STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011680	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOSEPHINE VERONICA HAUS	635 BONDOW DRIVE NEENAH, WI 54956

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N 000	Initial Comments On 03/20/2025 with additional information gathered through 04/08/2025, Surveyor conducted a standard survey and complaint investigation. As a result 2 deficiencies were identified. The complaint was substantiated. Census: 10	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. Resident 1 required emergency room treatment and hospitalization after being administered medications prescribed for a different resident, which resulted in an adverse reaction. Findings include: On 03/02/2025, the Department received a concern regarding medication administration.	N 165		

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

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N 165	Continued From page 1 On 03/20/2025, Surveyor reviewed Resident 1's medical record. Resident 1 had a guardian and required staff to administer all his/her medications. Resident 1's ISP (Individual Service Plan) dated 10/18/2024 indicated, Resident 1 required partial assistance with bathing and dressing and was independent with toileting, eating, grooming, positioning, transferring and ambulation, with a wheeled walker. An "Incident Report" dated 03/01/2025 indicated, "[Caregiver C] was prepping [Resident 2's] AM meds. [Resident 1] entered the dining room...[Caregiver C] set [Resident 2's] meds to the side...[Caregiver C] prepped [Resident 1's] medications into [his/her] med cup on the med cart and turned to the water station to mix [his/her] powder and "autopilot" grabbed the med cup next to the juice. Upon return to the cart [Caregiver C] saw [Resident 1's] full med cup still on the cart. [Caregiver C] was in a state of shock in realizing this astronomical mistake and for some reason after a panic attack, passed [Resident 1's] meds too. [Caregiver C] didn't want [Resident 1] to not get what [s/he] was supposed to....[Resident 1] ate breakfast normally, fell asleep in [his/her] chair, was barely able to ambulate with a walker to the lunch table... [Resident 1] was clearly not [him/herself] and could barely sit up enough to eat ...[Resident 1] did not look fine. Told Manager/On-call we need to send [Resident 1] out." On 04/08/2025, Surveyor reviewed Resident 1's Hospital Discharge Summary dated 03/06/2025 which indicated, "Date of admission: 03/01/2025. Date of Discharge: 03/06/2025...Chief complaint on admission and Primary discharge diagnosis: Accidental overdose...Summary of initial presentation: ...[Resident 1] was brought into the ED for evaluation after [s/he] was accidentally	N 165		

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N 165	Continued From page 2 given another residents medications. [Resident 1] was obtunded and minimally responsive on arrival...Hospital Course : 1. Neuroleptic malignant syndrome secondary to accidental drug overdose. [Resident 1] was unfortunately given someone else's medications in addition to [his/her] own which included clozapine. [Resident 1] developed neuroleptic malignant syndrome with significant fever, tachycardia, and muscle rigidity about 12 hours after ingestion of the medication. CK rose significantly until 3/5/2025, but has trended down now. Nontraumatic rhabdomyolysis has resolved...Physical Therapy and Occupational Therapy currently recommending slow-paced inpatient rehabilitation due to severe weakness...Order(s) for Discharge: Homecare and Therapy visits" On 03/20/2025 at approximately 11:00 AM, the requirement for reporting to the Department was reviewed with Licensee B and Director A. Licensee B and Director A confirmed with Surveyor a written report of the above incident involving Resident 1 had not been reported to the Department as required. Licensee B stated, "We should've reported the incident, but we didn't."	N 165		
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:	N 352		

