STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015285	A. BUILDING: _____ B. WING _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COURT WAUKESHA	1831 MEADOW LANE PEWAUKEE, WI 53072

(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 09/06/2023, with information gathered through 09/14/2023, the Bureau of Assisted Living, Southern Regional Office conducted an abbreviated licensing survey and complaint investigation at Heritage Court Waukesha, located at 1831 Meadow Lane in Pewaukee, WI. One citation of noncomplaince was issued. The complaint was substantiated. Census: 28	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, Resident 2, and Resident 3 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1, Resident 2, and Resident 3 did not receive prescribed powdered bowel medications, as prescribed. Resident 3 did not receive eye drops, as prescribed. The findings include: On 08/21/2023, the department received a	N 352		

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

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N 352	Continued From page 1 complaint alleging residents were not being administered medications as prescribed, including powdered medications and eye drops. Example 1: Resident 1's Reguloid, powdered bowel prescription On 09/06/2023 at 9:30 A.M., Surveyor conducted an interview with Caregiver D, Certified Nurse Aide (CNA) Supervisor/Caregiver, including observations of the east medication cart located in the east medication room. Surveyor observed Caregiver D remove a container psyllium powder labeled with Resident 1's name from the east medication cart. The container included the manufacturer's brand label, "Rugby," on the front of the container. The container's brand label included, "Orange Smooth Powder. Reguloid. Natural Psyllium Husk" and "Net WT [weight] 13 oz [ounces] (369 g [grams])." (Photo #1) Surveyor observed the pharmacy label affixed to Resident 1's container included, "Reguloid Pow [powder] Orange. Generic: Psyllium Powder 28.3%. Take 1 scoop as directed once daily" and included the dispensed date, "08/02/2023," and start date, "08/06/2023." (Photo #2) Surveyor observed Caregiver D open Resident 1's container of Reguloid and s/he told Surveyor the container was approximately two thirds full of the powder. (Photo #3) Caregiver D told Surveyor the container did not include the date it was opened for administration and there were no other containers of Reguloid for Resident 1 stored at the facility. Surveyor observed the container did not include a scoop to measure the powder. Caregiver D shifted the powder in the container and looked through the medication cart before telling Surveyor s/he was unable to locate a scoop to measure Resident 1's prescribed dose of "1 scoop." Surveyor asked Caregiver D how	N 352		

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much powder equaled 1 scoop and how much of the Reguloid s/he would administer to Resident 1. Caregiver D told Surveyor s/he would dissolve 15 ccs of the powder in liquid while pointing to 15 ccs on an empty medication cup. Caregiver D told Surveyor s/he did not know how much of the Reguloid was administered to Resident 1 during the morning medication pass on 09/06/2023 because s/he did not administer morning medications to the residents. Caregiver D told Surveyor Caregiver E passed the resident's morning medications from the east medication cart. Caregiver D told Surveyor s/he did not normally administer resident medications and Caregiver E was pulled from passing medications after Surveyor arrived at the facility.
Caregiver D told Surveyor Resident 1 required assistance with toileting. Caregiver D said the caregivers were to monitor Resident 1 so s/he did not strain during bowel movements related to a recent bowel issue. Caregiver D told Surveyor Resident 1 had a history of constipation.

On 09/06/2023 at approximately 11:00 A.M.,. Surveyor conducted an interview with Caregiver E, including observations of the east medication cart located in the east medication room. Surveyor asked Caregiver E to demonstrate where the medications were located on the cart before s/he administered them to Resident 1 during the morning medication pass on 09/06/2023. Caregiver E opened a drawer, removed a coil of individual packaged medications in pill form labeled with Resident 1's name, and told Surveyor the medications s/he administered to Resident 1 had been in an individual package attached to the coil of packaged medications. Surveyor asked if s/he was aware of any supplements in powdered form prescribed to Resident 1 and included within the

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morning medication pass. Caregiver E told Surveyor s/he was not aware of any powdered supplements prescribed for Resident 1. Surveyor asked Caregiver E to observe the lower drawer of the medication cart for Resident 1's prescribed Reguloid. Caregiver E removed the container, reviewed the label, and told Surveyor Resident 1 refused administration of this medication during the morning medication pass. Caregiver E told Surveyor Resident 1 only wanted regular water without this medication added. Surveyor asked Caregiver E to demonstrate how much Reguloid s/he would administer Resident 1, as prescribed. Caregiver E read the pharmacy label affixed to the container of Resident 1's Reguloid and told Surveyor "1 scoop." Surveyor asked Caregiver E to demonstrate the amount in 1 scoop. Caregiver E told Surveyor s/he would dissolve 10 ccs of the powder in liquid while pointing to 10 ccs on an empty medication cup.

