

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525212	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2024
NAME OF PROVIDER OR SUPPLIER  Wisconsin Rapids Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 River Run Dr Wisconsin Rapids, WI 54494	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40342</p> <p>Based on staff interview and record review, the facility did not ensure accurate administration of medication for 1 Resident (R) (R4) of 4 sampled residents.</p> <p>R4 received an incorrect medication due to a transcription error. In addition, R4 did not receive medication doses ordered by R4's physician.</p> <p>Findings include:</p> <p>The facility's Administering Medications policy, with a revised date of April 2019, indicates: Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame .6. Medication errors are documented, reported, and reviewed by the QAPI (Quality Assurance Performance Improvement) committee to inform process changes and or the need for additional staff training .24. Topical medications used in treatments are recorded on the resident's treatment record (TAR) .</p> <p>On 4/2/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including right fibula (a long bone in the lower leg) fracture and diabetes mellitus (a disease in which blood sugar levels are too high). R4's Minimum Data Set (MDS) assessment, dated 12/8/24, contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 had intact cognition. R4's medical record indicated R4 was responsible for R4's healthcare decisions. R4 was discharged home on 3/22/24.</p> <p>R4's medical record contained a handwritten order from R4's dermatologist, dated 2/7/24, that stated, .TAC (Triamcinolone) (used to treat certain skin conditions) ointment bid (twice daily) to active lesions on neck, trunk, ext (extremities) .</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R4's TAR indicated R4 received triple antibiotic ointment (used to treat infection) to active lesions on neck, trunk, extremities two times a day starting 2/7/24 and ending 2/20/24. R4's TAR contained an order for triamcinolone acetonide external ointment 0.1 % topically two times a day for bullous pemphigoid (a rare skin condition that causes large, fluid-filled blisters) for 14 days apply to neck, trunk, extremities where there are new/active lesions starting 2/21/24 and ending 3/6/24. R4's TAR indicated R4's evening dose of triple antibiotic ointment wasn't administered on 2/9/24. R4's TAR indicated R4's evening dose of triamcinolone ointment wasn't administered on 2/27/24, 2/28/24, 2/29/24, and 3/4/24. In addition, R4's TAR indicated R4 refused R4's evening dose of triamcinolone on 2/25/24 and 2/3/24 and the morning dose on 2/26/24, 2/27/24, 2/28/24, 2/29/24, 3/4/24, and 3/5/24. R4's TAR indicated all other scheduled doses were administered.</p> <p>R4's medical record contained the following nurse progress notes:</p> <p>~3/1/24: Called (dermatology clinic) in (city) to update (R4's) MD (Medical Doctor) about (R4's) intolerance to the triamcinolone. The phone rang then hung up. Will attempt to call back again later.</p> <p>~3/1/24: Updated (primary provider group) MD of (R4's) reaction to the triamcinolone cream.</p> <p>R4's medical record contained the following physician progress notes:</p> <p>~2/20/24: .(R4) is seen today for follow up. (R4) saw dermatology recently with biopsy done. (R4) was placed on triamcinolone by dermatology but it appears triple antibiotic was used instead. Discontinued this in (medical record program) and placed order for triamcinolone. Will continue for 14 days after discussion with (dermatology physician) .</p> <p>~3/6/24: .(R4) is seen today for a follow-up. In the notes, there is report of a reaction to the triamcinolone but it's unclear what the reaction is or if they got in touch with dermatology after. When I see (R4) today to evaluate how the lesions have responded, (R4) reports only having it applied once and having them take it off because it made the itching worse .Pictures placed in (medical record program) and sent to (dermatology physician) .I put instructions from dermatology for a trial of wet dressings .</p> <p>On 4/2/24 at 12:09 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-C who indicated LPN-C remembered R4 and worked with R4 often. LPN-C indicated R4 returned from a dermatology appointment with an order that was thought to be for triple antibiotic ointment but was for triamcinolone ointment. LPN-C indicated R4 had a reaction to the triamcinolone ointment and LPN-C called the dermatology clinic to have the triamcinolone ointment discontinued. LPN-C reviewed R4's progress notes and stated, On 3/6 (2024) I called them (dermatology clinic) to d/c (discontinue) the triamcinolone and then they faxed over a written order. I thought I called them before that too but couldn't get through .I told them the order we had and that (R4) had only tried it once and then refused additional doses .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/2/24 at 1:47 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R4's receipt of triple antibiotic ointment was a medication error caused by a transcription error. Following a discussion that R4's physician documented R4 only accepted one dose of triamcinolone ointment and LPN-C indicated the same, DON-B asked, If they (nurses) didn't give it, why are they marking they did? DON-B verified R4 should not have received triple antibiotic ointment. Following a discussion regarding the facility's policy that indicated medications should not be given without a physician's order, DON-B verified the facility did not have an order to administer triple antibiotic ointment to R4. DON-B indicated DON-B was aware of the above medication error on whatever day they changed it and stated, If they (nurses) can't read something, they need to clarify it and not just guess.</p> <p>On 4/2/24 at 2:25 PM, Surveyor completed a follow-up interview with DON-B who verified the facility did not have documented staff education regarding medication and transcription errors following the above incident.</p>		