STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017777	A. BUILDING: _____ B. WING _____	R-C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING-MADISON	5601 BURKE RD MADISON, WI 53718

(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 04/09/2025, Surveyors conducted a verification visit and a complaint investigation at Charter Senior Living- Madison. As a result of the survey, 1 deficiency of Chapter DHS 89 was identified. This is a repeat deficiency - See Statement of Deficiency (SOD) B33911, dated 08/13/2024. The complaint was unsubstantiated. 1 deficiency from SOD B33911, dated 08/13/2024, was substantially corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 43	{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.	{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}		

This Rule is not met as evidenced by:
Based on record review, observation and interview the provider did not ensure 2 of 4 tenants reviewed received medication management services.

Tenant 1's insulin administration was not documented correctly.

Tenant 2 did not receive his/her medications as prescribed.

This is a repeat deficiency - See Statement of Deficiency (SOD) B33911, dated 08/13/2024. Findings include:

04/09/2025 at approximately 10:00 a.m., Surveyor reviewed tenant records and noted the following concerns:

Example 1 - Tenant 1

Tenant 1 admitted to the provider's complex on 12/03/2023. Tenant 1's physician orders included an order for Insulin Lispro 100 unit/ml - Inject as per sliding scale before meals (150-200 = 2 units, 200-250=4 units, 250-300=6 units, 300-350=8 units, 350-400=10 units). Tenant 1's medication administration record (MAR), dated 03/01/2025 to 04/09/2025, did not document the correct units of insulin administered for 38 occurrences.

On 04/09/2025 at approximately 11:30 a.m., Surveyor interviewed Clinical Specialist B. Clinical Specialist B reviewed the MARs with Surveyor and acknowledged the incorrect units documented on the MAR. Clinical Specialist B stated that staff were including the daily dose of

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{U 118}	Continued From page 2 Insulin Lispro 8 units with the sliding scale units dosed. Clinical Specialist B stated that "it is definitely an education opportunity for staff." On 04/09/2025 at approximately 12:00 p.m., Surveyor reviewed concern with Executive Director A and Clinical Specialist B. Executive Director A acknowledged the documentation error for units administered for Tenant 1. Example 2- Tenant 2 On 04/09/2025, at approximately 8:40 AM, Surveyor conducted a medication cart audit with Caregiver E. Caregiver E explained typically the doses used were based on the date. Caregiver E confirmed a pill in bubble 3, would be meant for the April 3rd. Surveyor observed Tenant 2's Eliquis bubble pack, scheduled for 4:00 PM, which contained an individual tablet in each of the bubbles, 3 and 8, which would be for dates 04/03/2025 and 04/08/2025. Caregiver E was unable to provide an explanation for why the tablets were still in the pack. Clinical Specialist B was also present and could not provide a reason for the missed medication. Facility's records did not indicate Tenant 2 was out of the facility. Surveyor requested Tenant 2's records. Tenant 2 admitted to the provider's facility on 01/15/2021. Tenant 2's physician orders included an order for Eliquis Tab 2.5 mg- Take 1 tablet by mouth twice daily for blood thinner. Tenant 2's MAR, dated 04/01/2025 - 04/09/2025, documented the medication as administered. The MAR did not include any notes or documented exceptions for the Eliquis on 04/03/2025 or 04/08/2025. On 04/09/2025 at approximately 12:05 PM,	{U 118}		

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{U 118}	Continued From page 3 Surveyor reviewed Eliquis administration concern with Executive Director A and Clinical Specialist B. Clinical Specialist B agreed that without documentation supporting an explanation for the missed medication, that it must have been missed in error.	{U 118}		