STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020449	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEMORE VILLAGE	830 HIGH STREET WILD ROSE, WI 54984

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N 000	Initial Comments On 09/04/2025, Surveyor conducted an onsite visit to investigate one complaint. The complaint was substantiated and one deficiency was identified. Census: 39	N 000		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure Resident 1, Resident 2 and Resident 3 received medication administration appropriate to their needs; medications were not administered promptly for pain and medications scheduled three times daily were not spaced evenly. Findings include: The Department received a complaint alleging concerns with medication administration. On 09/04/2025 at 10:18 AM, Surveyor joined Caregiver A as s/he completed administration of	N 432		

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

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morning medications. Surveyor observed s/he was administering medications scheduled in the electronic medication administration record (MAR) at 8:00 AM. Caregiver A explained the provider typically adheres to a window of administering medications within 1 hour before or 1 hour after the scheduled time, however it is not uncommon for him/her to exceed that window and administer 8:00 AM medications after 10:00 AM.

SURVEYOR NOTE: "If you are told to take a medicine 3 times a day, then that usually means to take it at close to even intervals while you are awake."
Source:
https://www.drugs.com/medical-answers/you-prescription-3x-4x-day-3568810/ - retrieval date 09/08/2025

Resident 1
At 10:45 AM, Caregiver A administered 13 medications to Resident 1; all scheduled on the MAR for 8:00 AM. Surveyor noted 1 of the 13 medications was quetiapine fumarate 25 mg, scheduled on the MAR to be taken 3 times daily for schizophrenia. The scheduled times were evenly spaced every 6 hours while awake; 8:00 AM, 2:00 PM and 8:00 PM.

SURVEYOR NOTE: "Try to take Seroquel (generic - quetiapine) on a regular schedule...try to take it around the same time each morning and evening. This helps to keep a steady drug level in your body and helps the drug to work better."
Source:
https://www.healthline.com/health/drugs/seroquel-dosage#how-its-taken - retrieval date 09/08/2025

Surveyor reviewed Resident 1's August 2025

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MAR and noted the 8:00 AM dose of the medication was not consistently administered at the scheduled time or within the 1 hour window. There were also times when the 8:00 AM medication was administered late and the 2:00 PM dose was not adjusted to ensure administration was evenly spaced. Examples include:

08/01 - 9:21 AM and 1:00 PM
08/10 - 10:51 AM and 1:34 PM
08/15 - 9:34 AM and 1:15 PM
08/18 - 9:31 AM and 1:15 PM
08/22 - 10:17 AM and 1:38 PM
08/23 - 11:31 AM and 1:32 PM
08/27 - 9:34 AM and 12:55 PM
08/30 - 10:00 AM and 1:56 PM
08/31 - 9:28 AM and 12:45 PM

The MAR also documented times when the 8:00 PM dose was given later 9:00 PM (outside the 1 hour window):

08/07 - 9:18 PM
08/09 - 10:12 PM
08/10 - 9:44 PM
08/21 - 9:29 PM
08/22 - 9:57 PM
08/23 - 10:37 PM *see observation note below
08/24 - 10:14 PM

Surveyor reviewed Resident 1's observation notes at 1:09 PM and noted an entry on 08/23/2025 at 10:15 PM. The caregiver documented s/he was called to an emergency for another resident which took 30 minutes to resolve. When staff went to "finish passing bedtime meds." Resident 1 was upset his/her medication was late and "screamed at staff, 'don't even bother giving me my f'ing [sic] meds.'"

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N 432	Continued From page 3 Surveyor interviewed Administrator B at 1:00 PM. S/he confirmed Surveyor's review of the record and recalled the incident on 08/23/2025. Administrator B said the caregiver responded to a fall at 9:15 PM which delayed administration of the 8:00 PM medications and was upsetting to Resident 1. Administrator B said eventually at 10:37 PM, Resident 1 agreed to take the medication. Resident 2 On 09/04/2025 at 10:53 AM, Surveyor interviewed Resident 2. Resident 2 volunteered s/he had pushed his/her call button twice and was waiting for staff to bring his/her morphine and added, "I can hardly breathe." (Surveyor heard a call alarm alert in the hallway at approximately 10:40 AM.) Resident 2 said "sometimes" s/he has to wait for medication because "they are busy." The interview concluded at 10:57 AM and Surveyor waited in the hall outside of Resident 2's room until 11:15 AM. A caregiver did not arrive during that time to administer medication. At 11:17 AM, Surveyor located Caregiver A. S/he said Resident 2's call light was not currently activated, but it was possible someone had cleared it. Administrator B joined the interview. S/he said the call light system does not allow for review to determine when call lights were activated and/or responded to. At 11:22 AM, Caregiver A entered Resident 2's room to administer morphine. When Caregiver A entered Resident 2 said, "I know you are busy". Caregiver A tested Resident 2's call light, and it functioned properly. Surveyor reviewed Resident 2's September 2025 MAR on 09/04/2025 at 1:17 PM. Morphine was to	N 432		

