 was admitted to the facility on [DATE] with diagnoses that included pain left knee, pain in left hip, type two diabetes, solitary pulmonary nodule, panic disorder, difficulty walking, and cognitive communication deficit.Review of R8's Order Summary Report under the Orders tab of the EMR, revealed that R8 had a physician's order on 07/16/25, for oxycodone HCl [hydrochloric acid] Oral Tablet 5 MG [milligram] (Oxycodone HCl) Give 0.5 tablet by mouth every six hours as needed for pain (2. 5MG).Review of R8's Medication Administration Record (MAR) located under the Orders tab of the EMR, dated 08/08/25, revealed R8 was not administered the narcotic pain medication, oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 0.5 tablet by mouth every six hours as needed for pain.Review of R8's Controlled Drug Use Record for the narcotic pain medication, Oxycodone 5 milligram tablet Instant release (I. R.), revealed that two tablets were withdrawn from R8's medication card on 08/08/25 at 7:00 PM by Registered Nurse (RN) 2 with a note under the signature that revealed, it's given to R9 (Administrator knows this borrowing the medication for the resident).Example 2Review of R9's admission Record located under the Profile tab of the EMR revealed R9 was admitted to the facility on [DATE] with diagnoses that included spinal stenosis, cognitive communication deficit, muscle weakness, chronic embolism and thrombosis of unspecified deep veins of left lower extremity, primary insomnia, non-rheumatic aortic (valve) stenosis, lumbago with sciatica on the left side, and sciatica on left side. Review of R9's Order Summary Report located under the Orders tab of the EMR, revealed R9 had a physician's order on 08/08/25, for oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) (a narcotic pain medication). Give one tablet by mouth every four hours as needed, for pain.Review of R9's MAR located under the Orders tab of the EMR, revealed that R9 was administered the narcotic pain medication, oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) Give one tablet by mouth every four hours as needed for pain, on 08/08/25 at 6:52 PM. This record also revealed that R9 had a pain level of 9/10, indicating that R9 was experiencing strong/severe pain at that time.Review of the five-day investigation report that was signed on 08/19/25 by the Regional Registered Nurse (RRN) and provided by the facility, revealed that on 08/11/25, during a routine audit, it was discovered that two 5MG Oxycodone tablets were withdrawn from R8's medication card and these two tablets were administered to R9. This investigation further revealed that the two Oxycodone physician orders for the two residents were not the same. R8 had an order for five milligram Oxycodone tablets and R9 had an order for ten milligram