

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017742	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/26/2024
NAME OF PROVIDER OR SUPPLIER VESTA MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3965 BRADEE RD BROOKFIELD, WI 53005		
(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 03/20/2024, with information gathered through 03/26/2024, the Bureau of Assisted Living, Southern Regional Office conducted an standard licensing survey of Vesta Memory Care located at 3965 Bradee Road in Brookfield, WI. One citation of noncompliance was issued. Census: 7	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 and Resident 2's polyethylene glycol [powdered laxative medication to treat constipation] was not administered, as prescribed. The findings include: Example 1: Resident 1 On 03/20/2024 at 11:42 A.M., House Manager/Caregiver (Caregiver) B told Surveyor	N 352		

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

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N 352	Continued From page 1 Resident 1 took polyethylene glycol, as scheduled, every morning mixed in liquid to help him/her with having regular bowel movements. Caregiver B told Surveyor Resident 1 was incontinent of bowel and experienced bowel movements approximately every other day. Caregiver B told Surveyor Resident 1 required full assistance with all cares, including incontinence care. On 03/20/2024 at 11:48 A.M., Surveyor conducted an interview with Caregiver B including observations of the facility's medication cart located near the facility's kitchen. Surveyor observed Caregiver B remove a container of polyethylene glycol labeled with Resident 1's name from the medication cart. Caregiver B told Surveyor this container was the only container of polyethylene glycol currently available at the facility for Resident 1. The manufacturer's label, "Rugby," was affixed to the container. The label included, "Polyethylene Glycol 3350 Powder for Solution" and "Net Wt [weight] 17.9 oz [ounces] (510 g [grams] 30 Once-Daily Doses." (Photo #2) Surveyor observed the pharmacy label affixed to the container included, "Dissolve 1 capful (17 grams) in 8 ounces liquid and drink daily for constipation" and included the date dispensed by the pharmacy to the facility, "01/02/2024." (Photo #1) Surveyor observed Caregiver B open Resident 1's container of polyethylene glycol and place it on top of the medication cart. Surveyor observed the container was practically full of powder and Caregiver B verbally agreed to the amount remaining in the container. Caregiver B told Surveyor s/he did not know when the container was initially opened for administration to Resident 1 as the container was not dated with an 'opened' date. Caregiver B verbally acknowledged the date of 01/02/2024 included on	N 352		

Wisconsin Department of Health Services

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N 352	Continued From page 2 the pharmacy label was almost 3 months out and the container was almost full. Caregiver B told Surveyor Resident 1 did not refuse medication administration. On 03/20/2024, Surveyor reviewed Resident 1's record, as provided by Licensee A. Resident 1 was admitted to the facility on 06/26/2023 with diagnoses including cognitive impairment and constipation. Resident 1's current individual service plan (ISP) included, "Medication management: Requires all medications administered and monitored by staff. Administer PRN [as needed] medications if indicated by verbal or non-verbal indicators." Resident 1's current practitioner orders included, "Polyethylene glycol 3350 powd (Miralax powder) Oral (by mouth). Dissolve 1 capful (17 grams) in 8 ounces liquid and drink daily for constipation." Resident 1's current practitioner orders included an 'as needed' bowel prescription, "Bisacodyl 10 mg [milligram] suppository (Dulcolax 10 mg suppository) rectal (rectum). Unwrap and insert one suppository rectally daily as needed for constipation. Only RN [registered nurse] can administer." Resident 1's January 2024 medication administration record (MAR) included documentation of administration of Resident 1's polyethylene glycol, as prescribed, daily from 01/01/2024 through 01/31/2024. Resident 1's February 2024 MAR included documentation of administration of Resident 1's polyethylene glycol, as prescribed, daily from 02/02/2024 through 02/29/2024. One prescribed dose on 02/01/2024 was left blank on Resident 1's February 2024 MAR. Resident 1's March 2024 MAR included documentation of administration of Resident 1's polyethylene glycol, as prescribed, daily from 03/01/2024 through 03/20/2024, with the	N 352		

