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	0010589	A. BUILDING: _____ B. WING _____	C 01/26/2024

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PRAIRIE GARDENS	900 O'KEEFFE AVE SUN PRAIRIE, WI 53590

(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 01/25/2024, with information obtained through 01/26/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Prairie Gardens, a community-based residential facility (CBRF) located in Sun Prairie, WI. As a result of the survey, 2 deficiencies were identified. One deficiency is a repeat deficiency. See Statement of Deficiency (SOD) UTLD16, dated 07/21/2021. The complaint was substantiated Census: 41	N 000		
N 362	83.33(1)(d) Grievance procedure: written summary The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide a written summary of the grievance, its findings, its conclusions, and any action taken, to Resident 1's legal representative when 2 grievances were brought up. Concerns were brought up over the period of approximately 2-5 months to Manager C	N 362		

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

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N 362	Continued From page 1 regarding the correct administration of Resident 1's daily Exelon patch, the most recent of which being on 11/07/2023. Manager C did not document his/her grievance findings or its conclusions and did not provide a written summary of them to Resident 1's legal representative. On 11/07/2023, a concern was raised to Manager C regarding staff attempting to administer Resident 1's medications to Resident 2. Manager C did not document his/her grievance findings or its conclusions and did not provide a written summary of them to Resident 1's legal representative. Findings include: On 01/25/2024, Surveyor conducted a complaint investigation into concerns that issues discussed with staff were not being resolved. On 01/25/2024, at approximately 10:15 a.m., Surveyor conducted an interview with Administrator A and Manager C. Surveyor requested all grievances handled by the provider for 2023 as well as the provider's current grievance policy. On 01/25/2024, Surveyor reviewed the provider's grievance policy, provided by Administrator A. The policy documented the following: "Residents, resident representatives and family members are encouraged to express their concerns and grievances. If a resident, representative, or family member files a grievance regarding the care and support of a resident, management will make every effort to review the grievance and resolve the matter in a timely matter."	N 362		

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N 362	Continued From page 2 Under the "Guidelines for filing a grievance" heading of the policy: "If a resident, representative, or family member approaches a staff member with a concern or grievance, follow these guidelines." The guidelines listed were, "Speak to the party filing a grievance in a private area," "Together fill out a grievance/ complaint report form as thoroughly and accurately as possible," "Reassure them that you will forward the report to management," and, "Document the incident in the residents' chart." Under the "Procedure" heading of the policy: "Once a grievance report is filed, management will review the facts and conduct an investigation of the grievance, interviewing all parties involved. This shall be initiated within 24 hours of receipt of the grievance. Once the investigation is complete, management will decide on what actions need to be taken. These actions will then be discussed with the resident, representative, or family member. If the grievance is resolved then no further action is needed. If all parties involved cannot resolve the issue, the resident/representative will be directed to the Division of Health Services to file a formal grievance. Refer to the Resident Rights Handbook for appropriate contacts." A line at the bottom of the policy documented that contact information for the ombudsman was posted on each floor. Example 1 - Exelon patch handling concerns At approximately 10:55 a.m., Manager C reported that s/he had record of 2 grievances since 01/01/2023, one of which was for Resident 1. In reviewing the documents provided by Manager C, Surveyor reviewed papers titled "Resident Notes"	N 362		

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which had Resident 1's name handwritten on the bottom of each page. Surveyor reviewed an entry dated 12/21/2023, which documented the following:

- " ...[Person D] also had concerns about Exelon patch not being changed daily as ordered. I guess there has been incidents where the patch was dated for the day before, or the other patch was not removed when the new patch went on - there seems to have been several communications with various staff, yet problem has not been totally resolved. I'm unsure why it seems to be a problem with [Resident 1] but not with any of the other residents that get patches put on - staff is trained on applying patches and are aware that [illegible] to initial + date. Some of the incidences involve putting the wrong date which [Person D] questions if wasn't changed, but because staff changes so many other patches daily without incident, I believe that it was a result of sloppy documentation by staff who did not date accurately as the MAR indicates that the patches were indeed changed on most of those days ...Plan: [overnight (NOC)] staff to apply new patch, that is dated correctly and initialed, on [Resident 1]'s upper back and make sure that the previous days[sic] patch is removed. It will clearly be written on each cycles[sic] MAR and whomever applied patch will also need to initial that previous days[sic] patch ...NOC manager will ensure that [his/her] staff is properly trained and informed, and will follow-up to ensure that it's being done correctly - again, there are 2 point people, the NOC manager and one other [certified nursing assistant], who will take accountability, as one of them is always present. In the rare occasion that both are not there, then the [Director of Nursing] will follow up on ...The plan for ...the patch change seemed to please

