| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017383 | A. BUILDING: _____ B. WING _____ | C 06/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LEGACY AT NOEL MANOR (THE) | 435 PRAIRIE OAKS BLVD VERONA, WI 53593 |

| (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 |
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| N 000 | Initial Comments<br><br>On 06/28/2023, Surveyor conducted a complaint investigation at Legacy at Noel Manor, a CBRF in Verona.<br><br>Two deficiencies were identified. One is a repeat deficiency - See Statement of Deficiency (SOD) 1IUL11, dated 12/30/2022.<br><br>The complaint was substantiated.<br><br>Census: 26 | N 000 | | |
| N 352 | 83.32(3)(h) Rights of Residents: Receive medication<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed received all medications as prescribed.<br><br>Resident 1 did not receive his/her Oxycodone Hcl 10 mg as prescribed for pain.<br><br>Resident 2 did not receive his/her Acetaminophen 325 mg as prescribed for pain or fever.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 1IUL11, dated 12/30/2022.<br><br>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<br>On 06/28/2023, Surveyor conducted a complaint investigation regarding the facility's medication management.<br>At approximately 1:30 p.m., Surveyor reviewed records and conducted interviews, which concluded the following concerns:<br><br>Example 1 - Resident 1:<br><br>The facility's records included documentation of a medication error. The documentation stated that on 06/17/2023 the facility ran out of Resident 1's Oxycodone 10 mg so his/her Oxycodone 5 mg PRN was administered as a replacement, which was half the dose of Resident 1's scheduled Oxycodone. The report stated Resident 1 was upset s/he didn't receive his/her full dose of Oxycodone.<br><br>Surveyor then reviewed Resident 1's record and the facility's narcotic counts. Resident 1's physician orders included Oxycodone Hcl 10 mg (Start Date: 06/02/2023) - Take 1 tablet 3 times daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m. and Oxycodone 5 mg (Start Date: 02/01/2023) - Give 1 tablet every 6 hours as needed for pain. The facility's narcotic counts indicated the facility had no Oxycodone 10 mg remaining on 06/17/2023 at 8:00 a.m. and no Oxycodone 5 mg remaining on 06/18/2023 at 8:37 a.m. A refill of Oxycodone 10 mg arrived at the facility after Resident 1's 2:00 p.m. dose on 06/18/2023.<br><br>Surveyor reviewed Resident 1's Medication Administration Record (MAR) and the facility's narcotic counts with Community Director A, which indicated the following:<br><br>- Resident 1 received Oxycodone 5 mg instead of Oxycodone 10 mg on 06/17/2023 at 2:00 p.m., | N 352 | | |

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| N 352 | Continued From page 2<br>06/17/2023 at 8:00 p.m. and 06/18/2023 at 8:37 a.m.<br>- Resident 1 didn't receive any Oxycodone on 06/18/2023 at 2:00 p.m.<br><br>At approximately 2:45 p.m., Surveyor reviewed concern with Community Director A, Executive Director B and Care Coordinator C that Resident 1 did not receive his/her Oxycodone 10 mg as prescribed on 06/17/2023 at 2:00 p.m. and 8:00 p.m. and 06/18/2023 at 8:00 a.m. and 2:00 p.m. Executive Director B acknowledged concern and stated Resident 1 was prescribed the medication because s/he had cancer. Care Coordinator C stated the Director of Nursing worked with hospice to get a refill delivered to the facility as soon as s/he was aware of the concern.<br><br>Example 2 - Resident 2<br><br>Resident 2 was admitted to the provider's facility on 10/24/2022. Resident 2's physician orders included Acetaminophen 325 mg (Start Date: 06/01/2023) - Take 2 tablets at 2:00 a.m., 8:00 a.m., 2:00 p.m. and 8:00 p.m. Resident 2's MAR, dated 06/01/2023 to 06/28/2023, had blank entries for his/her Acetaminophen 325 mg at 2:00 a.m. on 06/11/2023, 06/14/2023, 06/19/2023, 06/22/2023 and 06/24/2023.<br><br>Surveyor asked Community Director A about the blank entries for Resident 2's Acetaminophen 325 mg. Community Director A and Surveyor then reviewed the facility's narcotic counts which concluded Resident 2 did not receive his/her Acetaminophen 325 mg on 06/11/2023. Community Director A stated sometimes med passers come over from another facility within their organization to administer nighttime medications and the med passer may have | N 352 | | |