Wisconsin Department of Health Services

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N 352	Continued From page 3 exception of 03/12/2024 which was left blank. On 03/20/2024 at 11:53 A.M., Surveyor reviewed Resident 1's bowel movement documentation for March 2024, as provided by Caregiver B. The documentation included one bowel movement documented on 03/01/2024 and no further bowel movement documented until 7 days later on 03/08/2024 and, again, on 03/09/2024. At 11:39 A.M., Caregiver C told Surveyor an 'as needed' bisacodyl suppository was administered to Resident 1 on 03/08/2024 because Resident 1 had not had a bowel movement for several days. Surveyor reviewed Resident 1's March 2024 MAR, including 'as needed' bowel medication documentation. Resident 1's March 2024 MAR included documentation of Resident 1's 'as needed' prescription of bisacodyl 10 mg was administered by a RN on 03/08/2024 at 1:08 P.M. for "constipation." The documentation related to "effectiveness of PRN medication" included, "No relief." Resident 1's bowel movement documentation included one bowel movement documented on 03/16/2024, 7 days following Resident 1's previously documented bowel movement on 03/09/2024. Resident 1's March 2024 MAR included no documentation of an "as needed" bowel movement medication administered to Resident 1's after 03/08/2024. On 03/20/2024 at 12:04 P.M., Surveyor conducted an interview with Pharmacy Staff D. Surveyor asked Pharmacy Staff D for the dates for all containers of Resident 1's scheduled daily polyethylene glycol filled by the pharmacy and delivered to the facility since Resident 1's admission to the facility. Pharmacy Staff D told Surveyor one container of polyethylene glycol, as prescribed, was delivered to the facility from the	N 352		

Wisconsin Department of Health Services

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N 352	Continued From page 4 pharmacy on or about 06/26/2023, Resident 1's admission to the facility. Pharmacy Staff D said the next container of polyethylene glycol, as prescribed, was delivered from the pharmacy to the facility on or about 08/30/2023, followed by another container, as prescribed, on 01/02/2024. Pharmacy Staff D told Surveyor the pharmacy delivered to the facility on the same day or the day after the date included on the pharmacy label affixed to Resident 1's polyethylene glycol container. Pharmacy Staff D told Surveyor Resident 1's polyethylene glycol prescription was not automatically refilled and delivered by the pharmacy on a monthly basis. Pharmacy Staff D said the facility contacted the pharmacy when a new, full container was required. On 03/20/2024 at approximately 3:15 P.M., Surveyor conducted an interview with Licensee A to discuss Resident 1's polyethylene glycol medication administration records, observations of Resident 1's current polyethylene glycol container, and the information provided by Pharmacy Staff D. Licensee A told Surveyor Resident 1 had recently experienced a significant change in condition including experiencing less bowel movements. Licensee A told Surveyor s/he was not aware of the discrepancy between the amount remaining in Resident 1's existing polyethylene glycol container and the daily documentation of administration of this medication, with few exceptions, between 01/01/2024 and this day, 03/20/2024. Licensee A told Surveyor s/he would be reviewing this situation, including having his/her facility nurse review all medications prescribed to residents. Example 2: Resident 2 On 03/20/2024 at 1:02 P.M., Surveyor conducted	N 352		

