STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019678	A. BUILDING: _____ B. WING _____	C 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDENRIDGE MUKWONAGO	841 E VETERANS WAY MUKWONAGO, WI 53149

(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 12/18/2025, Surveyor conducted 1 complaint investigation at LindenRidge Mukwonago. One deficiency was identified. The deficiency was a repeat violation, see Statement Of Deficiency (SOD) DCBV11, dated 07/30/2024, and SOD CSDD11, dated 04/23/2025. The complaint was substantiated. Census: 45	U 000		
U 267	89.34(16) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse medication unless there is a court order.	U 267		

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

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U 267	Continued From page 1	U 267		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the tenant's right to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician.

On 11/17/2025, staff did not administer Tenant 1's physician ordered bedtime medications.

This is a repeat violation. See Statement Of Deficiency (SOD) DCBV11, dated 07/30/2024, and
SOD CSDD11, dated 04/23/2025.

Findings include:

On 11/19/2025, the Department received a complaint alleging medications were not administered as ordered by the physician.

On 12/18/2025, Surveyor conducted an onsite investigation.

On 12/18/2025, at 9:40 AM, Surveyor interviewed Tenant 1 who stated on 11/14/2025, s/he did not receive his/her bedtime medications. Tenant 1 stated on 11/14/2025 when s/he asked staff for his/her medications staff said because the medications were already signed out as administered they could not administer them to him/her. Tenant 1 stated the PRN (as needed) pain medication was included in the signed-out medications, so s/he endured pain in the base of his/her neck.

On 12/18/2025, Surveyor reviewed the facility's Medication Error report dated 11/20/2025: " ...Nursing Description: it [sic] was reported to this writer that the resident did not receive [his/her]

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medications on Friday 11/7/2025 [sic] PM. Resident Description: I did not get my afternoon meds or my night time [sic] meds or my night time pain pill on Friday 11/7/2025 [sic] ...Immediate Action Taken: Investigation pending. Medication was signed out but not given. [primary care physician] aware ..."

On 12/18/2025, Surveyor reviewed Tenant 1's record. S/he was admitted 09/18/2017.

Physician orders included: diltiazem HCL ER 180 MG 1 capsule at bedtime for atrial fibrillation (start date 02/14/2025); pravastatin sodium 40 MG 1 tablet at bedtime for high cholesterol (start date 02/10/2025); and hydrocodone-acetaminophen 5-325 MG 1 tablet every 8 hours as needed (PRN) for pain (start date 09/21/2025).

November 2025 Medication Administration Record (MAR):
On 11/14/2025, the MAR was blank for 7:00 PM/HS (bedtime) diltiazem HCL ER 180 MG, pravastatin sodium 40 MG, and PRN hydrocodone-acetaminophen 5-325 MG.

Care Plan dated 11/19/2025:
In the area of Medications- " ...Will be supported to take all medications safely and as ordered ..."

On 12/18/2025 at 10:26 AM, Surveyor interviewed Director of Nursing B who stated on 11/20/2025, s/he was alerted by staff that Tenant 1 was upset. Director of Nursing B met with Tenant 1 who told Director of Nursing B that s/he had not received his/her PM medications on Friday 11/20/2025. Director of Nursing B stated s/he interviewed Nurse Supervisor C who stated s/he had gone to Tenant 1's apartment to administer medications but since Tenant 1 was

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not ready, Nurse Supervisor C took the medications to his/her office then forgot to administer them to Tenant 1. Director of Nursing B stated afterwards, Nurse Supervisor C was assigned to administer medications for extra training in the 5 rights of medication administration and to get accustomed to the medication administration time frames.

On 12/18/2025 at 10:42 AM, Surveyor discussed concern of medications not administered as ordered by the physician with Executive Director A who stated the concern was straight forward and appropriate.

On 12/18/2025 at approximately 10:50 AM, Surveyor interviewed Nurse Supervisor C who stated on Friday 11/14/2025, s/he was passing medication on the PM shift. Nurse Supervisor C stated s/he knocked on Tenant 1's apartment door asking if s/he was ready for his/her medications and Tenant 1 replied s/he was. Nurse Supervisor C stated s/he then prepped Tenant 1's medications and documented them as administered and returned to Tenant 1's apartment with the medications. Nurse Supervisor C stated when s/he knocked on Tenant 1's apartment door with the medications, Tenant 1 stated s/he was in the bathroom, so Nurse Supervisor C took the medications to his/her office and forgot to return to Tenant 1 with them. Nurse Supervisor C stated s/he made the mistake of signing the medications out on the MAR before they were administered and should have put the medications in the medication cart with a note instead of taking them to his/her office.

On 12/ 23/2025 at 12:45 PM, Surveyor interviewed Executive Director A and Nurse

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U 267	Continued From page 4 Consultant D. Nurse Consultant D verified the medication error involving Tenant 1's bedtime medications occurred on 11/14/2025. When Surveyor asked why Tenant 1 was denied bedtime medications on 11/14/2025 when the MAR was left blank, Nurse Consultant D stated Nurse Supervisor C probably documented administration of those medications then after realizing s/he had not administered them, cleared the MAR of that documentation. Nurse Consultant D stated s/he would have directed Nurse Supervisor C to clear the documentation so the MAR accurately identified the medications were not administered.	U 267		