STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011976	A. BUILDING: _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COURT	3515 E HAMILTON AVE EAU CLAIRE, WI 54701

(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 10/17/2023, Surveyor conducted a complaint investigation at Heritage Court. The complaint was substantiated. One deficiency was identified. Census: 32	N 000		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure medications were locked and the key available to designated staff when the key code to enter the medication storage room was shared between staff and the keys were left on top of the medication cart. Findings include: On 08/28/2023, the Department received a complaint regarding medication storage and missing medications. On 10/17/2023, Surveyor requested investigations of missing medication from Administrator A. RECORD REVIEW On 10/17/2023 at 11:35 AM, Administrator A provided Surveyor with the "Misconduct Incident Report" submitted to the Office of Caregiver Quality. The report read, "On 08/26/23 at 6:30AM,	N 419		

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

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N 419	Continued From page 1	N 419		

while counting controlled substances, two cards were missing, with the count sheet for one of them being torn out of the controlled substance proof of use records. Both cards were accounted for during the count on 06/25/23 [sic] at 9:45PM. Upon initial investigation, it was noted that during the NOC (overnight) shift, a non-med passing caregiver had been requesting the access code to the medication room. Another non-med passing caregiver with the code shared it with the other caregiver around 4:30AM on 06/26/23 [sic]. The requesting caregiver was observed entering the med room for about 10-minutes while facetiming someone else. [S/he] left the med room, went to the break room, grabbed [his/her] bag, and went to [his/her] car. Upon discovery of the missing narcotics, the two caregivers were suspending, pending investigation. [Local police] were notified and initiated their own investigation."

Administrator A confirmed the dates written above "06" should be "08" and as the incident occurred 08/25/23-08/26/23.

INTERVIEW

On 10/17/2023 at approximately 10:45 AM, Surveyor observed the medication storage room. The medication storage room was secured by a key code pad. Caregiver F was in the medication storage room at the time of observation. Caregiver F stated, "We switched meds (medications) to this one (room) after the incident. It used to be stored next door. Now the key code is only shared with designated med passers and management. I've been a med passer for years, so I keep the keys on me at all times, but we were also re-trained on keeping the keys on us if we're passing meds."

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N 419	Continued From page 2 On 10/17/2023 at approximately 11:40 AM, Surveyor interviewed Administrator A and asked for clarification on the incident. Administrator A provided the following information: - Resident 1 had a card of Alprazolam taken; count unknown as the narcotic count sheet was also taken/missing. - Resident 2 had a card of Oxycodone taken; 19 pills left in card. - Caregiver B verbally provided the keycode for the medication storage room to Caregiver C where the medication cart was stored with the medication cart keys on top. - Caregiver B and Caregiver C were not designated to pass medications, but Caregiver B was training to pass medications, so s/he knew the code. - The designated med passer for NOC shift was another caregiver who was working at the RCAC (Residential Care Apartment Complex) down the street. (Approximately a 2-3-minute drive down the road. The RCAC is not connected to the facility). - The evening shift med passer counted narcotics on 08/25/2023 at 9:45 PM. The keys to access the medication cart and controlled schedule II drugs were left on top of the medication cart in the medication storage room. Room was accessible to all staff working NOC shift 08/25/2023-08/26/2023 (Caregiver B, Caregiver C, Caregiver D and Caregiver E) after Caregiver B verbally shared the code in the hallway. -After the incident the medication room was relocated to the next storage room over and separated from other general supplies so only staff designated to pass medications have access to medications. -The code was previously shared with non-medication passers because staff would	N 419		

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N 419	Continued From page 3 have to access supplies. -Staff designated to pass medications were re-trained on keeping the keys on them at all times during their shift and not sharing the medication storage room code with non-medication passers. -Local law enforcement was notified to assist in the investigation but could not determine who took the medications. -Two of the caregivers working were terminated and one caregiver self-terminated after s/he refused to take a drug test. -Staff designated to pass medications were re-trained on 09/05/2023 on the following topics: drug counting, abuse, neglect, fraud and medication pass reminders. Surveyor further discussed the concern with Administrator A that a key code pad was still being used to access the medication storage room. Administrator A stated s/he would be open to looking at alternative locks or frequently changing the keypad code to keep the storage room secured.	N 419		