STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015977	A. BUILDING: _____ B. WING _____	R-C 12/05/2025

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{N 000}	Initial Comments On 12/05/2025, Surveyor conducted a verification visit at Hartland Place. Two deficiencies were identified. Two of 2 deficiencies were repeat violations. See Statements of Deficiencies (SOD) QPFI12, dated 12/11/2022, SOD QPFI13, dated 09/21/2023, and SOD QPFI15, dated 05/13/2025. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed. Census: 27	{N 000}		
{N 415}	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not document the need and/or response of as needed medications for 4 of 4 residents reviewed.	{N 415}		

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

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{N 415}	Continued From page 1 Additionally, staff did not record the number of sliding scale insulin units administered on 8 occurrences for Resident 10. This is a repeat violation. See Statement of Deficiency (SOD) QPFI12, dated 12/11/2022 and SOD QPFI15, dated 05/13/2025. Findings Include: On 12/05/2025, Surveyor reviewed resident records and identified the following: Example 1: Resident 10 Resident 10 was admitted to the provider on 10/02/2022 with diagnoses including type 1 diabetes and chronic kidney disease (stage 3). Resident 10 was their own legal decision maker. Resident 10's individual support plan (ISP) dated 09/19/2025 indicated staff administer his/her medications. Resident 10's physician orders documented: -" Insulin Lispro Kwik Pen with instructions to inject 4 units plus sliding scale subcutaneously 3 times day with meal; less than 90mg/dl=subtract 2u, greater than 150=add 1u, greater than 200= +2u, greater than 250=+3u, greater than 300=+4u, greater than 350=+5u, if not eating no base dose still give correction scale. Contact md if BS <70 or >400, with a start date of 08/12/2025. -Acetaminophen 650 mg with instructions to take 1 tablet by mouth every 8 hours as needed (pain/fever), with a start date of 05/12/2025 and end date of 09/10/2025. -Acetaminophen 500 mg with instructions to take 2 tablets (1000mg) by mouth 3 times a day as	{N 415}		

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{N 415}	Continued From page 2	{N 415}		

needed (pain), with a start date of 09/10/2025.
-Cyclobenzaprine 5mg with instructions to take 1 tablet by mouth 2 times a day as needed for 21 days (muscle spasms), with a start date of 09/12/2025.
-Lidocaine 4% (pain relief), with instructions to apply 1 patch topically to the right side of chest at noon and remove at bedtime as needed, with a start date of 10/01/2025."

Resident 10's Medication Administration Records (MARs), dated 09/01/2025 to 11/30/2025, staff recorded 8 blood glucose levels that would have required sliding scale insulin. There was no documentation showing how many units of insulin Resident 10 was administered on the following dates:
-09/15/2025 (dinner administration): blood sugar documented as 109 (within parameters for 4 units of insulin), there was no documentation showing how many units of insulin was administered.
-09/29/2025 (breakfast administration): blood sugar documented as 190 (within parameters for 5 units of insulin), there was no documentation showing how many units of insulin was administered.
-09/29/2025 (lunch administration): blood sugar documented as 101 (within parameters for 4 units of insulin), there was no documentation showing how many units of insulin was administered.
-11/13/2025 (lunch administration): blood sugar documented as 268 (within parameters for 7 units of insulin), there was no documentation showing how many units of insulin was administered.
-11/22/2025 (dinner administration): blood sugar documented as 143 (within parameters for 4 units of insulin), there was no documentation showing how many units of insulin was administered.
-11/24/2025 (lunch administration): blood sugar

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{N 415}	Continued From page 3	{N 415}		

documented as 143 (within parameters for 4 units of insulin), there was no documentation showing how many units of insulin was administered.
-11/26/2025 (dinner administration): blood sugar documented as 109 (within parameters for 4 units of insulin), there was no documentation showing how many units of insulin was administered.
-11/27/2025 (breakfast administration): blood sugar documented as 130 (within parameters for 4 units of insulin), there was no documentation showing how many units of insulin was administered.

Resident 10's MAR's dated 09/01/2025 to 11/30/2025, documented:
-Resident 10's Acetaminophen 650 mg. Administrations that did not document need and/or response occurred on: 09/08/2025 (2x).
-Resident 10's Acetaminophen 1000 mg. Administrations that did not document need and/or response occurred on: 09/10/2025, 09/13/2025 (2x), 09/18/2025, 10/03/2025, 10/10/2025, 10/16/2025, 11/17/2025
-Resident 10's Cyclobenzaprine 5 mg. Administrations that did not document need and/or response occurred on: 09/14/2025 (2x), 09/15/2025, 09/16/2025 (2x), 09/17/2025, 09/19/2025, 09/20/2025, 09/22/2025, 09/27/2025, 09/28/2025 (2x), 09/29/2025, 09/30/2025.
-Resident 10's Lidocaine patch. Administrations that did not document need and/or response occurred on: 10/10/2025.

