STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016846	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA POINTE III	W18 N8240 TOWN HALL RD MENOMONEE FALLS, WI 53051

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 01/30/2024, with information gathered through 01/31/2024, the Bureau of Assisted Living, Southern Regional Office conducted an abbreviated licensing survey of Vista Pointe III located at W180 N8240 Town Hall Rd in Menomonee Falls, WI. One citation of noncompliance was issued. Census: 15	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 1 and Resident 2 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1 did not receive powdered bowel medication and nasal spray medication, as prescribed. Resident 2 did not receive eye drops, as prescribed. The findings include: Example 1: Resident 1's prescribed polyethylene glycol (bowel medication, powdered)	N 352		

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

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N 352	Continued From page 1 On 01/30/2024 at 10:20 A.M., Surveyor conducted an interview with Caregiver B including observations of the facility's medication cart located in the facility's medication room. Surveyor observed Caregiver B remove a container of polyethylene glycol labeled with Resident 1's name from the medication cart. Surveyor observed the pharmacy label affixed to the container included, "Dissolve 17 grams in 8 oz [ounces] of liquid and drink by mouth daily for constipation" and included the date dispensed by the pharmacy to the facility, "12/04/2023." Surveyor observed Caregiver B open Resident 1's container of polyethylene glycol and place it on top of the medication cart. Surveyor observed the container was practically full and Caregiver B verbally agreed to the amount remaining in the container. Caregiver B told Surveyor Resident 1 should be administered this medication daily, as ordered. Caregiver B said Resident 1 did not refuse or resist medication administration. Caregiver B told Surveyor the container did not include the date it was initially opened for administration and there were no other containers of polyethylene glycol for Resident 1 stored at the facility. On 01/30/2024 at 11:00 A.M., Surveyor conducted an interview with Licensee A including observations of Resident 1's polyethylene glycol container. Licensee A told Surveyor s/he acknowledged Resident 1's polyethylene glycol container was approximately full of the powdered medication. Licensee A said the container originally contained 14 doses of medication, as labeled, if administered daily as ordered. Licensee A told Surveyor Resident 1 required assistance with toileting and had not experienced a significant issue with constipation within the	N 352		

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N 352	Continued From page 2 past 6 months. On 01/30/2024 at 1:20 P.M., Surveyor conducted an interview with Pharmacy Staff C. Surveyor asked Pharmacy Staff C for the dates of the last two containers of Resident 1's polyethylene glycol filled by the pharmacy and delivered to the facility. Pharmacy Staff C told Surveyor one container of polyethylene glycol, as prescribed, was delivered to the facility from the pharmacy on 06/02/2023. Pharmacy Staff C said the next container of polyethylene glycol container, as prescribed, was delivered from the pharmacy to the facility on 12/04/2023. Pharmacy Staff C told Surveyor Resident 1's polyethylene glycol refills were not delivered to the facility on an automatic refill cycle, the facility staff would need to call the facility for a refill of the medication. On 01/30/2024, Surveyor reviewed Resident 1's record, as provided by Licensee A. Resident 1 was admitted to the facility in January 2022. Resident 1's diagnoses included dementia and constipation. Residents 1's individual service plan (ISP) dated 01/10/2024 included, "Medications are administered by CBRF [facility] staff." Resident 1's ISP included, "Incontinent of B & B [bowel and bladder] - dependent [on caregiver assistance]" and "Miralax [polyethylene glycol], as ordered - bowel health." Resident 1's current practitioner orders included, "polyethylene glycol 3350 pow [powder]...dissolve 17 grams in 8 oz of liquid and drink by mouth daily for constipation." Resident 1's January 2024 medication administration record [MAR] included documentation of administration of Resident 1's polyethylene glycol, as prescribed, daily from 01/01/2024 through 01/30/2024. Resident 1's August 2023 MAR, September 2023 MAR,	N 352		