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N 362	Continued From page 4 [Person D] ..." At approximately 11:03 a.m., Surveyor interviewed Manager C and Director of Nursing B. Director of Nursing B confirmed that Person D was Resident 1's activated power of attorney for healthcare (POA). Director of Nursing B confirmed s/he was the one who wrote the above note. Director of Nursing B reported s/he didn't have any other documentation of patch dating concerns because s/he didn't consider this to be a "formal complaint." Director of Nursing B reported s/he considered "formal" complaints to be those regarding abuse, stealing, injury, and other serious issues. Director of Nursing B confirmed Surveyor's observation that the provider's grievance policy did not define an informal versus formal complaint and the document the differences in how each were handled. On 01/25/2024, Surveyor reviewed Resident 1's record. Surveyor observed a prescription for Exelon 9.5 mg/24 patches with instructions to, "Apply (1) patch topically once daily." There was no other information in Resident 1's record regarding errors of his/her Exelon patch administration, incidents of incorrectly dating patches, or incidents of staff not removing the previous day's patch before applying the new patch. At approximately 1:45 p.m., Surveyor interviewed Manager C and Director of Nursing B. Manager C confirmed that s/he had heard Person D express concerns with Resident 1's patch administration. Manager C reported that s/he estimated concerns were brought up about once a month for approximately 5 months off and on. Manager C	N 362		

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reported that the concerns brought up to him/her were that staff were not taking off Resident 1's old patch before applying a new one. Manager C reported that around summer of 2023, there was a day where Person D brought up an instance to him/her that a new patch wasn't put on Resident 1. Manager C stated that s/he spoke to the medication passer that day, (Former) Caregiver F, but Caregiver F told him/her that s/he had applied a new patch that day and had just dated it incorrectly. Manager C reported that no other concerns related to Resident 1's patch administration were brought up to him/her after this. When asked about the allegation in the above note of staff applying a new patch to Resident 1 without removing an old patch, Manager C reported that a concern of this was brought up to him/her in August of 2023 and that s/he had talked with staff about it. Manager C and Director of Nursing B reported that they had a staff in-service in August to re-train staff about proper patch administration. Manager C reported s/he did not document any of these concerns or incidents and did not document any follow up investigating s/he had done.

On 01/25/2024, Surveyor reviewed a document provided by Person D, which detailed concerns s/he had related to an Exelon patch that Resident 1 was prescribed. Person D documented that his/her understanding of patch administration process was that each day, staff were to remove Resident 1's patch from the previous day and apply a new patch to a different area on his/her back. Person D's document detailed the following:

- 08/30/2023: "Patch not changed, dated 8/29. Spoke to [Manager C]. [S/he] said staff had put the wrong date on it. I indicated that should not be

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happening; date should always be verified before initialing patch. This is something that should be shared with staff."

- 09/06/2023: "Patch not changed, dated 9/5. Spoke to [Manager C] who stated the following: [S/he] blamed [unidentified resident] and said [s/he] just put the wrong date on the patch again. I stated this is no excuse, calendars are available. [Manager C] said [s/he] would talk to [him/her].

- On 10/29/2023, while visiting Resident 1, Person D observed 2 patches on him/her: one on his/her upper back and one on his/her chest. On 10/31/2023, Person D spoke with Manager C about the concern and Manager C told him/her s/he would further investigate it.

- On 11/05/2023, while visiting Resident 1, Person D observed 2 patches on him/her and took a photo of them. On 11/07/2023, Person D spoke with Manager C in person and told him/her about this incident. Manager C reported to Person D that the provider had newly trained new staff and that may have been the reason behind the error. Manager C reported to Person D that s/he would talk with staff about it.