Example 2: Resident 15

Resident 15 was admitted to the provider on 04/03/2019 with diagnoses including type 2 diabetes and vascular dementia. Resident 15 had an activated healthcare power of attorney.

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{N 415}	Continued From page 4 Resident 15's ISP dated 06/06/2025 indicated staff administer his/her medications. Resident 15's physician orders documented: -"Acetaminophen 500 mg, with instructions to take 2 tablets by mouth every 4 hours as needed, with a start date of 04/01/2025. -Benzonatate 100 mg, with instructions to take 1 capsule by mouth 3 times day as needed (cough), with a start date of 04/22/2025." Resident 15's MAR's, dated 09/01/2025 to 11/30/2025, documented: -Resident 15's Acetaminophen 500 mg. Administrations that did not document need and/or response occurred on: 11/13/2025, 11/15/2025, 11/18/2025, 11/19/2025, 11/20/2025. -Resident 15's Cyclobenzaprine 5 mg. Administrations that did not document need and/or response occurred on: 11/19/2025, 11/20/2025. Example 3: Resident 18 Resident 18 was admitted to the facility on 09/19/2025. Resident 18's October to December 2025 MAR included staff initials for all of Resident 18's medications. Resident 18's physician orders documented: -"Hyoscyamine Sulfate 0.125 mg, with instructions to dissolve 1 tablet sublingually every 4 hours as needed (secretions), with a start date of 10/02/2025. -Lorazepam 0.5 mg, with instructions to take 1 tablet by mouth every hour as needed (moderate-severe pain, agitation, restlessness), with a start date of 10/01/2025. -Systane Hydration, with instructions instill 2	{N 415}		

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{N 415}	Continued From page 5 drops in both eyes every hours as needed (dry eyes), with a start date of 10/15/2025." Resident 18's MAR's, dated 10/01/2025 to 11/30/2025, documented: -Resident 18's Hyoscyamine Sulfate 0.125 mg. Administrations that did not document need and/or response occurred on: 10/24/2025, 10/25/2025. -Resident 18's Lorazepam 0.5 mg. Administrations that did not document need and/or response occurred on: 11/20/2025. -Resident 18's Systane Hydration. Administrations that did not document need and/or response occurred on: 11/23/2025. Example 4: Resident 19 Resident 19 was admitted to the facility on 10/23/2025. Resident 19's October to December 2025 MAR included staff initials for all of Resident 19's medications. Resident 19's physician orders documented: -"Morphine Sulf (prefilled syringe) 100 mg/5 ml, with instructions to take 0.5 ml (10mg) by mouth every hour as needed (anxiety, shortness of breath, pain, restlessness, agitation), with a start date of 11/21/2025. -Lorazepam 1 mg, with instructions to take 1 tablet by mouth every hour as needed (anxiety, shortness of breath, agitation, restlessness), with a start date of 11/21/2025." Resident 19's MAR's, dated 10/01/2025 to 11/30/2025, documented: -Resident 19's Morphine Sulf. Administrations that did not document need and/or response occurred on: 11/22/2025.	{N 415}		

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{N 415}	Continued From page 6 -Resident 19's Lorazepam. Administrations that did not document need and/or response occurred on: 12/02/2025. On 12/05/2025 at 11:10 AM, Surveyor interviewed Administrator BB, Wellness Director II, VP of Clinical Operations JJ, and Regional RN KK regarding the above concerns. The management team acknowledged the concerns. The management team reported they will continue to ensure caregivers are documenting the need and/or response of as needed medications on the MAR.	{N 415}		
{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, record review, and interview, the provider did not ensure 3 of 4 residents reviewed received medication administration services to meet their needs. Resident 10 received the incorrect dosage of	{N 432}		

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{N 432}	Continued From page 7 sliding scale insulin on 6 occasions between 09/01/2025 to 11/30/2025. Resident 18 and Resident 19 did not receive their Polyethylene Glycol as ordered by the physician. This is a repeat violation. See Statement of Deficiency (SOD) QPFI13, dated 09/21/2023 and SOD QPFI15, dated 05/13/2025. Findings include: On 12/05/2025, Surveyor reviewed resident records and identified the following: Example 1: Resident 10 Resident 10 was admitted to the provider on 10/02/2022 with diagnoses including type 1 diabetes and chronic kidney disease (stage 3). Resident 10 was their own legal decision maker. Resident 10's individual support plan (ISP) dated 09/19/2025 documented: "[Resident 10] requires insulin administration 4x per day including 3 doses of Insulin Lispro w sliding scale insulin at mealtime and at bedtime with Lantus Insulin. Care staff will notify the Wellness Director and Administrator of any changes or concerns." Resident 10's physician orders included: -Insulin Lispro Kwik Pen with instructions to inject 4 units plus sliding scale subcutaneously 3 times day with meal; less than 90mg/dl=subtract 2u, greater than 150=add 1u, greater than 200=+2u, greater than 250=+3u, greater than 300=+4u, greater than 350=+5u, if not eating no base dose still give correction scale. Contact md if BS <70 or >400, with a start date of 08/12/2025.	{N 432}		

