STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on observation, interview, and record review, the facility did not ensure residents receive adequate supervision and assistive devices to prevent accidents for 1 of 1 residents (R2) reviewed for elopement, safety and accidents. R2 was not identified by the facility for elopement risk, R2 was assessed to need stand by assistance with his 4-wheeled walker for safety. R2 left the facility without staff's knowledge and was unable to return independently. A staff member found R2 and assisted him back to the facility. This is evidenced by: The facility policy, Elopement/Missing Resident, revised May 2010, states, in part . Policy: It is the facility's policy to implement all possible measures to protect/minimize any resident who attempts to elope. Definition: Elopement, for purposes of this policy and procedure, is defined as that situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety needs, and therefore at risk for injury outside the confines of the facility, has left the facility without the knowledge of staff. Procedure: 1. upon admission / readmission, all residents will be assessed for risk of elopement. Residents will be re-assessed for elopement risk if the resident makes attempts to elope and/or as needed. 5. When the resident if found, an in-depth physical assessment is completed by the charge nurse or designee with a specific focus on hypothermia, injuries, etc., and treated as ordered by the physician. The physician is notified along with the family and police, as needed. An incident report is completed. Documentation in nurse's notes is made. 6. Care plan interventions are documented and/or revised. 7. An immediate intervention is implemented to prevent further elopement. This may include 15-30 minute checks for at least eight hours or more, placement to secured unit, or use of a wander-guard. 9. Each shift, nurse's notes are written following the elopement to reflect resident's response to the intervention(s). 11. The State is notified according to state regulations. R2 was admitted to the facility on [DATE] with diagnosis that include in part . Heatstroke and sunstroke, metabolic encephalopathy, schizophrenia, delirium, amblyopia left eye, PVD (peripheral vascular disease), and Type 2 Diabetes Mellitus. R2's admission MDS (Minimum Data Set) dated 6/22/21 gives a BIMS (Brief Interview of Mental Status) score of 11, indicating cognitive impairment. R2 requires supervision of one staff member for transfers, toileting, locomotion on and off the unit, and walking in room and in corridor. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ACLS ([NAME] Cognitive Level Screen)/LACLS (Large [NAME] Cognitive Level Screen) Report Form completed by therapy staff indicates the LACLS assessment tool was used to get a score of 4.0/5.8 (4.0 out of 5.8). Comment: At level 4.0 recommend 24-hour supervision to maintain safe surroundings, support consistent routines and assist with solving major and minor problems as they arise. Individual may prepare a cold meal, make incidental purchases, and complete own self-care tasks. Elopement Risk Assessments were completed on 6/17/21 and 8/12/21, both of which continue to support R2 is not at risk of elopement. R2's care plan states in part . Care Plan, initiated on 6/18/21 with Focus: Cognition: At risk and/or potential for complications with cognitive status: related to Schizophrenia. Note: There is no goal or intervention for this Focus Item prior to 8/12/21. Note: Prior to 8/12/21, R2's care plan does not include information about R2's primary admission diagnosis of a heat stroke, he has a history of dressing inappropriately for the weather, and he leaves the building for outings independently. Care Plan, Focus: ADL (Activities of Daily Living): Actual Deficit's with ADL's R/T (related/to) BLE (bilateral lower extremities) wounds; toe wounds to bilat (bilateral) feet and functional decline r/t heat [NAME] [sic], Date Initiated: 6/18/21. Ambulation: SBA (stand by assist) w (with)/walker. Locomotion: SBA of 1 with walker for ambulation, Indep (independent) with W/C (wheelchair). Transfers: SBA with walker. PT (physical therapy) as ordered. Nursing to follow recommendations of PT. R2's care plan does not address the risk for elopement. Occupational Therapy Treatment Encounter Notes from 8/10/21 state in part . Summary of Skill: Pt (patient) ambulated on the unit 4ww (4 wheeled walker) with good safety judgement. He was able to operate automatic doors and exit the facility with mod I (modified independence). Transfer to arm chair mod I with good safety awareness. Comments: Pt will demonstrate intact safety judgment during community mobility tasks using 4ww SBA, demonstrating safe