

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016888	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/22/2025
NAME OF PROVIDER OR SUPPLIER BELOIT SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2250 W HART RD BELOIT, WI 53511		
(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
U 000	INITIAL COMMENTS On 01/22/2025, Surveyor conducted an abbreviated survey and complaint investigation at Beloit Senior Living. One deficiency was identified. The complaint was unsubstantiated. Census: 44	U 000		
U 118	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure 2 of 2 Tenant records reviewed received all prescribed medications in the dosage and at intervals prescribed by a practitioner.	U 118		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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U 118	Continued From page 1 Tenant 1 and Tenant 2 did not receive polyethylene glycol as prescribed. Findings include: On 01/22/2025, Surveyor conducted an abbreviated survey and identified the following: Example 1: Tenant 1 On 01/22/2025 at 9:18 AM, Surveyor observed the provider's 2 medication carts with Administrator A located in the facility's medication room. Tenant 1's polyethylene glycol container noted a manufacturer's label including the container originally held 30 once-daily doses of 17 grams. The container included a pharmacy label including Tenant 1's practitioner's prescription for polyethylene glycol including, "Mix 17 grams (fill cap to line) in 8 oz of liquid. Stir well, and drink daily for constipation may increase to 2 capful daily if constipation not improving." The pharmacy label included a delivery date to the facility of 08/07/2024. Surveyor observed approximately ¼ of the medication remained within the container. Administrator A verbally confirmed same amount remained. Administrator A was able to find another container of polyethylene glycol with a delivery date to the facility of 01/13/2025. The pharmacy label included the same above directions. Surveyor observed approximately 2/3 of the medication remained within the container. Administrator A reported staff must be using the most current polyethylene glycol container, but could not speak to why the August 2024 container was still in the medication cart. Administrator A stated s/he would call the pharmacy. On 01/22/2025, Surveyor reviewed Tenant 1's	U 118			

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U 118	Continued From page 2 record. Tenant 1 was admitted to the facility on 02/01/2019 with diagnosis including chronic kidney disease stage 2, hypertension, and overactive bladder. A review of Tenant 1's August 2024-January 12th, 2025, medication administrator records (MARs) included Tenant 1 was administered 91 doses of 164 days between 08/01/2024 and 01/12/2025. Example 2: Tenant 2 On 01/22/2025 at 9:18 AM, Surveyor observed the provider's 2 medication carts with Administrator A located in the facility's medication room. Tenant 2's polyethylene glycol container noted a manufacturer's label including the container originally held 30 once-daily doses of 17 grams. The container did not have a cap and a pharmacy label including Tenant 2's practitioner's prescription for polyethylene glycol including, "Mix 17 grams (fill cap to line) in 8 oz of liquid. Stir well, and drink daily for constipation may increase to 2 capfuls daily if constipation not improving." The pharmacy label included a delivery date to the facility of 04/14/2023. Administrator A verbally confirmed same amount remained. Administrator A was able to find another container of polyethylene glycol with a delivery date to the facility of 04/25/2024. This container was not opened. Administrator A stated s/he would call the pharmacy. On 01/22/2025 at 1:03 PM, Surveyor interviewed Administrator A about Tenant 1's and Tenant 2's polyethylene glycol. Administrator A reported after speaking to the pharmacy, Tenant 1's polyethylene glycol was delivered from the pharmacy on 08/07/2024 and 01/13/2025. Administrator A acknowledged Tenant 1's polyethylene glycol container from 08/07/2024	U 118			

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U 118	Continued From page 3 was a 1-month supply and if administered as prescribed, the container would have been emptied on approximately 09/07/2024. Administrator A reported Tenant 2's polyethylene glycol was changed to as needed on 01/10/2025. Administrator A reported s/he could not explain why Tenant 2's polyethylene glycol from April 2023 was still in the medication cart. Administrator A stated s/he looked over Tenant 2's 2023 MARs and some days were documented as refused. Administrator A reported s/he was assuming staff were documenting as given, without administering the medication, but could not be certain without investigating further.	U 118		