On 09/06/2023 at approximately 11:05 A.M., Surveyor conducted an interview with Resident 1 in Resident 1's room. Resident 1 told Surveyor s/he did not decline or refuse any medications this morning, on 09/06/2023, including medications dissolved in liquid.

On 09/06/2023 at 11:30 A.M., Surveyor conducted an interview with Facility Nurse C, Registered Nurse and Director of Nursing, including observations of the east medication cart located in the east medication room and Resident 1's Reguloid, as prescribed. Surveyor asked Facility Nurse C how much Reguloid was prescribed to be administered Resident 1. Surveyor observed Facility Nurse C fill a cup with water and measure the amount of water in a medication cup to equal 45 ccs. Facility Nurse C told Surveyor the caregivers should measure out

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N 352	Continued From page 4 45 ccs of Reguloid using a medication cup, in the absence of a scoop, and dissolve the powder in liquid before administering to Resident 1. Facility Nurse C told Surveyor s/he did not see that the caregivers had dated Resident 1's Reguloid container with the date the container was opened. On 09/14/2023 at 1:23 P.M., Surveyor conducted an interview with Pharmacy Staff F. Pharmacy Staff F told Surveyor one Reguloid container was delivered to the facility for Resident 1 on 07/03/2023 with a start date of 07/07/2023, another container delivered to the facility on 08/02/2023 with a start date of 08/06/2023, and another delivered to the facility on 08/30/2023 with a start date of 09/04/2023. Pharmacy Staff F told Surveyor each Reguloid container included approximately 30 doses. Pharmacy Staff F told Surveyor Resident 1's Reguloid prescription was filled and delivered to the facility approximately every month automatically and there were no notes regarding special requests from the facility for this prescription. On 09/06/2023, Facility Nurse C and Surveyor reviewed Resident 1's record, as provided by Facility Nurse C and Regional Director B. Resident 1 was admitted to the facility on 04/12/2023 with diagnoses including dementia. Facility Nurse C said Resident 1 was a "pretty reliable" historian with some fluctuations in short term memory and did not often refuse medication administration. Facility Nurse C told Surveyor Resident 1 was hospitalized related to a prolapsed (bulging or falling out of a body part) rectum just prior to admission to the facility. Facility Nurse C said Resident 1 was prescribed to receive Reguloid related to Resident 1's history of constipation and straining with bowel movements.	N 352		

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N 352	Continued From page 5 Resident 1's practitioner's order, dated 05/01/2023, included, "D/C [discontinue] Miralax [polyethylene glycol; laxative medication to treat constipation]. Start fiber powder (Citrucel, Metamucil, or equivalent) one scoop daily. High fiber diet (low [sodium] also)." Facility Nurse C told Surveyor Resident 1's fiber powder (Reguloid) prescription was not clarified to indicate the dose amount equivalent to one scoop. Resident 1's May 2023 medication administration record (MAR) included Resident 1's Reguloid, as prescribed, and included "indications for use: constipation." Resident 1's May 2023 MAR included the administration of Reguloid started on 05/03/2023 and documented as administered daily with the exception of 2 doses. On 05/13/2023, Resident 1's MAR included documentation Reguloid was not administered to Resident 1 because the medication was not available to administer. Facility Nurse C told Surveyor there was no reason Resident 1's Reguloid would not have been available on 05/13/2023. On 05/14/2023, Resident 1's MAR included documentation Reguloid was not administered to Resident 1 because Resident 1 was "absent from home without meds [medications]." Resident 1's MAR included Resident 1 was not administered Reguloid by facility caregivers on 05/27/2023, 05/29/2023, and 05/30/2023 because Resident 1 was "absent from home with meds." Facility Nurse C said a caregiver documented Resident 1 was "absent from home without meds" on 05/28/2023, but the caregiver should have documented, "absent from home with meds" on this date. Resident 1's June MAR 2023 included Resident 1's Reguloid was as administered daily with the exception of 2 doses. On 06/02/2023 and 06/05/2023, Resident 1's MAR included	N 352		

