| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525520 | A. Building<br>B. Wing | 06/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Dove Healthcare - Lodi | 700 Clark St<br>Lodi, WI 53555 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility document review, the facility failed to prevent significant medication errors for two out of a total of five residents reviewed for medication administration (R2, and R3) out of a total sample of 13 residents. This failure had the potential for R2 and R3 to experience adverse reactions from receiving a wrong medication or wrong dosage of medication that was not prescribed for R2 and R3.<br><br>Findings include:<br><br>Review of the facility's policy Medication Administration dated 01/01/25 indicated, .Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation [sic] .Compare medication source (bubble pack, vial, etc.) with the MAR [Medication Administration Record] to [NAME] resident name, medication name, form, route, and time .<br><br>1.Review of R1's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R1 was admitted to the facility on [DATE] with the diagnosis of diabetes mellitus.<br><br>Review of R1's Physician Orders located under the Orders tab in the EMR indicated R1 had an order dated 04/17/25 Insulin Lispro Injection 100 Unit/ML (milliliter) Inject 12 units subcutaneously two times a day at lunch/dinner.<br><br>Review of R2's undated Face Sheet located under the Profile tab in the EMR indicated R2 was admitted to the facility on [DATE] with the diagnosis of diabetes mellitus, chronic respiratory failure, and stroke.<br><br>Review of R2's Physician's Orders located under the Orders tab in the EMR indicated R2 had an order dated 04/23/24 for Insulin Glargine Solution Inject 18 units subcutaneously in the morning daily. R2 also had an order dated 04/23/24 for blood sugar checks one time a day every Sunday.<br><br>Review of R2's Medication Administration Record dated April 2025 indicated R2 had received Glargine insulin 18 units subcutaneously at approximately 8:00 AM each day. R2's blood sugars were obtained at approximately 8:00 AM each day and ranged from 67 to 92.<br><br>(continued on next page) |



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

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Medication Error Investigation dated 04/30/25 at 6:00 PM, RN1 asked the Certified Nursing Assistant (CNA) what the resident's name was. CNA stated it was [R1]. RN1 proceeded to give R2, who she thought was R1, Lispro 11 unit subcutaneously. Later RN1 recognized she had given the insulin to R2 instead of R1, which was the wrong resident. At 7:00 PM, RN1 checked R2's blood sugar and it was 118. Snacks were given. R2's blood sugar was again checked at 10:30 PM, at which time the blood sugar was 106 and R2 was easily awakened. No further interventions were documented in the electronic medical record for R2.<br><br>Further review of the Medication Error Investigation indicated the physician was notified of the error on 04/30/25 at 9:30 PM with no documentation stating if the physician ordered any further monitoring for R2.<br><br>Education was documented as being completed on 04/30/25 with RN1 that consisted of printing off a . document that goes over the 6 [sic] rights of medication administration and went over it with the RN [RN1] who made the medication error . educated RN [RN1] on importance of updating NP/MD for advisement of treatment and reporting the error.<br><br>During an interview on 06/12/25 at 6:40 PM, RN1 stated, I gave the insulin to the wrong patient. I should have given the insulin to [R1]. Instead, I gave it to [R2].<br><br>2. Review of R3's undated Face Sheet located under the Profile tab in the EMR indicated R3 was admitted to the facility on [DATE] with the diagnosis of Alzheimer's Disease, and anxiety disorder.<br><br>Review of R3's Physician's Orders located under the Orders tab in the EMR indicated R3 had an order dated 10/18/24 for Alprazolam 0.25 mg (milligram) Give 0.25 mg by mouth in the morning for anxiety.<br><br>Review of R8's undated Face Sheet located under the Profile tab in the EMR indicated R8 was admitted to the facility on [DATE] with the diagnosis of panic disorder and anxiety disorder.<br><br>Review of R8's Physician's Orders located under the Orders tab in the EMR indicated R8 had an order dated 11/15/24 for Lorazepam 1 mg 0.5 tablet by mouth three times a day for anxiety.<br><br>Review of the Medication Error Investigation dated 01/17/25 indicated, During the morning medication pass I [Registered Nurse (R)2] pulled Lorazepam 0.5 mg tablet accidentally from another resident's medication [R8] rather than pulling resident's scheduled Alprazolam 0.25 mg. As soon as medication error was realized VS [vital signs] [sic] were assessed and error was reported.<br><br>Further review of the Medication Error Investigation indicated the on-call physician was notified of the medication error on 01/17/25 at 3:05 PM with no documentation stating if the physician ordered any further monitoring for R3.<br><br>During an interview on 06/13/24 at 11:05 AM, the DON stated, Education was given to [RN2] on the six rights of safe medication administration and an information print out of potential look alike sound alike drug names were also given.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/13/25 at 5:15 PM, RN2 stated, I know it was extremely busy that morning and I had a lot of distractions. I pulled the Lorazepam from [R8's] card and gave it to [R3] by mistake. At shift change is when the count was off for Lorazepam is when I realized what had happened. Asked RN2 what the milligram of Lorazepam she administered to R3 and RN2 stated, Whatever the order was for [R8] I gave it to [R3].<br><br>3. Review of R3's undated Face Sheet located under the Profile tab in the EMR indicated R3 was admitted to the facility on [DATE] with the diagnosis of Alzheimer's Disease, and anxiety disorder.<br><br>Review of R3's Physician's Orders located under the Orders tab in the EMR indicated R3 had an order dated 10/18/24 for Alprazolam 0.25 mg (milligram) Give 0.25 mg by mouth in the morning for anxiety.<br><br>Review of R9's updated Face Sheet located under the Profile tab in the EMR indicated R9 was admitted to the facility on [DATE] with the diagnosis of anxiety disorder.<br><br>Review of R9's Physician Orders located under the Orders tab in the EMR indicated R9 had an order dated 11/04/24 for Alprazolam 0.5 mg give one tablet by mouth three times a day for anxiety.<br><br>Review of the Medication Error Report dated 10/21/24 indicated on 10/19/24 [Licensed Practical Nurse (LPN)3] administered Alprazolam 0.5 mg to [R3] instead of administering Alprazolam 0.25 mg to [R3]. LPN3 stated she took the medication from [R9's] medication card and gave it to [R3].<br><br>During an interview on 06/13/25 at 10:40 AM, the Director of Nursing (DON) stated, For anyone that makes a medication error I go over the five rights of medication administration. Was asked if there were any audits, or medication administration observations that were done after any of the medication errors that were reviewed and the DON stated, No, there wasn't. The DON was asked if the facility had a phone number for [LPN3] and she stated, We don't have any contact information on file for [LPN3].<br><br>During an interview on 06/13/25 at 8:29 PM, the (DON) was asked what her expectations were when a nurse administered a medication. The DON stated, I expect them to follow the ten rights of medication administration which are the right resident, right medication, right dose, right route, right time, right documentation, right reason, right response, right education, and right to refuse. |