STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014220	A. BUILDING: _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAEBURN HAUS OF HARVEST HOME SENIOR LIVI	2003 APPLETREE RD HOWARDS GROVE, WI 53083

(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 09/19/2024, Surveyor conducted one (1) complaint investigation at Braeburn Haus of Harvest Home Sr Living Service. As a result of the survey the complaint was substantiated and 1 deficiency was identified. Census: 7	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 administer medication for 1 of 1 resident in the intervals prescribed by a practitioner. Resident 1's warfarin was not administered as prescribed. Findings Include: On 07/30/2024, the Department received a concern alleging residents were not receiving medications as prescribed. On 09/19/2024, Surveyor reviewed Resident 1's record. Resident 1 admitted to the facility on 05/24/2024, with diagnoses including acute chronic diastolic heart failure, hypertension, ventricular tachycardia, pacemaker, use of	N 352		

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

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N 352	Continued From page 1	N 352		

anticoagulant therapy, tachycardia-bradycardia syndrome CMD and anemia.

Resident 1:
July Medication Administration Record (MAR) documented:
"Warfarin 5 MG Tab, Take ½ Tablet by Mouth Daily Recheck Inr 7/3/24, 8:00 PM."
The MAR was shaded out starting 07/04/2024 at 8:00 PM through 07/31/2024. The MAR reflected:
"WARFARIN SODIUM 7.5 mg, 7.5mg for July 26, 3:00 PM
WARFARIN 5MGS [sic] TAB, Take 1 Tablet by Mouth at 8am on 7/27/24 and 7/28/24 Recheck Inr 8/5/24
WARFARIN 2.5MG TAB, Take 1 Tablet by Mouth Every Morning at 8am Starting 7/29/24 Recheck INR 8/5/24"

August MAR:
No Warfarin was documented given on 08/05/2024, 08/12/2024, 8/13/24 - Scheduled Medication Notations - nothing documented why warfarin was not given.

September MAR:
No Warfarin documented given on 09/09/2024 or reason held, 09/10/2024 charted as OTH - "9/10/24, 8:37P, Warfarin 2.5mg Tab - Hold per doctor"

Resident 1's Physician orders:
07/03/2024 - "Patient to continue current dose of 2.5mg warfarin daily, 7 days/wk. Recheck INR in 4 wks."
07/26/2024 - "Data - PT/INR done today because facility realized coumadin has not been given since 7-4-24 INR .09 PT 10.4 Please advise - ORDERS Patient to take 7.5mg warfarin today

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N 352	Continued From page 2	N 352		

(7/26/24). Patient to take 5mg of warfarin on 07/27/24 and 7/28/24. Patient to then resume dose of 2.5mg warfarin daily, beginning 7/29/24 Recheck INR on 8/5/24 & fax results."
08/05/2024 - "Patient to increase dose to 5MG warfarin 3 days/wk on Mondays, Wednesdays, and Fridays and 2.5MG warfarin 4 days/wk on all other days. Recheck INR on 8/12/24 & fax results."
08/12/2024 - "Patient to continue 5mg warfarin 3 days/wk on Mondays, Wednesday & Fridays and 2.5mg warfarin 4 days/wk on all other days. Recheck INR in 2 wks & fax results."

On 09/19/2024, Surveyor interviewed Licensed Practical Nurse (LPN) A. LPN A stated, "If med not in cart nurse should be notified, written up if nurse not notified." LPN A stated nurses get notified if med not given and charting not completed, or if prepped and not passed or if no follow up charting is completed." At 8:56 AM, LPN A contacted Nurse B. Nurse B stated ECP had an end date, and the med is discontinued, new order needs to be put in computer. LPN A confirmed the facility receives doctors' orders, but then faxes the new orders to pharmacy and pharmacy enters the orders in the computer. LPN A called pharmacy during visit and Pharmacy C confirmed the pharmacy did not received the 07/03/2024 order to continue current dose of warfarin. Pharmacy received a Kerlix order 07/01/2024, out of stock for bandage roll on 07/05/2024, and warfarin on 07/26/2024 for 7.5mg dose 8:00 PM, 5mg 07/27/2024 and 07/28/2024, and 2.5 mg daily starting 07/29/2024. LPN A stated after reviewing, the order has an end date with a 12:01 AM time. Medications would be ended at 12:01 AM and the med would not be passed that day as it would not show on the MAR. LPN A confirmed staff should have

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N 352	Continued From page 3 questioned medications in the cart not being given. LPN A confirmed s/he would not receive notification for med not passed as the med would have been discontinued at 12:01 AM on 07/04/2024. LPN A stated s/he would work with pharmacy to ensure this doesn't happen going forward. LPN A reviewed another resident with Warfarin and that resident did not have a time identified with the end date. LPN A confirmed the same thing happened in August with the end time and timing of the new order being put in the computer for Resident 1 missing additional doses. LPN A stated Resident 1 went to the ER on 09/09/2024, and doctor held the 9/10/2024 dose as it was given 09/09/2024. LPN A confirmed 09/09/2024 was not given as the computer discontinued the med at 12:01 AM on 09/09/2024. The provider did not ensure administration of medication for 1 of 1 resident in the intervals prescribed by a practitioner.	N 352		