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N 352	Continued From page 3 October 2023 MAR, November 2023 MAR, and December 2023 MAR included documentation of daily administration of Resident 1's prescribed polyethylene glycol with the exception of two dates without any documentation related to administration. Resident 1's MARs reviewed from 08/01/2024 through 01/30/2024 did not contain any documentation of Resident 1's refusal of polyethylene glycol administration. On 01/30/2024 at approximately 2:00 P.M., Surveyor conducted an interview with Licensee A about Resident 1's polyethylene glycol medication administration records from 08/01/2023 through 01/30/2024, observations of Resident 1's current container of polyethylene glycol, and the information provided by Pharmacy Staff C. Licensee A told Surveyor it was apparent Resident 1's polyethylene glycol was not administered as prescribed and as documented by the caregivers. Example 2: Resident 1's allergy nasal spray prescription On 01/30/2024 at 10:20 A.M., Surveyor conducted an interview with Caregiver B including observations of the facility's medication cart located in the facility's medication room. Surveyor observed Caregiver B remove a container of triamcinolone nasal spray labeled with Resident 1's name from the medication cart. Surveyor observed the pharmacy label affixed to the container included, "Instill 2 sprays in each nostril daily" and included the date dispensed by the pharmacy to the facility, "07/07/2023." Surveyor observed the container was approximately half full of medication and Caregiver B verbally agreed to the amount remaining in the container. Surveyor observed	N 352		

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N 352	Continued From page 4	N 352		

the manufacturer's label included, "120 sprays" were originally available within the container, which would equal 30 days of use if administered as prescribed. Caregiver B told Surveyor Resident 1 should be administered this medication daily, as ordered. Caregiver B said Resident 1 did not refuse or resist medication administration. Caregiver B told Surveyor the container did not include the date it was initially opened for administration and there were no other containers of triamcinolone nasal spray for Resident 1 stored at the facility.

On 01/30/2024 at 11:00 A.M., Surveyor conducted an interview with Licensee A including observations of Resident 1's triamcinolone nasal spray container. Licensee A told Surveyor s/he recognized a medication administration issue when comparing the amount remaining in Resident 1's triamcinolone nasal spray container and the date dispensed by the pharmacy as 07/07/2023.

On 01/30/2024 at 1:20 P.M., Surveyor conducted an interview with Pharmacy Staff C. Surveyor asked Pharmacy Staff C for the dates of the last two containers of Resident 1's triamcinolone nasal spray filled by the pharmacy and delivered to the facility. Pharmacy Staff C told Surveyor one container triamcinolone nasal spray, as prescribed, was delivered to the facility from the pharmacy last year on 01/24/2023. Pharmacy Staff C said the next container of triamcinolone nasal spray container, as prescribed, was delivered from the pharmacy to the facility on 07/07/2023. Pharmacy Staff C told Surveyor Resident 1's triamcinolone nasal spray refills were not delivered to the facility on an automatic refill cycle, the facility staff would need to call the facility for a refill of the medication.

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N 352	Continued From page 5 On 01/30/2024, Surveyor reviewed Resident 1's record, as provided by Licensee A. Resident 1 was admitted to the facility in January 2022. Resident 1's diagnoses included dementia and allergies. Residents 1's individual service plan (ISP) dated 01/10/2024 included, "Medications are administered by CBRF [facility] staff." Resident 1's current practitioner orders included, "Triamcinolone 55 mcg [microgram]...instill 2 sprays in each nostril daily" related to "allergies." Resident 1's January 2024 medication administration record [MAR] included documentation of administration of Resident 1's triamcinolone nasal spray, as prescribed, daily from 01/01/2024 through 01/30/2024. Resident 1's August 2023 MAR, September 2023 MAR, October 2023 MAR, November 2023 MAR, and December 2023 MAR included documentation of daily administration of Resident 1's prescribed triamcinolone nasal spray with the exception of a few dates without any documentation related to administration. Resident 1's MARs reviewed from 08/01/2023 through 01/30/2024 did not contain any documentation of Resident 1's refusal of triamcinolone nasal spray administration. On 01/30/2024 at approximately 2:00 P.M., Surveyor conducted an interview with Licensee A about Resident 1's triamcinolone nasal spray medication administration records from 08/01/2023 through 01/30/2024, observations of Resident 1's current container of triamcinolone nasal spray, and the information provided by Pharmacy Staff C. Licensee A told Surveyor it was apparent Resident 1's triamcinolone nasal spray was not administered as prescribed and as documented by the caregivers.	N 352		

