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 _____	R 03/24/2025

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 03/24/2025, the Bureau of Assisted Living, Southern Regional Office conducted a verification visit of statement of deficiency (SOD) NNWT11 at Sienna Crest Fort Atkinson, located at 1531 Commonwealth Drive in Fort Atkinson, WI. One citation of noncompliance was issued, a repeat violation. Census: 18 Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{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, Resident 3, Resident 4, Resident 5, and Resident 6 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1's, Resident 3's, Resident 4's, and Resident 5's polyethylene glycol was not administered, as ordered. Resident 6's Refresh eye drops were not administered, as ordered. This requirement is being cited for the second	{N 352}		

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

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{N 352}	Continued From page 1 time. See Statement of Deficiency (SOD) NNWT11, issued 01/27/2025. The findings include: On 03/24/2025 at approximately 1:48 P.M., Surveyor conducted an interview with House Manager E. House Manager E told Surveyor all of the facility's residents required medication administration from caregivers. Example 1: Resident 1's polyethylene glycol On 03/24/2025 at approximately 1:50 P.M., Surveyor and House Manager E observed Caregiver F remove a container of Gavilax (polyethylene glycol) labeled with Resident 1's name from the medication cart. Surveyor observed Caregiver F open the container and Surveyor observed the container with approximately one quarter of the medication remaining. 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." 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, "02/03/25 [2025]." Caregiver F told Surveyor s/he was unable to tell when this container was initially opened for administration after being delivered by the pharmacy. Surveyor observed Resident 1's polyethylene glycol container did not include a documented date the container was initially opened for administration. Photos #1, #2, and #3. Caregiver F told Surveyor Resident 1 was to be administered 17 grams of the polyethylene glycol	{N 352}		

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{N 352}	Continued From page 2 daily and did not normally refuse/decline medication administration. Caregiver F told Surveyor there were no additional containers of Resident 1's polyethylene glycol at the facility. House Manager E told Surveyor lead caregivers were required to request a new, full container of Resident 1's polyethylene glycol to be delivered from the pharmacy when the current container was close to empty.. On 03/24/2025, House Manager E 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 11/20/2024 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]." 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 05/20/2022. Resident 1's MARs were reviewed from 02/04/2025 through 03/24/2025. The caregiver documentation within this time frame included daily administration of Resident 1's polyethylene glycol, as ordered, for a total of 44 of 49 potential doses from a 30 once-daily dose container. The caregiver documentation within Resident 1's February 2025 and March 2025 MARs did not include "as needed" administration documentation of Resident 1's PRN "senna/docusate."	{N 352}		

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{N 352}	Continued From page 3 On 03/24/2025 at approximately 3:32 P.M., Surveyor conducted an interview with Pharmacy Staff G regarding the last 2 deliveries of Resident 1's polyethylene glycol 30 once-daily dose containers to the facility. Pharmacy Staff G told Surveyor Resident 1's polyethylene glycol was delivered, as ordered, to the facility on 01/06/2025 and lastly on 02/03/2025, as included on Resident 1's polyethylene glycol container. Staff G told Surveyor a request for refill of this medication was overdue, if administered to Resident 1 as prescribed daily since it was last delivered. Staff G told Surveyor the facility was required to request a refill of Resident 1's polyethylene glycol medication as it was not a 'cycle-fill' medication. Example 2: Resident 3's polyethylene glycol On 03/24/2025 at approximately 1:48 P.M., Surveyor and House Manager E observed Caregiver F remove a container of polyethylene glycol labeled with Resident 3's name and room number from the medication cart. Surveyor observed Caregiver F open the container and Surveyor observed the container with approximately one third of the medication remaining. The container included the manufacturer's brand label, "Rugby polyethylene glycol 3350 powder for oral solution, osmotic laxative" and "Net Wt [weight] 17.9 oz [ounces] (510 g [grams]) 30 Once-Daily Doses." Surveyor observed the pharmacy label attached to the container included, "Mix 17 GM [grams] (one capful) in 8 oz of liquid and drink every morning for constipation" and included the date, "02/07/25 [2025]." Caregiver F told Surveyor s/he was unable to tell when this container was initially opened for administration after being delivered by	{N 352}		

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{N 352}	Continued From page 4	{N 352}		

the pharmacy. Surveyor observed Resident 3's polyethylene glycol container did not include a documented date the container was initially opened for administration. Photos #4, #5, and #6.
Caregiver F told Surveyor Resident 3 was to be administered 17 grams of the polyethylene glycol daily and did not normally refuse/decline medication administration. Caregiver F told Surveyor there were no additional containers of Resident 3's polyethylene glycol at the facility. House Manager E told Surveyor lead caregivers were required to request a new, full container of Resident 3's polyethylene glycol to be delivered from the pharmacy when the current container was close to empty..

