STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018808	A. BUILDING: _____ B. WING _____	C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORETUM (THE)	W 180 N7890 TOWN HALL RD MENOMONEE FALLS, WI 53051

(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 09/06/2023, with information gathered through 09/15/2023, Surveyor conducted a complaint investigation at The Arboretum. Three deficiencies were identified; the complaint was substantiated. Census: 42	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 interview, the provider did not ensure Resident 1 received his/her prescribed morphine or lorazepam as ordered when nearing the end of life. Findings include: On 08/15/2023, the Department received a complaint alleging a medication error had been made with morphine. On 09/06/2023, Surveyor conducted a complaint investigation. The provider is a class CNA (non-ambulatory) community based residential facility able to serve up to 78 residents within the client groups of irreversible dementia/Alzheimer's and advanced age. The census at the time of the survey was 42.	N 352		

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

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At approximately 8:50 a.m., Surveyor asked Health Services Director B for any documentation of medication errors.

At 9:38 a.m., Health Services Director B provided Surveyor with an incident root cause analysis document that involved Resident 1, documenting the date of the incident was 07/30/2023. The incident analysis description of the incident documents:
-"Haloperidol (haldol) 2 mg/ml 1 mg dose given PO (orally) instead of MSO4 (morphine sulfate) PRN (as needed)"
-"Wrong medication was given to wrong resident"
-"Employee re-educated on rights of med pass"
The incident analysis was signed by Health Services Director B on 07/31/2023.
Surveyor asked Health Services Director B what happened. Health Services Director B stated that Charge Nurse C was asked to give Resident 1 prn morphine and gave him/her Resident 2's liquid haldol rather than his/her prescribed morphine.

At 10:01 a.m., Surveyor interviewed Charge Nurse C regarding the medication error with Resident 1. Charge Nurse C stated it was 07/29/2023 and it was a very busy day; Caregiver D was the medication passer and is afraid of morphine. Charge Nurse C stated s/he was asked to give Resident 1 his/her prn morphine but accidentally grabbed Resident 2's haldol from the medication cart and administered that to Resident 1 instead. Charge Nurse C stated that Resident 1, who was on hospice, had an order to receive morphine and lorazepam every hour or 2 due to restlessness. Surveyor asked if Charge Nurse C administered Resident 1's morphine and/or lorazepam multiple times that day. Charge Nurse

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N 352	Continued From page 2	N 352		

C stated no s/he only administered Resident 1's medication that one time. Surveyor asked Charge Nurse C when s/he was made aware that s/he had made a medication error. Charge Nurse C stated that Health Services Director B called around 9 o'clock p.m. and stated that not all the medications were signed out and the narcotic counts were off and that s/he realized his/her error.

At 10:24 a.m., Surveyor interviewed Caregiver D. Caregiver D stated s/he has never been comfortable with morphine and s/he ensures all resident medications are administered by asking the charge nurse on duty to administer resident's morphine as needed. Caregiver D stated that s/he was working first and second shift that day and that Charge Nurse C was on the unit and checking on Resident 1, who was actively passing. Charge Nurse C said Resident 1 was restless and asked Caregiver D to administer his/her prn morphine. Caregiver D then asked Charge Nurse C to administer the morphine instead. Surveyor asked Caregiver D how s/he was made aware that an error had occurred. Caregiver D stated that s/he discovered the error when s/he was doing narcotic counts at the end of his/her shift and noticed Resident 1's morphine counts were the same and Resident 2's haldol was off by 1. Caregiver D then reported this to Health Services Director D.

Surveyor reviewed Resident 1's medication administration record (MAR). Resident 1 had an order for morphine 20 mg/ml oral sol pfs to give 0.25ML (5MG) by mouth every three hours as needed for pain or dyspnea, with a start date of 07/17/2023. According to the provider's documentation of Resident 1's MAR, Resident 1 was only administered morphine on 07/28/2023

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N 352	Continued From page 3 at 10:20 p.m in July 2023. Cross Reference N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction N0415 DHS 83.37(2)(d) Documentation Of Medication Administration	N 352		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not document an error in the administration of Resident 1's record. On 07/29/2023, Resident 1 was administered Resident 2's haldol in error; this was not documented in Resident 1's record. Findings include: On 08/15/2023, the Department received a	N 410		

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N 410	Continued From page 4	N 410		

complaint alleging a medication error had been made with morphine.

On 09/06/2023, Surveyor conducted a complaint investigation. The provider is a class CNA (non-ambulatory) community based residential facility able to serve up to 78 residents within the client groups of irreversible dementia/Alzheimer's and advanced age. The census at the time of the survey was 42.

At approximately 8:50 a.m., Surveyor asked Health Services Director B for any documentation of medication errors.