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N 352	Continued From page 6 Example 3: Resident 2's glaucoma eye drop prescription On 01/30/2024 at 10:20 A.M., Surveyor conducted an interview with Caregiver B including observations of the facility's medication cart located in the facility's medication room. Surveyor observed Caregiver B remove a container of brimonidine eye drops labeled with Resident 2's name from the medication cart. Surveyor observed the pharmacy label affixed to the container included, "Instill 1 drop in the right eye twice a day for glaucoma...(family supplies)" and included the date dispensed by the pharmacy to the facility, "05/22/2023." Surveyor observed the container was approximately 3 quarters full of medication and Caregiver B verbally agreed to the amount remaining in the container. Caregiver B told Surveyor Resident 2's Family Member D supplies Resident 2's eye drops to the facility. Caregiver B said Resident 2 should be administered this medication twice daily, as ordered, by the facility caregivers. Caregiver B said Resident 2 did not refuse or resist medication administration. Caregiver B told Surveyor the container did not include the date it was initially opened for administration and there were no other containers of brimonidine eye drops for Resident 2 stored at the facility. On 01/30/2024 at 11:00 A.M., Surveyor conducted an interview with Licensee A including observations of Resident 2's brimonidine eye drops container. Licensee A told Surveyor s/he recognized a medication administration issue when comparing the amount remaining in Resident 2's brimonidine eye drops container and the date dispensed by the pharmacy as 05/23/2023. Licensee A verbally acknowledged Resident 2's brimonidine eye drops container did	N 352		

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not include the date it was initially opened for administration and there was no documentation of when this container was delivered to the facility by Family Member D.

On 01/30/2024, Surveyor reviewed Resident 2's record, as provided by Licensee A. Resident 2 was admitted to the facility in September 2022. Resident 2's diagnoses included glaucoma [a disease of the eye]. Residents 2's individual service plan (ISP) dated 09/22/2023 included, "Medications are administered by CBRF [facility] staff...eye gtts [drops] only." Resident 2's ISP included, "[Family Member D] supplies all meds [medications]." Resident 2's current practitioner orders included, "Brimonidine 0.2 % OP [ophthalmic] sol [solution]. Instill 1 drop in the right eye twice a day for glaucoma...(family supplies)."
Resident 2's January 2024 medication administration record [MAR] included documentation of administration of Resident 2's brimonidine eye drops, as prescribed, daily from 01/01/2024 through 01/29/2024 with the exception of two doses without documentation of administration. Resident 2's September 2023 MAR, October 2023 MAR, November 2023 MAR, and December 2023 MAR included documentation of daily administration of Resident 2's prescribed brimonidine eye drops with the exception of a few dates without any documentation related to administration. Resident 2's MARs reviewed from 09/01/2023 through 01/30/2024 did not contain any documentation of Resident 2's refusal of brimonidine eye drops administration.

On 01/30/2024 at approximately 2:00 P.M., Surveyor conducted an interview with Licensee A about Resident 2's brimonidine eye drops

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N 352	Continued From page 8 medication administration records from 09/01/2023 through 01/30/2024 and observations of Resident 2's current container of brimonidine eye drops. Licensee A told Surveyor it was apparent Resident 2's brimonidine eye drops were not administered as prescribed and as documented by the caregivers. On 01/31/2024 at 9:17 A.M., Surveyor conducted an interview with Family Member D. Family Member D told Surveyor s/he received one container of Resident 2's brimonidine eye drops in the mail after calling the pharmacy for a refill. Family Member D said s/he provided a new container of brimonidine eye drops when the facility staff requested a refill. Family Member D told Surveyor s/he could not recall the last time s/he was asked by a facility staff member for a new container of Resident 2's brimonidine eye drops. Summary: The provider did not ensure Resident 1 and Resident 2 received all prescribed medications in the dosage and at intervals prescribed by a practitioner.	N 352		