STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525729	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not consult with the resident's physician when there was a change in the resident's physical condition or a possible need to alter treatment for 1 of 4 sampled residents (R1.) R1 refused activities of daily living and therapy due to an increase in pain and the Medical Doctor was not notified of this change timely. Evidenced by: Facility policy, entitled Notification of Change, reviewed 1/13/2016, includes, in part: . facility will timely inform resident, consult with resident's physician/provider . a significant change in the resident's physical, mental, or psychosocial status . examples: deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications . A need to alter treatment significantly . or commence a new form of treatment . Facility policy, entitled Resident Change of Condition, revised 6/2016, includes, in part: To ensure prompt notification of physician . decline in ADL function, decline in cognitive functioning ., unplanned weight changes, change in baseline behaviors, [MEDICAL CONDITION] activity ., allegations of abuse or neglect, overall deterioration of resident's condition . R1 was admitted to the facility on [DATE] with diagnoses, to include: [DIAGNOSES REDACTED] of vertebra, [MEDICAL CONDITION] arthritis, chronic pain, urinary tract infection, and stage 2 pressure injury to coccyx. R1's Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 3/9/20, indicates R1's cognition to be intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. R1's Baseline and Comprehensive Care Plan, initiated 3/2/20, includes, in part: R1's pain goal is a 3 out of 10. R1's Nurses Notes dated 3/1/20 - 3/24/20, include, in part: 3/6/20 . In pain. PT (Physical Therapy) attempted to get R1 up but was unsuccessful . Seen by NP D (Nurse Practitioner) . slept most part of the entire shift . 3/7/20 .R1 complained of pain . and will often refuse cares. Refuses to get out of bed, to toilet, or use bedpan . Denies effectiveness of pain measures including topical and oral [MEDICATION NAME]. Toileting in brief and refusing to change brief for extended periods of time . Has not wanted to get out of bed due to pain. PT attempted today but start seizing once she got sat up at the edge of bed. 2 people in room at times of changing due to weird statements resident has said. 3/8/20 . R1 refused to get out of bed . R1 will at times refuse to be changed due to pain. Educated on risks and benefits of sitting on toilet to empty urine and stool. Educated about risks associated with digital removal of stool . R1 continues to complain of pain to right hip/leg area, requested ice pack for pain prior to going to sleep. Just had pain medications . 3/9/20 . Nurse offered twice and R1 still refused to be cleaned . continues to have pain to right leg/hip. Has not wanted to get out of bed due to pain. PT attempted today but start seizing once she got sat up at the edge of the bed . 2 people in room at times of changing due to weird statements R1 has said . Unable to obtain daily weight. R1 refused due to pain . 3/10/20 . R1 noted to have abrasions to left anterior mid forearm related to hospital bracelet . Notified NP D . gave orders to monitor for changes and update MD or NP if R1 develops any signs or symptoms of infection at site . continues to complain of pain to the right hip/lower back . 3/11/20 . R1 wants to change diclofec to three times a day instead of as needed. Called NP D and left a message . R1 continues to complain of pain to the right hip/lower back, requested an ice pack to the hip. Dosage of pain medications increased yesterday. Continue with scheduled Tylenol for pain. 3/12/20 . Obtained order from NP D. One time only 10 mg [MEDICATION NAME] before R1 goes for appointment on 3/23/20. NP D requested a recliner for R1's room . R1 continues to have pain when moved. Has chronic issues of not being able to control pain . 2 people complete cares when in room to prevent false delusions. 3/13/20 . R1's coccyx pressure ulcer is improving . resident does have macerated skin. Nurses report often she does not want to move in bed and refused to be changed when incontinent. Educated nurses to encourage R1 to be changed . 3/14/20 . R1 informed staff that she thinks she is wet and needed to be changed. Nurse offered to change R1 and R1 refused saying, I take full responsibility for not being changed and it hurts when I move, so don't worry. 3/15/2 .R1 is reporting pain in bilateral lower extremities from the knees down. R1 states no pain when resting in bed but when she turns or repositions or is repositioned by someone else she begins to have extremely painful bilateral lower extremity leg cramping that she finds it difficult to describe but states, It just starts rolling up and down my legs. Will monitor and request magnesium lab level as low magnesium seems to also cause cramping. 