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N 352	Continued From page 3 Based on record review and interviews, the provider did not ensure residents right to receive all medications as prescribed by their physician. On 03/01/2025, Resident 1 was given Resident 2's eight (8) AM medications along with his/her own prescribed medications. Following this incident Resident 1 became lethargic and weak and was sent to the ED (Emergency Department) for evaluation. Resident 1 developed NMS (Neuroleptic malignant syndrome) and was hospitalized for five days. On 03/06/2025, Resident 1 was discharged back to the facility with orders for physical and occupational therapy. Findings include: According to https://www.webmd.com/schizophrenia/what-is-neuroleptic-malignant-syndrome, last reviewed on 04/16/2024 indicated, "NMS is a rare reaction to antipsychotic drugs that are used to treat schizophrenia, bipolar disorder, and other mental health conditions. It affects the nervous system and causes symptoms such as a high fever and muscle stiffness. The condition is serious but treatable. Most people who get it make a full recovery if it's found early..." On 03/02/2025, the Department received a concern regarding medication administration. On 03/20/2025, Surveyor reviewed Resident 1's medical record. The record indicated Resident 1 was admitted to the facility on 02/09/2021 with diagnoses of depression, anxiety and schizoid personality disorder. Resident 1 had a guardian and required staff to administer all his/her medications. Resident 1's ISP (Individual Service Plan) dated 10/18/2024 indicated, Resident 1	N 352		

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N 352	Continued From page 4	N 352		

required partial assistance with bathing and dressing and was independent with toileting, eating, grooming, positioning, transferring and ambulated with a wheeled walker.

Review of Resident 1's "Incident Report" dated 03/01/2025 indicated, "[Caregiver C] was prepping [Resident 2's] AM meds. [Resident 1] entered the dining room...[Caregiver C] set [Resident 2's] meds to the side...[Caregiver C] prepped [Resident 1's] medications into [his/her] med cup on the med cart and turned to the water station to mix [his/her] powder and "autopilot" grabbed the med cup next to the juice. Upon return to the cart [Caregiver C] saw [Resident 1's] full med cup still on the cart. [Caregiver C] was in a state of shock in realizing this astronomical mistake and for some reason after a panic attack, passed [Resident 1's] meds too. [Caregiver C] didn't want [Resident 1] to not get what [s/he] was supposed to. Notified on-call, pharmacist, provider and attempted to notify guardian...Was advised by pharmacist [Resident 1] will likely continue to experience lethargy, weakness and may sleep a lot and we should continue to monitor. [Resident 1] ate breakfast normally, fell asleep in [his/her] chair, was barely able to ambulate with a walker to the lunch table... [Resident 1] was clearly not [him/herself] and could barely sit up enough to eat...[Resident 1] did not look fine. Told Manager/On-call we need to send [Resident 1] out...EMTs arrived within minutes."

On 03/20/2025, Surveyor reviewed Resident 2's medication list, which included the following 8 AM medications:
*Benztroprine 2 mg (milligrams) tablet (an anti-tremor medication)
*Clozapine 200 mg tablet (a antipsychotic drug)

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N 352	Continued From page 5 *Docusate Sodium 100 mg capsule (a laxative) *Dutasteride/Tamsulosin 0.5 mg - 0.4 mg capsule (a medication used for urine retention) *Senna-S 17.2 mg - 100 mg tablet (a laxative) *Celecoxib 200 mg capsule (an anti-inflammatory) *Haloperidol 5 mg tablet (a antipsychotic drug) *Loratadine 10 mg tablet (an antihistamine) On 03/26/2025, Surveyor reviewed Resident 1's observation notes from 03/01/2025-03/07/2025 and the following was noted: *03/01/2025- "...[Resident 1] got admitted to Theda Clark..." *03/03/2025- "[Resident 1] remains inpatient receiving IV fluids and working with therapy. PT (physical therapy) completed their initial assessment this afternoon noting poor direction following, poor arousal and difficulty with bed transfers and mobility. [Resident 1] presents with overall decreased activity tolerance. [Resident 1] will remain inpatient today and continue with inpatient PT/OT. [Resident 1] symptoms of NMS from the accidental Clozapine ingestion have resolved. UPDATE on [Resident 1] initially evaluated in ED with thoughts [s/he] may require intubation, but initially had improved alertness. Poison control recommended overnight observation after incorrectly receiving Cogentin, Celebrex, Clozaril, Haldol, MVI, Senna, Loratadine. EKG was appropriate. Yesterday developed a fever of unknown origin and continues to be monitored closely, receiving IV fluids. Blood cultures pending." *03/06/2025- "[Resident 1] returned today from the hospital right before supper..." *03/07/2025- "[Resident 1] will be working with Theda at Home for PT/OT..." On 04/08/2025, Surveyor reviewed the ED report	N 352		

