STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	R-C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 08/15/2024, Surveyors conducted a verification visit at Hope Stay Memory Care. Data collection continued through 08/29/2024. One deficiency was identified. One deficiency was a repeat violation. See Statement of Deficiency (SOD) 95N711, dated 09/15/2022, SOD J0PF11, dated 10/06/2023, and SOD J0PF12, dated 06/04/2024. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 26	{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 ensure Resident 1 received his/her prescribed medication as ordered. This is a repeat deficiency. See Statement of Deficiency (SOD) 95N711, dated 09/15/2022, SOD J0PF11, dated 10/06/2023, and SOD J0PF12, dated 06/04/2024. Findings include:	{N 352}		

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

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{N 352}	Continued From page 1 The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. On 08/15/2024, at 10:15 AM, Surveyors interviewed Registered Nurse (RN) B. RN B provided Surveyors with updated policies and procedures related to medication administration. RN B stated s/he had access to the pharmacy website which allowed him/her to see all the medications the provider was responsible for filling. RN B stated s/he completed weekly medication reviews. When asked about any recent medication errors, RN B stated a resident recently missed a medication over the weekend. RN B estimated the missed medication happened within the last week or 2. RN B could not recall the name of the resident but indicated s/he would try to find out. At approximately 11:55 AM, Surveyor requested Resident 1's records from the provider. At approximately 1:30 PM, RN B stated Resident 1 had missed his/her Duloxetine medication on 08/11/2024 and 08/12/2024. RN B stated it was missed on a weekend and s/he called the pharmacy right away on Monday. At approximately 1:55 PM, Surveyor interviewed Caregiver D, a designated medication passer. Caregiver D accessed the provider's computer and was able to review the medication administration history for Resident 1. Caregiver D stated the provider did not have Resident 1's Duloxetine on 08/11/2024 or 08/12/2024. Caregiver D stated a note was written on both dates indicating Duloxetine was not available to give.	{N 352}		

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{N 352}	Continued From page 2 At 2:00 PM, Surveyors reviewed Resident 1's records. Resident 1 was admitted on 05/24/2023 with multiple diagnoses including the following: anxiety disorder, personality disorder and major depressive disorder, single episode, unspecified. The Medication Administration Record (MAR) for August 2024 showed the following orders: -Duloxetine Cap 30MG, Give 3 Capsules (90MG) by Mouth Once Daily, to be given at 9:00 PM. The column attached to the order was signed off as administered by staff on 08/01/2024 through 08/08/2024. The remainder of the column was shaded gray, with no entries. -Duloxetine Cap 30MG, Give 3 Capsules (90MG) by Mouth Once Daily, Do Not Crush, Prescriber Only Wrote for 30 Day Supply, to be given at 9:00 AM. The column attached to the order was signed off as administered by staff on 08/10/2024. On 08/11/2024 and 08/12/2024, the entries were shaded black with "OTH" written where staff initials were typically entered. -On 08/09/2024, there was no indication Duloxetine was given. It was not signed off as administered, and was shaded gray on the MAR. At approximately 2:45 PM, Surveyors interviewed RN B. When asked about Resident 1's Duloxetine order and why it was shaded gray on the MAR and not signed off as administered on 08/09/2024, RN B stated s/he was not sure what happened. RN B stated that when a medication was shaded gray on the MAR, it usually meant the medication was not scheduled. RN B stated it was a MAR issue. RN B stated the medication was signed off as given up until 08/08/2024, and that was where s/he was stuck. When asked why	{N 352}		

