STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015942	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWICK CLINTON	306 OGDEN AVE CLINTON, WI 53525

(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 02/20/2025 to 02/25/2025, Surveyor conducted 2 complaint investigations at Willowick Clinton. Two deficiencies were identified. One complaint was substantiated. One complaint was unsubstantiated. Census: 19	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, interview, and record review, the provider did not ensure 1 of 1 resident record reviewed received all prescribed medications in the dosage and at intervals prescribed by a practitioner. From 09/01/2024 to 02/19/2025, Resident 1 did not receive his/her Polyethylene glycol as prescribed. From 12/01/2024 to 02/20/2025, staff administered Resident 1's blood pressure medication on 3 occurrences even though his/her blood pressure fell within parameters to hold his/her metoprolol.	N 352		

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

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N 352	Continued From page 1 Findings include: On 10/14/2024, the Department received a complaint alleging the provider is not administering medications as prescribed. Example 1: Polyethylene glycol On 02/20/2025 at 9:34 AM, Surveyor observed the provider's medication cart with Administrator B and identified the following: -Resident 1's polyethylene glycol container noted a manufacturer's label including the container originally held 30 once-daily doses of 17 grams. The container included a pharmacy label including Resident 1's practitioner's prescription for polyethylene glycol including, "Dissolve 17 grams in 4-8oz of liquid, stir well and drink once daily." The pharmacy label included a delivery date to the facility of 09/03/2024. Surveyor observed approximately ¾ of the medication remained within the container. Administrator B observed and verbally confirmed ¾ of the container remained. Surveyor observed another polyethylene glycol container with the same manufacturer's label and practitioner's prescription. The pharmacy label included a delivery date to the facility on 12/06/2024. Surveyor observed approximately ½ of the medication remained within the container. Administrator B observed and verbally confirmed ½ of the medication remained. On 02/25/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 07/20/2023 with a diagnosis of tachycardia. Resident 1's individual service plan (ISP) dated	N 352		

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N 352	Continued From page 2 01/13/2025 indicated care staff administer Resident 1's medications. Surveyor reviewed Resident 1's September 2024 to February 2025 medication administration records (MARs) and identified the following: Resident 1 was administered 89 doses of polyethylene glycol between 09/04/2024-12/05/2024 from a 30-dose container, based on Resident 1's practitioner's order, with ¾ of the medication remaining in the container. Resident 1 was administered 68 doses of polyethylene glycol between 12/06/2024-02/20/2025 from a 30-dose container, based on Resident 1's practitioner's order, with ½ of the medication remaining in the container. On 02/25/2025 at 3:06 PM, Surveyor interviewed Pharmacy C regarding Resident 1's polyethylene glycol order. Pharmacy C reported one 30 once-daily dose container of Resident 1's polyethylene glycol, as prescribed, was delivered to the facility from the pharmacy on 09/03/2024 and 12/06/2024. Pharmacy C reported if administered to Resident 1 as prescribed, the container from 09/03/2024 would have been emptied on approximately 10/03/2024 and the container from 12/06/2024 would have been emptied on approximately 01/06/2025. Pharmacy C reported this medication was not delivered on an automatic cycle fill and the facility would have to contact the pharmacy to request a refill of the medication. Example 2: Metoprolol Resident 1's physician orders included metoprolol 25 mg tablet with instructions to "take 1 tablet by	N 352		

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N 352	Continued From page 3 mouth once daily for tachycardia. (Hold for systolic B/P <100 and/or diastolic B/P <60.) Start date 12/17/24." Resident 1's MAR from 12/01/2024-02/20/2025 documented the following: -12/22/2024 (morning administration): Blood pressure documented as 96/62, metoprolol administered -01/09/2025 (morning administration): Blood pressure documented as 95/63, metoprolol administered -02/16/2025 (morning administration): Blood pressure documented as 81/65, metoprolol administered On 02/20/2025 at 9:40 AM, Surveyor interviewed Administrator B regarding Resident 1's polyethylene glycol. Surveyor questioned the amount still left in each container when Resident 1's prescription noted to be given daily. Administrator B confirmed that if the above medications were administered as prescribed the containers would have been empty. On 02/25/2025 at 3:34 PM, Surveyor interviewed and shared findings with Chief Executive Officer (CEO) A. CEO A acknowledged an understanding of the concerns. CEO A reported s/he was going to talk to with their nurse to see if Resident 1's polyethylene glycol could be switched from the powder form. Surveyor asked for additional information regarding why Resident 1 received his/her metoprolol when parameters indicated it should have been held. CEO A stated s/he would follow up with Administrator B.	N 352		
N 406	83.37(1)(g) Disposition of medications.	N 406		

