STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018392	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARIA CRESENTIA CBRF	16770 WEST NORTH AVENUE BROOKFIELD, WI 53005

(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 07/18/2023 with information gathered through 07/20/2023, Surveyor conducted a complaint investigation at St Maria Crescentia CBRF. Two deficiencies were identified. The complaint was substantiated. Census: 7	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 staff interview, the provider did not ensure Resident 1 received pain medication, as ordered by the physician following a knee injury, due to the medication not being available. Findings include: On 07/18/2023, Surveyor reviewed the record of Resident 1. Resident 1's diagnoses included epilepsy and severe intellectual disability. Resident 1's physician ordered Acetaminophen 325 MG take 2 tablets by mouth every six hours as needed for pain. The order was dated 09/19/2022. A review of the medication administration record for the month of June 2023	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		

noted Acetaminophen 325 MG was administered 06/02/2023; 06/03/2023; 06/06/2023; 06/19/2023; 06/29/2023. In July 2023, Acetaminophen 325 MG was not administered until 07/17/2023.

A review of the incident reports and "General Event Reports" noted on 06/29/2023, at 7:40 PM, staff discovered a bruise on Resident 1's left shoulder. The report contained a photo of the bruise and it appeared large and reddened. Staff attempted to ask Resident 1 what had happened. Resident 1 is unable to communicate. Staff applied ice.

Surveyor review of the "T Log" (progress notes) for 06/29/2023 and 06/30/2023 noted no concerns or bruising was documented. The notes did not identify any incidents or injuries.

Surveyor interviewed Regional Director A who stated they did not learn of the bruise immediately but on 06/30/2023, they did learn of the bruising and began an investigation into the injury of unknown origin. Regional Director A stated as of 07/18/2023, they are still interviewing staff to determine if anyone knows anything. A review of the medication administration record noted Acetaminophen was administered last on 06/29/2023 at 6:40 AM however, none administered until 07/17/2023.

A review of an "Incident Report" dated 07/05/2023, at 6:20 PM, noted Resident 1 was in the bathroom and staff heard screaming. Staff went to the bathroom to check on Resident 1 and Resident 1 was hunched over the toilet. Additional staff was called to assist. Resident 1 would not move knee and started to grab the knee. Resident 1 "cried and bit the back of (his/her) hand to cope with pain." Summary

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N 352	Continued From page 2	N 352		

report noted "After 10 minutes of sitting (Resident 1) was able to move on (his/her) own. On call arrived and called on call nursing. (Resident 1) iced knee 15 on 15 off and elevated it for the rest of the night. (S/he) not taken to the doctor, and has an appointment Friday (07/07/2023) for (his/her) knee."

According to the "T log" progress notes, dated 07/05/2023- "(Resident 1) arrived home from programming complaining about (his/her) left knee. Another staff member asked for assistance with (Resident 1) in the bathroom as (s/he) could not get up by self. We tried to assistance (him/her) with 2 persons assist in which we unable to, I called on call and followed protocol, on call arrived and gave me nursing instruction to pass a PRN (Tylenol or Ibuprofen.) Which was not in the home so (s/he) did not receive pain medication for tonight for pain. Staff was told to recliner (his/her) left leg and put a ice pack on it."

On 07/18/2023, at approximately 3:45 PM, Surveyor interviewed Manager B regarding the left knee. Manager B stated Resident 1 did have pain and is still attending physical therapy and has upcoming physician appointments. Manager B showed Surveyor Resident 1's medications. A card containing Acetaminophen 325 MG tablets were documented as dispensed by the pharmacy on 07/06/2023.

On 07/18/2023, at approximately 5:15 PM, Regional Director A stated Resident 1 did go to the physician on 07/07/2023 who ordered Naproxen 220 MG twice per day with food for four days. Left knee compression sleeve/brace to be used during the daytime and physical therapy.

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N 352	Continued From page 3 A review of the medication administration record for July 2023 noted staff began administering the Naproxen 220 MG on 07/10/2023. On 07/19/2023, at approximately 10:40 AM, Surveyor interviewed Regional Director A regarding the delay in obtaining and administering the Naproxen 220 MG. Regional Director A stated it took time with the pharmacy. Surveyor asked about the availability of the Acetaminophen. Regional Director A stated the house obtained the refill on 07/06/2023 but they did not want to give the Acetaminophen with Naproxen. Surveyor asked why staff did not administer the Acetaminophen until the Naproxen arrived. Regional Director A stated the family of Resident 1 is careful with medications and did not want to administer Naproxen initially. A review of the record noted Resident 1's physician ordered the Acetaminophen 325 MG PRN two tablets every 6 hours as needed on 09/19/2022 with no stop order. On 07/10/2023, the physician then ordered Acetaminophen 325 MG -"take two tablets by mouth every six hours as needed for pain." The record did not contain any stop order for Acetaminophen from 09/19/2022. On 07/20/2023, at 1:13 PM, Surveyor interviewed VP Operations C regarding the Naproxen. VP Operations C stated Resident 1's family wanted to speak with Resident 1's physician prior to starting the Naproxen and that was why the medication was not administered until 07/11/2023. VP Operations C stated they are cautious about administering Acetaminophen. On 07/20/2023, at 1:56 PM, Surveyor interviewed Regional Director A regarding the Acetaminophen	N 352		

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N 352	Continued From page 4 325 MG every 6 hours for Resident 1. Regional Director A stated Resident 1 could have had the Acetaminophen for pain however, they did not have it in the home on 07/05/2023. Surveyor asked if Resident 1 could have had Acetaminophen 325 MG every 6 hours as needed for pain prior to Naproxen. Regional Director A stated yes.	N 352		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on record review and staff interview, the	N 406		

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N 406	Continued From page 5	N 406		

provider did not send Resident 2's medications with Resident 2 when Resident 2 discharged from the provider.

The provider did not dispose of expired medications within 30 days of expiration date for Resident 3, Resident 4 and Resident 5.

Findings include:

On 07/18/2023, the department conducted a complaint investigation related to medication in the facility.

On 07/18/2023, at 3:40 PM, Surveyor observed the medication storage bins for Resident 2, Resident 3, Resident 4 and Resident 5. The following was observed:

Resident 2- stored in the medication cabinet was a plastic bag tabled for Resident 2. Inside the bag, two boxes containing 91 tablets of Setlakin each. The boxes dated 04/20/2023. A card containing Cephalexin 500 MG- with one capsule remaining. The card was dated 04/20/2023. Surveyor asked Manager B when Resident 2 discharged from the facility. Manager B stated approximately 4/2023 but was not positive.

Resident 3- stored in the medication cabinet was a 30 day supply of Loperamide 2 MG dated 05/03/2022. With a do not use date of 05/02/2023.

Resident 4- stored in the medication cabinet was a 30 day supply of Acetaminophen 325 MG. The medication was dispensed on 02/07/2022 with a do not use date of 02/06/2023.

Resident 5- stored in the medication refrigerator

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N 406	Continued From page 6 was Lantus insulin delivered on 04/27/2022 with an expiration date of 04/26/2023. On 07/18/2023, Surveyor interviewed Regional Director A regarding the medication. Regional Director A stated the medications should have been removed from the medication storage cabinet.	N 406		