performance in highly distractive environment and no LOB (loss of balance) during mobility. Baseline: Min (minimum) A (assist). Current, 8/12/21: Pt was found across the street using his 4WW, however [NAME] [sic] fatigued to return to the SNF (skilled nursing facility), pt was unable lift his RLE (right lower extremity) up to advance to walk. Pt was dressed warm for a hot humid day. SNF staff assisted pt to return to SNF with use of a w/c. Justification of Skilled Services: Impairments: Remaining impairments: Pt drags RLE when walking, does not use 4WW in room rather uses wall, door and bed for support. Edema BLE's. Cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/21 at 16:27 (4:27 PM), nurse's notes state, This writer was informed by therapy staff resident was outside the building. Resident stated he left the building because he wanted to go to the store to get his pick 3 lottery tickets. He thought the store was close enough for him to walk there. He stated he exited out the front door but did not sign out or let anyone in the building know where he was going. Resident assessed, appears to be in no apparent distress. Resident typically goes on outing by himself but signs out or informs staff because he asks for assistance to call a cab. Resident stated he did not have the money for the cab that is why he attempted to walk. Resident was educated on informing the staff he was intending to leave the building for safety purposes. Risk and benefit was completed as well. On 8/12/21 at 18:08 (6:08 PM), nurse's notes state in part . T (temperature) 98.2, O2 (Oxygen) 97%. Note: This is approximately one hour and thirty minutes after R2 returned to the facility. No assessment information regarding R2 is noted in the medical record immediately following R2's return. Despite being found dressed warm for a hot humid day and previous history of heat stroke. Risk/Benefit Record Tool was completed on 8/12/21 which states in part . Education provided to: R2 and daughter. Education Needed: 1. Safety. 2. Additional Information: Education on risk of going out in the community (store, bank, gas station) without signing out in the resident sign out book as well as attempting to walk to destination instead of using the cab. 4. Additional Information: Not signing out when you leave on an outing puts you at risk of the staff not knowing when you left and when you expect you back. This can put you at risk of the staff not going to look for you if something has happened to you while you are out delaying assistance if needed. We also need to use the sign out in the case of an emergency such as a weather emergency or a fire, if you are not in the building and did not sign out we will spend time looking for you in an evacuation situation. You are getting therapy to get stronger and to increase your endurance with physical activity. Walking to places instead of taking a cab increases your risk which could lead to hospitalization due to injury, which may include surgery to repair a fracture. If you fall and hit your head you could have a bleed in your rain (sic) that could result in a great decrease in function from mobility to swallowing, a brain bleed could also cause you to be in a coma, hooked up to life support or death. On 8/16/21 at 15:01 (3:01 PM), nurse's notes state, Writer spoke with residents POA/Sister about resident leaving facility without signing out and having a fall while outside, with no injury noted. Note: There is no further information in R2's medical record regarding any falls. On 9/01/21 at 9:23 AM, Surveyor interviewed OT E (Occupational Therapist). Surveyor asked OT E her account of what happened on 8/12/21 when R2 was found outside. OT E stated, R2 was walking on the road. He was in front of the auto repair shop on the sidewalk with 4WW. He had crossed the street to be in front of the auto shop. Surveyor asked OT E if R2 often leaves the facility. OT E stated, He often sits in front of the building but I have never seen him leave the facility. Surveyor asked OT E if R2 was safe to leave the facility independently. OT E stated, No, when you add in his poor vision and difficulty clearing his right foot when walking. He also has some cognitive impairment. Surveyor asked OT E if R2 stated where he was going. OT E stated, He wanted to go play numbers, which means he was going to get lottery tickets and it was much farther than it seemed in the van. He was also dressed in a long sleeve shirt and it was very warm that day. