

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525729	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2026
NAME OF PROVIDER OR SUPPLIER  Oak Park Place of Nakoma		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did not follow their Discharge Planning Process for 3 of 3 residents (R1, R2, R3) reviewed for discharge planning.</p> <p>R1, R2, and R3 did not have a recapitulation of their stay after discharge.</p> <p>R3 did not have a discharge goal in his care plan.</p> <p>Evidenced by:</p> <p>The facility policy entitled Discharge Summary and Plan, dated 10/2022, states, in part: .</p> <p>Policy Statement: When a resident's discharge is anticipated, a discharge summary and post- discharge plan is developed to assist the resident with discharge.</p> <p>Policy Interpretation and Implementation:</p> <p>The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident.</p> <p>3. Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan.</p> <p>4. The post-discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and includes:</p> <p>a. where the individual plans to reside;</p> <p>b. arrangements that have been made for follow-up care and services;</p> <p>c. a description of the resident's discharge goals;</p> <p>d. the degree of caregiver/support person availability, capacity and capability to perform required care; .</p> <p>12. A copy of the following is provided to the resident and .a copy will be filed in the resident's</p> <p>(continued on next page)</p>

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
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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>medical records:</p> <p>a. An evaluation of the resident's discharge needs;</p> <p>b. The post-discharge plan; and</p> <p>c. The discharge summary.</p> <p>Example 1:</p> <p>R1 was admitted to the facility for a respite stay on 11/21/25 and discharged [DATE]. R1 has diagnoses that include progressive supranuclear palsy (a rare progressive brain disorder causing gradual deterioration of the nerve cells, affecting movement, speech, swallowing, and cognition) and encounter for palliative care (a specialized medical care focused on relieving symptoms, pain, and stress from serious illness).</p> <p>R1's care plan, dated 10/2/25, states, in part: .</p> <p>Focus: Preparing for discharge and requires coordination of care, education and resources to ensure safe and effective transition to the next care setting. Date initiated:11/24/25.</p> <p>R1's progress note dated 12/19/25 at 12:00 PM, states Ascorbic Acid Oral Tablet 500 mg (milligrams). Give 0.5 tablet by mouth three times a day for supplementation. (250mg) Take with food. discharged .</p> <p>Of note: this is the only entry put in on R1's discharge date . There is no discharge summary.</p> <p>In R1's medical record in Point Click Care under Assessments, it shows Discharge Summary and Recap of Stay. Due 12/29/25. Overdue by 28 days. This entry is highlighted in red.</p> <p>On 1/8/26 at 11:35 AM, Surveyor interviewed DON B (Director of Nursing) and asked DON B to explain the entry: Discharge Summary and Recap of Stay. Due 12/29/25. Overdue by 28 days. under assessments in Point Click Care highlighted in red. DON B indicated it was not completed. DON B indicated he would expect it to be completed on R1's discharge date , 12/19/25.</p> <p>Example 2:</p> <p>R3 was admitted to the facility on [DATE] and has diagnoses that include fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing, and weakness. R3 discharged from facility on 12/29/25.</p> <p>R3's discharge instructions, dated [DATE] by R3, states, in part: .</p> <p>Date of discharge: [DATE]. Discharge to: home. Recommended Services: Home Health Agency Interim 1/12/2026, Physical Therapy Home Health, and Occupational Therapy Home Health.</p> <p>R3's progress notes for day of discharge, 12/29/25, includes:</p> <p>12/29/25 12:56 AM, Note Text: Pain monitoring every shift using 1-10 narrative or FACE scale.</p> <p>(continued on next page)</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident Pain Goal is:4 every shift. Generalized pain.</p> <p>12/29/25 1:56 AM. Note Text: oxycodone hci (hydrochloride) oral tablet 5 mg. Give 1 tablet by mouth every 4 hours as needed for acute pain. Take 0.5-1 tablet every 4 hours as needed.</p> <p>12/29/25 11:31 AM. Note Text: Acetaminophen Oral Tablet 325 mg. Give 2 tablets by mouth three times a day for pain management.</p> <p>Of note: there is no entry of a discharge summary or mention of discharge.</p> <p>R3's Care Plan dated 12/10/25 does not include a discharge goal.</p> <p>In R3's medical record in Point Click Care under Assessments, it shows Discharge Summary and Recap of Stay. Due 12/19/25. This entry is highlighted in red.</p> <p>On 1/8/26 at 11:35 AM, Surveyor interviewed DON B (Director of Nursing) and asked DON B to explain the entry: Discharge Summary and Recap of Stay, under assessments in Point Click Care highlighted in red. DON B indicated it was not completed. DON B indicated he would expect it to be completed on the day of discharge. Surveyor asked if he would expect residents' care plans to include a discharge goal. DON B indicated yes. Surveyor handed DON B R3's care plan and asked if R3 had a discharge goal in his care plan. DON B indicated no.</p> <p>Example 3</p> <p>R2 was admitted to the facility on [DATE] with diagnosis that include urinary tract infection, muscle weakness, cognitive communications deficit, and vascular dementia. R2 was discharged from the facility on 12/22/25 to a private residence.</p> <p>R2's electronic medical record, under Assessments, it shows Discharge Summary and Recap of Stay. Due 12/19/25. This entry is highlighted in red and is unable to be opened.</p> <p>On 1/8/26 at 11:35 AM, Surveyor interviewed DON (Director of Nursing) B and asked DON B to explain the entry: Discharge Summary and Recap of Stay highlighted in red. DON B indicated this means it was not completed. DON B indicated he would expect it to be completed upon discharge.</p> <p>Facility did not complete the required discharge documentation for R1, R2, and R3.</p>		