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documentation Reguloid was not administered because the medication was not available to administer. Facility Nurse C told Surveyor there was no reason Resident 1's Reguloid would not have been available on 06/02/2023 and 06/05/2023.
Resident 1's July MAR 2023 included Resident 1's Reguloid was as administered daily with the exception of 1 dose. On 07/18/2023, Resident 1's MAR included documentation Reguloid was not administered because the medication was not available to administer. Facility Nurse C told Surveyor there was no reason Resident 1's Reguloid would not have been available on 07/18/2023.
Resident 1's August MAR 2023 included Resident 1's Reguloid was documented as administered daily for the entire month. Resident 1's MAR included Resident 1 was not administered Reguloid by facility caregivers on 08/04/2023, 08/05/2023, and 08/06/2023 because Resident 1 was "absent from home with meds."
Facility Nurse C told Surveyor the dates documented Resident 1 was "absent from home with meds" were trips home with family and medications were packaged by caregivers and sent home with Resident 1 and Resident 1's family to administer.
Resident 1's September MAR 2023 included Resident 1's Reguloid was administered daily through this date, 09/06/2023, despite Caregiver E telling Surveyor s/he did not administer Resident 1's Reguloid because Resident 1 refused this specific medication.
Resident 1's MARs reviewed from May 2023 through 09/06/2023 included no documented refusals to take Reguloid, as prescribed.
Facility Nurse C, Regional Director B, and Surveyor discussed Resident 1's MARs reviewed from May 2023 through 09/06/2023 included 4

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N 352	Continued From page 7 doses of Reguloid not administered by caregivers because the medication was not available, Resident 1's current Reguloid container in use was two thirds full and dated as received from the pharmacy on 08/02/2023, and the dose amount of a scoop had not been clarified. Surveyor asked if administration of Resident 1's Reguloid, as prescribed, could be assured based on these findings. Facility Nurse C told Surveyor it was not right that the remaining amount in Resident 1's current Reguloid container did not comport with caregiver documentation of administration. Example 2: Resident 2's Metamucil, powdered bowel prescription On 09/06/2023 at 9:30 A.M., Surveyor conducted an interview with Caregiver D, including observations of the east medication cart located in the east medication room. Surveyor observed Caregiver D remove a cardboard box container of Metamucil packets labeled with Resident 2's name from the east medication cart. The container included the manufacturer's brand label including, "Metamucil Psyllium Fiber Supplement On-The-Go" on the front of the container. The manufacturer's brand label included, "44 - 0.21 oz [ounce] (5.8 g [gram]) powdered packets." (Photo #4) Surveyor observed the pharmacy label affixed to the container included, "Mix 1 packet of powder diluted in liquid and take by mouth once daily" and included the dispensed date, "07/24/2023," and start date, "07/25/2023." (Photo #5) Surveyor observed Caregiver D remove the remaining packets from the box and count them with Surveyor. Caregiver D and Surveyor observed 32 Metamucil packets remained, equaling 12 packets having been removed and potentially administered to Resident 2. Caregiver	N 352		

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N 352	Continued From page 8 D told Surveyor the container did not include the date it was opened for administration and there were no other boxes of Resident 2's Metamucil packets stored at the facility. Caregiver D told Surveyor Resident 1 required assistance with toileting. On 09/14/2023 at 1:23 P.M., Surveyor conducted an interview with Pharmacy Staff F. Surveyor asked Pharmacy Staff F for the dates of the last three boxes of Resident 2's Metamucil filled by the pharmacy and delivered to the facility. Pharmacy Staff F told Surveyor one 44 dose box of Metamucil packets was delivered to the facility for Resident 2 on 06/13/2023 with a start date of 06/14/2023, another box was delivered to the facility on 07/24/2023 with a start date of 07/25/2023, and another delivered to the facility on 08/31/2023 with a start date of 09/06/2023. Pharmacy Staff F told Surveyor each Metamucil box included 44 packets or doses. Pharmacy Staff F told Surveyor Resident 2's Metamucil prescription was filled and delivered to the facility automatically and there were no notes regarding special requests from the facility for this prescription. On 09/06/2023, Facility Nurse C and Surveyor reviewed Resident 2's record, as provided by Facility Nurse C and Regional Director B. Resident 2 was admitted to the facility on 04/27/2023 with diagnoses including dementia. Facility Nurse C said Resident 2 ambulated with a walker with reminders and required assistance from caregivers with toileting. Facility Nurse C told Surveyor Resident 2 would occasionally toilet self and was occasionally incontinent. Facility Nurse C told Surveyor Resident 2 would decline medications related to variations in mood and not solely because s/he did not want medication	N 352		

