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 06/14/2023

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 06/16/2023, Surveyor completed a verification visit at Lake Country Landing, a RCAC in Summit. One deficiency was identified. This is a repeat deficiency - See Statement of Deficiency (SOD) 5WJ112, dated 11/28/2022, SOD 5WJ111, dated 06/02/2022 and SOD TNU311, dated 03/26/2019. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 26	{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 record review and interview the provider did not ensure 3 of 4 tenants reviewed	{U 118}		

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

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{U 118}	Continued From page 1	{U 118}		

received health monitoring and medication management services.

Tenant 1 received his/her Midodrine Hcl 5 mg when his/her vitals were outside of parameters for administration and had his/her Midodrine Hcl 5 mg held when his/her vitals indicated medication should have been administered.

Tenant 6 did not receive his/her medications as prescribed due to lack of medication availability and insulin administered to him/her was not documented at times.

Tenant 4's insulin administration was not documented.

This is a repeat deficiency - See Statement of Deficiency (SOD) 5WJ112, dated 11/28/2022, SOD 5WJ111, dated 06/02/2022 and SOD TNU311, dated 03/26/2019.

Findings include:

On 06/14/2023 at approximately 11:00 a.m., Surveyor reviewed tenant records and noted the following concerns:

Example 1 - Tenant 1

Tenant 1 admitted to the provider's complex on 01/14/2022. Tenant 1's physician orders included an order for Midodrine Hcl 5 mg 1 tablet 2 times daily for hypotension - Hold if systolic blood pressure (SBP) is >120 (Start Date: 03/06/2023).

Tenant 1's Medication Administration Record (MAR), dated 05/01/2023 to 05/31/2023, documented Midodrine Hcl as administered on the following dates when Tenant 1's SBP was

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{U 118}	Continued From page 2 >120 and Midodrine Hcl should have been held: - 05/01/2023 PM: BP 124/83 - 05/02/2023 PM: BP 141/86 - 05/03/2023 AM: BP 143/88 - 05/04/2023 AM: BP 135/85 - 05/04/2023 PM: BP 122/84 - 05/07/2023 AM: BP 128/72 - 05/11/2023 AM: BP 126/74 - 05/11/2023 PM: BP 145/85 - 05/13/2023 AM: BP 121/64 - 05/14/2023 PM: BP 132/76 - 05/15/2023 PM: BP 123/83 - 05/17/2023 PM: BP 133/84 - 05/18/2023 PM: BP 128/81 - 05/19/2023 AM: BP 143/90 - 05/19/2023 PM: BP 133/77 - 05/20/2023 PM: BP 133/77 - 05/21/2023 AM: BP 132/82 - 05/21/2023 PM: BP 132/72 - 05/24/2023 AM: BP 139/78 - 05/26/2023 PM: BP 124/78 - 05/27/2023 AM: BP 131/74 - 05/27/2023 PM: BP 124/74 - 05/28/2023 PM: BP 127/78 - 05/29/2023 PM: BP 131/74 - 05/30/2023 PM: BP 121/66 - 05/31/2023 AM: BP 132/74 - 05/31/2023 PM: BP 124/78 Tenant 1's MAR, dated 05/01/2023 to 05/31/2023, documented Midodrine Hcl as "held per vitals" when Tenant 1's SBP was not greater than 120 and Midodrine Hcl should have been administered on the following dates: - 05/10/2023 AM: BP 116/71 - 05/16/2023 PM: BP 120/81 - 05/18/2023 AM: BP 120/74 - 05/30/2023 AM: BP 115/72	{U 118}		

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{U 118}	Continued From page 3 On 06/14/2023 at approximately 11:15 a.m., Surveyor reviewed concern with Nurse F that Tenant 1 received Midodrine Hcl when the medication should have been held and did not receive Midodrine Hcl when s/he should have based on recorded vitals. Nurse F reviewed Tenant 1's MAR and agreed with Surveyor's concern. On 06/14/2023 at approximately 1:00 p.m., Surveyor reviewed concerns related to Tenant 1's Midodrine with Director of Nursing C. Director of Nursing C stated Nurse F had been auditing resident records for some time, but that had tapered off because his/her time was usually spent with another facility. Director of Nursing C stated the provider would need to educate med passers. Example 2 - Tenant 6 Tenant 6 was admitted to the provider's complex on 04/11/2023. Tenant 6's MAR, dated 05/01/2023 to 05/31/2023, and corresponding progress notes documented the following medication concerns: - Breo Ellipta Inhaler: Physician order for 1 puff orally 1 time daily (Start Date: 04/11/2023). Documentation indicated the medication was unavailable on 05/05/2023 and 05/15/2023. Notes stated, "Needs to be ordered." *On 06/16/2023 at 1:30 p.m., Surveyor followed up with Pharmacist E, who stated a 60-day supply was sent to the provider's complex on 04/11/2023, so the medication should have been available. - Montelukast Sodium 10 mg: Physician order for	{U 118}		