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/1/21 at 10:56 AM, Surveyor interviewed NM F (Nurse Manager). Surveyor asked NM F about R2's cognitive status and why R2 is marked as non-interviewable on the sheet provided to Surveyors by facility. NM F stated, R2 answers my questions appropriately but his BIMS score indicates cognitive deficit. Surveyor asked NM F if R2 was safe to leave the facility independently. NM F stated, R2 is safe if he has appropriate transportation, not if walking. Surveyor asked NM F if R2's MDS indicates he needs supervision should he leave the facility independently. NM F stated, No, he would not be safe leaving independently. Surveyor asked NM F about R2's elopement assessment. NM F stated, Elopement assessments can be done by any nurse but perceptions can be slightly different between staff. Surveyor asked NM F how far from the facility R2 was when he was found by therapy staff. NM F stated, He was by the auto place which is not that far. Note: Surveyor reviewed Google Maps and noted auto place where R2 was found is approximately 600 feet from the facility. On 9/1/21 at 11:23 AM, Surveyor interviewed TD/MDS G (Therapy Director/Minimum Data Set). Surveyor asked TD/MDS G about R2's cognition and functional abilities. TD/MDS G stated, I think his cognition fluctuates. It is recommended that R2 go to an AL (assisted living) due to poor decisions. Therapy did pick him back up too as his insurance provider wanted him to return home. We found during that evaluation R2 still needs an AL. Surveyor asked TD/MDS G if R2 was safe to leave the facility independently. TD/MDS G stated, R2 should not leave for any distance. He is not strong enough or doesn't have the activity tolerance to be walking or taking a cab anywhere. On 9/1/21 at 3:06 PM, Surveyor interviewed IR H (Interim Receptionist). Surveyor asked IR H about R2's outings. IR H stated, R2 hasn't went out since his elopement. Prior to that he would go to the back 1 to 2 times a week and always signed out. Surveyor asked IR H if R2 has every forgotten to sign out prior to 8/12/21. IR H stated, the very first time being in the facility and leaving he did not sign out. He was educated and there have been no issues since. I would help him get his cab. On 8/12/21, he didn't get a cab. Surveyor asked IR H if R2 needed assistance getting in and out the cab and what time of day R2 would leave facility. IR H stated, I don't have any idea but he didn't need assistance getting in and out of the cab. R2 always left on day shift, never on the PM (evening) shift that I know of. On 9/1/21 at 5:44 PM, Surveyor interviewed DON B. Surveyor asked DON B how staff know R2 will remember to sign out. DON B stated, Education was provided and he understood. There is also the risk and benefits we talked about. R2 seems to be pretty good with things like that. The girl at the front desk helps with that. Surveyor asked DON B, if anyone in the facility was awareR2 was out of the building on 8/12/21. DON B stated, No, we didn't know he was gone. On 9/1/21 at 5:55 PM, Surveyor interviewed NHA A. Surveyor asked NHA A if anyone was aware R2 was out of the building on 8/12/21. NHA A stated, We were not aware, he didn't tell anyone. R2 is noted to have cognitive impairment, R2's therapy assessment indicates R2 requires stand by assist with a 4ww for ambulation. R2 left the facility without staff's knowledge and was found by a staff member 600 feet off the facility campus R2 had to cross the street to get to the location R2 was found and unable to physically return to the building.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility did not ensure the facility provided pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 4 sampled residents (R9) reviewed for medications. R9 had an order for Insulin Aspart with meals that was not administered on 9/29/21 at 5:30 PM. Evidenced by: The facility's Policy and Procedure entitled, Insulin Administration, with a revision date of May 2020, states, in part: Policy- Medications given by injection will be physician ordered and will be administered following professional standards of practice by a licensed professional. Procedure- Insulin Administration via Pen 1) Check the physician's order to make sure of the correct type, dosage, and time of administration . Example 1 R9 was admitted to the facility on [DATE], and has diagnoses that include Type 2 Diabetes Mellitus without Complications and Hyperglycemia Unspecified. R9's Care Plan, dated 9/26/2021, with a target date of 10/06/21, states: Diabetes: At risk for complications R/T (related to) diagnosis of DMI, INSULIN DEPENDENT- Daily &/or Sliding Scale. Goal: WILL BE FREE OF SERIOUS COMPLICATIONS R/T DX'S AS MD FOLLOWS SX'S AND LABS THROUGH NEXT REVIEW. Interventions include .