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administration.
Resident 2's practitioner's order, dated 05/01/2023, included, "Metamucil Pak [packets]...mix 1 packet of powder diluted in liquid and take by mouth daily."
Resident 2's May 2023 medication administration record (MAR) included Resident 2's Metamucil, as prescribed, and included "indications for use: stool softener." Resident 2's May 2023 MAR included the administration of Metamucil started on 05/01/2023 and documented as administered daily with the exception of 1 dose. On 05/27/2023, Resident 2's MAR included documentation Metamucil was not administered to Resident 2 because Resident 2 was "absent from home without meds [medications]." However, all other medications prescribed to be administered at the same time on Resident 2's MAR were documented as administered on 05/27/2023.
Resident 2's June MAR 2023 included Resident 2's Metamucil was as administered daily with the exception of 2 doses. On 06/04/2023, Resident 2's MAR included documentation Metamucil was not available for administration. Facility Nurse C told Surveyor there was no reason Resident 2's Metamucil would not have been available on 06/04/2023. On 06/12/2023, Resident 2's MAR included documentation Metamucil was not administered to Resident 2 related to "nauseated/vomiting." However, all other medications prescribed to be administered at the same time on Resident 2's MAR were documented as administered on 06/12/2023.
Resident 2's July MAR 2023 included Resident 2's Metamucil was documented as administered daily for the entire month.
Resident 2's August MAR 2023 included Resident 2's Metamucil was as administered daily with the exception of 6 doses. Resident 2's MAR included

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N 352	Continued From page 10 Resident 2 was not administered Metamucil related to Resident 2 being "hospitalized" or "absent from home without meds." Resident 2's September MAR 2023 included Resident 2's Metamucil was administered daily through this date, 09/06/2023. Resident 2's MARs reviewed from May 2023 through 09/06/2023 included no documented refusals to take Metamucil, as prescribed. Facility Nurse C, Regional Director B, and Surveyor discussed Resident 2's MARs reviewed from May 2023 through 09/06/2023 included 6 doses of Metamucil not administered by caregivers because Resident 2 was hospitalized and Resident 2's current Metamucil container in use contained 32 remaining doses/packets dated as received from the pharmacy on 07/24/2023. Surveyor asked if administration of Resident 2's Metamucil, as prescribed, could be assured based on these findings. Facility Nurse C told Surveyor it was not right that the remaining doses/packets in Resident 2's current Metamucil container did not comport with caregiver documentation of administration. Example 3: Resident 3's polyethylene glycol, powdered bowel prescription On 09/06/2023 at 9:30 A.M., Surveyor conducted an interview with Caregiver D including observations of the west medication cart located in the west medication room. Surveyor observed Caregiver D remove a container of polyethylene glycol labeled with Resident 3's name from the west medication cart. Surveyor observed the pharmacy label affixed to the container included, "Mix 17 gms [grams] in 4 [to] 8 ounces of juice or water and take by mouth once daily" and included the dispensed date, "08/03/2023," and start date, "08/08/2023." (Photo #6) Surveyor observed	N 352		

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N 352	Continued From page 11 Caregiver D open Resident 3's container of polyethylene glycol and told Surveyor the container was approximately one half full of the powder. Surveyor observed the container approximately one half full of powder when placed on the medication cart and light shown through the container. (Photo #7) Caregiver D told Surveyor the container did not include the date it was opened for administration and there were no other containers of polyethylene glycol for Resident 3 stored at the facility. Caregiver D told Surveyor Resident 3 required assistance with toileting. On 09/14/2023 at 1:23 P.M., Surveyor conducted an interview with Pharmacy Staff F. Surveyor asked Pharmacy Staff F for the dates of the last three containers of Resident 3's polyethylene glycol filled by the pharmacy and delivered to the facility. Pharmacy Staff F told Surveyor one 30 dose polyethylene glycol container was delivered to the facility for Resident 3 on 07/05/2023 with a start date of 07/09/2023, another 30 dose container was delivered to the facility on 08/03/2023 with a start date of 08/08/2023, and another delivered to the facility on 08/31/2023 with a start date of 09/06/2023. Pharmacy Staff F told Surveyor Resident 3's polyethylene glycol prescription was filled and delivered to the facility approximately every month automatically and there were no notes regarding special requests from the facility for this prescription. On 09/06/2023, Facility Nurse C and Surveyor reviewed Resident 3's record, as provided by Facility Nurse C and Regional Director B. Resident 3 was admitted to the facility on 05/10/2023 with diagnoses including dementia. Facility Nurse C said Resident 3 required the use of a wheelchair and one caregiver transfer	N 352		

