STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010309	A. BUILDING: _____ B. WING _____	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRO HEALTH CARE REGENCY SENIOR COMMUNITIE	777 NORTH BROOKFIELD ROAD BROOKFIELD, WI 53045

(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 03/19/2025, the Bureau of Assisted Living, Southern Regional Office conducted an abbreviated licensing survey at Pro Health Care Regency Senior Communities [RCAC], located at 777 North Brookfield Road in Brookfield, WI. One citation of noncompliance was issued. Census: 58	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: Based on observation, interview, and record review, the provider did not ensure 2 residents (Resident 1 and Resident 2) were administered polyethylene glycol (a bowel medication), as prescribed by a practitioner.	U 118		

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

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U 118	Continued From page 1 The findings are: Definitions: DHS 89.13(22) "Medication management" means oversight by a nurse, pharmacist or other health care professional to minimize risks associated with use of medications. Medication management includes proper storage of medications; preparation of a medication organization or reminder system; assessment of effectiveness of medications; monitoring for side effects, negative reactions and drug interactions; and delegation and supervision of medication administration. Example 1: Resident 1's polyethylene glycol On 03/19/2025 at approximately 10:40 A.M., Director of Health Services/[Facility Nurse] B and Surveyor observed the medication carts located in the facility's health office. Surveyor observed Facility Nurse B remove one 30-daily dose container of polyethylene glycol labeled with Resident 1's name from a medication cart. The container's pharmacy label included "01/29/25 [2025]" as the date dispensed to the facility from the pharmacy and the practitioner's order including, "Mix 17 grams (fill cap to line) in 4-8 oz [ounces] of liquid, stir well, and drink once daily for constipation." Surveyor observed the container's unbroken/unopened seal when Facility Nurse B removed the cap from the container. Facility Nurse B told Surveyor this container was the only container of Resident 1's polyethylene glycol at the facility. Photos #1 and #2. On 03/19/2025 at 11:53 A.M., Caregiver E told Surveyor Resident 1 did not normally refuse to take medications administered by facility caregivers.	U 118		

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U 118	Continued From page 2 On 03/19/2025 at 12:00 P.M., Resident 1 told Surveyor the facility caregivers administered his/her medications and s/he believed s/he was receiving all medications prescribed by Resident 1's practitioners. Resident 1 told Surveyor s/he did not recall being administered a powdered medication mixed with water on a daily basis. On 03/19/2025, Surveyor reviewed Resident 1's record, as requested from Administrator A. Resident 1 was admitted to the facility on 03/16/2023 with diagnoses including end stage renal disease and a history of cerebral infarction (stroke). Resident 1's practitioner's orders included an order for polyethylene glycol with directions to "mix 17 grams (fill cap to line) in 4-8 oz of liquid, stir well, and drink once daily for constipation." Resident 1's January 2025 medication administration record (MAR) included documentation of Resident 1's hospitalization from 01/06/2025 through 01/29/2025. The documentation included Resident 1's daily dose order of polyethylene glycol was added to the MAR on 01/30/2025 in the "PRN (as needed) medications" section of the MAR and not in the "scheduled medications" section of the MAR. Resident 1's polyethylene glycol order was included on Resident 1's February 2025 MAR and March 2025 MAR in the same manner. Resident 1's January 2025, February 2025, and March 2025 MARs did not contain any documentation of administration of Resident 1's scheduled, daily dose of polyethylene glycol, as prescribed, for approximately 49 of 49 potential daily doses. On 03/19/2025 at 12:51 P.M., Administrator A told Surveyor Resident 1's practitioner's orders for medications, including the polyethylene glycol	U 118		

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U 118	Continued From page 3	U 118		

order, were sent to the pharmacy, the pharmacy uploaded the orders to Resident 1's electronic MAR, and Facility Nurse B, Clinical Supervisor C, and/or Clinical Supervisor D were to verify all medications received from the pharmacy matched the practitioner's order and MAR. At 1:01 P.M., Administrator A told Surveyor Facility Nurse B confirmed with the pharmacy Resident 1's polyethylene glycol was ordered as a scheduled, daily dose and was uploaded to the PRN section of the MAR. Administrator A told Surveyor this was an oversight and would be corrected.

