STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016878	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTRY LANDING	2255 N STONEHEDGE TRL SUMMIT, WI 53066

(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
U 000	INITIAL COMMENTS On 03/06/2025, Surveyor conducted a complaint investigation at Lake Country Landing. Two deficiencies were identified. One of 2 deficiencies was a repeat violation. See Statement of Deficiency (SOD) TNU311, dated 03/26/2019, SOD 5WJ111, dated 06/02/2022, SOD 5WJ112, dated 11/28/2022, SOD 5WJ113, dated 06/14/2023, and SOD 5WJ115, dated 03/12/2024. The complaint was substantiated. Census: 35	U 000		
U 118	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by:	U 118		

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

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U 118	Continued From page 1 Based on record review and interview, the provider did not ensure complete medication management, medication administration, and health monitoring services for 2 of 2 tenant records reviewed. Between 01/01/2025-03/05/2025, there was 14 occasions in which Tenant 1's metoprolol and apixaban medications were not available due to non-availability. From 11/01/2024 to 03/06/2025, Tenant 2 did not receive his/her clearlax as prescribed. This deficiency is being cited for the 6th time. See Statement of Deficiency (SOD) TNU311, dated 03/26/2019, SOD 5WJ111, dated 06/02/2022, 5WJ112, dated 11/28/2022, SOD 5WJ113, dated 06/14/2023, and SOD 5WJ115, dated 03/12/2024. Findings include: Example 1: Tenant 1 On 03/06/2025, Surveyor reviewed Tenant 1's record. Tenant 1 was admitted to the provider on 03/06/2023 with diagnoses including cardiomegaly, chronic atrial fibrillation, and hypertension. The provider utilized individual service plans (ISPs), where the tenants' needs and services were documented. Tenant 1's ISP, dated 11/29/2024 documented staff were responsible for administering Tenant 1's medications. Tenant 1's physician orders included the following: -Apixaban 5mg with instructions to give 1 tablet by mouth every morning and at bedtime for cardiomegaly, with a start date of 04/08/2024. -Metoprolol 25mg with instructions to give 0.5	U 118		

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U 118	Continued From page 2	U 118		

tablet two times a day for hypertension, with a start date of 03/06/2023.

Surveyor reviewed Tenant 1's medication administration records (MARs) from 01/01/2025-03/05/2025 and observed the following administrations marked as "9", per charting codes 9=Other/See Progress Notes:

January 2025: Observed 5 occurrences in which Metoprolol was marked as "9":
-01/19/2025 (7:00 AM): "9"
-01/19/2025 (PM): "9"
-01/20/2025 (PM): "9"
-01/21/2025 (PM): "9"
-01/27/2025 (PM): "9"

February 2025: Observed 4 occurrences in which Metoprolol was marked as "9"
-02/12/2025 (7:00AM): "9"
-02/18/2025 (PM): "9"
-02/19/2025 (7:00AM): "9"

February 2025: Observed 5 occurrences in which Apixaban was marked as "9"
-02/03/2025 (HS): "9"
-02/07/2025 (HS): "9"
-02/08/2025 (7:00AM): "9"
-02/08/2025 (HS): "9"
-02/09/2025 (7:00AM): "9"

Surveyor observed progress notes from 01/01/2025-03/05/2025 and identified the following:
"01/19/2025: Type: Orders-Administration note: not available. Metoprolol: needing refill on medication.
01/20/2025: Metoprolol: out.
01/21/2025: Metoprolol: resident is out.
01/27/2025: Metoprolol: out.

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U 118	Continued From page 3	U 118		

02/03/2025: Apixaban: out.
02/07/2025: Apixaban: resident is out of medication.
02/08/2025: Apixaban: resident is out of medication. Not available.
02/09/2025: Apixaban: resident is out of medication.
02/10/2025: Notified Dr. Richard Terry's office that 4 doses of Apixaban were missed between 2/7/2025 and 2/9/2025. Resident started receiving doses the PM med pass of 2/9/2025 once medication was located. Clinic representative stated that they would update Dr. Richard Terry and call back if any additional information is needed.
02/12/2025: Metoprolol: Needing refill on medication.
02/18/2025: Metoprolol: resident is out.
02/19/2025: Metoprolol: resident is out of medication."