-MEDICATION/TREATMENTS AS ORDERED . R9's physician's orders, dated 9/16/21, includes, in part: -Insulin Aspart Flex Pen Solution Pen-Injector 100 UNIT/ML (Insulin Aspart) Inject 10 unit subcutaneously with meals for Diabetes R9's MAR (Medication Administration Record), for September 2021, includes, in part: -Insulin Aspart Flex Pen Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject 10 unit subcutaneously with meals for Diabetes Start Date-9/16/2021 Administration times: 0730 1130 1730 R9's 9/2021 MAR indicates R9 did not receive the scheduled dose of Insulin Aspart Flex Pen Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject 10 unit subcutaneously with meals on 9/29/2021 at 1730. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of # 1462 Medication Error, dated 9/29/2021 17:30 (5:30 PM), states, in part: -Resident: R9 -Incident Location: Medication Error -Person Preparing Report: DON B (Director of Nursing) -Resident Location: (Facility Hall and Room Number) Incident Description: -Nursing Description: Split shift and per previous shift Novolog at 17:30 did not pop up on the MAR for her to give, found at 20:30 with HS (hour of sleep) med pass. Blood Sugar 194 -Resident Description: I know she took my blood sugar Immediate Action Taken Description: call to find out if insulin was given, took blood sugar and updated PA (physician assistant) answering service Resident Taken to Hospital? N (meaning No) Predisposing Environmental Factors: Med Error- Dispensing box checked . Predisposing Physiological Factors: Med Error-Administrating- Omission box checked . On 10/14/21, at 2:25 PM, Surveyor interviewed DON (Director of Nursing) B asking about R9's medication error (insulin omission) on 9/29/2021 at 5:30 PM. DON B indicated she had caught it on her shift as she was working a split shift starting at 6:00 PM. DON B indicated it popped up as red as not given by the previous nurse on her shift. Surveyor asked DON B if education was provided to staff and DON B indicated no education was provided and she should have provided education but she had been working the floor the month of September. DON B indicated she phoned the nurse to find out if the insulin had been missed and was informed it was missed by the previous nurse. Surveyor asked DON B what intervention was put into place to prevent an error such as this from occurring in the future. DON B indicated DON B changed the time on the MAR from 6:00 PM to 5:30 PM. DON B indicated it was a miscommunication between DON B and the previous nurse. Surveyor asked DON B if the omission of the insulin is considered a medication error and DON B indicated yes it was a medication error. On 10/14/21, at 3:10 PM, Surveyor asked DON B if there was an audit of other residents that had an order for blood sugar checks and insulin with meals. DON B indicated no and everything else is fine. Surveyor asked DON B if she had any documentation to verify everything else is fine or audits and DON B indicated no. The facility did not ensure R9 received her insulin on 9/29/2021 at 5:30 PM per Physician Orders.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on interview and record review, the facility did not ensure that residents are free of any significant medication errors for 1 of 1 residents (R4) reviewed for medication errors. R4 admission orders from the physician were transcribed incorrectly resulting in significant medication errors. R4 received Victoza and Levemir (medications used to control diabetes) prior to hospital discharge. The facility administered a 2nd dose of Victoza and a double dose of Levemir at bed time which resulted in R4 having multiple episodes of vomiting requiring physician intervention and orders for Zofran. R4 also received Metoprolol ER (Extended Release) 100 mg (milligrams). R4 had received Metoprolol IR (Immediate Release) 25 mg in two doses in the hospital prior to admission. (Metoprolol is a medication to control blood pressure). This is evidenced by: The facility policy titled, Medication Administration from a Cart, revised May, 2020, states in part . Policy: It is the policy to administer all medications and treatments in a safe and effective manner. Procedure: 7. Read medication orders on medication sheet and have medication cup ready. 8. For solid medications, remove medication container (blister pack or bottle) and compare label with medication sheet. Place appropriate dosage into medication cup. Re-read label and check label. Re-read label and medication sheet, and return drug to its proper location (triple check). 