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N 352	Continued From page 6 for Resident 1 dated 03/01/2025 which indicated, "Chief Complaint: Accidental Drug Ingestion. [Resident 1] was given [his/her] regular medications this morning along with someone else's medication at 0930. [Resident 1] did walk to the dining room, but is now minimally responsive and sleeping...[Resident 1] was brought in by EMS for chief complaint of somnolence...This incident took place around 0830-0930 this morning. [Resident 1] started becoming somnolent with increased sleepiness so resident was brought to ED for evaluation... [Resident 1] was given the following wrong meds between 0830-0930, Benztropine, Celecoxib, Clozapine, Docusate Sodium, Dutasteride/Tamsulosin, Haloperidol, Loratadine, Multivitamin, and Senna-S...ED SUMMARY AND PLAN: [Resident 1] was placed on a cardiac monitor with continuous pulse ox and periodic measurement of blood pressure throughout the stay in the ED. Dx: Accidental medication overdose...ED course: [Resident 1] presents to ED for evaluation after medication overdose...Discussed the case with hospitalist service will admit the resident..." On 04/08/2025, Surveyor reviewed Resident 1's Hospital Discharge Summary dated 03/06/2025 which indicated, "Date of admission: 03/01/2025. Date of Discharge: 03/06/2025...Chief complaint on admission and primary discharge diagnosis: Accidental overdose...Summary of initial presentation: ...[Resident 1] was brought into the ED for evaluation after [s/he] was accidentally given another residents medications. [Resident 1] was obtunded and minimally responsive on arrival...Hospital Course : 1. Neuroleptic malignant syndrome secondary to accidental drug overdose. [Resident 1] was unfortunately given someone else's medications in addition to	N 352		

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N 352	Continued From page 7 [his/her] own which included clozapine. [Resident 1] developed neuroleptic malignant syndrome with significant fever, tachycardia, and muscle rigidity about 12 hours after ingestion of the medication. CK rose significantly until 03/05/2025, but has trended down now. Nontraumatic rhabdomyolysis has resolved...PT and OT currently recommending slow-paced inpatient rehabilitation due to severe weakness...Order(s) for Discharge: Homecare and Therapy visits." On 03/20/2025 at 10:00 AM, Surveyor questioned Director A regarding the medication error with Resident 1 on 03/01/2025. Director A verified the medication error occurred and stated, "[Caregiver C] gave [Resident 1] all of [Resident 2's] 8 AM medications by mistake, and then gave [Resident 1] all of [his/her] scheduled 8 AM medications on top of receiving [Resident 2's] AM medications." Director A went on to say, "[Caregiver C] called the pharmacy after the incident, but [s/he] did not wait for the pharmacy to call back and decided to administer all of [Resident 1's] prescribed AM medications...[Caregiver C] also called on-call after the incident and [Resident 1] seemed to be ok. When I arrived around noon, [Resident 1] seemed very lethargic and we sent [him/her] out to the ED." Surveyor asked Director A what steps were taken following this incident. Director A stated, "After the med error [Caregiver C] received a verbal warning, was taken off the medication cart, and re-trained on the facility's medication administration procedures." Surveyor then asked if all staff who passed medications in the facility were re-trained on the facility's medication administration procedures following this incident. Director A stated, "No, only [Caregiver C]."	N 352		

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N 352	Continued From page 8 On 03/20/2025 at 11:00 AM, Surveyor interviewed Licensee B regarding the above medication error involving Resident 1. Licensee B stated, "[Caregiver C] administered both [Resident 2's] and [Resident 1's] prescribed 8 AM meds to [Resident 1] the morning of 03/01/2025...Following the incident we immediately took [Caregiver C] off all med pass duties...[Caregiver C] will have to do a clinical check/re-train with our Registered Nurse in order for [her/him] to pass meds again." Surveyor then asked Licensee B if all staff with med pass duties were re-trained following the incident. Licensee B stated, "[Caregiver C] was retrained, but no other staff. We felt this was an isolated incident and haven't had any issues with other staff."	N 352		