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 07/30/2024

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 07/24/2024, Surveyors conducted a verification visit, a complaint investigation, and a self-report investigation at Cambridge Senior Living. Data was collected through 07/30/2024. The complaint was substantiated. Two violations were identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 39.	{N 000}		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure a medication error was documented in the record or immediately reported to a licensed practitioner, supervising	N 410		

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 07/30/2024

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 410	Continued From page 1 nurse, or pharmacist. Findings include: On 05/31/2024, the Department received a complaint about a medication error. The provider is licensed to care for 68 residents in the client groups advanced aged, physically disabled, and irreversible dementia/Alzheimer's disease. On 7/25/2024 at approximately 3:16 PM, Surveyor interviewed Caregiver D, who stated that on 5/23/2024, s/he was doing PM (evening) medication pass when Caregiver E gave Resident 1 the wrong medication. Surveyor asked Caregiver D what s/he did following the medication error. Caregiver D stated that Caregiver F called the MOD (management on call) who did not give them specific orders other than to check on the resident every two hours. Caregiver D did not recall if Resident 1's medical provider or poison control was called that night. On 7/24/2024, at 2:45 PM, Surveyor interviewed Caregiver E, who stated s/he was asked to help give medication to Resident 1 so s/he picked up the cups that Caregiver D set on the medication cart, thinking they were for Resident 1. Caregiver E stated that when s/he came out of Resident 1's room, Caregiver F told him/her that s/he had given the wrong medication to Resident 1. Caregiver E stated management was updated but was unsure what they were to do for follow-up. Surveyor reviewed Resident 1's record. Resident 1 was admitted on 09/16/2021 and diagnosed with major depressive disorder and Alzheimer's disease. Resident 1 had an activated power of	N 410		

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 07/30/2024

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 410	Continued From page 2	N 410		

attorney. The medication administration record (MAR) dated 05/01/2024 to 05/31/2024 indicated Resident 1 was to receive the following medication at 8:00 PM: Aspirin 81 mg (milligram): chew 1 tablet at bedtime. The MAR did not indicate there was a medication error on 05/23/2024 and there was no documentation that blood pressure or other vitals were taken.

On 07/25/2024, Surveyor received an email communication from Administrator A that included the Policy and Procedure for Medication Errors and read, in part, " ...Processing a Medication Error ...Any staff member being involved, witnessing, or first discovering a medication error should report the incident promptly to the RN [registered nurse]/LPN [licensed practical nurse]/designee. Assess the resident for side effects, including vital signs ...error must be documented on the Medication Error Report. Nursing Services ...must notify the primary physician of medication incidents ...Clinical Care Assistant will meet and review the medication error with Nursing Services ...will observe a medication pass ...and complete a Medication Observation Competency Evaluation."

Surveyor reviewed progress notes for Resident 1, dated 05/24/2024, that read, in part, "Writer sent a fax today to [Resident 1's] primary physician to inform [him/her] of the medication error that occurred on 05/23/2024 at 8:30pm where staff gave [Resident 1] another resident's medication ...".

Surveyor reviewed medication error reports from 05/01/2024 to 07/24/2024, provided by Administrator A that included 3 medication error reports. The documents did not include a medication error report for Resident 1.

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 07/30/2024

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 410	Continued From page 3 On 07/24/2024 at approximately 2:30 PM, Surveyor interviewed Administrator A, who stated s/he became aware of a medication error with Resident 1 on 05/24/2024, when reviewing progress notes. Administrator A stated, "We need more staff direction on medication errors, staff need to know who to turn to." Administrator A stated s/he had reached out to Poison Control and found they had no records of a call from the provider regarding a medication error with Resident 1. On 07/30/2024, from 10:09 AM to 10:46 AM, Surveyor interviewed Administrator A, who stated s/he would have been the MOD on call on 05/23/2024. Administrator A stated poison control should have been called or Resident 1's medical provider should have been contacted. Surveyor inquired if a medical provider was contacted on 05/23/2024, to which s/he responded, "No." Administrator A stated that if directed to take vitals, they would have been recorded on the MAR. The provider did not ensure Resident 1's medication error was documented or that his/her primary care physician was immediately notified when s/he was given another resident's anti-psychotic medication.	N 410		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of	N 432		