At 9:38 a.m., Health Services Director B provided Surveyor with a QAPI POST INCIDENT ROOT CAUSE ANALYSIS document that involved Resident 1, documenting the date of the incident was 07/30/2023. The document states that it is a confidential part of QAPI process for internal use only. The incident analysis description of the incident documents:
-"Haloperidol (haldol) 2 mg/ml 1 mg dose given PO (orally) instead of MSO4 (morphine sulfate) PRN (as needed)"
-"Wrong medication was given to wrong resident"
-"Employee re-educated on rights of med pass"
The incident analysis was signed by Health Services Director B on 07/31/2023.
Surveyor asked Health Services Director B what happened. Health Services Director B stated that Charge Nurse C was asked to give Resident 1 prn morphine and gave him/her Resident 2's liquid haldol rather than his/her prescribed morphine.

At 10:01 a.m., Surveyor interviewed Charge Nurse C regarding the medication error with Resident 1. Charge Nurse C stated it was

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N 410	Continued From page 5	N 410		

07/29/2023 and it was a very busy day; Caregiver D was the medication passer and is afraid of morphine. Charge Nurse C stated s/he was asked to give Resident 1 his/her prn morphine but accidentally grabbed Resident 2's haldol from the medication cart and administered that to Resident 1 instead. Surveyor asked Charge Nurse C when s/he was made aware that s/he had made a medication error. Charge Nurse C stated that Health Services Director B called around 9 o'clock p.m. and stated that not all the medications were signed out and the narcotic counts were off and that s/he realized his/her error. Surveyor asked if Charge Nurse C documented the error anywhere in Resident 1's record. Charge Nurse C stated s/he does not remember. Surveyor asked where the error would be documented. Charge Nurse C stated in the progress notes.

At 10:24 a.m., Surveyor interviewed Caregiver D. Surveyor asked Caregiver D how s/he was made aware that Resident 1 had a medication error on 07/29/2023 when s/he was the medication passer. Caregiver D stated that s/he discovered the error when s/he was doing narcotic counts at the end of his/her shift and noticed Resident 1's morphine counts were the same and Resident 2's haldol was off by 1. Caregiver D stated that neither medication was signed out on Resident 1 or Resident 2's medication administration record (MAR) or documented as administered on the narcotic proof of use record. Surveyor asked if Caregiver D was aware if the medication error was recorded anywhere in Resident 1's record. Caregiver D stated not that s/he was aware of.

Surveyor reviewed Resident 1's MAR. Resident 1 had an order for morphine 20 mg/ml oral sol pfs to give 0.25ML (5MG) by mouth every three hours

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N 410	Continued From page 6	N 410		

as needed for pain or dyspnea, with a start date of 07/17/2023. According to the provider's documentation of Resident 1's MAR, Resident 1 was only administered morphine on 07/28/2023 at 10:20 p.m. in July 2023. There was no documentation of administration or an attempt to administer any prn medication on 07/29/2023.

Surveyor Reviewed Resident 1's progress notes for July and August 2023, which document: 07/29/2023, Charge Nurse C documents, "Resident continues to transition and is unresponsive today. [Hospice] nurse in to see resident. [Family members] are at [his/her] bedside. NOR. DC All oral nonessential medications. Start Ativan 0.5mg SL TID (3x daily) for restlessness. NPO (nothing by oral) unless resident wakes up and asks for fluids or food." No documentation for 07/30/2023-08/02/2023 08/03/2023, "...resident has Expired."

At 11:04 a.m., Surveyor interviewed Health Services Director B and asked if Resident 1 receiving haldol in error was documented in his/her record. Health Services Director B stated that it should be in a progress note and then acknowledged that there was no documentation of it in Resident 1's progress notes. Health Services Director B stated that typically when an incident report is made up it triggers an incident report note in the progress notes and s/he is unsure of why that did not happen in this event. Surveyor clarified that the medication error is not in the MAR or progress notes and asked if there was anywhere else it may be documented in Resident 1's record. Health Services Director B stated no, the only documentation of the error is in the provider's internal documentation.

