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 _____	R-C 08/27/2025

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 08/27/2025, Surveyor conducted a verification visit at Lake Country Landing, a RCAC in Summit. One deficiency was identified. One of 1 deficiency was a repeat violation. See Statements 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, SOD 5WJ115, dated 03/12/2024, and SOD 0Y6211, dated 03/06/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. 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.	{U 118}		

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

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{U 118}	Continued From page 1 This Rule is not met as evidenced by: Based on observation, 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. From 07/04/2025 to 08/27/2025, Tenant 2 and Tenant 3 did not receive their Polyethylene Glycol as prescribed. This deficiency is being cited for the 7th 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, SOD 5WJ115, dated 03/12/2024, and SOD 0Y6211, dated 03/06/2025. Findings include: Example 1: Tenant 2 On 08/27/2025 at 8:55 AM, Surveyor observed the provider's 2 medication carts with Director of Nursing (DON) E. Inside the 2nd floor medication cart, Surveyor observed Tenant 2's Polyethylene Glycol container noted a manufacturer's label including the container originally held 14 once-daily doses of 17 grams. The container included a pharmacy label included Tenant 2's practitioner's prescription for Polyethylene Glycol including "take 17G by mouth every day." The pharmacy label included a delivery date to the facility of 06/11/2025. Surveyor observed the container to be full and DON E verbally confirmed same amount remained. Surveyor observed another container of Polyethylene Glycol that included a delivery date to the facility of 03/07/2025. This container was almost empty.	{U 118}		

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{U 118}	Continued From page 2 On 08/27/2025, Surveyor reviewed Tenant 2's record. Tenant 2 was admitted to the facility on 10/28/2021. Tenant 2's individual service plan (ISP), dated 04/11/2025 documented staff were responsible for administering Tenant 2's medications. A review of Tenant 2's July 2025-August 2025 Medication Administration Record (MAR), included Tenant 2 was administered 50 doses of Polyethylene Glycol between 07/04/2025-08/26/2025 from a 14-dose container, based on Tenant 2's practitioner's order, with 1 empty container, and 1 container that was full. Example 2: Tenant 3 On 08/27/2025 at 8:55 AM, Surveyor observed the provider's 2 medication carts with Director of Nursing (DON) E. Inside the 2nd floor medication cart, Surveyor observed Tenant 3's Polyethylene Glycol container noted a manufacturer's label including the container originally held 14 once-daily doses of 17 grams. The container included a pharmacy label included Tenant 3's practitioner's prescription for Polyethylene Glycol including "give 17 grams by mouth daily mix with 8oz water." The pharmacy label included a delivery date to the facility of 06/11/2025. DON E measured the amount left in the container, which was approximately 4 doses. Surveyor and DON E did not observe any other containers of Tenant 3's Polyethylene Glycol. On 08/27/2025, Surveyor reviewed Tenant 3's record. Tenant 3 was admitted to the facility on 09/27/2021. Tenant 3's ISP, dated 04/11/2025 documented staff were responsible for administering Tenant 3's medications. A review of Tenant 3's July 2025-August 2025 MAR included	{U 118}		

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{U 118}	Continued From page 3 Tenant 3 was administered 55 doses of Polyethylene Glycol between 07/04/2025-08/27/2025 from a 14-dose container, based on Tenant 3's practitioner's order, with 4 doses of the medication remaining in the container. On 08/27/2025 at 9:30 AM, Surveyor interviewed DON E. Surveyor asked why the Polyethylene Glycol containers still contained medication if the orders were delivered in March and June 2025 and both tenants received the medication daily. DON E looked at the provider's electronic health record and noted Tenant 2's and Tenant 3's polyethylene glycol orders were still active, and staff were documenting as given. DON E reported s/he talked to staff who stated Tenant 2 mostly refuses, but Tenant 3 accepts the medication. DON E reported staff stated they mark as administered but if a tenant refused, they forget to go back and strike out the administration. DON E stated s/he would call the pharmacy. On 08/27/2025 at 9:40 AM, Surveyor interviewed Caregiver F. Caregiver F reported s/he was the med passer for the 2nd floor today. Caregiver F reported Tenant 2 refuses his/her Polyethylene Glycol approximately 3 days/week and Tenant 3 accepted this medication daily. Caregiver F reported s/he will prep the medication, mark as administered, but if Tenant 2 refused, s/he forgets to go back into the system to strike out the administration. Caregiver F stated, "I know I messed up, but I'm not the only one." Caregiver F reported s/he told DON E s/he "messed up" and should have struck out the administrations that were refused. Surveyor asked about the amount of medication remaining in the containers from a 14-dose supply. Caregiver F acknowledged the medications should have been gone months ago	{U 118}		

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{U 118}	Continued From page 4 even with the number of refusals by Tenant 2. On 08/27/2027 at 9:47 AM, Surveyor interviewed DON E. DON E reported s/he spoke to the pharmacy and the last delivery dates for the polyethylene glycol for Tenant 2 was 03/07/2025 and 06/11/2025 and for Tenant 3 was 06/11/2025. DON E noted no other containers were sent. DON E acknowledged if both tenants polyethylene glycol was administered as prescribed the container would have been emptied much earlier and requests for refills would have been sent to the pharmacy. DON E reported staff had been retrained following the last survey, so this was frustrating that staff continued to document as administered when the medication wasn't given.	{U 118}		