STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018270	A. BUILDING: _____ B. WING _____	C 02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN CROSSING AT MARITIME GARDENS	1945 DEWEY STREET MANITOWOC, WI 54220

(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 02/06/2025, with information gathered through 02/12/2025, Surveyor conducted a standard survey and 1 complaint investigation at Sylvan Crossings At Maritime Gardens in Manitowoc. One (1) of 1 complaint was unsubstantiated. As a result of the survey, 3 deficiencies will be issued. Census: 22	N 000		
N 400	83.37(1)(a) Written order for medications, supplements. Practitioner ' s order. There shall be a written practitioner ' s order in the resident ' s record for any prescription medication, over-the-counter medication or dietary supplements administered to a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there was a written practitioner's order for prescription medications for 1 of 1 (Resident 1) residents reviewed. Resident 1's resident record did not contain a written order for Resident 1's prescription medications. Findings Include: On 02/06/2025, Surveyor reviewed Resident 1's resident record.	N 400		

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

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N 400	Continued From page 1 On 02/06/2025, Surveyor reviewed Resident 1's resident record. Resident 1 was admitted to the facility on 08/27/2024 with diagnoses to include Alzheimer's Disease, depression, hyperlipidemia and hypertension. Resident 1's ISP, with a print date of 02/06/2025, stated medications are administered by staff at the facility. Surveyor reviewed Resident 1's February 2025 MAR. Resident 1's MAR stated, "Give Pill Pack. Preceptor to fill pill packs every two weeks. You are to give them to [him/her] at bedtime." On 02/06/2025 at 1:45 PM, Surveyor interviewed Vice President (VP) of Compliance and Training A. VP of Compliance and Training A stated they were filling in as Director until a new one was hired. VP of Compliance and Training A was unaware the MAR did not list the medications Resident 1 was taking. Surveyor requested a list of Resident 1's current medications from VP of Compliance and Training A. VP of Compliance and Training A stated s/he would contact Resident 1's physician to get a current list. On 02/10/2025 at 11:20 AM, Surveyor received an email from VP of Compliance and Training A containing Resident 1's current medication list. Resident 1's physician sent a fax to the facility on 02/06/2025 which stated Resident 1 is receiving the following medications: -Pravastatin 80mg take one-half tablet by mouth every evening -Cholecalcif 25mcg(micrograms) take two tablets by mouth at bedtime -Donepezil HCL 10mg take one tablet by mouth at bedtime -Odefsey take 1 tablet by mouth at bedtime -Memantine HCL 10mg take one tablet by mouth	N 400		

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N 400	Continued From page 2 at bedtime -Mirtazapine 15mg take 1 tablet by mouth at bedtime -Acetaminophen 325mg take one tablet by mouth every 4 hours as needed -Olanzapine 5mg take one half tablet by mouth every day as needed In summary, Surveyor reviewed Resident 1's record. Resident 1's record did not contain written physician orders until Surveyor requested the records from VP of Compliance and Training A. Cross Reference: N0414 83.37(2)(c) Medication Administration Not Supervised N0415 83.37(2)(d) Documentation of Medication Administration	N 400		
N 414	83.37(2)(c) Medication administration not supervised Medication administration not supervised by a registered nurse, practitioner or pharmacist. When medication administration is not supervised by a registered nurse, practitioner or pharmacist, the CBRF shall arrange for a pharmacist to package and label a resident ' s prescription medications in unit dose. Medications available over-the-counter may be excluded from unit dose packaging requirements, unless the physician specifies unit dose. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure a pharmacist packaged and labeled prescription medications in unit dose for 1 of 1 (Resident 1) residents	N 414		

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N 414	Continued From page 3	N 414		

reviewed when the medication administration was not supervised by a registered nurse, practitioner or pharmacist.

Resident 1's medications were stored in a purple daily (Sunday-Saturday) pill container with each day containing 6 pills. The purple pill container did not indicate Resident 1's name, the type of medication, dosage and how often each medication should be administered. In addition, a bottle of Olanzapine 5mg (milligrams) with Resident 1's name on it was found in the medication cart with several pills in it, not in unit dose form.