On 03/24/2025, House Manager E provided Surveyor with Resident 3's current individual service plan (ISP), practitioner's orders, and medication administration records [MARS]. Resident 3 was admitted to the facility on 02/21/2024 with diagnoses including heart disease and diabetes. Resident 1's current ISP dated 02/19/2025 included, "staff administers medications" and "...is incontinent with [his/her] bladder and bowel and wears Depends [incontinence product], but is able to self manages [sic]." Resident 1's ISP included, "[Resident 3] experiences occasional constipation with evidence of [him/her] verbally telling [caregivers]. Staff will administer PRN [as needed medication]..." and "When [Resident 3] says [s/he] [staff] [s/he] feels constipated staff will administer laxative [a medication for constipation] as directed by dr [doctor/practitioner]." Resident 3's current practitioner's orders included, "Polyethylene [glycol] powder. Mix 17 gm [grams] (one capful) in 8 oz of liquid and drink every morning for constipation." This medication was

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{N 352}	Continued From page 5 originally ordered on 02/07/2025. Resident 3's MARs were reviewed from 02/08/2025 through 03/24/2025. The caregiver documentation within this time frame included daily administration of Resident 3's polyethylene glycol, as ordered, for a total of 45 of 45 potential doses from a 30 once-daily dose container dated 02/07/2025. The caregiver documentation within Resident 3's February 2025 and March 2025 MARs did not include "as needed" administration documentation of Resident 1's PRN laxative medication. On 03/24/2025 at approximately 3:32 P.M., Surveyor conducted an interview with Pharmacy Staff G regarding delivery of Resident 3's polyethylene glycol 30 once-daily dose container to the facility. Pharmacy Staff G told Surveyor Resident 3's polyethylene glycol was delivered, as ordered, to the facility on 02/07/2025. Staff G told Surveyor this was the only delivery since this medication was ordered for Resident 3 on 02/07/2025. Staff G told Surveyor a request for refill of this medication was overdue, if administered to Resident 3 as prescribed daily since it was last delivered. Staff G told Surveyor the facility was required to request a refill of Resident 3's polyethylene glycol medication as it was not a 'cycle-fill' medication. Example 3: Resident 4's polyethylene glycol On 03/24/2025 at approximately 1:51 P.M., Surveyor and House Manager E observed Caregiver F remove a container of polyethylene glycol labeled with Resident 4's name from the medication cart. Surveyor observed Caregiver F open the container and Surveyor observed the container with approximately one quarter of the medication remaining. The container included	{N 352}		

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{N 352}	Continued From page 6	{N 352}		

the manufacturer's brand label, "Rugby polyethylene glycol 3350 powder for oral solution, osmotic laxative" and "Net Wt [weight] 17.9 oz [ounces] (510 g [grams]) 30 Once-Daily Doses." 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 *Hold for loose stools [bowel movement]*" and included the date, "02/17/25 [2025]." Caregiver F told Surveyor s/he was unable to tell when this container was initially opened for administration after being delivered by the pharmacy. Surveyor observed Resident 4's polyethylene glycol container did not include a documented date the container was initially opened for administration. Photos #7, #8, and #9.
Caregiver F told Surveyor Resident 4 was to be administered 17 grams of the polyethylene glycol daily and did not normally refuse/decline medication administration. Caregiver F told Surveyor there were no additional containers of Resident 4's polyethylene glycol at the facility. House Manager E told Surveyor lead caregivers were required to request a new, full container of Resident 4's polyethylene glycol to be delivered from the pharmacy when the current container was close to empty..

