STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020448	A. BUILDING: _____ B. WING _____	R-C 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE	2201 EAGLE SUMMIT STEVENS POINT, WI 54482

(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 01/13/2026, Surveyor conducted a standard survey and verification visit at North Ridge. As a result of the survey the previous citation was corrected and one (1) new deficiency was identified. Per state statutes a $200 re-visit fee was assessed. Census: 22	{N 000}		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not provide medication administration appropriate to the resident's needs. Residents 2, 3, and 4's insulin pens were not labeled with the date opened. Resident 3's inhaler was not labeled with the date opened.	N 432		

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

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N 432	Continued From page 1 Resident 5 was administered an expired medication on three separate occasions. Findings include: On 01/13/2026 from approximately 8:10 AM to 8:45 AM, Surveyor observed the following during medication pass with Caregiver D: -- Resident 2's Lantus Solostar insulin pen in the medication cart. The insulin pen did not have a date documented as to when it was opened or when it could be used by. The insulin pen had a label on it which read, "DATE OPENED ...DISCARD AFTER 28 DAYS." -- Resident 3's Lantus Solostar insulin pen in the medication cart. The insulin pen did not have a date documented as to when it was opened or when it could be used by. The insulin pen had a label on it which read, "DATE OPENED ...DISCARD AFTER 28 DAYS." -- Resident 3's Breo Ellipta inhaler in the medication cart. The inhaler and storage bag did not have a date documented as to when it was opened or when it could be used by. The storage bag had a label on it which read, "DISCARD 42 DAYS AFTER OPENING." Surveyor note: "All insulins must be stored with care to ensure that they remain safe and effective. Improper storage could result in the breakdown of insulin, affecting its ability to effectively and predictably control your blood sugar level... Once you open a new vial (meaning once you stick a needle in the vial) or pen, use a Sharpie to note the date you opened it right on the packaging. This will help you remember when to stop using it ..." (Source: Harvard Health Blog, Safe and Effective Use of Insulin Requires Proper Storage, 12/04/2018,	N 432		

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N 432	Continued From page 2 https://www.health.harvard.edu/blog/safe-and-effective-use-of-insulin-requires-proper-storage-2018120415486 , retrieved 01/21/2026.) On 01/13/2026 at 8:15 AM and 8:39 AM, Surveyor interviewed Caregiver D. S/he acknowledged that Resident 2 and Resident 3's insulin pens were not labeled with the dates opened and stated, "I didn't open this one ...pen must have rubbed off." Caregiver D acknowledged Resident 3's inhaler was not labeled with the date opened and stated that s/he would not know when the medications were opened and therefore was unsure when to properly discard them. On 01/13/2026 at 10:54 AM, Surveyor reviewed the provider's medication storage system with Facility Director (F.D.) E, Registered Nurse (R.N.) F, and Regional Director of Operations (R.D.O.) G and observed the following: -- Resident 4 had a Lantus Solostar insulin pen in the medication cart. The insulin pen did not have a date documented as to when it was opened or when it could be used by. The insulin pen had a label on it which read, "DATE OPENED ...DISCARD AFTER 28 DAYS." -- A bubble pack containing Lorazepam 0.5MG tablets for Resident 5 which read in part, "TAKE 1 TABLET BY MOUTH THREE TIMES DAILY AS NEEDED FOR ANXIETY." The bubble pack displayed an expiration date of 11/05/2025 on the pharmacy label. The bubble pack also had an expiration date of 10/31/2025 displayed on the back. Surveyor observed three handwritten dates of 11/04/2025, 11/07/2025, and 12/31/2025 where the pill was removed from the bubble pack. On 01/13/2026 at 2:00PM, Surveyor reviewed	N 432		

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N 432	Continued From page 3 Resident 5's medication administration record (MAR) and current physician orders. Physician orders read in part, " ...lorazepam 0.5 mg tablet Take 1 tablet by mouth three times a day as needed (PRN); anxiety ..." Surveyor reviewed November and December 2025 MARs which documented 3 occurrences on 11/04/2025, 11/07/2025, and 12/31/2025 that F.D. E had administered Resident 5 his/her expired Lorazepam. On 01/13/2026 at 11:00 AM, Surveyor interviewed F.D. E, R.N. F, and R.D.O. G who acknowledged the missing opened dates on three insulin pens and one inhaler. F.D. E acknowledges that Resident 5's medication had expired as of 10/31/2025 and that s/he had administered Resident 5's Lorazepam medication on three separate occasions following the expiration date.	N 432		