| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525689 | A. BUILDING _____ B. WING _____ | 03/04/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| MAPLE LANE HEALTH SERVICES | N4231 STATE HWY 22 SHAWANO, WI 54166 |

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) |
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| F 0755<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interview, the facility did not provide pharmacy services to ensure the accurate administration of prescribed medications for 7 Residents (R) (R10, R1, R2, R9, R3, R4 and R5) of 7 residents reviewed. R10 had a history of [REDACTED]. R10 had a physician's orders [REDACTED]. When the facility ran out of magnesium, staff did not ensure the medication was reordered, obtained or administered in a timely manner. R1 had a physician's orders [REDACTED]. When the facility ran out of magnesium, staff did not ensure the medication was reordered, obtained or administered in a timely manner. R2 had a physician's orders [REDACTED]. When the facility ran out of magnesium, staff did not ensure the medication was reordered, obtained or administered in a timely manner. In addition, R2's physician was not notified of the missed doses. R9 had a physician's orders [REDACTED]. When the facility ran out of magnesium, staff did not ensure the medication was reordered, obtained or administered in a timely manner. R3 had a physician's orders [REDACTED]. When the facility ran out of artificial tears, staff did not ensure the medication was reordered, obtained or administered in a timely manner. In addition, R3's physician was not notified of the missed doses. R4 and R5 had physician's orders [REDACTED]. When the facility ran out of artificial tears, staff did not ensure the medication was reordered, obtained or administered in a timely manner. In addition, R4 and R5's physicians were not notified of the missed doses. Findings include: Medication Shortages/Unavailable Medications policy, revised 1/01/13, states: Procedure: 1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes a delay or missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. 3. If a medication shortage is discovered after normal pharmacy hours: 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to mange the plan of action. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. 7. If facility nurse is unable to obtain a response from the attending physician/prescriber in a timely manner, facility nurse should notify the nursing supervisor and contact facility's Medical Director for orders/direction, making sure to explain the circumstances of the medication shortage. 8. When a missed dose is unavoidable, facility nurse should document the missed dose and the explanation for such missed dose on the MAR (medication administration record) or TAR (treatment administration record) and in the nurses' notes per facility policy. Such documentation should include the following information: 8.1 A description of the circumstances of the medication shortage; 8.2 A description of the pharmacy's response upon notification; and 8.3 Action(s) taken. 1. On 3/04/20, the Surveyor reviewed a complaint filed with the State Agency. The complaint stated multiple residents did not receive magnesium and eye drops for two weeks because the facility ran out of stock medication. The complainant also alleged the residents' physicians were not notified of the missed doses. On 3/04/20, the Surveyor reviewed R10's medical record. R10 was admitted to the facility with [DIAGNOSES REDACTED]. R10 had a physician's orders [REDACTED]. R10's MAR indicated magnesium was scheduled to be administered during the AM, Noon, PM and HS (bedtime) medication passes. A progress note, dated 12/09/19, stated R10 was admitted to the hospital with [REDACTED]. A hospital discharge summary, dated 12/10/19, stated, Reason for admission: electrolyte imbalances .Does have a history of electrolyte imbalances so (resident) is on magnesium supplementation . The summary indicated R10 received IV (intravenous) magnesium in the ED (emergency department). R10 was readmitted to the hospital on [DATE] for electrolyte imbalances, most notably [MEDICAL CONDITION] (a high potassium level) and returned to the facility on [DATE]. A progress note, dated 12/23/19, stated, Resident noted to have missed (six) doses of (scheduled magnesium). Medication was not available in stock and pharmacy would not provide without signed consent from DON (Director of Nursing). DON notified. (ADON (Assistant Director of Nursing)-C) contacted pharmacy to have them send med. Doctor notified and magnesium lab ordered . The Surveyor reviewed R10's December 2019 nursing notes and MAR and noted the following: On 12/23/19, R10's magnesium was not administered because the medication was unavailable. On 12/20/19, [DATE] and 12/28/19, R10's PM magnesium was not administered because the medication was unavailable. On 12/22/19, R10's MAR indicated progress notes were generated for R10's AM and Noon doses of magnesium. The Surveyor noted the progress notes did not indicate whether magnesium was administered or held and why the progress notes were generated. 