On 03/24/2025, House Manager E provided Surveyor with Resident 4's current individual service plan (ISP), practitioner's orders, and medication administration records [MARS]. Resident 4 was admitted to the facility on 07/15/2024 with diagnoses including dementia. Resident 4's current ISP dated "05/17/2024 [sic]" included, "[Resident 4] is continent bowel and has some incontinence of bladder and will need assistance toileting." Resident 1's ISP included, "[Resident 4] may experience constipation. May give [him/her] Milk of Magnesia [laxative

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medication]" and "Staff to administer Milk of Magnesia for constipation as prescribed by MD [medical doctor]." House Manager E told Surveyor Resident 4's ISP would need to be updated to include accurate care and services information. Resident 4's current practitioner's orders included, "Polyethylene [glycol] powder. Mix 17 gm [grams] in 8 oz of liquid and drink once daily for constipation *Hold for loose stools*" originally ordered 07/15/2024 and Senna/docusate [bowel medication] 8.6/50 mg [milligrams], take 1 to 2 tablets by mouth every 12 hours as needed." Resident 4's MARs were reviewed from 02/17/2025 through 03/24/2025. The caregiver documentation within this time frame included daily administration of Resident 4's polyethylene glycol, as ordered, for a total of 36 of 36 potential doses from a 30 once-daily dose container. The caregiver documentation within Resident 4's February 2025 MAR included a total of 5 doses of Senna/docusate "as needed" administered to Resident 4 between 02/08/2025 and 02/28/2025, documented as "02/08/[2025] at 5:00 P.M., 02/09/[2025] at 4:50 P.M., 02/25/[2025] at 8:00 A.M., 02/25/[2025] at 8:00 P.M., and 02/28/[2025] at 5:10 P.M." House Manager E reviewed the caregiver documentation related to each administration of Resident 4's "as needed" Senna/docusate on Resident 4's February 2025 MAR and told Surveyor each dose was administered in response to Resident 4's complaints of constipation. Resident 4's March 2025 MAR did not include "as needed" administration documentation of Resident 4's PRN "Senna/docusate."

On 03/24/2025 at approximately 3:32 P.M., Surveyor conducted an interview with Pharmacy Staff G regarding the last 2 deliveries of Resident 4's polyethylene glycol 30 once-daily dose

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{N 352}	Continued From page 8 containers to the facility. Pharmacy Staff G told Surveyor Resident 4's polyethylene glycol was delivered, as ordered, to the facility on 12/20/2024 and lastly on 02/17/2025, as included on Resident 4's polyethylene glycol container. Staff G told Surveyor a request for refill of this medication was overdue, if administered to Resident 4 as prescribed daily since it was last delivered. Staff G told Surveyor the facility was required to request a refill of Resident 4's polyethylene glycol medication as it was not a 'cycle-fill' medication. Example 5: Resident 5's polyethylene glycol On 03/24/2025 at approximately 1:53 P.M., Surveyor and House Manager E observed Caregiver F remove a container of polyethylene glycol labeled with Resident 5's name from the medication cart. Surveyor observed Caregiver F open the container and Surveyor observed the container with approximately one half of the medication remaining. The container included the manufacturer's brand label, "Rugby polyethylene glycol 3350 powder for oral solution, osmotic laxative" and "Net Wt [weight] 17.9 oz [ounces] (510 g [grams]) 30 Once-Daily Doses." Surveyor observed the pharmacy label attached to the container included, "Mix 17 GM [grams] in 8 oz of liquid and drink every morning for bowel management" and included the date, "02/17/25 [2025]." Caregiver F told Surveyor s/he was unable to tell when this container was initially opened for administration after being delivered by the pharmacy. Surveyor observed Resident 5's polyethylene glycol container did not include a documented date the container was initially opened for administration. Photos #10 and #11. Caregiver F told Surveyor Resident 5 was to be administered 17 grams of the polyethylene glycol	{N 352}		

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daily and did not normally refuse/decline medication administration. Caregiver F told Surveyor there were no additional containers of Resident 5's polyethylene glycol at the facility. House Manager E told Surveyor lead caregivers were required to request a new, full container of Resident 5's polyethylene glycol to be delivered from the pharmacy when the current container was close to empty.