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{N 432}	Continued From page 8 Surveyor reviewed Resident 10's medication administration record (MAR) from 09/01/2025 to 11/30/2025 and observed the following 6 errors: Sliding scale insulin: -09/04/2025 (breakfast administration): blood sugar documented as 54 (within parameters for 2 units of insulin), 5 units documented as administered -09/09/2025 (lunch administration): blood sugar documented as 72 (within parameters for 2 units of insulin), 4 units documented as administered -10/07/2025 (breakfast administration): blood sugar documented as 97 (within parameters for 4 units of insulin), 2 units documented as administered -11/11/2025 (dinner administration): blood sugar documented as 98 (within parameters for 4 units of insulin), 2 units documented as administered -11/15/2025 (breakfast administration): blood sugar documented as 176 (within parameters for 5 units of insulin), 1 unit documented as administered -11/30/2025 (lunch administration): blood sugar documented as 88 (within parameters for 2 units of insulin), 4 units documented as administered Example 2: Resident 18 On 12/05/2025 at 9:23 AM, Surveyor observed the provider's A medication cart with Wellness Director II. Surveyor observed Resident 18's Polyethylene Glycol container noted a manufacture's label including the container originally held 30 once-daily doses of 17 grams. The container included a pharmacy label included Resident 18's practitioner's prescription for Polyethylene Glycol including "take 17gm (1 capful) dissolved in 8oz liquid by mouth in the morning (constipation)." The pharmacy label included a delivery date to the facility of 10/20/2025. Surveyor observed the	{N 432}		

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{N 432}	Continued From page 9	{N 432}		

container to be ¼ full and Wellness Director II verbally confirmed same amount remained. No other containers of Polyethylene Glycol were observed in the medication cart.

On 12/05/2025, Surveyor reviewed Resident 18's record. Resident 18 was admitted to the facility on 09/19/2025. Resident 18's October to December 2025 MAR included staff initials for all of Resident 18's medications. A review of Resident 18's October to December 2025 MAR, included Resident 18 was administered 46 doses of Polyethylene Glycol between 10/21/2025-12/05/2025 from a 30-dose container, based on Resident 18's practitioner's order, with ¼ of the medication remaining in the container.

Example 3: Resident 19

On 12/05/2025 at 9:23 AM, Surveyor observed the provider's A medication cart with Wellness Director II. Surveyor observed Resident 19's Polyethylene Glycol container noted a manufacture's label including the container originally held 30 once-daily doses of 17 grams. The container included a pharmacy label included Resident 19's practitioner's prescription for Polyethylene Glycol including "take 17gm (1 capful) dissolved in 8oz liquid by mouth in the morning (constipation)." The pharmacy label included a delivery date to the facility of 10/24/2025. Surveyor observed the container to be ¼ full and Wellness Director II verbally confirmed same amount remained. No other containers of Polyethylene Glycol were observed in the medication cart.

On 12/05/2025, Surveyor reviewed Resident 19's record. Resident 19 was admitted to the facility on

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{N 432}	Continued From page 10 10/23/2025. Resident 19's October to December 2025 MAR included staff initials for all of Resident 19's medications. A review of Resident 19's October to December 2025 MAR, included Resident 19 was administered 35 doses of Polyethylene Glycol between 10/30/2025-12/05/2025 from a 30-dose container, based on Resident 19's practitioner's order, with ¼ of the medication remaining in the container. Interviews: On 12/05/2025 at 9:46 AM, Surveyor interviewed VP of Clinical Operations JJ. VP of Clinical Operations JJ. VP of Clinical Operations JJ provided Surveyor with Resident 18's and Resident 19's MAR's. VP of Clinical Operations JJ stated there were no refusals documented on the MAR's, and acknowledged there should not be any Poly Glycol medication remaining in the containers. VP of Clinical Operations JJ reported s/he would investigate which staff were responsible and immediately reeducate. On 12/05/2025 at 10:45 AM, Surveyor reviewed Resident 10's November 2025 MAR with Wellness Director II. Wellness Director II acknowledged staff did not administer the correct number of sliding scale insulin units on a few dates. On 12/05/2025 at 11:10 AM, Surveyor interviewed Administrator BB, Wellness Director II, VP of Clinical Operations JJ, and Regional RN KK regarding the above concerns. The management team acknowledged if both resident's polyethylene glycol was administered as prescribed the container would have been emptied earlier and requests for refills would have been sent to the	{N 432}		

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{N 432}	Continued From page 11 pharmacy. VP of Clinical Operations JJ reported s/he had compiled a list of staff who were responsible for documenting Resident 18's and Resident 19's poly glycol as administered when the medication wasn't given. VP of Clinical Operations JJ stated s/he plans to reeducate these staff. Wellness Director II noted s/he will continue to complete weekly audits of the medication carts. The management team acknowledged Resident 10's sliding scale insulin units were not administered correctly and staff would be retrained.	{N 432}		