Wisconsin Department of Health Services

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N 352	Continued From page 5 an interview with Licensee A and Caregiver B including observations of the facility's medication cart located near the facility's kitchen. Caregiver B told Licensee A and Surveyor Resident 2 took polyethylene glycol, as scheduled, every morning mixed in liquid for constipation and did not refuse administration of this medication. Surveyor observed Licensee A remove two containers of polyethylene glycol labeled with Resident 2's name from the medication cart. Licensee A told Surveyor these containers were the only containers of polyethylene glycol currently available at the facility for Resident 2 as prescribed daily. The manufacturer's label, "Rugby," was affixed to each container. The label on each container included, "Polyethylene Glycol 3350 Powder for Solution" and "Net Wt [weight] 17.9 oz [ounces] (510 g [grams] 30 Once-Daily Doses." (Photos #4 and #8) Surveyor observed the pharmacy label affixed to each container included, "Dissolve 1 capful (17 grams) in 4 ounces of fluid and drink by mouth daily for constipation" and included the date dispensed by the pharmacy to the facility. The first container's pharmacy label included "10/19/2023." (Photos #3 and #5) Surveyor observed Licensee A open this container of polyethylene glycol and place it on top of the medication cart. Surveyor observed this container included approximately one third of powder remained at the bottom of the container. (Photo #6) Licensee A verbally agreed to the amount remaining in the container. Licensee A said s/he did not know when the container was initially opened for administration to Resident 2 because the container was not dated with an 'opened' date. The second container's pharmacy label included "01/04/2024." (Photos #7) Surveyor observed Licensee A remove this container of polyethylene glycol and place it on top of the medication cart.	N 352		

Wisconsin Department of Health Services

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N 352	Continued From page 6 Surveyor observed this container was unopened and the seal remained unbroken. (Photos #9 and #10) Licensee A verbally agreed this container remained sealed. On 03/20/2024, Surveyor reviewed Resident 2's record, as provided by Licensee A. Resident 2 was admitted to the facility on 10/17/2023 with diagnoses including dementia and constipation. Resident 2's current individual service plan (ISP) included, "Medication management: Requires all medications administered and monitored by staff." Resident 2's ISP included Resident 2 was incontinent of bowel movements and required assistance with incontinence care. Resident 2's current practitioner orders included, "Polyethylene glycol 3350 powd (Miralax powder) Oral (by mouth). Dissolve 1 capful (17 grams) into 4 ounces of fluid and drink daily for constipation." Resident 2's December 2023 MAR included documentation of administration of Resident 2's polyethylene glycol, as prescribed, daily from 12/01/2023 through 12/31/2023 with the exception of Resident 2's refusal to take the prescribed dose on 12/26/2023. Resident 2's January, February, and March 2024 MARs included documentation of administration of Resident 2's polyethylene glycol, as prescribed, daily from 01/01/2024 through 03/20/2024. On 03/20/2024 at 1:53 P.M., Surveyor conducted an interview with Pharmacy Staff E. Surveyor asked Pharmacy Staff E for the dates for all containers of Resident 2's scheduled daily polyethylene glycol filled by the pharmacy and delivered to the facility since Resident 2's admission to the facility. Pharmacy Staff E told Surveyor one container of polyethylene glycol, as prescribed, was delivered to the facility from the pharmacy on or about 10/19/2023, 2 days	N 352		

Wisconsin Department of Health Services

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N 352	Continued From page 7 following Resident 2's admission to the facility. Pharmacy Staff E said another container of polyethylene glycol, as prescribed, was delivered from the pharmacy to the facility on or about 01/04/2024. Pharmacy Staff E said these were the only daily dose containers of polyethylene glycol delivered to the facility since Resident 2's admission to the facility. Pharmacy Staff E told Surveyor the pharmacy delivered to the facility on the same day or the day after the date included on the pharmacy label affixed to Resident 2's polyethylene glycol containers. Pharmacy Staff E told Surveyor Resident 2's polyethylene glycol prescription was not automatically refilled and delivered by the pharmacy on a monthly basis, and the facility contacted the pharmacy when a new, full container was required. On 03/20/2024 at approximately 3:15 P.M., Surveyor conducted an interview with Licensee A to discuss Resident 2's polyethylene glycol medication administration records, observations of Resident 2's current polyethylene glycol containers, and the information provided by Pharmacy Staff E. Licensee A told Surveyor s/he was not aware of the discrepancy between the amount remaining in Resident 2's polyethylene glycol containers and the daily documentation of administration of this medication, with one exception, between 12/01/2023 and this day, 03/20/2024. Licensee A told Surveyor s/he would be reviewing this situation, including having his/her facility nurse review all medications prescribed to residents. Summary: The provider did not ensure Resident 1 and Resident 2 received all prescribed medications in the dosage and at intervals prescribed by a practitioner.	N 352		