Surveyor reviewed the photo provided by Person D, which showed 2 patches on Resident 1's upper back - 1 closer to midline and 1 more towards her left side. The patches contained a manufacturer label of "Rivastigmine 9.5mg/24 hr" (Rivastigmine being the generic for Exelon). One patch contained initials with the date "11/5" and the other patch contained initials with the date "11/4" - all written in black marker.

At approximately 2:15 p.m., Surveyor interviewed Manager C and Director of Nursing B. Director of

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N 362	Continued From page 7 Nursing B reported that the first time s/he heard about patch administration concerns was around the time that Person D requested a meeting to discuss various concerns, and that this meeting occurred on 12/20/2023. Manager C reported that s/he could not recall any conversation s/he had with Person D on 10/31/2023 (as documented above) regarding 2 patches being observed on Resident 1. Manager C reported that s/he could not recall any conversation s/he had with Person D on 11/07/2023 (as documented above) regarding 2 patches being observed on Resident 1. Manager C reported that the above conversations "may have" happened but s/he couldn't recall them. On 01/26/2024, at approximately 12:55 p.m., Surveyor interviewed Person D. Person D reports that s/he visits Resident 1 near daily and that there have been multiple instances since his/her admission of patch dating concerns. Person D reported that in these instances s/he checks the patch and has seen that it's dated for the previous day, despite being after the current day's morning medication administration time. Person D reports that s/he has brought this up to caregiving staff and gets told that staff are changing the patch daily but incorrectly dating it for the previous day. Person D reported that what s/he really has concerns about is that a new patch isn't being put on and that staff are just telling him/her or Manager C that they are mistaking the dates to cover up the lack of new patch administration. Person D reported that s/he started taking notes to track the occurrences because s/he wasn't hearing any other follow up with staff regarding the concerns. Person D reported that on 02/06/2023 s/he discussed the concerns of staff not changing out Resident 1's patches with Manager C. Person D reported that	N 362		

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Manager C told him/her that patches are probably just being written with the incorrect date. Person D reported that s/he told Manager C s/he was not accepting that excuse again because that excuse was previously given to him/her. Regarding the 10/29/2023 incident, Person D reported that s/he specifically requested a callback from Manager C after bringing the concern to his/her attention but did receive any follow up information. Regarding the 11/05/2023 incident, Person D reported that s/he did not receive any follow up information from Manager C after bringing it to his/her attention. Person D reported that a few days prior to 12/20/2023, she was frustrated at not feeling heard and arranged a meeting with Director of Nursing B and Manager C. Person D reported that s/he provided all his/her notes regarding the Exelon patch concerns to them. Person D reported that at that meeting, his/her understanding was that it was decided to have the overnight (NOC) shift administer the patch so that the night shift manager could supervise the application and dating but confirmed s/he did not receive a written summary of the grievance, including this action to be taken.

Example 2: Medication administration concerns

On 01/25/2024, at approximately 10:55 a.m., Manager C reported that s/he had record of 2 grievances since 01/01/2023, one of which was for Resident 1. In reviewing the documents provided by Manager C, Surveyor did not observe any information regarding concerns for residents' medications being administered to other residents.

On 01/25/2024, Surveyor reviewed a document provided by Person D, which detailed concerns s/he had regarding an incident of staff attempting

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to administer one resident's medications to another resident. The document detailed that on 11/07/2023, Resident 2 told Person D that a staff member that day around noon attempted to administer eye drops and medications to him/her, but Resident 2 replied to him/her that s/he does not get medications at noon and is not prescribed eye drops. Resident 2 told Person D that the staff member initially insisted the medications were his/hers but eventually left. Resident 2 told Person D that s/he believed the staff member had confused him/her for Resident 1, since Resident 1 is prescribed medications to take at noon as well as eye drops. Person D documented that s/he relayed concern of this incident to Manager C.

