STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016337	A. BUILDING: _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF KAUKAUNA (THE)	793 TARRAGON DRIVE KAUKAUNA, WI 54130

(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 01/30/2025, Surveyor conducted a standard licensure survey at The Landings of Kaukauna. Four deficiencies were identified. Census: 23	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 3 of 4 residents. Resident 1's Fluticasone Propionate (nasal spray) was scheduled for 90 days, and s/he did not receive the medication. Resident 2 was prescribed Fluticasone which had not been administered as prescribed. Resident 5 was prescribed Fluticasone Salmeterol which had not been administered as prescribed. Findings Include: Example 1: Resident 1 On 01/30/2025, at approximately 12:50 PM, Surveyor observed the medication cart with Administrator A and observed Resident 1's bottle	N 352		

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

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N 352	Continued From page 1	N 352		

of Fluticasone Propionate, which had a dispensed date of 05/07/2024. The label on the bottle read: Instill 2 sprays in each nostril once daily for 90 days. Surveyor and Administrator A did not observe any other bottles of Fluticasone Propionate for Resident 1. Surveyor and Administrator A noted that the bottle of Fluticasone Propionate appeared to be full.

"Each bottle contains a net fill weight of 16 g (grams) and will provide 120 actuations. Each actuation delivers 50 mcg (micrograms) of fluticasone propionate in 100 mg (milligram) of formulation through the nasal adapter. The correct amount of medication in each spray cannot be assured after 120 sprays even though the bottle is not completely empty." (Source: National Institute of Health website, Fluticasone Propionate, 12/2022, https://dailymed.nlm.nih.gov/dailymed/fda (retrieval date - January 31, 2025).)

Surveyor determined Resident 1's bottle of Fluticasone Propionate would have provided medication for 30 days (120 actuations / 4 (2 sprays in each nostril per day) = 30).

On 01/30/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the facility 04/25/2018.

Resident 1's January 2025 Medication Administration Record (MAR), dated 01/01/2025 to 01/30/2025, documented:
Fluticasone 50 MCG (microgram) Nasal Spray - Instill 2 sprays in each nostril once daily for 90 days. Start Date: 05/10/2024. No end date was recorded.
The MAR documented the medication had been

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N 352	Continued From page 2 administered 26 out of 30 opportunities. Surveyor determined the Fluticasone was dispensed 05/07/2024, the medication was documented on the MAR 05/10/2024, and the bottle appeared to be full. Therefore, the medication had not been administered as prescribed. On 01/30/2025, at approximately 2:30 PM. Administrator A stated s/he had spoken with Resident 1's Primary Care Physician (PCP) B, as s/he was in the facility, and PCP B stated the medication should have been discontinued after 90 days. Administrator A stated s/he would remove the bottle of Fluticasone Propionate from the med cart. Administrator A stated s/he would discuss the concern with staff as it appeared Resident 1's Fluticasone Propionate had not been administered as prescribed, that the order should have been refilled twice, and staff were documenting they were administering the medication when it was not being given. Example 2: Resident 2 On 01/30/2025, at approximately 1:00 PM, Surveyor and Administrator A observed the medication cart and observed Resident 2's bottles of Fluticasone which were not dated when opened. One bottle had a dispensed date of 04/22/2024 and one had a dispensed date of 10/01/2024. Both bottles appeared to be full. The labels read, "Instill 1 spray into both nostrils once daily for nasal congestion. "Each bottle contains a net fill weight of 16 g (grams) and will provide 120 actuations. Each actuation delivers 50 mcg (micrograms) of fluticasone propionate in 100 mg (milligram) of	N 352		

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N 352	Continued From page 3	N 352		

formulation through the nasal adapter. The correct amount of medication in each spray cannot be assured after 120 sprays even though the bottle is not completely empty." (Source: National Institute of Health website, Fluticasone Propionate, 12/2022, https://dailymed.nlm.nih.gov/dailymed/fda (retrieval date - January 31, 2025).)