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be administered every 2 hours as needed (PRN) for shortness of breath and pain. On 09/04/2025 it was administered at 9:03 AM for shortness of breath and at 11:20 AM for "body pain all over."

Resident 3
On 09/04/2025 at 11:29 AM, Surveyor interviewed Resident 3. Resident 3 said s/he experiences "chronic pain" and as soon as the medication wears off the pain is especially bad. Resident 3 said s/he takes gabapentin and PRN morphine for pain, but when s/he requests morphine, "It takes forever to come. I push that call button and request it and it doesn't come for hours and I give up."

SURVEYOR NOTE: "If you're taking gabapentin more than once a day, it's best to space out your doses as evenly as you can. Taking them too close together could put you at a higher risk for side effects. Doing so can also make gabapentin less effective since only so much of it can be absorbed at once. However, waiting too long in between doses can leave your condition undertreated...Another reason to space your gabapentin doses evenly is that going more than 12 hours between doses can lead to withdrawal symptoms, such as anxiety and restlessness." Source: https://www.goodrx.com/gabapentin/dosage-guide?srsltid=AfmBOopXQcg5HkCcWLeGUyz5bf_etXdcN5qXh4bhDG1CVuSmsxl-26S7 - retrieval date 09/08/2025

Surveyor reviewed Resident 3's August 2025 MAR. Gabapentin 600 mg was scheduled 3 times daily for neuropathy and fibromyalgia (condition that causes widespread body pain.) The scheduled times were evenly spaced every 6 hours while awake; 8:00 AM, 2:00 PM and 8:00

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N 432	Continued From page 5 PM. Surveyor noted the 8:00 AM dose of the medication was not consistently administered at the scheduled times or within the 1 hour window. When the 8:00 AM medication was administered late, this resulted in more than 12 hours passing since the bedtime dose the night before and then the 2:00 PM dose was not adjusted to ensure administration was evenly spaced. Examples include: 08/02 - 9:00 PM 08/03 - 9:52 AM and 1:10 PM 08/04 - 9:08 PM 08/05 - 9:51 AM and 1:33 PM 08/06 - 9:48 AM, 1:37 PM and 8:57 PM 08/07 - 9:52 AM and 1:32 PM 08/08 - 9:11 PM 08/09 - 10:39 AM and 1:43 PM 08/11 - 9:10 PM 08/12 - 9:48 AM, 1:11 PM and 8:59 PM 08/13 - 9:54 AM, 1:30 PM and 8:49 PM 08/14 - 9:40 AM and 1:07 PM 08/15 - 9:42 AM, 1:17 PM and 8:58 PM 08/16 - 9:53 AM and 1:27 PM 08/17 - 8:21 PM 08/18 - 10:43 AM and 1:55 PM 08/19 - 8:21 PM 08/20 - 9:38 AM, 1:58 PM and 9:12 PM 08/21 - 10:05 AM and 1:32 PM 08/22 - 9:36 PM 08/23 - 11:57 AM, 1:42 PM and 10:22 PM 08/24 - 10:44 AM and 1:52 PM 08/26 - 9:58 AM, 1:10 PM and 8:30 PM 08/27 - 9:41 AM, 1:54 PM and 7:49 PM 08/28 - 10:38 AM, 1:53 PM and 7:47 PM 08/29 - 9:40 AM, 1:48 PM and 8:48 PM 08/30 - 10:07 AM, 2:07 PM and 8:36 PM	N 432		

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N 432	Continued From page 6 08/31 - 9:15 AM During the aforementioned interview with Administrator B, s/he confirmed Resident 3 struggles with chronic pain. S/he also confirmed their expectation is for caregivers to administer medications within an hour of the scheduled times and acknowledged that was not consistently happening. Administrator B stated they would make corrections to ensure residents are receiving medications at evenly spaced intervals and caregivers are adhering to the 1 hour administration window.	N 432		