On 03/24/2025, House Manager E provided Surveyor with Resident 5's current individual service plan (ISP), practitioner's orders, and medication administration records [MARS]. Resident 5 was admitted to the facility on 03/06/2023 with diagnoses including dementia and history of polio. Resident 5's current ISP dated 01/14/2025 included, "staff administers medications" and "...is continent of both bladder and bowels..." Resident 5's ISP included, "[Resident 5] at times has issues with constipation with signs of [him/her] not going staff will administer PRN [as needed medication]" and "Staff will offer foods high in fiber and when having issues with constipation on the 2nd day staff will administer docusate Senna-docusate [a medication for constipation] as directed by dr [doctor/practitioner]." Resident 5's current practitioner's orders included, "Polyethylene [glycol] powder. Mix 17 gm [grams] in 8 oz of liquid and drink every morning for bowel management." This medication was originally ordered on 03/02/2023. Resident 5's MARs were reviewed from 02/17/2025 through 03/24/2025. The caregiver documentation within this time frame included daily administration of Resident 5's polyethylene glycol, as ordered, for a total of 36 of 36 potential doses from a 30 once-daily dose container. The caregiver documentation within Resident 5's February 2025 and March

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{N 352}	Continued From page 10 2025 MARs did not include "as needed" administration documentation of Resident 5's PRN "Senna/docusate." On 03/24/2025 at approximately 3:32 P.M., Surveyor conducted an interview with Pharmacy Staff G regarding the last 2 deliveries of Resident 5's polyethylene glycol 30 once-daily dose containers to the facility. Pharmacy Staff G told Surveyor Resident 5's polyethylene glycol was delivered, as ordered, to the facility on 01/14/2025 and lastly on 02/17/2025, as included on Resident 5's polyethylene glycol container. Staff G told Surveyor a request for refill of this medication was overdue, if administered to Resident 5 as prescribed daily since it was last delivered. Staff G told Surveyor the facility was required to request a refill of Resident 5's polyethylene glycol medication as it was not a 'cycle-fill' medication. Example 6: Resident 6's eye drops On 03/24/2025 at approximately 1:57 P.M., Surveyor and House Manager E observed Caregiver F remove a container of Refresh Tears lubricating eye drops labeled with Resident 6's name from a plastic bag located in the medication cart. Surveyor observed Caregiver F shake the container and told the container was approximately full of the liquid medication. Surveyor observed House Manager E shake the container and s/he told Surveyor the container was "pretty much full." The container included the manufacturer's label, "Refresh Tears Lubricant Eye Drops" and "0.5 fl [fluid] oz [ounces] (15 mL [milliliters]) Sterile." Surveyor observed the pharmacy label attached to the container and bag included, "Instill 1 drop into both eyes every morning for dry eyes" and	{N 352}		

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included the date, "01/08/25 [2025]." The bag included a second affixed pharmacy label including an "as needed" order of "Instill 1 drop into both eyes every 6 hours as needed for dry eyes." Caregiver F told Surveyor s/he was unable to tell when this container was initially opened for administration after being delivered by the pharmacy. Surveyor observed Resident 6's eye drops container did not include a documented date the container was initially opened for administration. Photos #12, #13, #14, and #15. Caregiver F told Surveyor Resident 6 was to be administered 1 drop of this medication into both eyes once a day and did not normally refuse/decline medication administration. House Manager E told Surveyor lead caregivers were required to request a new, full container of Resident 6's Refresh eye drops to be delivered from the pharmacy when the current container was close to empty.

At 3:48 P.M., House Manager E told Surveyor s/he located another container of Resident 6's Refresh eye drops located in the medication storage room. Surveyor observed the container included the manufacturer's label, "Refresh Tears Lubricant Eye Drops" and "0.5 fl [fluid] oz [ounces] (15 mL [milliliters]) Sterile." Surveyor observed the pharmacy label attached to the container included, "Instill 1 drop into both eyes every morning for dry eyes" and included the date, "02/17/25 [2025]." The bag included a second affixed pharmacy label including an "as needed" order of "Instill 1 drop into both eyes every 6 hours as needed for dry eyes." Surveyor observed the container included an intact/unbroken seal indicating the container had not been opened. Photos #16, #17, and #18. House Manager E told Surveyor it was clear Resident 6 had not been administered Refresh eye drops, as prescribed, based on the amount

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SIENNA CREST FORT ATKINSON	1531 COMMONWEALTH DR FORT ATKINSON, WI 53538

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{N 352}	Continued From page 12	{N 352}		

left in the opened bottle and the other bottle remaining sealed/unopened.

