STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017325	A. BUILDING: _____ B. WING _____	R-C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE SENIOR LIVING	**820 BEAR PAW AVE RICE LAKE, WI 54868**

(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 06/13/2023, Surveyor conducted a standard survey, verification visit, and complaint investigation at Cambridge Senior Living. Data was collected through 06/21/2023. One of 2 complaints was substantiated. One violation was identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 35.	{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 medications as ordered by the prescriber. Findings include: The provider is licensed to care for 68 residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's disease. On 04/12/2023, the Department received a complaint alleging Resident 1 had not received	N 352		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017325	A. BUILDING: _____ B. WING _____	R-C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE SENIOR LIVING	820 BEAR PAW AVE RICE LAKE, WI 54868

(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 352	Continued From page 1	N 352		

his/her nebulizer treatments as prescribed.

On 06/13/2023, from 11:38 AM to 11:47 AM, Surveyor interviewed Clinical Care Assistant (CCA) A. CCA A stated that when a medication was running low, they were directed to send a secure email to the nursing team who would order the medication. CCA A stated s/he had never borrowed a medication from a resident to administer to another resident.

On 06/13/2023, from 2:02 PM to 2:27 PM, Surveyor interviewed Clinical Care Coordinator (CCC) B. CCC B stated s/he was aware that Resident 1 ran out of nebulizer treatments and the issue was with the pharmacy. CCC B stated routine medications were automatically filled and sent to the provider every Tuesday. CCC B stated there may have been a shortage of this medication.

On 06/20/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 10/13/2022 and diagnosed with atherosclerotic heart disease of native coronary artery, hypertension, hypokalemia, hypothyroidism, chronic obstructive pulmonary disease (COPD) and vitamin B-12 deficiency. Resident 1 did have a power of attorney (POA) but it was not activated.

Resident 1's medication administration record (MAR), dated 01/01/2023-01/31/2023, indicated the following:
-"IPRA/ALB [Ipratropium/Albuterol] 0.5MG-3MG/3ML NEB SOL [nebulizer solution] use 1 vial via nebulizer twice daily for shortness of breath or wheezing (Related Diagnosis: Chronic obstructive pulmonary disease, unspecified)." The MAR indicated the AM dose on 01/03/2023 and 01/04/2023 were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017325	A. BUILDING: _____ B. WING _____	R-C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE SENIOR LIVING	820 BEAR PAW AVE RICE LAKE, WI 54868

(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 352	Continued From page 2	N 352		

administered because the medication was not available.

Resident 1's PROGRESS NOTES, dated 01/04/2023 9:58 AM, read, in part, "[Resident 1's] [Family Member] approached staff quite consistently this morning regarding [Resident 1's] nebulizer treatments. Staff had alerted writer yesterday that the treatments were out, and they were immediately called into Pharmacy [sic] for a refill. They are scheduled to arrive with [sic] today, 1/4/23 with [sic] Pharmacy delivery ...also letting [Family Member] know that they cannot take a nebulizer treatment from another resident's meds."
-Entry on 01/05/2023 08:47 AM, read, in part, "[Resident 1] was sent out by EMS [emergency medical services] per [Family Member]. [Resident 1] was lethargic and per EMS, shows signs of infection or sepsis."

On 06/21/2023, from 11:04 PM to 12:13 PM, Surveyor interviewed Regional Director of Operations (RDO) C, Administrator D, and President E. RDO C stated it was their policy to notify a resident's physician when a medication was not administered for 2 days and they notify the pharmacy when 7 days remain of a medication. RDO C stated there had been delays with receiving updated medication orders from the physician. Administrator D stated s/he recalled Resident 1's family did not want to wait for nebulizer treatment to be refilled and had it filled at another pharmacy.

At approximately 4:45 PM, Surveyor interviewed RDO C. RDO C stated Resident 1's situation was unique because insurance denied the medication refill.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017325	A. BUILDING: _____ B. WING _____	R-C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE SENIOR LIVING	**820 BEAR PAW AVE RICE LAKE, WI 54868**

(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 352	Continued From page 3 The provider did not ensure Resident 1 received his/her Ipratropium Nebulizer Solution medication as ordered, resulting in the AM dose of medication not being administered for 2 consecutive days.	N 352		