STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310733	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIENNA CREST FORT ATKINSON	1531 COMMONWEALTH DR FORT ATKINSON, WI 53538

(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 11/14/2024, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey at Sienna Crest Fort Atkinson, located at 1531 Commonwealth Drive in Fort Atkinson, WI. Two citations were issued. Census: 17	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 Resident 1 and Resident 2 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1's polyethylene glycol was not administered, as ordered, between February 2024 and November 2024. Resident 2's polyethylene glycol was not administered, as ordered, between July 2024 and November 2024. The findings include: On 11/14/2024 at approximately 10:00 A.M.,	N 352		

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

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N 352	Continued From page 1 Surveyor conducted an interview with House Manager C. House Manager C told Surveyor all of the facility's residents had diagnoses including dementia and required medication administration from caregivers. Example 1: Resident 1's polyethylene glycol On 11/14/2024 at approximately 11:36 A.M., Surveyor observed Caregiver D remove a container of Gavilax (polyethylene glycol) labeled with Resident 1's name and room number from the medication cart. Surveyor observed Caregiver D open the container and Surveyor observed the container near empty with approximately one eighth of the medication remaining. Caregiver D told Surveyor the container was "almost empty" and a new container would need to be ordered from the pharmacy. The container included the manufacturer's brand label, "GaviLAX polyethylene glycol 3350 powder for oral solution, osmotic laxative" and "Net Wt [weight] 17.9 oz [ounces] (510 g [grams]) 30 Once-Daily Doses." Photo #3. Surveyor observed the pharmacy label attached to the container included, "Mix 17 GM [grams] in 8 oz of liquid and drink once daily for constipation" and included the date, "02/19/24 [2024]." Photo #4. Caregiver D told Surveyor s/he thought the pharmacy delivery date of "02/19/2024" was "odd" since it was currently November 2024, Resident 1 was to be administered 17 grams of the polyethylene glycol daily, and there were only 30 doses originally available within the container. Surveyor observed Caregiver D demonstrate the amount of 17 grams to be administered to Resident 1 daily, as marked by the manufacturer within the container's lid. Caregiver D and Surveyor reviewed a 3-ring	N 352		

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binder containing a document labeled "BM [bowel movement] Schedule - 20 bed" for September 2024, October 2024, and November 2024 including Resident 1's room number. Caregiver D told Surveyor Resident 1's bowel movements were to be documented daily corresponding with Resident 1's room number. Caregiver D and Surveyor observed no documented bowel movements for Resident 1 during September 2024, October 2024, and November 2024. Caregiver D said it was difficult to track all of Resident 1's bowel movements because Resident 1 will toilet his/her self at times. Caregiver D told Surveyor Resident 1 did not complain to Caregiver D of feeling constipated.

On 11/14/2024, Operations Manager B and House Manager C provided Surveyor with Resident 1's current individual service plan (ISP), practitioner's orders, and medication administration records [MARS]. Resident 1 was admitted to the facility on 05/20/2022 with diagnoses including dementia. Resident 1's current ISP dated 05/17/2024 included, "staff administers medications" and "...is continent of both bladder and bowels..." Resident 1's ISP included, "[Resident 1] at times has issues with constipation..." and "When [Resident 1] tells us [staff] [s/he] is having trouble having a BM [bowel movement] staff will administer docusate senna [a medication for constipation] as directed by dr [doctor/practitioner]." House Manager C told Surveyor Resident 1 had an order for both scheduled and PRN medications for constipation. Resident 1's current practitioner's orders included, "Polyethylene [glycol] powder. Mix 17 gm [grams] in 8 oz of liquid and drink once daily for constipation." This medication was originally ordered on 05/22/2022. Resident 1's MARs were reviewed from January 2024 through November

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2024. The caregiver documentation within Resident 1's January 2024 through November 2024 MARs included daily administration of Resident 1's polyethylene glycol, as ordered, with the exception of 1 dose not administered related to Resident 1 being hospitalized on 05/16/2024. The caregiver documentation within Resident 1's January through November 2024 MARs included one dose of Resident 1's PRN "senna/docusate" was administered to Resident 1 on 01/16/2024.