On 03/24/2025, House Manager E provided Surveyor with Resident 6's current individual service plan (ISP), practitioner's orders, and medication administration records [MARS]. Resident 6 was admitted to the facility on 01/27/2022 with multiple diagnoses including dementia and Parkinson's disease. Resident 6's current ISP dated 01/14/2025 included, "staff administers medications" and "[Resident 6] at times has issue with dry eyes with [him/her] verbally telling [caregivers] and has a PRN for this." Resident 6's ISP included, "When [s/he] tells staff that [s/he] has dry eyes staff will offer Artificial Tear's as directed by dr [doctor/practitioner]." Resident 6's current practitioner's orders included, "Refresh Tears 0.5 % eye drop, instill 1 drop into both eyes every morning for dry eyes." This medication was originally ordered on 04/01/2024. Resident 6's MARs were reviewed from 01/08/2025 through 03/24/2025. The caregiver documentation within this time frame included daily administration of Resident 6's Refresh eye drops, as ordered, for a total of 68 of 75 potential doses from an approximately full 15 ml container dated 01/08/2024. In regard to the 7 doses not documented by caregivers as being administered within this timeframe, the caregiver documentation included 7 dates between 02/01/2025 and 03/24/2025 in which this medication was sent with Resident 6 on an outing from the facility. The caregiver documentation within Resident 6's January 2025, February 2025, and March 2025 MARs did not include "as needed" administration documentation of this medication for Resident 6. House Manager E told Surveyor Resident 6 did go on outings from

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 _____	R 03/24/2025

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

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{N 352}	Continued From page 13 the facility in which Resident 6's medications were sent with Resident 6 and the caregivers would not know whether Resident 6 actually received administration of the Refresh eye drops. On 03/24/2025 at approximately 3:32 P.M., Surveyor conducted an interview with Pharmacy Staff G regarding the last 2 deliveries of Resident 6's Refresh eye drop containers to the facility. Pharmacy Staff G told Surveyor a 15 ml container of Resident 6's Refresh eye drops was delivered, as ordered, to the facility on 01/08/2025, as dated on the container. Staff G told Surveyor a 15 ml container of Refresh eye drops was delivered to the facility on 02/17/2025 because the pharmacy had received a continuation order for this medication and not the result of being requested by the facility. Staff G told Surveyor each 15 ml container of Refresh eye drops would contain approximately 24 days worth of eye drops, if administered 1 drop into both eyes as prescribed daily for Resident 6 and sooner if any "as needed" doses were administered. Staff G told Surveyor a request for refill of this medication was overdue, if administered to Resident 6 as prescribed daily since it was last delivered on 02/17/2025. Staff G told Surveyor the facility was required to request a refill of Resident 6's Refresh eye drop medication as it was not a 'cycle-fill' medication. On 03/24/2025 at approximately 4:10 P.M., Surveyor conducted an interview with Licensee/Administrator A and House Manager E. Licensee/Administrator A told Surveyor Director of Operations H provided training for the caregivers which included information about this citation of noncompliance including with SOD NNWT11. Licensee/Administrator A said the caregiver should have been "on their game."	{N 352}		

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{N 352}	Continued From page 14 Licensee/Administrator A told Surveyor Former House Manager C was terminated from employment and House Manager E had been in his/her position for approximately 1 week. Licensee/Administrator A told Surveyor House Manager E would provide documentation of the training provided by Director of Operations H. House Manager E provided Surveyor with a document titled, "02/25/2025 training - corrective measures 2 hours in length with staff at [facility]." The documentation included, "Medication review and state notice of violation and imposed order SOD #NNWT11." The documentation included, "Reviewed resident rights in medication administration. Alternative plans for other medication situations such as resident refusing meds [medications]. Medications will be given as ordered per prescriber. The physician will be contacted to provide alternate orders if resident refuses medications on a consistent bases or leaves medication after mixing the poly [polyethylene glycol] for him/her. Additional medication information provided for staff to prevent medication errors was discussed and reviewed. See attached [university] training information used for best practices. MARs reviewed and staff questions answered. Reviewed individual residents. Staff will report to manager any concerns with resident medications and/or repeated medication refusals. Manager will provide information to provider."	{N 352}		