On 01/25/2024, at approximately 1:45 p.m., Surveyor interviewed Manager C and Director of Nursing B. Manager C reported that s/he recalled the above concerns being brought up to him/her by Person D. Manager C reported that after this conversation, s/he spoke with the medication passer that day who told him/her that that didn't happen. Manager C denied that s/he documented this concern or the follow up investigating that s/he had done.

On 01/26/2024, at approximately 12:55 p.m., Surveyor interviewed Person D. Person D reported that Manager C told him/her that s/he couldn't trust Resident 2 who had initially brought up the incident and that staff are supposed to check names and room numbers for verification when administering medications. Person D reported that s/he did not see or hear any follow up information related to this concern.

Cross Reference:
N0432 DHS 83.38(1)(h) Medication

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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 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 record review and interview, the provider did not ensure that medication administration was provided to Resident 1 appropriate to his/her needs. Staff did not discontinue Resident 1's old anticonvulsant medication (levetiracetam) prior to starting his/her anticonvulsant medication (lacosamide), as directed to do by his/her medical provider. Resident 1 was administered doses of both medications on 3 occasions: 12/22/2023 at 8:00 p.m., 12/23/2023 at 8:00 a.m., and 12/23/2023 at 8:00 p.m. Resident 1's Exelon patches ran out prior to 02/06/2023 and required medical provider correspondence to initiate a refill. There was no evidence that Resident 1's medical provider or his/her POA were contacted regarding the issue until 02/06/2023 when his/her patches had	N 432		

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already run out. Resident 1's next refill of patches was provided on 02/08/2023. On at least one occasion, staff applied a new Exelon patch without removing the old patch. The provider did not document locations of patch administration, which according to Pharmacist H, was a recommended practice to assist staff in finding old patches.

This is a repeat deficiency. See Statement of Deficiency (SOD) UTLD16, dated 07/21/2021.

Findings include:

On 01/25/2024, Surveyor conducted a complaint investigation into concerns of medication administration.

Example 1 - Resident 1's anticonvulsant medication

On 01/25/2024, at approximately 10:15 a.m., Surveyor conducted an interview with Administrator A and Manager C. Surveyor requested all grievances handled by the provider for 2023. In reviewing the documents provided by Manager C, Surveyor reviewed papers titled "Resident Notes" which had Resident 1's name handwritten on the bottom of each page. Surveyor reviewed an entry dated 12/26/2023 which documented the following:

"Situation occurred where new seizure med was delivered ...and directions to start @ 8pm and [discontinue] other seizure med. [Illegible] that processed the order had not pulled the old seizure med so [Resident 1] was given @ 8p 12/22 and 8a + 8p on 12/23 - the old med was pulled and not given on 12/24 ...I did call neurologist today to report incident and to relay

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that no adverse reactions have been observed or reported ...

On 01/25/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 07/20/2022 with diagnoses including dementia. Surveyor reviewed Resident 1's individual service plan (ISP), which was last signed as reviewed on 07/24/2023, but contained dated notes since then. Within Resident 1's ISP, Surveyor observed the following handwritten note: "10/19-10/24/23 - slumped over and became non-responsive while getting hair done so transported to [emergency room] via 911. Hospitalized / diagnosed with [illegible] seizure ..." Surveyor reviewed observation notes for Resident 1, provided by Director of Nursing B. An entry on 12/26/2023 documented:

"Received new med lacosamide ...to replace levetiracetam [brand name: Keppra]. Med received on 12/22 to start @ 8pm levetiracetam not pulled so given 8 pm on 12/22, 8a + 8p on 12/23, along with lacosamide 50 mg oral [twice daily]. Student [registered nurse (RN)] processed order incorrectly even though [prescription] accompanied new med in which clearly said to [discontinue] Keppra - [resident assistant] noticed on 12/24 am after [Person D, Resident 1's activated power of attorney (POA)] said something. So both meds have not been given since 12/23 ...Order that came with med was not in my basket per usual, so was not even aware that a med change was made until I received a call from [resident assistant] on 12/24 - I said call pharmacy today to obtain copy of order ...Student RN that originally made error is on vacation this week but will address when [s/he] returns ..."