On 11/14/2024 at 1:12 P.M., House Manager C handed Surveyor a handwritten note and told Surveyor s/he called and spoke to Resident 1's pharmacy regarding the last 3 deliveries of Resident 1's polyethylene glycol 30 day dose containers to the facility. House Manager C told Surveyor Resident 1's polyethylene glycol was delivered, as ordered, to the facility on 05/11/2023, in August 2023, and February 2024. House Manager C said Resident 1's last container of polyethylene glycol was delivered to the facility on 02/19/2024, as included on Resident 1's polyethylene glycol container.

On 11/14/2024 at approximately 3:15 P.M., Operations Manager B, House Manager C, and Surveyor observed Resident 1's polyethylene glycol container, dated 02/19/2024. Operations Manager B verbally confirmed the date included within Resident 1's pharmacy label and the amount remaining within the container. House Manager C verbally confirmed there were no additional containers of Resident 1's polyethylene glycol at the facility. House Manager C told Surveyor the pharmacy did not automatically refill Resident 1's polyethylene glycol monthly, like most oral medications. House Manager C said the caregivers/medication passers request a new, full container of Resident 1's polyethylene glycol

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N 352	Continued From page 4 to be delivered from the facility when the current container was close to empty. Example 2: Resident 2's polyethylene glycol On 11/14/2024 at approximately 10:00 A.M., Surveyor conducted an interview with House Manager C, including Resident 2's needs and services. House Manager C told Surveyor Resident 2 had experienced a significant change in condition following a fall with injury to Resident 2's hip on 11/12/2024. House Manager C told Surveyor Resident 2 was no longer ambulatory and needed assistance with all cares following this change in condition. House Manager C said Resident 2 was receiving hospice services and had required regular administration of "as needed" morphine [narcotic pain medication] related to pain since 11/12/2024. House Manager C said s/he was aware a potenital side effect of narcotic pain medication was constipation. On 11/14/2024 at approximately 11:36 A.M., Surveyor observed Caregiver D remove a container of polyethylene glycol labeled with Resident 2's name and room number from the medication cart. Surveyor observed Caregiver D open the container and Surveyor observed the container included approximately one-third of the medication remaining. Caregiver D told Surveyor the container was less than one-half empty and a new container would need to be ordered from the pharmacy when it was closer to being empty. The container included the manufacturer's brand label, "Geri-Care Live Life Well, polyethylene glycol 3350 powder for oral solution, osmotic laxative" and "Net Wt [weight] 17.9 oz [ounces] (510 g [grams]) 30 Once-Daily Doses." Photo #5. Surveyor observed the pharmacy label attached	N 352		

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to the container included, "Mix 17 GM [grams] in 8 oz of liquid and drink once daily for constipation" and included the date, "08/21/24 [2024]." Photo #6.
Caregiver D and Surveyor reviewed a 3-ring binder containing a document labeled "BM [bowel movement] Schedule - 20 bed" for September 2024, October 2024, and November 2024 including Resident 2's room number. Caregiver D told Surveyor Resident 2's bowel movements were to be documented daily corresponding with Resident 2's room number. Caregiver D and Surveyor observed 4 documented bowel movements for Resident 2 during September 2024, 9 documented bowel movements for Resident 2 October 2024, including 3 days with 3 bowel movements, and 2 documented bowel movements for Resident 2 during November 2024. Caregiver D said Resident 2 required full assistance with all toileting and incontinence care, including with bowel movements, and Resident 2 had been having more bowel movements than what was documented. Caregiver D said the facility had been training several new caregivers and perhaps documentation of Resident 2's bowel movements had been missed.