9. For liquid medications, remove prescribed liquid medications and compare label with medication sheet. Pour prescribed amount into calibrated cup. Pour away from label and check label. Re-read label and medication sheet and return drug to its proper location (triple check). Certain medications may be required to be calibrated with a syringe. According to Victoza.com, the most common side effects of Victoza may include in part . nausea, diarrhea, and vomiting. DOSAGE AND ADMINISTRATION2.1 Important Dosing and Administration Instructions: Inject VICTOZA(R) subcutaneously once-daily at any time of day, independently of meals. If a dose is missed, resume the once-daily regimen as prescribed with the next scheduled dose. Do not administer an extra dose or increase the dose to make up for the missed dose. OVERDOSAGE: Overdoses have been reported in clinical trials and post-marketing use of VICTOZA(R). Observed effects have included severe nausea, severe vomiting, and severe hypoglycemia. In the event of over dosage, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms. Evidenced by: R4 was admitted to the facility on [DATE] with diagnoses that include in part . Type 2 Diabetes Mellitus with foot ulcer, Essential Hypertension, osteomyelitis left ankle and foot, severe sepsis with septic shock. R4's Hospital Discharge Packet including Final Discharge Medication List includes the following medications in part . - Victoza 18MG (milligrams)/3ML (milliliter) soln (solution) pen injector. Inject: 1.2 mg under skin one time daily. Notes: Indication: Type 2 Diabetes Mellitus. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	- Levemir FlexTouch 100 Unit soln pen-injector. Inject 30 units under skin at 10 am and 15 units at 8 pm. Purpose: Type 2 diabetes Mellitus. - Metoprolol Succinate 100 MG 24hr (hours) ER (extended release) tab. Take 1 tab by mouth every day at bedtime. Notes: Take for high blood pressure. R4's Hospital Medication Administration Record for the last 3 days includes in part . - Custom medication unit dose. Freq (frequency): 1x (time) daily. Last given on 6/29/21 at 9:13 AM (morning). - Lantus 100 Unit/mL injection 20 units. Freq: 1x daily (HS) (bedtime). Last given on 6/28/21 at 8:30 PM (evening). - Metoprolol Tartrate tab 25 mg. Dose 25 mg. Freq: 4 X daily. Last dose given 6/29/21 at 11:59 AM. Note: R4 was not receiving Levemir in the hospital. On 9/07/21 at 1:20 PM, Surveyor spoke with Hospital RPH C (Registered Pharmacist) who indicated the Custom Medication that is listed above is Victoza. The medication was brought into the hospital by the resident and administered by the hospital at the time indicated on the Medication Administration Record. The facility eMAR (Electronic Medication Record) for R4 from the time of admission indicates the following in part . - Metoprolol Succinate ER tablet Extended Release 24 hour. Give 100 mgs (milligrams)by mouth at bedtime for blood pressure. Given on 6/29/21 and 6/30/21 at HS (bedtime). Start 6/29/21 20:30 (8:30 PM). - Victoza Solution Pen-Injector 18 MG/3ML. Inject 1.2 mg subcutaneously one time a day for DM2 (Diabetes Mellitus Type 2). Start 6/30/21 0730 (7:30 AM). - Levemir FlexTouch Solution Pen-Injector 100 Unit/ML (Insulin Detemir). Inject 30 unit subcutaneously two times a day for DM2. Start Date: 6/29/21 2000 (8:00 PM), D/C (Discontinued) Date: 6/30/21 1059 (10:59 AM). - Note: R4 was not scheduled to get Victoza until 6/30/21 in the morning. Levemir was transcribed incorrectly to give 30 units at HS, instead of the ordered 15 units. R4 had also already received two doses of Metoprolol 25mg immediate release prior to admission. Thus R4 received an extra dose of Victoza, a double dose of Levemir and a daily total of 150 mgs of Metoprolol. Note: Discharge medications orders do not match the eMAR orders. On 6/30/21 R4 was seen by PA (Physician's Assistant) for Transitional Visit from Hospital to SNF (Skilled Nursing Facility). PA notes state the following in part . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Visited patient today (6/30/21): Upon arrival to room, patient comfortable lying in bed watching TV. States feels better after getting the medication for my upset stomach. Patient reported vomiting 4-5x last night - starting around 0100 (1:00 AM): 0100 (1:00 AM): medium amount of undigested food 0200 (2:00 AM): medium amount of undigested food 0600 (6:00 AM): medium amount of mostly 7up and water Ate breakfast at hospital yesterday, missed lunch because of transfer to SNF, ate dinner (beef stroganoff) at SNF. No reports of nausea or abdominal discomfort until right before emesis. Had soft formed BM (bowel movement) at 0300 (3:00 AM) and 0930 (9:30 AM) this morning - no blood noted in stool. No fever or chills. Today, denies any N/V/F/C/D (Nausea, Vomiting, Fever, Chills, Diarrhea). Denies any abdominal pain or distention. Given Zofran around 0800 (8:00 AM). Ate a little breakfast: 1-2 French toast sticks and cartoon [sic] of milk. Took AM (morning) PO (by mouth) medications. No further vomiting since 0600 (6:00 AM). Did take PO antibiotics on empty stomach around 2300 (11:00 PM) - however he endorses doing that all the time at the hospital without GI issues. ++ He reported getting Victoza at hospital yesterday morning and at SNF last night around 2300 (11:00 PM). He is only supposed to receive once daily in AM. Per his report, he questioned SNF RN about this second dose, but she was adamant and gave it. Levemir orders were transcribed wrong at SNF. He was discharged from hospital on Levemir BID, 30 units in AM and 15 units in PM - HOWEVER SNF ordered Levemir 30 units BID (twice a day). So not only did he get a second dose of Victoza at 22230 (11:00 PM) he also received 15 extra units of Levemir at HS. Wonder if this may have caused the nausea/vomiting. 