Surveyor determined Resident 2's bottle of Fluticasone would have provided medication for 60 days (120 actuations / 2 (1 spray in each nostril per day) = 60).

Resident 2's January 2025 MAR documented:
Fluticasone 50 MCG Nasal Spray - Instill 1 spray into both nostrils once daily for nasal congestion.
Start Date: 04/23/2024. No end date.
The MAR documented the medication had been administered 26 out of 30 opportunities.

Surveyor determined the bottle of Fluticasone that was dispensed 04/22/2024, the medication was documented on the MAR 04/23/2024, and the bottle appeared to be full. Therefore, the medication had not been administered as prescribed. The other bottle of Fluticasone that was dispensed 10/01/2024, was not dated when opened and the bottle appeared to be full.

On 01/30/2025, at approximately 2:30 PM. Administrator A stated s/he would discuss the concern with staff as it appeared Resident 2's Fluticasone had not been administered as prescribed; the April bottle appeared to be at least half full and it should have been replaced in June and August. The Fluticasone dispensed in October, if administered properly, should have been reordered in December. Administrator A stated staff would be reeducated on proper

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N 352	Continued From page 4 administration of medications. Example 3: Resident 5 On 01/30/2025, at approximately 12:55 PM, Surveyor and Administrator A observed Resident 5's Fluticasone Salmeterol inhaler, with a dispensed date of 08/26/2024. Surveyor and Administrator A did not observe any other inhalers for Resident 5. Resident 5's January 2025 MAR documented: Fluticasn-Salmet (Fluticasone Salmeterol) - Inhale 1 puff by mouth twice daily. Start Date: 08/26/2024. No end Date. The MAR documented the medication had been administered 50 out of 59 opportunities. "You should keep track of the number of inhalations used from your inhaler. Then throw away the inhaler after you have used 120 inhalations. Even though the canister might not be empty and will keep spraying, you might not get the right amount of medicine in each inhalation. Before you get to 120 inhalations, ask your doctor if you need to refill your prescription." (Source: FDA (US Food and Drug Administration) website, Advair HFA 45/21, Advair HFA 115/21, Advair HFA 230/21, undated, https://www.accessdata.fda.gov/drugsatfda_docs/label/2006/021254lbl.pdf (retrieval date - January 31, 2025).) Surveyor determined Resident 5's bottle of Fluticasone would have provided medication for 60 days (120 actuations / 2 (1 puff by mouth twice daily) = 60). Surveyor determined the bottle of Fluticasone that was dispensed 08/26/2024 was the original	N 352		

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N 352	Continued From page 5 inhaler when the prescription was written and would have been reordered in 10/2024 and again in 12/2024. Therefore, the medication had not been administered as prescribed. On 01/30/2025, at approximately 2:30 PM. Administrator A stated s/he would discuss the concern with staff as it appeared Resident 5's Fluticasone had not been administered as prescribed. Administrator A stated staff would be reeducated on proper administration of medications.	N 352		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's Individual	N 387		

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N 387	Continued From page 6 Service Plan (ISP) was signed by the resident or resident's legal representative acknowledging their involvement in, understanding of, and in agreement with the plan for 2 of 2 residents (Resident 1 and Resident 2). Findings include: On 01/30/2025, Surveyor reviewed Resident 2's and Resident 3's record. Resident 1 moved into the facility 04/25/2018 and is his/her own person. Resident 1's ISP, dated 07/26/2024, was not signed by Resident 1. Resident 2 moved into the facility 12/21/2020 and is his/her own person. Resident 2's ISP, dated 06/19/2024, was not signed by Resident 2. On 01/30/2025, at approximately 3:00 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was not aware that residents, who were their own person, were to sign their ISP and would review their processes going forward.	N 387		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed	N 415		

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by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure proper documentation within the Medication Administration Record (MAR) for 4 of 4 residents reviewed.