3/16/20 R1 . reported pain when being changed or repositioned in bed . Requested ice pack to the right thigh area. 3/17/20 . R1 was in a lot of pain last night. [MEDICATION NAME] appears not to be very effective. Will pass in report to update NP D/MD. R1 continues to have pain to right hip and leg pain. Not tolerant of repositioning well. 2 people in room with cares as she can be delusional. Working with MD to decrease pain . R1 reported more (pain) during repositioned in bed. Reported pain of 4/10 to lower back and right thigh tonight and scheduled Tylenol was administered. Requested ice pack to the right thigh area. 3/18/20 . R1 refused weight today. R1's lab results came back. NP D has seen and been notified of abnormal results. Results have been faxed to MD with infectious disease as well . [MEDICATION NAME] as needed administered . ineffective follow up pain scale: 8 . R1 continues to complain of intense pain to the low back during repositioning . Reported pain 7/10 to lower back and right thigh tonight . PRN (as needed) [MEDICATION NAME] and scheduled Tylenol given . Requested ice pack to the right thigh area . 3/19/20 . R1 refused to get out of bed to get weighed .R1 rates pain 7/10 this shift in bilateral lower extremities .R1 reported lesser pain of 4/10 because her as needed [MEDICATION NAME] was administered with her scheduled Tylenol. This also helped with repositioning her in bed . 3/20/20 . R1 continues to complain of pain . R1 reporting pain 7/10 this shift .R1 refused to be changed and/or checked to ensure she was not incontinent . 3/22/20 . R1 continues to complain of pain to back of right thigh area and the lower back. 3/23/20 . New order: give [MEDICATION NAME] 10 mg orally one time only for pain until 3/23/20 .R1 is refusing to get out of bed stating too much pain in her back and her legs. R1 stated not feeling strong enough to bear weight with transfers and ambulation. Therefore, R1 refusing active therapy as ordered. Writer administered as needed [MEDICATION NAME] in hope she would be able to actively participate with evening cares. Writer also noted at supper meal resident did not eat more than 30%. Snack at evening encouraged but refused at this time . Care conference . Hospice referral suggested, main concern was pain management. Nursing will look into pain medication changes as needed . communication with MD . R1 has had chronic back pain. Even with medication adjustments she has had uncontrolled pain. She has lost 10 pounds in the last 3 weeks. States it hurts too much too eat. R1 is pale white today . R1 is refusing to get out of bed stating has too much pain in her back and her legs. R1 continues to refuse to get out of bed due to pain in her back/muscle cramps to bilateral legs if they are moved . 3/24/20 . left message for NP D regarding R1's weight loss, order for speech therapist for swallowing difficulty and hospice evaluation . NP D called to have R1 sent out to emergency department via non emergent ambulance and stated for staff and paramedics to take COVID precautions at this time suspected, not confirmed . 3/25/20 . R1 mainly admitted to hospital for pain control. They are still trying to figure out why she is having so much pain . Continues IV antibiotics for osteo[DIAGNOSES REDACTED] and abscess to back. On 8/5/20 at 11:30 AM, during an interview, NP D indicated she was not made aware in real time of R1's excruciating pain, refusal of therapy,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) refusals to be changed, refusals to get out of bed, changes in cognition or behavior, refusals of being weighed, refusals of meals or a decline in ability to self-feed, swallowing issues, skin changes or R1 seizing when sitting upright. NP D indicated R1 was admitted primarily for therapy and IV antibiotics, but on 3/24/20 when she was notified, R1 was down 10 pounds, had a history of [REDACTED]. NP D questioned why she wasn't notified in real time of these declines. NP D indicated if she was made aware of R1's uncontrolled pain she could have adjusted med dosages and times in an effort to get R1 to participate in ADL's and attend therapy. NP D would have addressed the swallowing concern sooner in an effort to prevent weight loss. NP D indicated hospice was not appropriate as the facility did not attempt any other form of interventions guided by NP D or MD. On 8/5/20 at 2:00 PM, during an interview, RN E indicated R1 was in pain the whole time she was at facility, from the moment she arrived, to the moment she left. RN E indicated if a resident is refusing activities of daily living, the resident's MD should be notified. RN E also indicated if a resident is having pain that is not being controlled or having swallowing difficulties she would call resident's MD. On 8/5/20 at 3:30 PM, during an interview DON B indicated she was not in the role of DON during this time period. DON B indicated she would expect RN's to update her and the resident's MD when changes occur.