Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019035	A. BUILDING: _____ B. WING _____	R-C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE WISCONSIN CORNER PRAIRIE HOUSE	2010 PRAIRIE RD MADISON, WI 53711

(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
{M 000}	INITIAL COMMENTS On 09/01/2023, Surveyor conducted a verification visit at Care Wisconsin Corner Prairie House. Two deficiencies were identified. Two of the 2 deficiencies were repeat violations (see Statement of Deficiency (SOD) N2Z211). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 1	{M 000}		
{M 466}	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure accurate records were kept of all prescription medications administered for Resident 3. This is as repeat deficiency. See Statement of Deficiency (SOD) N27211 dated 05/31/2023. Findings include: On 9/01/2023, Surveyor reviewed Resident 3's record.	{M 466}		

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

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{M 466}	Continued From page 1 Resident 3's August 2023 MAR, dated 08/08/2023 to 08/31/2023, documented: "Thioridazine (anti-psychotic medication) - Take 1 tablet by mouth three times daily (8:00 AM, 12:00 PM, 8:00 PM)." The medication was not documented as administered 08/10/2023 to 08/15/2023 for the 12:00 PM and 8:00 PM scheduled administration times. There was a handwritten note on the MAR that stated, "Waiting for the doc (doctor) to refill 08/13/2023; refill delivered 08/25/2023." The MAR did not have any documented administration dates after the 08/25/2023 refill date. Surveyor did not observe unadministered medication in the med closet. "Sertraline (antidepressant) - Take 1/2 tablet (25 MG) by mouth every morning for 7 days. Start Date: 07/26/2023 to 08/01/2023." The Sertraline was documented as administered 08/01/2023 to 08/08/2023. "Sertraline - Take 1 tablet (50 MG) by mouth every morning for 7 days (08/02 to 08/08)." The Sertraline was documented as administered 08/01/2023 to 08/08/2023. Surveyor did not observe unadministered medication in the med closet. On 09/01/2023, at approximately 4:10 PM, Surveyor interviewed Administrator A. Administrator A stated that recent staff had been dismissed from employment due to medication administration and documentation concerns.	{M 466}		
{M 582}	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage	{M 582}		

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{M 582}	Continued From page 2 and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3's as needed (PRN) Lorazepam medication was administered as prescribed from 08/12/2023 to 08/29/2023. This is as repeat deficiency. See Statement of Deficiency (SOD) N27211 dated 05/31/2023. Findings include: On 9/01/2023, Surveyor reviewed Resident 3's record. Resident 3's August 2023 MAR, dated 08/08/2023 to 08/31/2023, documented: "Lorazepam (medication for anxiety), Take 1 tablet by mouth every 6 hours as needed (PRN) for agitation." Resident 3's "Individual Resident Controlled Substance Record," dated 08/12/2023 to 08/29/2023, for Resident 3's Lorazepam, documented that the medication was given every day at 8:00 AM and 8:00 PM. Surveyor noted the MAR did not document rationale as to why the Lorazepam was administered every day at 8:00 AM and 8:00 PM. Resident 3's August 2023 progress notes did not	{M 582}		

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{M 582}	Continued From page 3 document any behaviors that resulted in Resident 3 requiring a PRN Lorazepam. On 09/01/2023, at approximately 4:10 PM, Surveyor interviewed Administrator A. Administrator A stated that recent staff had been dismissed from employment due to medication administration and documentation concerns.	{M 582}		