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{U 118}	Continued From page 4 1 tablet daily (Start Date: 04/11/2023). Documentation indicated the medication was unavailable 20 of 31 days in May. Notes stated, "Needs to be ordered." *On 06/16/2023 at 1:30 p.m., Surveyor followed up with Pharmacist E, who stated this medication was not delivered to the provider's complex until 06/05/2023 and s/he was unsure why it was not sent out sooner. - Carvedilol 6.25: Physician order for 1 tablet every Tuesday, Thursday and Saturday (Start Date: 04/11/2023). Documentation indicated the medication was unavailable on 05/02/2023 and 05/04/2023. *On 06/16/2023 at 1:30 p.m., Surveyor followed up with Pharmacist E, who stated a 30-day supply was delivered on 04/11/2023, so s/he was unsure why the medication was unavailable. - Ezetimbe 10 mg: Physician order for 1 tablet daily (Start Date: 04/11/2023). Documentation indicated the medication was unavailable 20 of 31 days in May. Notes stated, "Needs to be ordered." *On 06/16/2023 at 1:30 p.m., Surveyor followed up with Pharmacist E, who stated this medication was not delivered to the provider's complex until 06/04/2023 and s/he was unsure why it was not sent out sooner. - Fexofenadine 180 mg: Physician order for 1 tablet daily (Start Date: 04/12/2023). Documentation indicated the medication was unavailable 9 days from 05/14/2023 to 05/31/2023. *On 06/16/2023 at 1:30 p.m., Surveyor followed up with Pharmacist E, who stated a 30-day supply was delivered on 04/11/2023 and then not again until 05/25/2023.	{U 118}		

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{U 118}	Continued From page 5 - Insulin Aspart: Physician order to inject as per sliding scale before meals and at bedtime (150-200 = 2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units and call physician). The amount of insulin administered to Tenant 6 was not documented for 28 occurrences when Tenant 6's blood sugar level would have required insulin. On 06/14/2023 at approximately 1:00 p.m., Surveyor reviewed medication availability and insulin documentation concerns with Director of Nursing C and Medical Records G. Medical Records G stated s/he believed there were insurance issues with obtaining Tenant 6's medications. Director of Nursing C stated s/he was unsure why medications were unavailable. Director of Nursing C stated med passers were responsible for reordering medications. Director of Nursing C reviewed Tenant 6's MAR and agreed with concern that amount of insulin administered was not documented at times. Director of Nursing C went through the provider's online charting program and showed Surveyor how med passers should be informed how many units of insulin to administer once a blood sugar is entered and the amount of insulin administered should then be documented in the record. Director of Nursing C stated something must not have been clicked during the medication passes. Director of Nursing C stated s/he was going to follow up with med passers regarding insulin documentation. Example 3 - Tenant 4: Tenant 4 was admitted to the provider's complex on 03/01/2022. Tenant 4's physician orders included Humalog 100 unit/ml - Inject as per	{U 118}		

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{U 118}	Continued From page 6 sliding scale before meals (150-200 = 2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, greater than 400=Call physician). Tenant 4's MAR, dated 05/01/2023 to 05/31/2023, did not document the amount of insulin administered for 82 occurrences when Tenant 4's blood sugar would have required insulin. On 06/14/2023 at approximately 1:00 p.m., Surveyor reviewed medication availability and insulin documentation concerns with Director of Nursing C and Medical Records G. Director of Nursing C reviewed Tenant 4's MAR and agreed with concern that amount of insulin administered was not documented. Director of Nursing C went through the provider's online charting program and showed Surveyor how med passers should be informed how many units of insulin to administer once a blood sugar is entered and the amount of insulin administered should then be documented in the record. Director of Nursing C stated something must not have been clicked during the medication passes. Director of Nursing C stated s/he was going to follow up with med passers regarding insulin documentation.	{U 118}		