Findings Include:

On 02/06/2025, Surveyor conducted a review of the facility's 2 medication carts. Upon review, Surveyor observed a purple daily pill container which had 7 individual boxes. Each box was marked with a corresponding day of the week, "SUN," MON," "TUE," "WED," "THU," "FRI," and "SAT". Six (6) of the 7 boxes/days contained 6 pills in each of the boxes/days. The pill container did not contain a resident name, the name of the medications in the box, the dosage or how often each medication should be administered.

Additionally, upon review of the narcotic box in the medication cart. Surveyor observed a pill bottle for Resident 1 which contained a prescription for Olanzapine 5mg to take one-half tablet by mouth every day as needed for moderate/severe agitation not responsive to verbal de-escalation. The pill bottle contained several pills, not in unit dose form.

Surveyor reviewed Resident 1's resident record. Resident 1 was admitted to the facility on

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N 414	Continued From page 4 08/27/2024 with diagnoses to include Alzheimer's Disease, depression, hyperlipidemia and hypertension. Resident 1's ISP, with a print date of 02/06/2025, stated medications are administered by staff at the facility. On 02/06/2025 at 10:15 AM, Surveyor interviewed Caregiver B. Caregiver B verified s/he was a medication passer. Caregiver B stated "a nurse" comes in every week to fill the purple pill container and then the medication passers administer the medications at night. Caregiver B also indicated the Olanzapine is to be given before Resident 1 takes a shower due to increased agitation. On 02/06/2025 at 1:45 PM, Surveyor interviewed Vice President (VP) of Compliance and Training A. VP of Compliance and Training indicated s/he is filling as Director until they can hire one. Surveyor and VP of Compliance and Training A observed the medication carts together. VP of Compliance and Training A acknowledged the medications were not stored properly and would "fix" this immediately. On 02/12/2025 at 8:45 AM, Surveyor interviewed VP of Compliance and Training A. VP of Compliance and Training A stated s/he was unsure why the medications were packaged that way. VP of Compliance and Training A indicated s/he spoke with staff and apparently the previous director allowed it so staff just did it that way. VP of Compliance and Training A indicated the situation has been fixed and the medications are now in unit dose form. Cross Reference: N0400 83.37(1)(a) Written Order for Medications, Supplements	N 414		

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N 414	Continued From page 5 N0415 83.37(2)(d) Documentation of Medication Administration	N 414		
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 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 record review and interview, the provider did not ensure staff administering medications documented in the resident record the name, dosage, date and time of administration for 1 of 1 (Resident 1) residents reviewed. Resident 1's MAR (Medication Administration Record) did not contain the name and dosage of Resident 1's medications to be administered. In addition, Resident 1 had a prescription for Olanzapine 5mg PRN (as needed) for agitation. Per staff interview, Olanzapine was given prior to bathing to help with behaviors. Resident 1's MAR did not contain documentation of Olanzapine being prescribed and/or administered.	N 415		

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N 415	Continued From page 6 Findings Include: On 02/06/2025, Surveyor reviewed Resident 1's resident record. Resident 1 was admitted to the facility on 08/27/2024 with diagnoses to include Alzheimer's Disease, depression, hyperlipidemia and hypertension. Resident 1's ISP, with a print date of 02/06/2025, stated medications are administered by staff at the facility. Surveyor reviewed Resident 1's February 2025 MAR. Resident 1's stated, "Give Pill Pack Preceptor to fill pill packs every two weeks. You are to give them to [him/her] at bedtime." The MAR did not contain the name and dosage of each medication in the "Pill Pack" that was prescribed for Resident 1. In addition, the MAR did not list Olanzapine 5mg to be administered. On 02/06/2025 at 10:15 AM, Surveyor interviewed Caregiver B. Caregiver B verified s/he was a medication passer. Caregiver B indicated the Olanzapine is to be given before Resident 1 takes a shower due to increased agitation. On 02/06/2025 at 1:45 PM, Surveyor interviewed Vice President (VP) of Compliance and Training A. VP of Compliance and Training A was unaware the MAR did not list the medications Resident 1 was taking. VP of Compliance and Training A stated s/he would have this "fixed" immediately. Cross Reference: N0400 83.37(1)(a) Written Order for Medications, Supplements N0414 83.37(2)(c) Medication Administration Not Supervised	N 415		