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 07/30/2024

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 432	Continued From page 4 the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure medications were correctly administered when a resident was given the wrong medication. Findings include: On 05/31/2024, the Department received a complaint about a medication error. The provider is licensed to care for 68 residents in the client groups advanced aged, physically disabled, and irreversible dementia/Alzheimer's disease. On 07/24/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 09/16/2021 and diagnosed with major depressive disorder and Alzheimer's disease. Resident 1 had an activated power of attorney. On 7/25/2024 at approximately 3:16 PM, Surveyor interviewed Caregiver D, who stated on 5/23/2024 s/he was doing PM (evening) medication pass when Caregiver E gave Resident 1 the wrong medication. Caregiver D stated she was helping another resident when Resident 1 rang and had wanted his/her nighttime medications. Caregiver D asked Caregiver E to help pass medications to Resident 1. Caregiver D set Resident 1's medication in front of Caregiver	N 432		

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 07/30/2024

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 432	Continued From page 5	N 432		

E. At this same time, Caregiver D was preparing Resident 2's PM medications. Caregiver D stated that Caregiver E grabbed both cups of medication and passed them to Resident 1. Surveyor asked Caregiver D what they did following the medication error. Caregiver D stated that Caregiver F called the management on call who did not give them specific orders other than to check on the resident every two hours. Caregiver D did not recall if Resident 1's medical provider or poison control was called that night. Caregiver D stated s/he thought the pill administered to Resident 1 was a sleeping pill.

On 7/24/2024, at 2:45 PM, Surveyor interviewed Caregiver E, who stated s/he was asked to help give medication to Resident 1. Caregiver E stated she was trained to only prepare 1 resident's medication at a time, so s/he grabbed the cups that Caregiver D had set on the medication cart, thinking they were for Resident 1. Caregiver E stated that when s/he came out of Resident 1's room, Caregiver F told her that s/he had given the wrong medication to Resident 1. Caregiver E stated management was updated but was unsure what they stated to do for follow up.

On 7/24/2024, at 11:20 AM Surveyor interviewed Caregiver C, who stated that during med pass, s/he had never witnessed a caregiver, not assigned to administer medications, take a medication cup filled with medication and administer the medication without setting the medication up him/herself.

At approximately 2:30 PM, Surveyor interviewed Administrator A, hired 02/01/2024, who stated s/he did not know where Resident 1's medication error report was. Administrator A stated Licensed Practical Nurse (LPM) B may not have completed

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 07/30/2024

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 432	Continued From page 6	N 432		

the report and that s/he was no longer employed as of 06/05/2024.

Surveyor reviewed Resident 1's medication administration report (MAR), dated 05/01/2024 to 05/31/2024. The report did not include information that Resident 1 was given an incorrect medication on 05/23/2024.

Surveyor reviewed a document prepared by Administrator A that was faxed to Resident 1's medical provider on 05/24/2024 at 12:18 PM that read, in part, "..inform you that there was a medication error on [Resident 1]. On 05/23/2024 at 8:30pm by mistake the staff had given [him/her] another resident's pill which was Quetiapine 50mg tablet ..."

On 07/30/2024 from 10:09 AM to 10:46 AM, Surveyor interviewed Administrator A, who stated s/he was the manager on duty (MOD) on 05/23/2024 and had spoken to staff about Resident 1's medication error. Administrator A stated that any vitals staff were directed to take would have been recorded in his/her record. Surveyor inquired if it is policy for a medication passer to ask another staff to pass a medication and Administrator A stated this was not normal procedure.

The provider did not ensure Resident 1 received medications as prescribed when Resident 2's evening Quetiapine was incorrectly administered.