Surveyor reviewed a document titled "Prairie

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	0010589	A. BUILDING: _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE GARDENS	900 O'KEEFFE AVE SUN PRAIRIE, WI 53590

(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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Gardens Medication / Service Request Form." The note was dated 12/26/2023 and documented the following:

"Lacosamide 50 mg [twice daily] ordered to start @ 8pm 12/22 and Keppra 500 mg [twice daily] to be [discontinued] when starting lacosamide - nursing student entered lacosamide to [Resident 1]'s supply but did not pull the Keppra, therefore [Resident 1] had both meds for 3 doses 12/22 @ 8pm and 12/23 8a + 8pm. It was brought to my attention on 12/24 by [Person D] that Keppra was to be [discontinued] so it was pulled from [Resident 1]'s supply then [Resident 1] received only the one med (lacosamide) ..." The note documented that since 12/24/2023 staff had not observed any adverse reactions and that on 12/26/2023, Director of Nursing B discussed the incident with Resident 1's neurology staff.

Surveyor reviewed Resident 1's medication administration record (MAR), dated 12/11/2023 - 01/10/2024 and observed entries for levetiracetam 500 mg tablets, with instructions to take 1 tablet twice daily, and lacosamide 50 mg tablets, with instructions to take 1 tablet twice daily. A handwritten note by the levetiracetam line documented, "[Discontinued] 12/25]," and a start date for the lacosamide was documented as 12/21/2023. The MAR corroborated the above documents, showing that levetiracetam was initialed as administered on 12/22/2023 at 8:00 p.m., 12/23/2023 at 8:00 a.m., and 12/23/2023 at 8:00 p.m., while the lacosamide was initialed as administered at the same 3 dates and times.

Surveyor reviewed prescriptions for Resident 1's levetiracetam and lacosamide. The order for his/her lacosamide was dated 12/21/2023 and documented, "Take 1 (one) tablet by mouth 2

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times daily. Stop Keppra tomorrow. Start Lacosamide."

At approximately 1:45 p.m., Surveyor interviewed Director of Nursing B and Manager C. Director of Nursing B confirmed the details as provided from the above records.

On 01/26/2024, at approximately 12:55 p.m., Surveyor interviewed Person D. Person D reported that on 12/24/2023, at around 8:15 a.m. s/he was picking up Resident 1 to leave when s/he observed staff give Resident 1 a medication cup with his/her morning medications. Person D reported that s/he observed a pill s/he did not recognize, and asked staff that morning if it was a new medication. Person D reported after staff confirmed with her that there was a new medication for Resident 1, s/he reported his/her concern that staff did not pull his/her old prescription for Keppra out, which was supposed to be discontinued prior to administering the new seizure medication. Person D reported that s/he called Resident 1's pharmacy on 12/26/2023 and that pharmacy staff confirmed with him/her that a new prescription for Vimpat (brand name for lacosamide), which contained the instructions to discontinue the Keppra prior to starting, was sent to the facility on 12/21/2023 and signed for by a staff member that evening.

Example 2 - Resident 1's Exelon patches

On 01/25/2024, at approximately 10:15 a.m., Surveyor conducted an interview with Administrator A and Manager C. Surveyor requested all grievances handled by the provider for 2023. In reviewing the documents provided by Manager C, Surveyor reviewed papers titled "Resident Notes" which had Resident 1's name

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handwritten on the bottom of each page.
Surveyor reviewed an entry dated 12/21/2023, which documented the following:

- " ...[Person D] also had concerns about Exelon patch not being changed daily as ordered. I guess there has been incidents where the patch was dated for the day before, or the other patch was not removed when the new patch went on - there seems to have been several communications with various staff, yet problem has not been totally resolved. I'm unsure why it seems to be a problem with [Resident 1] but not with any of the other residents that get patches put on - staff is trained on applying patches and are aware that [illegible] to initial + date. Some of the incidences involve putting the wrong date which [Person D] questions if wasn't changed, but because staff changes so many other patches daily without incident, I believe that it was a result of sloppy documentation by staff who did not date accurately as the MAR indicates that the patches were indeed changed on most of those days - the dates in late Oct and early Nov where both patches were left on was done by the same [resident assistant] who knows better as [s/he] has been employed here for a long time and is a result of being in a hurry, so consequently [s/he] has been removed from passing meds until a later date that is to be determined. [S/he] will need to complete the medication review binder and test, as well as medication eval that will be completed by [Director of Nursing B] - I did share this with the family ..."