2. On 3/04/20, the Surveyor reviewed R1's medical record. R1 was admitted to the facility with [DIAGNOSES REDACTED]. R1 had a physician's orders [REDACTED]. R1's MAR indicated magnesium was scheduled to be administered during the AM and PM medication passes. The Surveyor reviewed R1's December 2019 nursing notes and MAR and noted the following: On 12/20/19, 12/24/19 and 12/29/19, R1's AM and PM doses of magnesium were not administered because the medication was unavailable On 12/21/19, 12/23/19, 12/26/19, [DATE], 12/28/19 and 12/30/19, R1's PM magnesium was not administered because the medication was unavailable. On 12/21/19 AM, 12/22/19 AM, 12/23/19 AM, 12/25/19 AM and PM, 12/26/19 AM, [DATE] AM, 12/30/19 AM and 12/31/19 AM, R1's MAR indicated progress notes were generated for each dose of magnesium. The Surveyor noted the progress notes did not indicate whether magnesium was administered or held and why the progress notes were generated. 3. On 3/04/20, the Surveyor reviewed R2's medical record. R2 was admitted to the facility with [DIAGNOSES REDACTED]. R2 had a physician's orders [REDACTED]. R2's MAR indicated magnesium was scheduled to be administered during the AM and PM medication passes. The Surveyor reviewed R2's December 2019 nursing notes and MAR and noted the following: On 12/24/19 and 12/28/19, R2's AM and PM magnesium were not administered because the medication was unavailable. On 12/19/19, 12/21/19, 12/23/19 and 12/26/19, R2's PM magnesium was not administered because the medication was unavailable. On 12/29/19, R1's AM magnesium was not administered because the medication was unavailable. On 12/21/19 AM, 12/22/19 AM and PM, 12/23/19 AM, 12/25/19 AM and PM, 12/26/19 AM, [DATE] PM and 12/29/19 PM, R2's MAR indicated progress notes were generated for each dose of magnesium. The Surveyor noted the progress notes did not indicate whether the medication was administered or held and why the progress notes were generated. 4. On 3/04/20, the Surveyor reviewed R9's medical record. R9 was admitted to the facility with [DIAGNOSES REDACTED]. R9 had a physician's orders [REDACTED]. R9's MAR indicated magnesium was scheduled to be administered during the AM and PM medication passes. The Surveyor reviewed R9's December 2019 nursing notes and MAR and noted the following: On 12/24/19, 12/28/19 and 12/29/19, R9's magnesium was not administered because the medication was unavailable. On 12/21/9, 12/23/19, 12/26/19 and 12/30/19, R9's PM magnesium was not administered because the medication was unavailable. On 12/21/19 AM, 12/22/19 AM and PM, 12/23/19 AM, 12/25/19 AM and PM, 12/26/19 AM, |

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

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.

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| F 0755<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>[DATE] PM, 12/30/19 AM and 12/31/19 AM and PM, R9's MAR indicated progress notes were generated for each dose of magnesium. The Surveyor noted the progress notes did not indicate whether the medication was administered or held and why the progress notes were generated. 5. On 3/04/20, the Surveyor reviewed R3's medical record. R3 was admitted to the facility with [DIAGNOSES REDACTED]. R3 had a physician's orders [REDACTED]. R3's Artificial Tears were scheduled to be administered during the AM and PM medication passes. The Surveyor reviewed R3's December 2019 nursing notes and MAR and noted the following: On 12/07/19 AM, R3's MAR indicated R3's dose of Artificial Tears was held. A progress note associated with the administration did not indicate whether or not the medication was held. On 12/11/19, 12/12/19, 12/13/19, 12/15/19, 12/17/19, 12/23/19 and 12/24/19, R3's PM Artificial Tears were not administered because the medication was unavailable. On 12/10/19 PM, 12/12/19 AM, 12/13/19 AM, 12/14/19 PM, 12/15/19 AM, 12/16/19 AM and 12/31/19 PM, R3's MAR indicated progress<br>notes were generated for each dose of Artificial Tears. The Surveyor noted the progress notes did not indicate whether the medication was administered or held and why the progress notes were generated. 