STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525408	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middle River Health and Rehabilitation Center	8274 E San Rd South Range, WI 54874

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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48793 Based on observation, interview and record review, the facility did not ensure a system of records of receipt and disposition of all controlled drugs in sufficient detail to reconcile accurately. This affected 12 out of 49 residents (R) in the facility. (R1, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R14) The facility did not ensure medications were administered under professional standards of clinical practices for residents. This had the potential to affect all residents on 1 of 2 floors in the facility. Findings include: Facility policy titled, Administering Medications, dated 2019, states in part, .#22. The individual administering the medication initials the resident's Medication Administration Record (MAR) on the appropriate line after giving each medication and before administering the next ones. #23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: g. The signature and title of the person administering the drug . Facility policy titled, Documentation of Medication Administration, dated 2022 reviewed on, states in part, .#2. Administration of medication is documented immediately after it is given. #3. g. initials, signature and title of the person administering the medication . Example 1 Surveyor reviewed medication errors for the past 6 months. -On 03/30/35, medication error report indicates staff did not give R7 Lorazepam medication as it was not signed out on narcotic count sheet. Director of Nursing (DON) B indicated staff to not sign out medication on the narcotic book until medication is given to R7. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 03/30/35, medication error report indicates staff did not give R4 Clonazepam medication as it was not signed out on narcotic count sheet. DON B indicated staff to not sign out medication on the narcotic book until medication is given to R4. -On 04/13/25, medication error report indicates staff gave R5 an extra dose of oxycodone due to staff prepping medication in advance and another nurse not knowing it was prepped ahead and gave another 1/2 dose to R5. DON B educated nurses on not prepping medications ahead of time before administering. -On 04/13/25, medication error report indicates R6 was given an extra dose of tramadol. One nurse set up medication and the second nurse went to administer medications and took out an extra tramadol tab. DON B educated nurses on not prepping medications ahead of time before administering and only administering medications in which the individual nurse prepares themselves. DON B indicated to sign out medication on the narcotic book when the narcotic is removed from the pill pack. Surveyor reviewed facility's investigation pertaining to narcotic diversion that occurred on 03/03/25. Facility reviewed R1, R8, R9, R10, R11, R12, R13, R14, and R4's MAR from 03/03/25 and found controlled medications signed out, which indicated that Licensed Practical Nurse (LPN) L administered R1, R8, R9, R10, R11, R12, R13, R14, and R4's-controlled medications to residents on 03/03/25. Through investigation, the facility found R1 who was in hospital on 03/03/25, and R8, R9, R10, R11, R12, R13, R14, and R4 did not receive the controlled medications signed out by LPN L on 03/03/25 as documented. Facility called police and notified Department of Health Services within two hours of the facility knowing that there were missing narcotics. Police found LPN L had oxycodone, lorazepam, and hydrocodone in LPN L's possession. Facility terminated LPN L and began pain assessments on R8, R9, R10, R11, R12, R13, R14, and R4. Facility found no concerns with R8, R9, R10, R11, R12, R13, R14, and R4's pain levels. DON B started narcotic reconciliation audits weekly. On 04/28/25 at 12:43 PM, Surveyor observed LPN D sitting at the nurse's station with two narcotic books on desk and LPN D signing out narcotics and documenting quantity of narcotics left in locked narcotic box. On 04/28/25 at 12:45 PM, Surveyor interviewed LPN D and asked what LPN D was doing with the narcotic books. LPN D indicated that LPN D gave narcotics to several residents and was currently signing out R4's Clonazepam. Surveyor asked LPN D what the normal process is for signing out narcotics after giving narcotics to residents. LPN D stated, I know this process isn't right and I should have signed the narcotics out as I gave each one to each resident. LPN D indicated that LPN D just knows when LPN D gave the controlled medications and leaves sticky notes for self on the medication cart across the nurse's station if LPN D forgets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor asked LPN D to show Surveyor the locked narcotic box located in the medication cart across from the nurse's station. LPN D got up from the nurses' station and walked across the nurse's station to the medication cart and unlocked the narcotic box. Surveyor asked LPN D to show Surveyor R4's Clonazepam card. Surveyor observed R4's Clonazepam card that was labeled with 30 tabs on the card. Surveyor asked LPN D to show Surveyor R4's Clonazepam count sheet out of the narcotic book. Surveyor observed on R4's Clonazepam count sheet quantity started with 30 tabs and noted LPN D signed out, Gave 1 tab of Clonazepam at 12:00 PM. Surveyor asked LPN D how there were 30 tabs accounted for in R4's Clonazepam card, but the count sheet that LPN D signed, indicated 29 tabs of Clonazepam left in R4's Clonazepam card. LPN D immediately apologized to Surveyor and stated, Well I did not give this medication yet, but I was signing it out. LPN D indicated that LPN D did the documentation incorrectly and was going to go back and give the Clonazepam but did not yet. Surveyor asked LPN D it was normal to sign controlled