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N 352	Continued From page 12 assistance. Facility Nurse C said Resident 3 required assistance with toileting and was incontinent of urine and bowel movements. Facility Nurse C told Surveyor Resident 3 would not know polyethylene glycol was dissolved in liquid to refuse it. Resident 3's practitioner's order, dated 05/11/2023, included, "Polyethylene glycol...mix 17 gms [grams] in 4 [to] 8 ounces of juice or water and take by mouth once daily." Resident 3's May 2023 medication administration record (MAR) included Resident 3's polyethylene glycol, as prescribed, and included "indications for use: constipation." Resident 3's May 2023 MAR included the administration of polyethylene glycol started on 05/11/2023 and documented as administered daily with the exception of 2 doses. On 05/12/2023 and 05/13/2023, Resident 3's MAR included documentation polyethylene glycol was not administered to Resident 3 because Resident 3 refused administration. Resident 3's June MAR 2023 included Resident 3's polyethylene glycol was documented as administered daily for the entire month. Resident 3's July MAR 2023 included Resident 3's polyethylene glycol was documented as administered daily with the exception of 4 doses. On 07/20/2023, 07/21/2023, 07/25/2023, and 07/30/2023, Resident 3's MAR included documentation polyethylene glycol was not administered to Resident 3 because the "med not available." Facility Nurse C told Surveyor there was no reason Resident 3's polyethylene glycol would not have been available on these 4 dates. Resident 3's August MAR 2023 included Resident 3's polyethylene glycol was documented as administered daily for the entire month. Resident 3's September MAR 2023 included Resident 3's polyethylene glycol was documented as administered daily through this date,	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015285	A. BUILDING: _____ B. WING _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COURT WAUKESHA	1831 MEADOW LANE PEWAUKEE, WI 53072

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N 352	Continued From page 13 09/06/2023. Facility Nurse C, Regional Director B, and Surveyor discussed Resident 3's MARs reviewed from May 2023 through 09/06/2023 included 3 doses of polyethylene glycol not administered by caregivers because Resident 3 refused the medication soon after admission to the facility and Resident 3's current polyethylene glycol container in use was half full and dated as received from the pharmacy on 08/03/2023 with a start date of 08/08/2023. Surveyor asked if administration of Resident 3's polyethylene glycol, as prescribed, could be assured based on these findings. Facility Nurse C told Surveyor it was not right that the remaining polyethylene glycol in Resident 3's current container did not comport with caregiver documentation of administration. Example 4: Resident 3's glaucoma eye drop prescription On 09/06/2023 at 9:30 A.M., Surveyor conducted an interview with Caregiver D including observations of the west medication cart located in the west medication room. Surveyor observed Caregiver D remove two unsealed, unopened containers of latanoprost ophthalmic [eye drop used to treat glaucoma] solution labeled with Resident 3's name from the west medication room refrigerator. Surveyor observed the pharmacy label affixed to one out-dated container included, "Instill 1 drop into both eyes at bedtime....B.U.D. [beyond use/use by date] 42 days [which would be 08/09/2023]" and included the dispensed date, "06/26/2023," and start date, "06/29/2023." (Photo #8 and #9) and the other container included, ""Instill 1 drop into both eyes at bedtime....B.U.D. [beyond use date] 42 days" and included the dispensed date, "08/14/2023," and start date, "08/17/2023." (Photo #10 and	N 352		

