STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510381	A. BUILDING: _____ B. WING _____	C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD HILLS	1403 TRUAX BLVD EAU CLAIRE, WI 54703

(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 01/11/2024, Surveyor conducted a complaint investigation and abbreviated survey at Orchard Hills. Data collection continued through 01/12/2024. The complaint was unsubstantiated. Two deficiencies were identified. Census: 38	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 observation and interview, the provider did not ensure Resident 1 and Resident 2 received prescribed medications in the dosage and at intervals prescribed by a practitioner on 01/11/2024. Findings include: This facility is licensed to serve up to 40 residents in the client group advanced aged. RESIDENT 1 On 01/11/2024 at approximately 10:00 AM, Surveyor observed Caregiver D with an empty medication card. Caregiver D informed Caregiver	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		

E that s/he had to call the pharmacy to see if the medication had been re-ordered. The empty medication card had a label and was prescribed to Resident 1. The label read, "Acetaminophen-Hydrocodone 325 mg - 5 mg oral tablet. Give 1 to 2 tablets by mouth every 6 hours as needed for pain."

Surveyor asked Caregiver D if Resident 1 had requested the medication. Caregiver D stated, "Yeah, [s/he] requested it about 9:30 AM this morning."

Caregiver D called the pharmacy and informed Surveyor they were waiting for a script from the doctor to refill the medication.

On 01/11/2024 at approximately 11:15 AM, Surveyor interviewed Registered Nurse (RN) A and asked if there was evidence to show staff had contacted the pharmacy to refill Resident 1's medication. RN A stated, "We called the pharmacy yesterday." Surveyor asked who would have called the pharmacy to re-order the medication. RN A stated, "Staff scheduled yesterday would have called." Surveyor asked RN A if staff document when they contact the pharmacy. RN A stated staff do document in the medication administration record (MAR) if a medication is held or not available. RN A informed Surveyor that no documentation was available to show the pharmacy had been contacted about Resident 1's medication. RN A stated s/he would follow up with the staff person working with the pharmacy to see if they maintained a record of the request.

On 01/11/2024 at approximately 2:45 PM, Administrator B sent an email which read. in part, "[Pharmacy name] does not keep phone records

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N 352	Continued From page 2 when we call to request updates and/or refills. We will continue to document in our charts when we call to follow up on medication orders and requests." Resident 1 did not receive medication for pain when requested on 01/11/2024, as the medication was not available for staff to administer. RESIDENT 2 On 01/11/2024 at approximately 12:07 PM, Surveyor observed Caregiver D draw up a syringe for Resident 2's scheduled noon medication. The MAR read, "Megestrol Acetate 40MG/ML Suspension (1ml/40mg) by mouth daily for appetite stimulation." Surveyor observed the syringe drawn up by Caregiver D exceeded the 1 ml line on the syringe (approximately 0.1 ml more than the dose prescribed). Surveyor asked Caregiver D how much s/he had drawn up and Caregiver D stated, "1 ml." Caregiver D approached Resident 2 who was seated in the dining room and administered the medication. On 01/11/2024 at approximately 1:00 PM, Surveyor interviewed Registered Nurse (RN) A and asked if staff were trained on the use of syringes for liquid oral medication. RN A stated all staff were trained on "skills day" training annually and for new hires. Surveyor asked if Caregiver D had received the "skills day" training. RN A stated Caregiver D was signed up to attend on the 17th. Surveyor discussed with RNA A, Administrator B, and Assistant Director (AD) C, the concerns regarding the above observations of Caregiver D administering medications. Administrator B and	N 352		

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N 352	Continued From page 3 RN A informed Surveyor they would pull Caregiver D from the medication cart until s/he received further training. Resident 2 did not receive the correct dose of Megestrol Acetate when Caregiver D administered more than the prescribed dose.	N 352		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Caregiver D was delegated by a registered nurse or licensed practical nurse within the scope of their license to administer injectables, nebulizers, and enteral medication prior to performing tasks. Findings include: This facility is licensed to serve up to 40 residents in the client group advanced aged. Wis. Admin. Code § N 6.03(3) states, "In the supervision and direction of delegated acts an RN shall do all of the following: (a) Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.	N 416		

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N 416	Continued From page 4 (b) Provide direction and assistance to those supervised. (c) Observe and monitor the activities of those supervised. (d) Evaluate the effectiveness of acts performed under supervision." On 01/11/2024 at approximately 10:00 AM, Surveyor interviewed Caregiver D at the medication cart near the dining room about medication administration. During the interview, Caregiver D retrieved a bottle of nasal spray from the drawer and stated s/he was going to "administer a PRN (as needed medication)" to Resident 3, who had requested it. Caregiver D entered Resident 3's room where Resident 3 was receiving a nebulizer treatment. Surveyor asked Caregiver D if s/he administered the albuterol treatment to Resident 3. Caregiver D stated, "Yes." Caregiver D stopped the nebulizer machine and informed Resident 3 s/he was going to administer the nasal spray. Caregiver D took off the top of the spray bottle and quickly placed it back on (did not need to be removed). Caregiver D placed the tip of the spray bottle under Resident 3's left nostril and administered 2 sprays. Caregiver D then placed the tip of the bottle below Resident 3's right nostril and administered 2 sprays and instructed Resident 2 to breathe. The tip of the spray bottle did not enter Resident 2's nasal cavity to ensure the medication was properly administered. Caregiver D informed Surveyor s/he had not administered Resident 3's nasal spray before. Surveyor asked Caregiver D what s/he has administered for medications since s/he started passing medications. Caregiver D stated, "I've	N 416		

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N 416	Continued From page 5	N 416		

taken the med class and was trained by [Caregiver E]. I've done blood sugars, eye drops, nebulizers and pills."

On 01/11/2024 at approximately 11:20 AM, Surveyor interviewed Registered Nurse (RN) A and asked what the expectation was for the administration of nasal spray. RN A stated s/he would expect staff to pull up the order on the medication administration record (MAR), hold the opposite nostril down while inserting the tip into the other nostril to administer the medication into the nasal cavity. Surveyor asked RN A and Assistant Director (AD) C if Caregiver D had received delegation to administer nasal spray. RN A informed Surveyor Caregiver D was scheduled for the next "skills day" on the 17th. RN A further stated that Caregiver D had received objectives and met with AD C to get set up with training and had recently taken the medication course. RN A stated Caregiver D had also completed 4 days of training on the medication cart with Caregiver E. The responses provided by RN A and AD C did not confirm Caregiver D had been delegated tasks prior to performing them.

On 01/11/2024 at approximately 12:45 PM, Surveyor interviewed Caregiver E and asked if s/he had credentials for delegating medication tasks. Caregiver E stated, "I'm a CNA (certified nursing assistant) and a lead. [RN A] is a nurse and can delegate tasks."

On 01/11/2024 at 2:45 PM, Surveyor received an email from Administrator B which read, in part, "Going forward, during orientation we will ensure we schedule the new employee for skills check off with the facility RN to be completed and signed off prior to them being on the floor by themselves. We will continue to complete annual

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N 416	Continued From page 6 skills check offs with all employees." On 01/12/2024 at 1:14 PM, Surveyor received an email from RN A stating s/he would be responsible, moving forward, for delegating tasks to non-licensed staff.	N 416		