STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020522	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHIPPOORWHILL	**683 N PRAIRIE RD FOND DU LAC, WI 54935**

(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
M 000	INITIAL COMMENTS On 09/29/2025, with additional information gathered through 10/02/2025, Surveyor investigated 1 complaint at Whippoorwhil. The complaint was substantiated and 1 new deficiency was identified. Census: 4	M 000		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure medications were administered in the dosage and intervals prescribed by the resident's physician for Resident 1. Findings Include: On 09/17/2025, the department received a complaint alleging medications were not administered as prescribed. On 09/29/2025, at approximately 7:30AM, Surveyor interviewed Supervisor A. Supervisor A explained Caregiver B was the caregiver on shift	M 582		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 582	Continued From page 1	M 582		

at the time of medication administration on 09/14/2025. Supervisor A confirmed Caregiver B did not administer Resident 1's medication as s/he forgot. Caregiver B noticed s/he forgot and reported it. Supervisor A stated Resident 1 had a seizure and was sent to the emergency department.

On 10/01/2025, Surveyor reviewed Resident 1's individual support plan (ISP) with a print date of 10/01/2025. The ISP noted Resident 1 was diagnosed with epilepsy and Lennox-Gastaut syndrome. The ISP specified Resident 1 was prescribed psychotropic medications for seizure control. The ISP further noted, "Staff will administer all of [Resident 1's] psychotropic medications on time, as prescribed by [his/her] doctor ..."

According to the National Institute of Neurological Disorders and Stroke, Lennox-Gastaut Syndrome "is a severe form of epilepsy ..."

Information found on 10/02/2023 at 11:00AM at: https://www.ninds.nih.gov/health-information/disorders/lennox-gastaut-syndrome

On 10/01/2025, Surveyor reviewed Resident 1's September 2025 medication administration record (MAR). The MAR documented Resident 1 missed the following evening medications:

8:00PM Dose: Clobazam 10mg - take ½ tablet twice daily for Lennox-Gastaut Syndrome

9:00PM Dose: Clonazepam 2mg - take 2 tabs twice daily (noon and 9:00PM) for Lennox-Gastaut Syndrome

8:00PM Dose: Lamotrigine 200mg - take 2 tablets

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M 582	Continued From page 2 in the morning and at bedtime for epilepsy 8:00PM Dose: Topiramate 100mg at bedtime for seizures On 10/01/2025, Surveyor reviewed the General Event Report (GER) dated 09/15/2025, for Resident 1. The GER noted the error in administration was discovered on 09/15/2025 at 2:28AM. The GER indicated on 09/14/2025, Resident 1 was not administered his/her 8:00PM medications and s/he had an emergency room consult. On 10/01/2025, Surveyor reviewed Resident 1's August and September 2025 MAR. The MARs noted the following medications were not administered and included the corresponding reason: Clonazepam 2mg - take 1 tab twice daily at 8:00AM and 5:00PM for Lennox-Gastaut Syndrome (5:00PM Dose) 08/16/2025: Missed Clonazepam 10mg - take ½ tab every evening for Lennox-Gastaut Syndrome 09/19/2025: Missed Topiramate 100mg - take 2 tabs at bedtime for seizures 08/01/2025: Do not have med 09/19/2025: Missed Topiramate 50mg - take 1 tab at 8:00am and 12:00PM for Lennox-Gastaut Syndrome (8:00PM Dose) 09/19/2025: Missed Vienva tab 0.1-20 - take 1 tab daily 08/11/2025: Don't have	M 582		

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M 582	Continued From page 3 Clonazepam 2mg - take 2 tabs at noon and 9:00PM for Lennox-Gastaut Syndrome 09/19/2025: Missed Lamotrigine 200mg - take 2 tabs in the morning and bedtime for epilepsy 09/19/2025: Missed On 10/02/2025, at 12:25PM, Surveyor interviewed Residential Manager C. Residential Manager C confirmed Resident did not receive his/her 8:00PM medication on 09/14/2025 resulting in an emergency room visit. Resident Manager C acknowledged the findings.	M 582		