6/29 HS blood sugar = 105; 6/30 AM blood sugar = 115; noon blood sugar -143. Order given to HOLD Levemir this AM. Denies any symptoms of hypoglycemia. Discussed PM RN's medication error and blatant disregard to patients concerns re: (regarding) Victoza with SNF RN manager. She will be following up with PM RN. Nurses Notes reviewed and state the following in part . 6/29/21 at 20:30 (8:30 PM), Nurse Progress Note. Note Text: Resident got Victoza, but Levemir was scheduled for 30 units. Called place out to Doctor if resident should get the 30 units Levemir. Order gave to give because is long acting. Resident got the insulin and Linezolid antibiotic after Pharmacy got to the facility. 6/30/21 at 03:12 (3:12 AM), Nurse Progress Note: Resident threw up undigested food several times. He also had a large BM (bowel movement). MD (Medical Doctor) on call notified and order for TUMS given. Nurse Manager notified. (continued on next page)

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	525074	A. Building B. Wing	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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F 0760 Level of Harm - Actual harm Residents Affected - Few	6/30/21 at 07:09 (7:09 AM), eMAR Administration Note: Ondansetron HCL (hydrochloride) tablet 4 MG. (medication for nausea and vomiting) Give 1 tablet by mouth every 6 hours as needed for GI upset/nausea. 6/30/21 at 07:41 (7:41 AM), Nurse Progress Note: PRN (as needed) Zofran (medication for nausea and vomiting) given per new orders. Resident ate poorly for breakfast but had good fluid intake. Resident reports nausea has improved and has had no further emesis as of present time. Will cont (continue) to monitor. 6/30/21 at 08:00 (8:00 AM), Nurse Progress Note: Received follow-up call from NP (Nurse Practitioner) to discuss GI (Gastrointestinal) sx (symptoms). Writer updated on prn (as needed) orders given from on-call on NOC (night) and NP approved of use. Writer updated that prn Zofran was given with no further emesis and plan to monitor for further sx (symptoms). NP approved. 6/30/21 at 09:15 (9:15 AM), eMAR Administration Note: Ondansetron HCL (hydrochloride) tablet 4 MG. Give 1 tablet by mouth every 6 hours as needed for GI upset/nausea. PRN Administration was: Effective 6/30/21 at 11:28 (11:28 AM), Nurse Progress Note: Levemir FlexTouch Solution Pen-injector 100 UNIT/ML. Inject 30 unit subcutaneously two times a day for DM2. Held per NP order. Clarified dose on shift. 6/30/21 at 13:03 (1:03 PM), Nurse Progress Note: Resident request writer take BP (blood pressure) as he was feeling like his BP may have dropped. Fatigue and overall weakness reported. BP 101/71 at this time. No parameters for Metoprolol which is due HS tonight. Writer left message to report low BP reading, indifferent from 141/80 taken this am. BG (blood glucose) 125 on check of BP as well. Will cont (continue) to monitor. 6/30/21 at 14:57 (2:57 PM), Nurse Progress Note: Call placed to APP (Advanced Practice Provider) line to request BP parameters for Metoprolol as there are no current orders. Resident was getting 25mg QID (three times a day) in hospital, however new order upon admit is for 100 mg ER tabs QHS (every bedtime). This dose was given last night in addition to the two 25 mg given in hospital yesterday for total dose of 150mg. Above info (information) given to APP team via voice-message. Request for clarification and/or parameters ASAP (as soon as possible) today. RNCM (Registered Nurse Case Manager) also notified. 6/30/21 at 22:05 (10:05 PM), Nurse Progress Note: Resident did not have any emesis in this shift. Denies Nausea, no c/o (complaints of) pain noted. 6/30/21 at 23:39 (11:39 PM), Nurse Progress Note: On call MD called and Ondansetron (Zofran) discontinued per pharmacy recommendation. 7/01/21 03:43 (3:43 AM), Comprehensive Nursing Note: GI status/Appliances- Continent of Bowel - Yes (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Date of Last Bowel Movement - 6/30/21 Change in Bowel Status - No Abdomen - Soft Bowel Sounds - Within Normal Limits Drain - No Ostomy - No 7/01/21 13403 (1:30 PM), Comprehensive Nursing Note: GI status/Appliances- Continent of Bowel - Yes Date of Last Bowel Movement - 6/30/21 Change in Bowel Status - Yes Abdomen - Soft Bowel Sounds - Within Normal Limits Drain - No Ostomy - No Denies N/V/D (Nausea/Vomiting/Diarrhea) states he feels better than yesterday. 