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Duloxetine appeared to be given on 08/10/2024 but was unaccounted for on 08/09/2024, and unavailable on 08/11/2024 and 08/12/2024, RN B stated it was possible the staff had some medication left over and mixed quantities to pass the medication. RN B stated the provider did not have the new medication card at that time. RN B stated that if the medication was there, s/he was not sure how it got switched to the AM (morning) slot. RN B accessed the provider's computer in attempt to identify what had happened with the medications. RN B stated the medication was not scheduled on 08/09/2024 for the AM or PM (afternoon) dose. RN B stated 08/10/2024 was highlighted red in the system, which signified there was something new with the order. RN B stated a note was entered on 08/12/2024 indicating Duloxetine was out of stock. RN B stated that if a medication order came in after 12:00 PM on a Friday, the provider would likely not receive it until Monday. RN B stated s/he could not have done anything over the weekend. RN B stated the pharmacy was closed on the weekend. RN B stated that in urgent cases, the provider had used an alternative pharmacy to obtain medication orders during the evening or weekend hours.

On 08/16/2024, Surveyors received an email with attachments from RN B regarding Resident 1's missed medication. The contents of the email read, in part, "I have done some research on the Duloxetine with [Resident 1] that was not given on 8/11 & 8/12/24 ...The only thing that didn't show in color were the two "no pass" where I wrote "in red" when the med (medication) passer thought the med was missing..."

In the email attachment labeled, "IMG_0003," there was a snapshot of what appeared to be the

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provider's electronic medication system. There was a handwritten note stating, "Duloxetine on MAR in computer to give 08/10/24 9:00 AM. As seen on bubble pack card #1. Spot 10 was given from the origanally [sic] labeled 9pm card also showing dates 1-8 given on PM's and the 9th missed because it was not in the MAR." In parenthesis next to the handwritten note, it stated, "Not sure why [sic] Computer glitch?"

In the email attachment labeled, "IMG_0004," there was another snapshot of the provider's electronic medication system. There was a handwritten note stating, "Scheduled on MAR for AM and no pass because card could not be found [sic] (it was in the PM spot [sic])

In the email attachment labeled, "IMG_0007," there was a snapshot of what appeared to be Resident 1's morning medications scheduled on 08/13/2024. There was a handwritten note stating, "Notified and back in office [sic] also [sic] to contact pharmacy when open that we needed a new card and 11, 12th were missed...The 11th and 12th were here just in the wrong spot in the cart. I have re-educated staff to always look threw [sic] the cart if a card cannot be found for this reason. How it switched from PM to AM in the MAR is a mystery."

On 08/19/2024, at 2:10 PM, Surveyor interviewed Pharmacy Representative (PR) F regarding Resident 1's medications. When asked to explain what may have happened to Resident 1's Duloxetine order, the representative stated that on 07/08/2024, the pharmacy received a request from the provider to refill the medication. PR F stated the pharmacy sent out a tote full of medications to the provider on 07/23/2024, including a 28-day supply of the Duloxetine

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medication. PR F stated the provider's new cycle started on 07/25/2024, which was the day the provider could start dispensing the medications for the current cycle. PR F stated the Duloxetine should have been available. PR F stated there should have been an active order for Resident 1's Duloxetine on 08/09/2024. PR F stated the pharmacy received a renewal for the same dose from Resident 1's medical provider on 08/08/2024. PR F stated the pharmacy sends out monthly notifications to the provider regarding all maintenance medications and Duloxetine was a maintenance medication. PR F stated the pharmacy implemented that practice, so the provider had time to review the medications and identify if anything was missing.

On 08/29/2024, at 9:00 AM, Surveyor interviewed Director of Operations (DOO) A, RN B, Licensee C, and Caregiver E. Surveyor discussed findings related to medication administration. RN B stated the situation with Resident 1's medication was accidental and was a mistake that could have happened with anyone. RN B stated the medication was at the facility and the medication card got mixed and put into the PM slot. RN B stated it was a matter of searching for the medication and not all staff did that. DOO A stated that if staff had followed protocol, the medication error would not have happened. DOO A stated the medication passer should have contacted someone for assistance with finding the medication. Licensee C stated the medication passer did not follow protocol. Caregiver E stated s/he attended a medication training recently which dealt with medication auditing practices and s/he would be sharing what was learned with the provider.