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N 406	Continued From page 4 Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications that had been changed, discontinued, or expired were removed from the medication cart and disposed of within 30 days. Findings include: On 10/14/2024, the Department received a complaint alleging the provider is not destroying discontinued medications. On 02/20/2025 at 9:39 AM, Surveyor toured the	N 406		

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N 406	Continued From page 5 provider's medication room with Administrator B. To the left of the medication cart, Surveyor observed a brown paper bag filled with the following blister cards of medications: Resident 1's blister card of Docusate 100 mg (bedtime), with a dispensed date of 12/24/24, contained 2 tablets. Resident 1's blister card of Senna 8.6 mg (bedtime), with a dispensed date of 12/24/24, contained 2 tablets. Resident 1's blister card of Midodrine 5 mg (evening), with a dispensed date of 12/24/24, contained 8 tablets. Resident 1's blister card of Ropinirole 0.5 mg (bedtime), with a dispensed date of 12/24/24, contained 2 tablets. Resident 2's blister card of Trazodone 50 mg (bedtime), with a dispensed date of 12/24/24, contained 1 tablet. Resident 3's blister card of Ocuvite (morning), with a dispensed date of 01/10/25, contained 19 tablets. This blister card did not have any doses dispensed from it. Resident 3's blister card of Sucralfate 1 mg (morning), with a dispensed date of 12/24/24, contained 12 tablets. Resident 3's blister card of Sucralfate 1 mg (noon), with a dispensed date of 12/24/24, contained 12 tablets. Resident 3's blister card of Sucralfate 1 mg (evening), with a dispensed date of 12/24/24,	N 406		

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N 406	Continued From page 6 contained 9 tablets. Resident 3's blister card of Sucralfate 1 mg (bedtime), with a dispensed date of 12/24/24, contained 11 tablets. Resident 3's blister card of Florajen Acidophilus (morning), with a dispensed date of 12/24/24, contained 12 tablets. Resident 3's blister card of Docusate 100 mg (morning), with a dispensed date of 12/24/24, contained 12 tablets. Resident 3's blister card of Pantoprazole 40 mg (morning), with a dispensed date of 12/24/24, contained 10 tablets. Resident 3's blister card of Pantoprazole 40 mg (bedtime), with a dispensed date of 12/24/24, contained 8 tablets Resident 3's blister card of Furosemide 20 mg (bedtime), with a dispensed date of 12/24/24, contained 16 tablets. Resident 3's blister card of Potassium 20 mg (morning), with dispensed date of 12/24/24, contained 16 tablets. Resident 3's blister card of Senna Docusate 8.6 mg (morning), with a dispensed date of 12/24/24, contained 12 tablets. Resident 3's blister card of Senna Docusate 8.6 mg (evening), with a dispensed date of 12/24/24, contained 10 tablets. Resident 4's blister card of Tamsulosin 0.4 mg (bedtime), with a dispensed date of 12/24/24,	N 406		

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N 406	Continued From page 7 contained 2 tablets. Resident 4's blister card of acetaminophen 500 mg (bedtime), with a dispensed date of 12/24/24, contained 2 tablets. On 02/20/2025 at 9:40 AM, Surveyor interviewed Administrator B and Nurse Manager D regarding the large number of medications retained beyond 30 days for the above residents. Administrator B and Nurse Manager D acknowledged the above medications should have been destroyed within 30 days. Administrator B and Nurse Manager B stated, "they did not know why the medications were not destroyed per their policy." Administrator B shared the provider's policy for destroying discontinued, changed, or expired medications.	N 406		