6. On 3/04/20, the Surveyor reviewed R4's medical record. R4 was admitted to the facility with [DIAGNOSES REDACTED]. R4 had a physician's orders [REDACTED]. R4's Artificial Tears were scheduled to be administered during the AM, Noon, PM and HS medication passes. The Surveyor reviewed R4's December 2019 nursing notes and MAR and noted the following: On 12/15/19, R4's Artificial Tears were not administered because the medication was unavailable. On 12/12/19, 12/23/19 and 12/24/19, R4's PM and HS Artificial Tears were not administered because the medication was unavailable. On 12/12/19 AM, 12/13/19 Noon, 12/16/19 AM and 12/31/19 PM and HS, R4's MAR indicated progress notes were generated for each dose of Artificial Tears. The Surveyor noted the progress notes did not indicate whether the medication was administered or held and why the progress notes were generated. 7. On 3/04/20, the Surveyor reviewed R5's medical record. R5 was admitted to the facility with [DIAGNOSES REDACTED]. R5 had a physician's orders [REDACTED]. R5's Artificial Tears were scheduled to be administered during the AM, Noon, PM and HS medication passes. The Surveyor reviewed R5's December 2019 nursing notes and MAR and noted the following: On 12/15/19, R5's Artificial Tears were not administered because the medication was unavailable. On 12/10/19, R5's AM, PM and HS Artificial Tears were not administered because the medication was unavailable. On 12/12/19, 12/14/19, 12/17/19 and 12/24/19, R5's PM and HS Artificial Tears were not administered because the medication was unavailable. Ob 12/28/19, R5's AM and Noon Artificial Tears were not administered because the medication was unavailable. On 12/23/19, R5's HS Artificial Tears were not administered because the medication was unavailable. On 12/12/19 AM and Noon, 12/13/19 AM and Noon, 12/16/19 AM and 12/31/19 PM and HS, R5's MAR indicated progress notes were generated for each dose of Artificial Tears. The Surveyor noted the progress notes did not indicate whether the medication was administered or held and why the progress notes were generated. On 3/04/20 at 6:33 AM, the Surveyor interviewed CSC (Central Supply Clerk)-D regarding stock medication. CSC-D, who was in charge of ordering supplies for the facility, verified the facility ran out of stock medications during the holiday season. CSC-D stated, I ordered one day late and the supplier was shut down for inventory. CSC-D stated the facility was able to get what was needed from Walgreens or somewhere. When asked if residents missed medication during that time, CSC-D stated, (DON-B) took care of that. I didn't receive any complaints that residents missed medications. On 3/04/20 at 9:20 AM, the Surveyor interviewed ADON-C regarding stock medication. ADON-C stated the facility ran out of magnesium over the Christmas holiday and stated, The nurses knew we didn't have it, but didn't tell me .They were marking (the medication) as not available .The day they notified me, I faxed the pharmacy and we got it. They were documenting (the missed medication) in the progress notes. When asked if the facility ran out of Artificial Tears, ADON-C stated, I was not aware of that .Staff tell (DON-B) or myself when meds are out, but I think they go to (DON-B) first. On 3/04/20 at 10:05 AM, the Surveyor interviewed DON-B regarding stock medication. DON-B stated DON-B was notified by an unnamed nurse that the facility was out of magnesium and had been for several days. DON-B stated, When I investigated, I discovered we were in fact out of magnesium. I checked the residents who were on magnesium and went out and bought it. DON-B stated DON-B implemented an action plan following the incident. DON-B stated R1, R9 and R10's physicians were notified of the missed doses, staff education was completed and medication pass audits were conducted. When asked if R2 was included in the investigation, DON-B stated DON-B was not aware R2 received magnesium as R2 discharged to the hospital on [DATE]. DON-B verified R2 was not included in the action plan and R2's physician was not notified of R2's missed doses of magnesium. When asked about R3, R4 and R5's missed doses of Artificial Tears, DON-B stated DON-B was not aware the residents missed multiple doses of Artificial Tears. DON-B stated R3, R4 and R5 were not included in the facility's action plan and the residents' physicians were not notified of the missed doses of Artificial Tears. On 3/04/20 at 11:10 AM, the Surveyor interviewed AS (Anonymous Staff)-E regarding stock medication. AS-E stated, We were out of magnesium for awhile and it was requested multiple times . On 3/04/20 at 11:25 AM, the Surveyor interviewed AS-F regarding stock medication. AS-F stated, (R10) was in and out of the hospital multiple times because (R10's) magnesium was off .I said something to (DON-B) and (NHA (Nursing Home Administrator)-A), but nothing happened. AS-F verified the medication was obtained from the pharmacy after AS-F notified ADON-C. AS-F stated a card of magnesium was delivered for R10; however, R1, R9 and R2 didn't get their magnesium for a couple weeks. AS-F also verified the facility was out of Artificial Tears in December 2019. AS-F stated, I don't recall (going to management) about that . |