On 11/14/2024, Operations Manager B and House Manager C provided Surveyor with Resident 2's practitioner's orders and medication administration records [MARS]. Resident 2 was admitted to the facility on 09/18/2023 with diagnoses including dementia. House Manager C told Surveyor Resident 2 had orders for both scheduled and PRN medications for constipation. Resident 2's current practitioner's orders included, "Polyethylene [glycol] powder. Mix 17 gm [grams] in 8 oz of liquid and drink once daily for constipation." This medication was changed from ordered "as needed" to scheduled on

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N 352	Continued From page 6 "07/08/2024." Resident 2's MARs were reviewed from July 2024 through November 2024. The caregiver documentation within Resident 2's July 2024 through November 2024 MARs included daily administration of Resident 2's polyethylene glycol, as ordered, with the exception of 1 dose not administered on 10/28/2024 without a documented reason/rationale. The caregiver documentation within Resident 2's July 2024 through November 2024 MARs did not include documentation of any "as needed' bowel medications being administered to Resident 2. On 11/14/2024 at 1:12 P.M., House Manager C handed Surveyor a handwritten note and told Surveyor s/he called and spoke to Resident 2's pharmacy regarding the last 2 deliveries of Resident 2's scheduled polyethylene glycol 30 day dose containers to the facility. House Manager C told Surveyor Resident 2's polyethylene glycol was delivered, as ordered, to the facility on 07/08/2024 and then on 08/21/2024, as documented on Resident 1's only remaining polyethylene glycol container. House Manager C told Surveyor the last container of Resident 2's "as needed" polyethylene glycol was delivered to the facility on 09/23/2023 and would be expired. On 11/14/2024 at approximately 3:15 P.M., Operations Manager B, House Manager C, and Surveyor observed Resident 2's polyethylene glycol container, dated 08/21/2024. Operations Manager B verbally confirmed the date included within Resident 2's pharmacy label and the amount remaining within the container. House Manager C verbally confirmed there were no additional containers of Resident 2's polyethylene glycol at the facility. House Manager C told Surveyor the pharmacy did not automatically refill	N 352		

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N 352	Continued From page 7 Resident 2's polyethylene glycol monthly, like most oral medications. House Manager C said the caregivers/medication passers were to request a new, full container of Resident 2's polyethylene glycol to be delivered from the facility when the current container was close to empty. On 11/14/2024 at 3:30 P.M., Surveyor conducted an exit conference with Licensee/Administrator A, Operations Manager B, and House Manager C. Licensee/Administrator A told Surveyor the concern with medication administration, including administration of polyethylene glycol, would be reviewed with the caregivers/medication passers and corrected.	N 352		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation and interview the provider did not safeguard residents from environmental hazards to which it is likely the residents will be exposed. The facility's front entrance/exit passageway utilized by residents, visitors, and caregivers	N 358		

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N 358	Continued From page 8 included one concrete slab positioned approximately 1.5 to 2 inches higher than next concrete slab directly placed in front of the doorway. This difference in height could pose a potential tripping hazard for ambulatory residents and a hindrance in the safe movement with the use of mobility devices. The findings include: The facility may serve up to 20 ambulatory, semi-ambulatory, and/or non-ambulatory residents of advanced age and/or had diagnoses including irreversible dementia/Alzheimer's disease. On 11/14/2024 at 12:00 P.M., Operations Manager B and Surveyor observed the facility's entrance passageway leading to and from the facility's front door, including concrete slabs. Surveyor observed a concrete slab positioned approximately 1.5 to 2 inches lower in placement than the next concrete slab leading directly to and from the front door. Surveyor observed a piece of yellow tape placed at the edge of the lower concrete slab. Operations Manager B told Surveyor the facility's front door and passageway were one of two emergency exits leading from the facility. Photos #1 and #2. On 11/14/2024 at 12:20 P.M., House Manager C told Surveyor s/he placed the yellow tape on the concrete slab leading to and from the facility's entrance to show there was a height difference between the two concrete slabs so no one would trip while utilizing this passageway. House Manager C told Surveyor s/he did not notify anyone in management, including maintenance staff, to request repair of the difference in height between the concrete slabs.	N 358		

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N 358	Continued From page 9 On 11/14/2024 at 3:30 P.M., Surveyor conducted an exit conference with Licensee/Administrator A, Operations Manager B, and House Manager C. Licensee/Administrator A told Surveyor the front entrance/exit passageway concrete slab would be fixed as soon as possible.	N 358		