STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015620	A. BUILDING: _____ B. WING _____	R-C 10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOUGHTON MEADOWS ASSISTED LIVING	2321 JACKSON ST STOUGHTON, WI 53589

(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 10/10/2025, with information gathered through 10/14/2025, Surveyor conducted a verification visit at Stoughton Meadows Assisted Living. One deficiency was identified. One of 1 deficiences was a repeat violation (see Statement of Deficiency (SOD) RN3011, SOD RN3012, SOD RN3013, SOD KFJM11, SOD KFJM12, and SOD BTKI11). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 41	{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, record review and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 3 out of 5 residents reviewed. This deficiency is being cited for a seventh time. See Statement of Deficiency (SOD) KFJM11, dated 5/06/2020, SOD KFJM12, dated 12/16/2020, SOD BTKI11, dated 11/15/2023, SOD RN3011, dated 07/01/2024, SOD RN3012, dated 11/15/2024, and SOD RN3013, dated 06/09/2025.	{N 352}		

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

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{N 352}	Continued From page 1 Resident 25 was prescribed Pregabalin which was not administered as prescribed. Resident 26 was prescribed Azithromycin, Baclofen, Gabapentin and Trulicity which were not administered as prescribed. Resident 27 was prescribed acetaminophen which was not administered as prescribed. Findings include: On 10/10/2025, at approximately 2:00 PM, Surveyor interviewed Director of Clinical Services P. Surveyor asked what day the med cycle started. Director of Clinical Services P stated the medications were dispensed on 09/17/2025 and were utilized starting 09/25/2025. Example 1: Resident 25 On 10/10/2025, at approximately 2:10 PM, Surveyor and Med Passer S observed Resident 25's blister card of bedtime Pregabalin in the med cart, which was dispensed on 09/17/2025, and had 23 of 28 capsules remaining. The blister card had handwritten dates next to dispensed capsules of 09/29/2025, 10/03/2025 to 10/06/2025. On 10/10/2025, Surveyor reviewed Resident 25's record. Resident 25 moved into the facility 05/08/2025. Resident 25's Medication Administration Records (MAR), dated 09/25/2025 to 10/10/2025, documented: Pregabalin Cap (capsule) 225 MG (milligram) - Take 1 capsule by mouth twice daily for fibromyalgia and RA (rheumatoid arthritis). Order	{N 352}		

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{N 352}	Continued From page 2 Date: 08/29/2025. May fill on /after 09/19/2025. Scheduled at AM 07 (7:00 AM to 11:00 AM) and Eve 1 (4:00 PM to 8:00 PM). Based on med cycle, the medication would have started 09/25/2025 and 15 capsules would have been administered. On 10/10/2025, at approximately 5:00 PM, Surveyor interviewed Director of Clinical Services P. Surveyor asked if Resident 25's Pregabalin had been changed to a PRN (as needed) medication due to the dispensed dates. Director of Clinical Services P stated s/he would need to review Resident 25's record to determine if a change had been made to the Pregabalin prescription. As of 10/14/2025 at 9:00 AM, Surveyor did not receive any additional documentation. Example 2: Resident 26 On 10/10/2025, at approximately 2:20 PM, Surveyor and Med Passer S observed Resident 26's medications in the med cart. Surveyor observed: -Bottle of Azithromycin (antibiotic) that had 1 of 4 tables remaining. Start Date: 10/05/2025. -Noon blister card of Gabapentin that still contained his/her 10/10/2025 dose. -Noon blister card of Baclofen that still contained his/her 10/10/2025 dose. Surveyor asked Med Passer S for clarification as to why Resident 26's noon medications had not been dispensed. Med Passer S stated Resident 26 had been out of the facility during med pass. On 10/10/2025, Surveyor reviewed Resident 26's record.	{N 352}		

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{N 352}	Continued From page 3 Resident 26 moved into the facility 05/08/2025. Resident 26's urgent care documentation, dated Saturday, 10/04/2025, at 6:47 AM, documented: "A prescription for antibiotics (Azithromycin) was sent to [pharmacy]. You were given your first dose here in the emergency room. It's taken once a day, so your next dose is due tomorrow morning (10/05/2025)." Resident 26 did not receive his/her next dose until 10/06/2025. Resident 26's MARs, dated 09/25/2025 to 10/10/2025, documented: -Azithromycin Oral Tablet 250 MG - Give 1 tablet by mouth one time a day for infection for 4 days. Start Date: 10/05/2025. Scheduled at AM 07 (7:00 AM to 11:00 AM). The MAR documented that the medication was not administered until 10/06/2025 and was administered until 10/09/2025. Surveyor noted if the medication had been administered 10/06/2025 through 10/09/2025, all medication would have been administered but there was one tablet remaining. Surveyor noted the medication was to start 10/05/2025 and did not until 10/06/2025. On 10/10/2025, at approximately 4:00 PM, Surveyor interviewed Director of Clinical Services P and Med Passer S. Surveyor asked for clarification as to why there was a tablet left of Resident 26's Azithromycin when the MAR documented all 4 doses were administered. Med Passer S stated that Resident 26 had the medication filled at his/her preferred pharmacy and the medication had also been ordered by the provider's preferred pharmacy. Med Passer S stated s/he was unable to pick up the medication until 10/06/2025. Director of Clinical Services P	{N 352}		

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{N 352}	Continued From page 4	{N 352}		

stated that the provider's preferred pharmacy did not deliver medications on a weekend after noon on Saturday. Director of Clinical Services P followed up with the provider's preferred pharmacy and was informed Azithromycin had not been ordered nor delivered for Resident 26. Director of Clinical Services P confirmed Resident 26's Azithromycin had not been administered as prescribed.