Tenant 1's progress notes did not document evidence of the provider contacting the pharmacy or physician regarding the missed metoprolol doses.

On 03/06/2025 at 10:20 AM, Surveyor interviewed Interim Director of Nursing (DON) C regarding the above medications not being available to Tenant 1. Interim DON C reported Tenant 1's Apixaban was not available due to staff not being able to find the blister pack in the med cart. Interim DON C reported after looking into the concern, Tenant 1's blister pack was rubber banded to another blister pack, so Tenant 1 missed four doses of their Apixaban. Interim DON C reported s/he was out of the building during this time. Interim DON C reported ongoing concerns with reordering medications with their pharmacy.

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U 118	Continued From page 4 On 03/06/2025 at 2:11 PM, Surveyor interviewed Caregiver D. Caregiver D reported s/he was the med passer for today. Surveyor asked about the charting code "9" identified in Tenant 1's MAR's. Caregiver D reported when staff select "9", it means the medications is not available. Caregiver D reported the provider's nurse is responsible for reordering medications. Example 2: Tenant 2 On 03/06/2025 at 10:33 AM, Surveyor observed the provider's 2 medications carts with Interim DON C located in the facility's medication room. Tenant 2's clearlax powder contained noted a manufacturer's label including the container originally held 30 once-daily doses of 17 grams. The container included a pharmacy label included Tenant 2's practitioner's prescription for clearlax powder including, "Take 17G by mouth every day." The pharmacy label included a delivery date to the facility of 10/29/2024. Surveyor observed approximately ½ of the medication remained within the container. Interim DON C verbally confirmed same amount remained. Surveyor and Interim DON C did not observe any other containers of Tenant 2's clearlax within the medication cart. Surveyor asked why the clearlax container was still ½ full if the medication was delivered on 10/29/2024 and Tenant 2 received this medication daily. Interim DON C did not provide an answer and stated "s/he would call the pharmacy." On 03/06/2025, Surveyor reviewed Tenant 2's record. Tenant 2 was admitted to the facility on 10/28/2021. Tenant 2's ISP, dated 11/26/2024 documented staff were responsible for administering Tenant 2's medications. A review of Tenant 2's November 2024-March 2025 MARs,	U 118		

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U 118	Continued From page 5 included Tenant 2 was administered 119 doses of clearlax between 11/01/2024-03/06/2025 from a 30-dose container, based on Tenant 2's practitioner's order, with ½ of the medication remaining in the container. On 03/06/2025 at 2:25 PM, Surveyor conducted an exit conference and shared findings with Executive Director A. Executive Director A reported Interim DON C had called the pharmacy and confirmed the last delivery of Tenant 2's clearlax was 10/29/2024. Executive Director A acknowledged if Tenant 2's clearlax was administered as prescribed the container would have been emptied much earlier and requests for refills would have been sent to the pharmacy. Surveyor expressed concern with the amount still left in the container and staff continuing to document as administered. Executive Director A reported s/he was assuming staff were documenting as given, without administering the medication. Executive Director A stated s/he staff would be retrained.	U 118		
U 268	89.34(17) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (17) SAFE ENVIRONMENT. To a safe environment in which to live.	U 268		

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U 268	Continued From page 6 This Rule is not met as evidenced by: Based on observation and interview, the facility did not ensure a safe environment in which to live by not having all clothes dryers in the facility properly vented with rigid metal material. Findings Include: 03/06/2025, from 11:14 AM to 11:24 AM, Surveyor toured 4 laundry rooms with Maintenance Director B. Four dryers on the 1st floor and 4 dryers on the 2nd floor. Each dryer was vented using semi-rigid metal material. On 03/06/2025 at 11:25 AM, Surveyor interviewed Maintenance Director B regarding the above concerns. Maintenance Director B reported s/he started 3 weeks ago, and the dryers were vented like that upon hire. Maintenance Director B did not have evidence of compliance with requirements to use semi-rigid vents. Maintenance Director B stated s/he would replace each dryer with rigid metal material.	U 268		