In reviewing Resident 1's record, Surveyor observed a prescription for Exelon 9.5 mg/24 patches with instructions to, "Apply (1) patch topically once daily."

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There was no other information in Resident 1's record regarding errors of his/her Exelon patch administration, incidents of incorrectly dating patches, or incidents of staff not removing the previous day's patch before applying the new patch.

At approximately 1:45 p.m., Surveyor interviewed Manager C and Director of Nursing B. Manager C confirmed that s/he heard Person D express concerns with Resident 1's patch administration. Manager C reported that s/he estimated concerns were brought up about once a month for approximately 5 months off and on. Manager C reported that the concerns brought up to him/her were that staff were not taking off Resident 1's old patch before applying a new one. Manager C reported that around summer of 2023, there was a day where Person D brought up an instance to him/her that a new patch wasn't put on Resident 1. Manager C stated that s/he spoke to the medication passer that day, (Former) Caregiver F, but Caregiver F told him/her that s/he had applied a new patch that day and had just dated it incorrectly. Manager C reported that no other concerns related to Resident 1's patch administration were brought up to him/her after this. When asked about the allegation in the above note of staff applying a new patch to Resident 1 without removing an old patch, Manager C reported that a concern of this was brought up to him/her in August of 2023 and that s/he had talked with staff about it. Manager C and Director of Nursing B reported that they had a staff in-service in August to re-train staff about proper patch administration. Manager C reported s/he did not document any of these concerns or incidents and did not document any follow up investigating s/he had done.

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N 432	Continued From page 17 On 01/25/2024, Surveyor reviewed a document provided by Person D, which detailed concerns s/he had related to an Exelon patch that Resident 1 was prescribed. Person D documented that his/her understanding of the patch administration process was that each day, staff were to remove Resident 1's patch from the previous day and apply a new patch to a different area on his/her back. Person D's document detailed the following: - On the evening of 02/06/2023, s/he visited Resident 1 and saw that the patch on his/her back was dated 02/05/2023. Upon calling and speaking with Manager C about it, Manager C confirmed that Resident 1's patch that day was missed. Manager C reported to Person D that Caregiver E called the pharmacy the prior Wednesday (02/01/2023), and the patches wouldn't be in until 02/06/2023 but that a phone call to Resident 1's physician was required first. On 02/07/2023, Manager C called Person D and told him/her that Resident 1's patches wouldn't be in until the next day 02/08/2023 due to an issue with insurance coverage. Person D documented that the next patch was administered to Resident 1 on 02/08/2023. - On 10/29/2023, while visiting Resident 1, Person D observed 2 patches on him/her: one on his/her upper back and one on his/her chest. On 10/31/2023, Person D spoke with Manager C about the concern and Manager C told him/her s/he would further investigate it. - On 11/05/2023, while visiting Resident 1, Person D observed 2 patches on him/her and took a photo of them. On 11/07/2023, Person D spoke with Manager C in person and told him/her about this incident. Manager C reported to Person D	N 432		

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that the provider had newly trained new staff and that may have been the reason behind the error. Manager C reported to Person D that s/he would talk with staff about it.

Surveyor reviewed the photo provided by Person D, which showed 2 patches on Resident 1's upper back - 1 closer to midline and 1 more towards her left side. The patches contained a manufacturer label of "Rivastigmine 9.5mg/24 hr" (Rivastigmine being the generic for Exelon). One patch contained initials with the date "11/5" and the other patch contained initials with the date "11/4" - all written in black marker.

Surveyor reviewed Resident 1's record again and did not observe any provider documentation of issues regarding Resident 1's patch refill around 02/06/2023, evidence that Resident 1's medical provider was contacted regarding the refill, or that Person D was informed prior to that day of issues warranting medical provider follow up.