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| N 352 | Continued From page 3<br>gotten busy and been unable to administer medications that evening.<br><br>Cross Reference: N0415 DHS 83.37(2)(d) Documentation Of Medication Administration | N 352 | | |
| N 415 | 83.37(2)(d) Documentation of medication administration.<br><br>Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not accurately document the administration of 2 of 3 residents reviewed.<br><br>The administration of Resident 1's Oxycodone 5 mg was documented as Oxycodone 10 mg 2 times from 06/01/2023 to 06/28/2023.<br><br>The administration of Resident 2's Acetaminophen 325 mg was not documented in his/her record 4 times from 06/01/2023 to 06/28/2023.<br><br>Findings include: | N 415 | | |

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|---|---|---|---|---|
| N 415 | Continued From page 4<br><br>On 06/28/2023, Surveyor conducted a complaint investigation regarding the facility's medication management.<br>At approximately 1:30 p.m., Surveyor reviewed records and conducted interviews, which concluded the following concerns:<br><br>Example 1 - Resident 1:<br><br>The facility's record included documentation of a medication error. The documentation stated that on 06/17/2023 the facility ran out of Resident 1's Oxycodone 10 mg and his/her Oxycodone 5 mg PRN was administered as a replacement, which was half the dose of Resident 1's scheduled Oxycodone.<br><br>Surveyor reviewed Resident 1's record and the facility's narcotic counts. Resident 1's physician orders included Oxycodone Hcl 10 mg (Start Date: 06/02/2023) - Take 1 tablet 3 times daily at 8:00 a.m., 2:00 p.m. and 8:00 a.m. and Oxycodone 5 mg (Start Date: 02/01/2023) - Give 1 tablet every 6 hours as needed for pain. The facility's narcotic counts indicated the facility had 0 Oxycodone 10 mg left on 06/17/2023 at 8:00 a.m. A refill of Oxycodone 10 mg arrived to the facility after Resident 1's 2:00 p.m. dose on 06/18/2023.<br><br>Surveyor reviewed the facility's narcotic counts with Community Director A which concluded the following: Resident 1 received Oxycodone 5 mg instead of Oxycodone 10 mg on 06/17/2023 at 2:00 p.m., 06/17/2023 at 8:00 p.m. and 06/18/2023 at 8:37 a.m.<br><br>Surveyor reviewed Resident 1's Medication Administration Record (MAR), dated 06/01/2023 | N 415 | | |

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| N 415 | Continued From page 5 | N 415 | | |

to 06/28/2023. The MAR documented Resident 1 received Oxycodone 10 mg, rather than Oxycodone 5 mg that was administered, on 06/17/2023 at 2:00 p.m. and 8:00 p.m.

At approximately 2:45 p.m., Surveyor reviewed concern with Community Director A, Executive Director B and Care Coordinator C that Resident 1 received Oxycodone 5 mg on 06/17/2023 at 2:00 p.m. and 06/17/2023 at 8:00 p.m., but med passers documented Oxycodone 10 mg as administered. All 3 individuals nodded their heads in understanding of the concern.

Example 2 - Resident 2

Resident 2 was admitted to the provider's facility on 10/24/2022. Resident 2's physician orders included Acetaminophen 325 mg (Start Date: 06/01/2023) - Take 2 tablets at 2:00 a.m., 8:00 a.m., 2:00 p.m. and 8:00 p.m. Resident 2's MAR, dated 06/01/2023 to 06/28/2023, had blank entries for his/her Acetaminophen 325 mg at 2:00 a.m. on 06/11/2023, 06/14/2023, 06/19/2023, 06/22/2023 and 06/24/2023.

Surveyor reviewed the facility's narcotic counts with Community Director A which concluded Resident 2 did receive his/her Acetaminophen 325 mg on 06/14/2023, 06/19/2023, 06/22/2023 and 06/24/2023, but the med passer did not document administration. Community Director A stated sometimes med passers come over from another facility within their organization to administer nighttime medications and the med passer may have forgotten to document administration.

Cross Reference: N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication

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