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
	0017060	A. BUILDING: ______ B. WING ______	C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING ELM CBRF	**750 ELM ST WOODRUFF, WI 54568**

(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 12/02/2024, Surveyor conducted a complaint investigation (x4) at Milestone Senior Living Elm CBRF. Data collection continued through 12/04/2024. One of 4 complaints was substantiated. One deficiency was identified. Census: 15	N 000		
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 Resident 1 was provided with medication administration appropriate to his/her needs on 08/25/2024. Findings include: The facility is licensed to serve up to 16 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, and terminally ill.	N 432		

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

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N 432	Continued From page 1	N 432		

On 09/05/2024, the Department received a complaint alleging a resident received a nebulizer treatment shortly after medication was administered and the caregiver did not ensure the resident swallowed the medication prior to placing a nebulizer mask over the resident's mouth.

On 12/02/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 01/10/2024. On 05/09/2024, Resident 1 started receiving nebulizer treatments four times per day until the treatments were discharged on 08/26/2024. Resident 1's record did not contain an order to self-administer nebulizer treatments. Resident 1 discharged from the facility on 09/26/2024.

On 12/02/2024 at approximately 3:00 PM, Surveyor interviewed Director A. Surveyor requested internal investigations involving medication administration. Director A confirmed that in August 2024, Resident 1 received a nebulizer treatment after medication administration and the caregiver did not ensure Resident 1 swallowed his/her medications prior to administering the nebulizer treatment. Director A provided Surveyor with an internal investigation, date of incident: 08/25/2024, involving Caregiver B administering a nebulizer treatment and medication to Resident 1 on 08/25/2024.

On 12/02/2024, Surveyor reviewed an internal investigation, date of incident: 08/25/2024. The investigation noted,

"Summary of Investigative Findings: Employee attempted to administer a medication that had already been administered by the previous shift. This is because the medication administration was not documented. This may have been due to a lack of understanding on how

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to change filters to chart medications due on the next shift. The employee who administered the medication by accident felt that the resident had swallowed the medication based on movement of the throat. The staff member ([Caregiver B]) then placed resident's nebulizer mask over the resident's face. Approximately 5 minutes later, the resident spit out the medication in the presence of the [daughter/son]. The resident did not swallow the medication and therefore was not double dosed.

"Summary of Investigation Conclusions: Education is needed for staff on verifying that medications have been swallowed prior to placing a nebulizer on residents. Education is needed for staff on changing filters with the EMAR (electronic medication administration record) to show future shift administration. No harm was done to the resident as a result of the incident."

On 12/02/2024, at approximately 3:40 PM, Surveyor interviewed Caregiver B. Caregiver B reported that sometime in August 2024 (08/25/2024), Caregiver B gave Resident 1 his/her medication and then administered a nebulizer treatment without ensuring Resident 1 swallowed all of his/her medications prior to the nebulizer treatment. Caregiver B indicated that Caregiver B thought Resident 1 swallowed the pills based on Resident 1 "Mumbling - mhmm [sic] (affirmative)" and "nodding yes with [his/her] head that s/he swallowed the pills." Caregiver B reported that Caregiver B started the nebulizer treatment and then left the room.

On 12/04/2024, at approximately 1:00 PM, Surveyor interviewed Director A. Director A

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N 432	Continued From page 3 confirmed that Resident 1 did not have an order to self-administer his/her nebulizer treatment and the nebulizer treatment was discontinued on 08/26/2024.	N 432		