Resident 1, Resident 2, and Resident 5 had blanks on the MAR where scheduled medication administration should have been documented. Resident 3's GNP Acidol Phil Us (GNP Acidophilus Probiotic Blend [urinary tract infection medication]) was documented as administered when the medication had not been dispensed from the blister card.

Findings include:

On 01/30/2025, Surveyor reviewed Resident 1's, Resident 2's, Resident 3's and Resident 5's record.

Example 1: Resident 1

Resident 1's January 2025 MAR did not document the following medications as administered:
6:30 AM: Levothyroxine - 01/23, 01/25, 01/30
8:00 AM: Docusate Sodium, Oyster Calcium, Amlodipine, Losartan, Ferrous Sulfate, Potassium, Polyethylene Glycol, Pantoprazole, Aspirin - 01/22, 01/23, 01/26, 01/27
Surveyor observed Resident 1's blister cards and

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N 415	Continued From page 8 these medications had been dispensed from the blister cards. 12:00 PM: Florajen Acidophilus - 01/08, 01/13, 01/15, 01/18, 01/26, 01/29 Example 2: Resident 2 Resident 2's January 2025 MAR did not document the following medications as administered: 8:00 AM: Carvedilol, Allopurinol, Acetaminophen, Hydralazine, Tramadol, Aspirin, Furosemide, Polyethylene Glycol, Ciprofloxacin - 01/22, 01/23, 01/26, 01/27 12:00 PM: Hydralazine, Tramadol, Ferrous Sulfate - 01/08, 01/13, 01/15, 01/17, 01/18, 01/26, 01/28, 01/29 Surveyor observed Resident 2's blister cards and these medications had been dispensed from the blister cards. Example 3: Resident 3 On 01/30/2025, at approximately 2:00 PM, Surveyor and Administrator A observed Resident 3's blister card of GNP Acidol Phil Us. The blister card contained the capsules for 01/28, 01/29 and 01/30. Administrator A stated the medications had been held because Resident 3, who was on hospice, was unable to swallow medications so they were held. Resident 3's January 2025 MAR documented: GNP Acidophilus - Take one capsule by mouth once daily. Start Date: 12/23/2024. No end date. The MAR documented the medication had been administered on 01/28 and 01/30. The MAR had a blank box regarding 01/29 opportunity.	N 415		

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N 415	Continued From page 9 Example 4: Resident 5 Resident 5's January 2025 MAR did not document the following medication as administered: 12:00 PM: Acetaminophen - 01/08, 01/13, 01/15, 01/17, 01/18, 01/26, 01/29 On 01/30/2025, at approximately 3:30 PM, Surveyor interviewed Administrator A. Administrator A stated all staff would be re-educated on proper documentation of medication administration.	N 415		
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, record review and interview, the provider did not ensure 1 of 1 resident's medications were stored as outlined by the pharmacy. Resident 4's Latanoprost eye drops were not refrigerated until opened.	N 432		

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N 432	Continued From page 10 Findings include: On 01/30/2025, Surveyor reviewed Resident 4's and Resident 5's record. On 01/30/2025, at approximately 12:45 PM, Surveyor and Administrator A observed Resident 4's bottle of unopened Latanoprost in the original packaging that had a blue label on it that stated, "Refrigerate." The eye drops had been dispensed 08/26/2024. Surveyor and Administrator A observed another bottle of Resident 4's Latanoprost, with a dispense date of 10/08/2024, which did not have an open date written on it. "Unopened bottles should be stored in the refrigerator. Once opened, the bottle can be kept at room temperature for either 6 weeks (Xalatan) or 30 days (Iyuzeh). For Xelpros, the bottle should continue to be kept in the refrigerator, even after opening, until the expiration date on the bottle." (Source: MedlinePlus website, Latanoprost Ophthalmic, August 15, 2023, https://medlineplus.gov/druginfo/meds/a697003.html (retrieval date - January 31, 2025).) On 01/30/2025, at approximately 3:15 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would discuss the concern with staff.	N 432		