On 09/15/2023, Surveyor reviewed Resident 1's

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N 410	Continued From page 7 hospice notes which did not include the known medication error. There was no documentation of Resident 1 receiving Resident 2's haldol in error in his/her record. Cross Reference N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0415 DHS 83.37(2)(d) Documentation Of Medication Administration	N 410		
N 415	83.37(2)(d) Documentation of medication administration. 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. This Rule is not met as evidenced by: Based on record review and interview, Charge Nurse C did not document in Resident 1's medication administration record (MAR) when s/he administered medication, any side effects after administering the wrong medication or Resident 1's response to PRN (as needed) medication. Findings include:	N 415		

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N 415	Continued From page 8 On 08/15/2023, the Department received a complaint alleging a medication error had been made with morphine. On 09/06/2023, Surveyor conducted a complaint investigation. The provider is a class CNA (non-ambulatory) community based residential facility able to serve up to 78 residents within the client groups of irreversible dementia/Alzheimer's and advanced age. The census at the time of the survey was 42. At approximately 8:50 a.m., Surveyor asked Health Services Director B for any documentation of medication errors. At 9:38 a.m., Health Services Director B provided Surveyor with an incident root cause analysis document that involved Resident 1, documenting the date of the incident was 07/30/2023. The incident analysis description of the incident documents: -"Haloperidol (haldol) 2 mg/ml 1 mg dose given PO (orally) instead of MSO4 (morphine sulfate) PRN (as needed)" -"Wrong medication was given to wrong resident" -"Employee re-educated on rights of med pass" The incident analysis was signed by Health Services Director B on 07/31/2023. Surveyor asked Health Services Director B what happened. Health Services Director B stated that Charge Nurse C was asked to give Resident 1 prn morphine and gave him/her Resident 2's liquid haldol rather than his/her prescribed morphine. At 10:01 a.m., Surveyor interviewed Charge Nurse C regarding the medication error with Resident 1. Charge Nurse C stated it was	N 415		

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07/29/2023 and it was a very busy day; Caregiver D was the medication passer and is afraid of morphine. Charge Nurse C stated that Resident 1 was restless and needed a prn. Surveyor asked if Charge Nurse C documented any symptoms Resident 1 displayed that would suggest s/he needed a prn. Charge Nurse C stated, "I don't know if I documented that." S/he stated that s/he was going to give Resident 1 his/her prn morphine but accidentally grabbed Resident 2's haldol from the medication cart and administered that to Resident 1 instead. Surveyor asked Charge Nurse C when s/he was made aware that s/he had made a medication error. Charge Nurse C stated that Health Services Director B called around 9 o'clock p.m. and stated that not all the medications were signed out and the narcotic counts were off and that s/he realized his/her error. Surveyor asked if Charge Nurse C had documented in Resident 1's MAR when s/he believed s/he was administering his/her morphine or Resident 1's proof of use record for administering a narcotic. Charge Nurse C stated, "I don't know, I don't remember if I documented it." S/he stated that the next day the Health Services Director B told him/her to write up the error and document it. Surveyor asked if Charge Nurse C observed Resident 1's response to the prn or documented any side effects of the medication error. Charge Nurse C stated that s/he checked up on Resident 1 on 07/31/2023 but does not remember if s/he documented that.

At 10:24 a.m., Surveyor interviewed Caregiver D. Caregiver D stated that s/he was working first and second shift that day and that Charge Nurse C was on the unit and checking on Resident 1, who was actively passing. Charge Nurse C said Resident 1 was restless and asked Caregiver D

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N 415	Continued From page 10	N 415		

to administer his/her prn morphine. Caregiver D then asked Charge Nurse C to administer the morphine instead. Surveyor asked Caregiver D how s/he was made aware that an error had occurred. Caregiver D stated that s/he discovered the error when s/he was doing narcotic counts at the end of his/her shift and noticed Resident 1's morphine counts were the same and Resident 2's haldol was off by 1. Caregiver D stated s/he double checked and that neither medication was signed out on Resident 1 or Resident 2's MAR or documented as administered on the narcotic proof of use record.

Surveyor reviewed Resident 1's medication administration record (MAR). Resident 1 had an order for morphine 20 mg/ml oral sol pfs to give 0.25ML (5MG) by mouth every three hours as needed for pain or dyspnea, with a start date of 07/17/2023. According to the provider's documentation of Resident 1's MAR, Resident 1 was only administered morphine on 07/28/2023 at 10:20 p.m. in July 2023. There was no documentation of administration or an attempt to administer any prn medication on 07/29/2023.

Surveyor Reviewed Resident 1's progress notes for July and August 2023, which document:
07/29/2023, Charge Nurse C documents, "Resident continues to transition and is unresponsive today. [Hospice] nurse in to see resident. [Family members] are at [his/her] bedside. NOR. DC All oral nonessential medications. Start Ativan 0.5mg SL TID (3x daily) for restlessness. NPO (nothing by oral) unless resident wakes up and asks for fluids or food."
No documentation for 07/30/2023-08/02/2023
08/03/2023, "...resident has Expired."
There was no documentation of Resident 1's prn medication administration on 07/29/2023, no

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N 415	Continued From page 11 documentation of the need for prn medication and no documentation of Resident 1's response to the medication, including any side effects or adverse reactions to the medication error. Cross Reference N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction	N 415		