On 10/10/2025, at approximately 4:20 PM, Surveyor toured the facility and observed the resident logbook which did not document that Resident 26 had checked him/herself out of the building on 10/10/2025 as stated by Med Passer S. Surveyor walked to Resident 26's room and was able to interview Resident 26. Surveyor asked if s/he was concerned that s/he did not receive his/her noon meds when s/he returned from being out of the building during med pass. Resident 26 stated, "I have been here all day and all day I have gotten my meds late. I get the morning meds at noon, the noon meds whenever, it is frustrating. They say they have until 11:00 to give you your morning meds. I don't understand that." Resident 26 stated, "There was a time they said my Trulicity medication wasn't available. I couldn't understand why, but I didn't get the medication."

On 10/10/2025, at approximately 4:45 PM, Surveyor requested Resident 26's September and October MARS, with timestamps, from Wellness Director O. Surveyor asked Director of Clinical Services P for Resident 26's pharmacy delivery reports for his/her Trulicity. Director of Clinical Services P stated that Resident 26 did not receive his/her Trulicity on 09/12/2025 because there was an insurance concern with the pharmacy. Director of Clinical Services P and

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{N 352}	Continued From page 5 Surveyor walked to the med room and observed Resident 26's box of Trulicity, with a dispensed date of 09/12/2025. Surveyor asked for clarification as to why Resident 26 did not receive the Trulicity when the medication had been dispensed on 09/12/2025. Director of Clinical Services P explained that it was past his/her window for administration and since s/he only received the medication once a week, Resident 26 would have to wait until the next scheduled administration time. Surveyor asked if Director of Clinical Services P had documentation to show that Resident 26's prescribing physician had been contacted to determine if the dose could be administered late. Director of Clinical Services P stated s/he had not contacted the prescribing physician. Surveyor discussed the concern that Resident 26's noon medications had not been administered when his/her medications were reviewed at approximately 2:20 PM. Director of Clinical Services P stated the Med Passer S had informed him/her that Resident 26 was out of the building during med administration. On 10/10/2025, Surveyor and Director of Clinical Services P reviewed Resident 26's timestamped MARs which documented: Baclofen Tab 10 MG - Take 1 tablet by mouth three times daily for pain. Scheduled at 7:00 AM, 11:00 AM and 4:00 PM Gabapentin Cap 300 MG - Take 1 capsule by mouth 3 times daily for pain. Scheduled at 7:00 AM, 11:00 AM and 4:00 PM. The MAR documented on 10/10/2025 that the 7:00 AM and 11:00 AM doses had been administered at 10:19 AM and the 4:00 PM doses were administered at 4:49 PM. Surveyor stated that the MARs documented that Resident 26 received his/her 11:00 AM (blister card labeled as Noon) doses of Baclofen and	{N 352}		

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{N 352}	Continued From page 6	{N 352}		

Gabapentin but they were still in the blister card at approximately 2:20 PM. Surveyor asked Director of Clinical Services P for clarification as to why the AM meds and the Noon meds were documented as administered at the same time and documented as administered when the medication was still in the blister card. Director of Clinical Services P stated s/he did not have a rationale as to why staff had documented medication administration in that manner.

"Trulicity is designed to fit into your busy life. Trulicity is taken once a week. On your Trulicity day, you can take your dose at any time of the day, with or without food. So start by picking the best day for you and mark it as your Trulicity day. Do your best to stick to the same day every week." (Source: Trulicity website, How to Use Trulicity, July 2025, https://trulicity.lilly.com/how-to-use#how-to-use-trulicity-pen (retrieval date - October 13, 2025).)

"If you miss a dose of this medicine, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not double doses. If you miss a dose, use it as soon as possible within 3 days after your missed dose. If you miss a dose by more than 3 days, wait until your next regular weekly dose." (Source: Mayo Clinic website, Dulaglutide (subcutaneous route), 2025, https://www.mayoclinic.org/drugs-supplements/dulaglutide-subcutaneous-route/description/drg-20122526 (retrieval date - October 13, 2025).)

Example 3: Resident 27

On 10/10/2025, at approximately 2:10 PM, Surveyor and Med Passer S observed Resident

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{N 352}	Continued From page 7 27's blister cards of acetaminophen, which were dispensed 09/17/2025, in the med cart. The blister card scheduled for 'Early AM' had 25 of 28 tablets remaining. The blister card scheduled for 'AM' had 15 of 28 tablets remaining. On 10/10/2025, Surveyor reviewed Resident 27's record. Resident 27 moved into the facility 10/19/2023. Resident 27's MARs, dated 09/25/2025 to 10/10/2025, documented: Acetaminophen 325 MG - Take 1 tablet by mouth every 4 hours while awake. Scheduled at AM 07 (7:00 AM to 11:00 AM), Mid 1 (11:00 AM to 3:00 PM), Eve 1 (4:00 PM to 8:00 PM), HS 20 (8:00 PM). The MARs documented the meds had been administered as prescribed for the 16 identified days, meaning 12 tablets would be remaining in the blister cards. Resident 27's record did not have evidence as to why the Early AM blister card contained 25 doses or why the AM blister card contained 15 doses when only 12 tablets should have been remaining. On 10/14/2025 at 9:30 AM, Surveyor interviewed Wellness Director O, Director of Clinical Services P, Director Q, and Market Leader R. Surveyor reviewed the observations and documentation of medications and medication administration. Market Leader R stated staff would continue to be re-educated on proper medication administration.	{N 352}		