On 01/25/2024, Surveyor reviewed Resident 1's medication administration records (MARs) from 01/11/2023 - 04/10/2023 and 10/11/2023 - 11/10/2023 and observed the following correlating to the above dates of incidents as documented by Person D:

- Exelon patch administration was initialed off on 02/06/2023 and 02/07/2023

- Exelon patch initialed as administered on 10/29/2023. No other annotations were documented.

- Exelon patch initialed as administered on 11/05/2023. No other annotations were documented.

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N 432	Continued From page 19 At approximately 2:15 p.m., Surveyor interviewed Manager C and Director of Nursing B. Director of Nursing B reported that the first time s/he heard about patch administration concerns was around the time that Person D requested a meeting to discuss various concerns, and that this meeting occurred on 12/20/2023. Manager C reported s/he did not recall any conversations had with Person D around 02/06/2023 - 02/08/2023 regarding issues with Resident 1's patch refill. Manager C reported that s/he could not recall any conversation s/he had with Person D on 10/31/2023 (as documented above) regarding 2 patches being observed on Resident 1. Manager C reported that s/he could not recall any conversation s/he had with Person D on 11/07/2023 (as documented above) regarding 2 patches being observed on Resident 1. Manager C reported that the above conversations "may have" happened but s/he couldn't recall them. On 01/26/2024, at approximately 9:40 a.m., Surveyor interviewed Pharmacy Technician G and Pharmacist H from the pharmacy that refilled Resident 1's prescription medication. Pharmacy Technician G confirmed that a prescription for 1 box of 30 Exelon patches was filled on 02/07/2023 and delivered on 02/08/2023. Pharmacy Technician G reported s/he could not find any record of conversations or calls from the provider's staff regarding an issue with refilling Resident 1's Exelon patches. Pharmacist H reported that it was considered standard practice to remove an old patch of medication before applying a new one. Pharmacist H reported that staff are encouraged to document a location of patch administration so that they know where to look for an old one to remove and also to not apply the patch to the same location for	N 432		

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successive days. Pharmacist H reported in this specific case s/he was not as concerned for potential adverse effects of the double patching but that it sounded more like an overall concern of the system in place.

Upon reviewing the above MARs again, Surveyor did not observe any body part documented as part of the administration record of Resident 1's Exelon patches.

On 01/26/2024, at approximately 12:55 p.m., Surveyor interviewed Person D. Regarding the 02/06/2023 incident, Person D confirmed that after the patch for 02/05/2023 was removed, there were no leftover patches for Resident 1 due to the provider being out, according to Manager C. Person D confirmed that s/he did not observe a new patch applied to Resident 1 that day. Person D reported s/he did not receive any communication about the refill being an issue warranting physician contact prior to the conversation had on site that day. Person D reported that Manager C called her on 02/08/2023 to tell him/her that the refill finally came in and a patch was applied that day. Regarding the 10/29/2023 incident, Person D reported that s/he specifically requested a callback from Manager C after bringing the concern to his/her attention but did receive any follow up information. Regarding the 11/05/2023 incident, Person D reported that s/he did not receive any follow up information from Manager C after bringing it to his/her attention.

According to the full prescribing information from the pharmaceutical company that created the Exelon patches, patients are instructed "to only wear 1 patch at a time (remove the previous day's patch before applying a new patch)." Instructions

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N 432	Continued From page 21 are also documented to "Change the site of the patch application daily to minimize potential irritation, although a new patch can be applied to the same general anatomic site (e.g., another spot on the upper back) on consecutive days. Do not apply a new patch to the same location for at least 14 days." Under the "WARNINGS AND PRECAUTIONS" heading of the guide, "Medication errors with EXELON PATCH have resulted in serious adverse reactions; some cases have required hospitalization, and rarely, led to death. The majority of medication errors have involved not removing the old patch when putting on a new one and the use of multiple patches at one time," (Source: Novartis, Highlights of Prescribing Information, June 06, 2020, https://www.novartis.com/us-en/sites/novartis_us/files/exelonpatch.pdf (retrieval date - January 26, 2024).). Cross Reference: N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary	N 432		