medications out of the count book before pulling from the card. LPN D indicated that LPN D performed the wrong process and knows that LPN D should not have done that, but LPN D stated, It has just been so busy here today. LPN D indicated that facility process is to sign out the narcotic or controlled medication once the medication is pulled and administered to R4. LPN D indicated that LPN D should not have signed out before giving the medication. On 04/28/25 at 2:35 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B what is DON B's expectation for signing out narcotic count sheets when administering a controlled medication. DON B indicated that LPN D approached DON B and let DON B know that LPN D messed up by signing out a controlled medication before giving the controlled medication making the count off in the narcotic book. DON B indicated that DON B's expectation is that nurses do not prep medications ahead of time or sign out medications that have not been given first. DON B's expectation was that LPN D give R4's Clonazepam and sign out the medication in the narcotic book once the medication was administered. DON B indicated that LPN D should have counted how many tabs were left in R4's Clonazepam card then documented the correct quantity on narcotic count sheet. Surveyor asked DON B how often DON B audits to make sure the narcotic count sheets are accurate, and they are being signed out appropriately. DON B indicated that audits started back in beginning of March 2025, and DON B performs the audits weekly. Surveyor tried reviewing narcotic count sheets and DON B indicated the narcotic count sheets were being audited as we were speaking. Surveyor asked DON B if there are any discrepancies with the narcotic sign out count sheets. DON B indicated that in fact there were some missing signatures on narcotic count for shift change. Surveyor requested a copy of the narcotic sign out sheet. DON B indicated that DON B understands that LPN D still is not utilizing the correct process for narcotic count to prevent narcotic diversion and will handle the situation immediately. Surveyor asked if DON B thinks there is still an issue with narcotic count and facility's process. DON B indicated that DON B has educated staff, but DON B can see that staff are still having issues and DON B will reeducate. On 04/28/25 at 2:55 PM, Surveyor reviewed narcotic sign out sheets and observed on 04/10/25 missing second signature on night shift for narcotic count. On 04/25/25, day shift was missing two signatures for narcotic count. Example 2 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/29/25 at 10:42 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked NHA A if facility was aware of any delegation of tasks, treatments, and/or administering of medications from nurses to Certified Nurse Assistants (CNA)s. NHA A indicated there was a recent event in March where a resident observed LPN C delegating medication administration to a CNA. NHA A indicated that Trained Medication Aide (TMA) M was acting as a CNA on 03/19/25 but then stayed about two hours after day shift to help LPN C pass medications. On 04/29/25 at 10:47 AM, Surveyor interviewed LPN C and asked if LPN C had ever delegated medication administration to a CNA. LPN C indicated that LPN C has never allowed a CNA to pass medications. LPN C indicated the facility has TMAs. LPN C indicated that on 03/19/25 LPN C was overwhelmed with a recent fall on that evening shift and asked TMA M to stay and help pass medications. LPN C indicated that LPN C prepped all medications and would hand them to TMA M to administer the medications to whichever residents LPN C delegated the medication pass. Surveyor asked LPN C if LPN C followed TMA M in the rooms while TMA M passed medications. LPN C stated, Well I was in close proximity like in the room next to the other room [TMA M] was in. I did not physically go into the rooms [TMA M] administered medications but that shouldn't matter as [TMA M] is trained to administer medications. Surveyor asked LPN C what the process is for preparing and administering medication to residents. LPN C indicated that medications are to be prepared right when LPN C is about to administer the medications to residents and should be the nurse who is prepping the medication to administer the medication. Surveyor asked if LPN C remembers which residents TMA M administered medications to on 03/19/25. LPN C indicated that LPN C had TMA M help with most of all medications needing to be administered. Surveyor asked LPN C who signed out the medications in the MAR. LPN C indicated that LPN C documented that LPN C administered all medications on the evening shift of 03/19/25. Surveyor asked LPN C if LPN C did not administer the medications, why was it documented that LPN C administered the medications. LPN C indicated that LPN C knew better, and TMA M should have signed the medications that TMA M administered. Surveyor asked LPN C what the process for medication administration is and not falsifying documentation. LPN C indicated that LPN C should have had TMA M prep, administer, and document the medications that TMA administered. LPN C indicated next time LPN C will not prepare medications ahead and delegate someone else to give the medications. On 04/29/25 at 11:43 AM, Surveyor interviewed DON B and asked DON B's expectation for medication administration. DON B indicated nurses are to follow facility policy. Surveyor asked DON B if it was acceptable for LPN C to prepare residents medications and then delegate TMA M to administer the medications. DON B indicated that TMA M can administer medications as TMA M is trained. Surveyor asked DON B what the process or expectation for documenting medications when administered to residents. DON B indicated that LPN C should have not prepared medications ahead and delegated TMA M to administer medications and LPN C should not have documented that LPN C gave the medications when TMA M is the one who administered the medications.