7/02/21 13:52 (1:52 PM), Comprehensive Nursing Note: GI status/Appliances- Continent of Bowel - Yes Date of Last Bowel Movement - 7/02/21 Change in Bowel Status - Yes Abdomen - Soft Bowel Sounds - Within Normal Limits Drain - No (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ostomy - No On 8/31/21 at 10:40 AM, Surveyor interviewed R4. R4 stated, On my day of admission the Nurse came in between 10:00 PM and 11:00 PM to give me night medication. She had Victoza with her and Levemir 30 units. I told the nurse I had received the Victoza that morning in the hospital and shouldn't get it again and I also explained I don't get that much insulin at night. The nurse insisted on giving both medications to me anyway. I was up most of the night after that vomiting. On 8/31/21 at 2:00 PM, Surveyor interviewed DON B. Surveyor asked DON B for any medication error information. DON B stated she would look. Surveyor asked DON B about R4's admission medication errors. DON B stated, I did some informal education with the nurse about listening to residents who are alert and oriented. No formal education. DON B states, R4's vomiting more than likely from the Victoza as I have seen that before. Surveyor asked about education to the nurse on Levemir dosing. DON B stated, I wasn't aware that a wrong dose of Levemir was also given that same night. On 8/31/21 at 4:35 PM, Surveyor interviewed APNP D (Advanced Practice Nurse Prescriber). Surveyor asked APNP D about R4's admission. APNP D states, R4 was seen on 6/30/21 by my colleague. When she saw R4 he reported to her he had received an extra dose of Victoza and a double dose of Levemir at bedtime. R4 informed her he had questioned the nurse and she gave him the medication anyway. I have attributed his GI symptoms to the extra dose of Victoza as it has a lot of side effects. The dose increase, increases the chance of adverse effects and attributed to an overdose reaction. Surveyor asked APNP D what her expectation would be if a resident who is cognitively intact questioned a dose or stated they have already received a medication. APNP D stated, I would expect they question that and call a provider, not give it. I would also expect blood sugars to be checked more frequently but not too concerned as this was long acting insulin. From what I can see she only called the Physician about the Victoza not the double dose of Levemir. I would expect that if I hadn't seen the resident yet they call and clarify the medication with the hospital. Surveyor asked APNP D if dose orders for Metoprolol were every clarified with her. APNP D stated, Note was on line on 6/30/21, there is a note that states someone tried to call stayed on the line for 5 plus minutes but there is no note that they ever clarified the Metoprolol. On 7/06/21, R4 was hospitalized with GI symptoms. Hospital note states in part . Vomiting x7 days. Last emesis yesterday afternoon. Was able to tolerate soup and Jell-O for dinner. Loose stools over the weekend. Patient in no distress on arrival. ED (Emergency Department) Note from 7/06/21 states in part . R4 states he was discharged from the hospital on 6/29/21 to rehab, that night was having vomiting, vomits up to 4 times a day, also recently developed diarrhea. Has not vomited today at all, last emesis yesterday. Currently does not endorse any nausea. States that his diarrhea has continued however. MDM (Medical Decision Making): There is evidence of diarrhea. Discussed results of w/u (work up) with patient, symptoms possible due to viral GI infection, plan to discharge back to facility given asymptomatic at least from n/v (nausea/vomiting) standpoint for which he was initially sent to ED. Note: Though R4 was seen in the ED on 7/06/21 and states he has been vomiting since 6/29/21 at least 4 times a day, the medical record for R4 does not show evidence of such. In fact, the medical record shows that R4's nausea and vomiting began on 6/30/21 lasting until approximately 6:00 AM, with no further emesis documented until 7/04/21. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R4's medication were incorrectly transcribed from the discharge orders to the eMAR. This resulted in a double dose of Levemir, a 2nd dose of Victoza, and additional dose of Metoprolol on top the 50 mg he received in the hospital prior to admission. After receiving these medications R4 developed severe nausea and vomiting which required physician intervention and orders for Zofran.