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N 352	Continued From page 14 #11). Surveyor observed Caregiver D review the west medication cart and told Surveyor the cart did not include an opened latanoprost container for current administration to Resident 3 and there were no other containers of latanoprost drop eye solution for Resident 3 stored at the facility. Caregiver D told Surveyor Resident 3 required caregiver administration of latanoprost eye drops. On 09/06/2023, Surveyor reviewed the facility's documentation of medication storage inspection conducted by a pharmacy on 07/26/2023. The documentation included, "West cart: Removed sealed [unopened] latanoprost, past B.U.D." The report did not include resident identification to whom the latanoprost belonged. On 09/14/2023 at 1:23 P.M., Surveyor conducted an interview with Pharmacy Staff F. Surveyor asked Pharmacy Staff F for the dates of Resident 3's last 2 latanoprost eye drop solution filled by the pharmacy and delivered to the facility. Pharmacy Staff F told Surveyor one latanoprost container was delivered to the facility for Resident 3 on 07/19/2023 with a start date of 07/23/2023 with a beyond use/use by date 42 days from 07/23/2023 on 09/02/2023, another container was delivered to the facility on 08/14/2023 with a start date of 08/14/2023 with a beyond use/use by date 42 days from 08/14/2023. Pharmacy Staff F told Surveyor Resident 3's latanoprost prescription was filled and delivered to the facility every month automatically and there were no notes regarding special requests from the facility for this prescription. On 09/06/2023, Facility Nurse C and Surveyor reviewed Resident 3's record, as provided by Facility Nurse C and Regional Director B. Resident 3 was admitted to the facility on	N 352		

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N 352	Continued From page 15 05/10/2023 with diagnoses including dementia. Resident 3's practitioner's order, dated 05/11/2023, included, "Latanoprost sol [solution]...instill 1 drop into both eyes at bedtime...B.U.D. 42 days." Resident 3's May 2023 medication administration record (MAR) included Resident 3's latanoprost, as prescribed. Resident 3's May 2023 MAR included the administration of latanoprost started on 05/11/2023 and documented as administered daily with the exception of 3 doses. On 05/18/2023, Resident 3's MAR included documentation latanoprost was not administered to Resident 3 because Resident 3 refused administration. On 05/27/2023 and 05/30/2023, Resident 3's MAR included documentation latanoprost was not administered to Resident 3 because the "med not available." Facility Nurse C told Surveyor there was no reason Resident 3's latanoprost would not have been available on these 2 dates. Resident 3's June MAR 2023 included Resident 3's latanoprost was documented as administered daily with the exception of 5 doses. On 06/01/2023, 06/03/2023, 06/05/2023, 06/09/2023, and 06/10/2023, Resident 3's MAR included documentation latanoprost was not administered to Resident 3 because the "med was not available." Facility Nurse C told Surveyor there was no reason Resident 3's latanoprost would not have been available on these 5 dates. Resident 3's July MAR 2023 included Resident 3's latanoprost was documented as administered daily with the exception of 1 dose. On 07/16/2023, Resident 3's MAR included documentation latanoprost was not administered to Resident 3 because Resident 3 refused administration. Resident 3's August MAR 2023 included Resident 3's latanoprost was documented as administered	N 352		

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N 352	Continued From page 16 daily with the exception of 1 dose. On 08/10/2023, Resident 3's MAR included documentation latanoprost was not administered to Resident 3 because the "med was not available." Facility Nurse C told Surveyor there was no reason Resident 3's latanoprost would not have been available on this 1 date. Resident 3's September MAR 2023 from 09/01/2023 through 09/05/2023, Resident 3's latanoprost was documented as not administered on 09/02/2023 and 09/05/2023 because the "med was not available." Facility Nurse C told Surveyor there was no reason Resident 3's latanoprost would not have been available on these 2 dates. Facility Nurse C, Regional Director B, and Surveyor discussed Resident 3's MARs reviewed from May 2023 through 09/05/2023 included 2 doses of latanoprost not administered by caregivers because Resident 3 refused the medication, there was no opened container of latanoprost for current use on the medication cart, and two unsealed, unopened containers of Resident 3's latanoprost were stored in the medication room refrigerator, including one out-dated container. Surveyor asked if administration of Resident 3's latanoprost, as prescribed, could be assured based on these findings. Facility Nurse C told Surveyor the lack of a an opened container of latanoprost and 2 unsealed containers of latanoprost stored in the refrigerated, as dated, did not comport with caregiver documentation of administration. Summary: The provider did not ensure Resident 1, Resident 2, and Resident 3 received all prescribed medications in the dosage and at intervals prescribed by a practitioner.	N 352		