On 03/19/2025 at 1:47 P.M., Facility Nurse B and Surveyor reviewed a document titled, "[Resident 1's] Medication Listing for 03/20/2025" identifying how Resident 1's medications would look on Resident 1's MAR beginning 03/20/2025. Facility Nurse B said s/he verified Resident 1's scheduled, daily dose of polyethylene glycol with the pharmacy and the pharmacy changed the "medication listing" of Resident 1's polyethylene glycol to scheduled, as ordered, on Resident 1's medication listing and MAR moving forward. Administrator A and Facility Nurse B told Surveyor they would be conducting a review/assessment of Resident 1's medications which would include reaching out to Resident 1's practitioner regarding polyethylene glycol order and whether or not it would remain a scheduled, daily dose or an "as needed" dose.

Example 2: Resident 2's polyethylene glycol

On 03/19/2025 at approximately 10:40 A.M., Director of Health Services/[Facility Nurse] B and Surveyor observed the medication carts located in the facility's health office. Surveyor observed Facility Nurse B remove one 30-daily dose

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U 118	Continued From page 4	U 118		

container of polyethylene glycol labeled with Resident 2's name from a medication cart. The container's pharmacy label included "01/16/24 [2024]" as the date dispensed to the facility from the pharmacy and the medications expiration date of "01/15/25 [2025]." The container's pharmacy label included the practitioner's order including, "Mix 17 grams (fill cap to line) in 4-8 oz [ounces] of liquid, stir well, and drink once daily (hold for loose stools)." Surveyor observed the container included approximately 3 quarters of the powdered medication. Facility Nurse B told Surveyor s/he agreed with the amount remaining in this container and told Surveyor s/he was not aware the container expired in January 2025. Facility Nurse B told Surveyor s/he would be removing this container permanently from the cart and said it was the only container of Resident 2's polyethylene glycol at the facility. Photos #3 and #4.

On 03/19/2025 at 11:53 A.M., Caregiver E told Surveyor Resident 2 routinely took all of Resident 2's scheduled medications administered by facility caregivers and did not normally refuse medication administration.

On 03/19/2025, Surveyor reviewed Resident 2's record, as requested from Administrator A. Resident 2 was admitted to the facility on 08/28/2021 with diagnoses including heart disease and a history of cerebral infarction. Resident 1's practitioner's orders included an order for polyethylene glycol with directions to "mix 17 grams (fill cap to line) in 4-8 oz of liquid, stir well, and drink once daily (hold for loose stools)."
Resident 2's December 2024, January 2025, February 2025, and March 2025 MARs included documentation of Resident 2's daily dose order of

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U 118	Continued From page 5	U 118		

polyethylene glycol in the "scheduled medications" section of the MAR. Resident 2's December 2024, January 2025, February 2025, and March 2025 MARs included documentation of administration of Resident 2's scheduled, daily dose of polyethylene glycol, as prescribed, for 25 of 109 potential daily doses from an almost full container originally containing 30-daily doses and had expired in January 2025.

On 03/19/2025 at 1:21 P.M., Resident 2 told Surveyor the facility caregivers administered his/her medications and s/he believed s/he was receiving all medications prescribed by Resident 2's practitioners. When Surveyor asked Resident 2 about polyethylene glycol administration, Resident 2 said the caregivers would routinely ask if s/he wanted to take it (polyethylene glycol). Resident 2 told Surveyor s/he usually did not take polyethylene glycol because s/he did not need it. Resident 2 told Surveyor s/he had a container of polyethylene glycol in his/her apartment and would take it when s/he felt constipated. Surveyor observed Resident 2 remove a container of polyethylene glycol including a manufacturer's label and no pharmacy label. Surveyor observed an expiration date of January 2024 on the bottom of the container. Resident 2 opened the container and Surveyor observed approximately two 17 gram doses remaining within the container.

On 03/19/2025 at 1:47 P.M., Administrator A and Facility Nurse B told Surveyor they would be conducting a review/assessment of Resident 2's need for polyethylene glycol which would include reaching out to Resident 2's practitioner to determine whether or not it would remain a scheduled, daily dose or an "as needed" dose.