STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009763	A. BUILDING: _____ B. WING _____	C 03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COURT DEER CREEK	3585 S 147TH ST NEW BERLIN, WI 53151

(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 03/30/2026, Surveyors conducted a complaint investigation at Heritage Court Deer Creek in New Berlin. One (1) deficiency was identified. The complaint was substantiated. Census: 33	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 record review and interview, the provider did not ensure that residents received all prescribed medications in the dosage and at intervals prescribed by a practitioner. On 02/07/2026, Resident 1 received another resident's medication, which resulted in Resident 1 requiring hospitalization due to becoming hypotensive and bradycardiac. On 02/02/2026, Resident 2 received another resident's tramadol and lorazepam. On 02/10/2026, Resident 3 received another resident's atorvastatin. This is a repeat violation from statement of deficiency (SOD) U8H011, dated 03/23/2023.	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 02/08/2026, the department received a complaint alleging that medication errors are being made, resulting in hospitalizations. On 03/30/2026, Surveyors conducted a complaint investigation. Surveyors asked to review the provider's known medication errors in February. Example 1 - Resident 1 Surveyors reviewed the record of Resident 1. Resident 1 was admitted to the provider on 01/24/2018 with diagnoses including coronary angioplasty implant and graft, major depressive disorder, and cognitive impairment. Surveyor reviewed an investigation summary, dated 02/07/2026, that documented: "On 2/7/26 around 7:15am, [Resident 1] was witnessed laying on the floor next to [his/her] bed by [Caregiver B], [Caregiver B] then immediately went to med passer [Caregiver C] for assistance. [Caregiver C] was in the middle of [his/her] med pass for another resident and brought the medication cup with [him/her] when assisting [Resident 1] off the ground. At around 7:25am, med passer [Caregiver C] mistakenly thought the medications that [s/he] brought in the room with [him/her] were for [Resident 1] and administered another resident's medications to [Resident 1]. [Resident 1] received the following medications in error: Acetaminophen 500mg, Aspirin 81mg, Calcium 315mg/Vit D3 5mcg, Carvedilol 25mg, Clopidogrel 75mg, Furosemide 40mg, Hydralazine 100mg, Isosorbide Mononitrate 30mg, Pantoprazole 40mg, Sertraline 100mg, and Spironolactone 25mg...	N 352		

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N 352	Continued From page 2 CHRONOLOGY 2/7/26 7:15am [Resident 1] is observed on the floor next to [his/her] bed by [Caregiver B]. 2/7/26 7:15am [Caregiver B] immediately found med passer [Caregiver C] and asked for assistance with transferring [Resident 1] off of the ground. [Caregiver C] was mid-med pass for another resident and brought the other resident's medication into [Resident 1's] room with [him/her]. 2/7/26 7:25am [Resident 1] was fully situated back into bed. [Caregiver C] mistakenly administered the other resident's medication to [Resident 1] while [s/he] was still in [his/her] room. 2/7/26 7:25am [Caregiver C] returned to the med cart and realized [his/her] error. [S/he] immediately called [Director of Nursing (DON) D] who then instructed [Caregiver C] to call [Hospice E]. 2/7/26 8:31am RN (nurse) from [Hospice E] arrived to the community. Initially, [Resident 1] was observed to be lethargic with a low blood pressure. When the nurse took [Resident 1's] blood pressure again, [s/he] could not get a reading and called 911. 2/7/26 9am [Resident 1] was transported via ambulance to [Hospital F]. Surveyor reviewed Resident 1's Hospital F report, dated 02/07/2026-02/09/2026, that documented: "[Resident 1] is critically ill with circulatory failure and severe metabolic derangement(s) and required high complexity decision making for assessment and support including volume resuscitation, frequent vasoactive agent adjustment, assessment and treatment of complex metabolic derangement, frequent evaluation of titration of therapies, application of advanced monitoring technologies, extensive	N 352		

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N 352	Continued From page 3	N 352		

interpretation of multiple databases, and Critical care...
ED (emergency department) COURSE:
VS (vital signs): Afebrile on presentation heart rate was in the 50s, hypotensive to 58/29. [S/he] was comfortable on 5L NC (nasal cannula) with RR (respiratory rate) of 22.
Labs:
-VBG (Venous Blood Gas) showed pH of 7.41, pCO2 of 40. CBC showed no leukocytosis, hemoglobin was 11.3, platelets within normal limits. Magnesium was 1.5 and K was 3.3.
-EKG (electrocardiogram) consistent with sinus bradycardia with low voltage likely secondary to (his/her) COPD
Imaging:
-N/A (not applicable)
Intervention:
Given K-Phos 20mg and 2g of magnesium"

Surveyor reviewed Resident 1's individualized service plan (ISP), dated 02/05/2025, which documented, "MEDICATIONS - I am unable to self-administer medications. Staff assist with administering medication, reordering medications, and processing new prescriptions. I will be monitored for increased expressions of sadness, despair and self-harm."

Example 2 - Resident 2

Surveyor reviewed an Investigation Summary, dated 02/02/2026 at 7:45 a.m. that documented: Resident 2 was provided another resident's medications, s/he received tramadol and lorazepam in his/her apartment during medication administration. Resident 2 was sleepy and tired but had no injury noted. The provider notified hospice service and Resident 2's primary care provider. Resident 2 was evaluated for a change

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N 352	Continued From page 4 in condition, and his/her prescription hydrocodone was held. Example 3 - Resident 3 Surveyor reviewed an Investigation Summary, dated 02/10/2026 at 8:10 p.m. that documented: Resident 3 received another resident's medications, s/he received atorvastatin in his/her apartment during medication administration. Resident 3 had no changes and had no injury noted. The provider notified Resident 3's primary care provider. On 03/30/2026, at approximately 3:00 p.m., Surveyors discussed the above concerns with Administrator A. Administrator A stated that s/he investigated the errors and found that staff were getting distracted during medication administration. Administrator A stated that s/he provided additional medication administration training and that there has not been any known medication errors since the additional training.	N 352		