STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111056	A. BUILDING: _____ B. WING _____	R 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN CROSSINGS AT HUNTER RIDGE	626 MONROE ST BEAVER DAM, WI 53916

(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 10/16/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit for Statement of Deficiency (SOD) V0S815, dated 05/29/2024, and SOD T82P11, dated 08/07/2024, at Sylvan Crossings at Hunter Ridge, a community based residential facility (CBRF) located in Beaver Dam, WI. As a result of the survey, 1 deficiency was identified. The deficiency is a repeat deficiency. See Statement of Deficiency (SOD) T82P11, dated 08/07/2024, SOD V0S815, dated 05/29/2024, SOD V0S814, dated 01/03/2024, SOD V0S813, dated 08/08/2023, SOD V0S812, dated 02/17/2023, and SOD V0S811, dated 07/01/2022. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 17	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 record review and interview, the provider did not ensure that 4 residents received all their prescribed medications in the dosages and at intervals prescribed by their practitioners.	N 352		

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

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N 352	Continued From page 1 From 09/01/2024 - 10/16/2024, there were 11 discrepancies between staff's administration/holding of Resident 5's midodrine HCl and the systolic blood pressure values as indicated in his/her prescription hold parameter. Resident 11's polyethylene glycol, prescribed for daily use, was last dispensed on 03/28/2024 in a container that had 30 once-daily doses but was observed to be nearly full by Surveyors on 10/16/2024. Despite this, staff documented administering 49 daily doses of polyethylene glycol to Resident 11 from 08/29/2024 to 10/16/2024. Resident 14's fluticasone propionate nasal spray, prescribed for twice daily use in both nostrils, was opened for use on 08/31/2024 but was observed to be approximately 75% full by Surveyors on 10/16/2024. Based on Resident 14's dosing instructions, the bottle contained 30 days worth of fluticasone. Despite this, staff documented administering 45 daily doses worth of fluticasone from 09/01/2024 - 10/15/2024. From 09/01/2024 - 10/16/2024, there were 4 discrepancies between staff's administration/holding of Resident 18's amlodipine and metoprolol and the blood pressure and pulse values as indicated in his/her prescription hold parameters. This is a repeat deficiency. See Statement of Deficiency (SOD) T82P11, dated 08/07/2024, SOD V0S815, dated 05/29/2024, SOD V0S814, dated 01/03/2024, SOD V0S813, dated 08/08/2023, SOD V0S812, dated 02/17/2023, and SOD V0S811, dated 07/01/2022.	N 352		

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N 352	Continued From page 2 Findings include: Example 1 - Resident 5 On 10/16/2024, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 09/07/2019 with diagnoses including unspecified hypotension, unsteadiness on feet, and history of falling. Resident 5's prescriptions included midodrine HCl 2.5 mg oral tablet (medication used to treat orthostatic hypotension, a condition characterized by a drop in blood pressure with body position changes) with instructions to, "Give 1 tablet by mouth two times a day related to hypotension, unspecified (I95.9), hold for systolic [blood pressure] greater than 120..." Surveyor reviewed Resident 5's medication administration records (MARs) from 09/01/2024 - 10/16/2024 and observed the following 11 discrepancies between Resident 5's systolic blood pressure values and staff's holding versus administration of his/her midodrine: - 09/02/2024 (3:00 p.m.): Systolic blood pressure recorded as 120, staff documented holding midodrine due to vitals outside of parameters (despite being within parameters for administration) - 09/11/2024 (8:00 a.m.): Systolic blood pressure recorded as 129, staff documented administering midodrine (despite being within parameters for holding) - 09/11/2024 (3:00 p.m.): Systolic blood pressure recorded as 121, staff documented administering midodrine (despite being within parameters for holding) - 09/12/2024 (8:00 a.m.): Systolic blood pressure recorded as 121, staff documented administering	N 352		

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N 352	Continued From page 3 midodrine (despite being within parameters for holding) - 09/13/2024 (8:00 a.m.): Systolic blood pressure recorded as 123, staff documented administering midodrine (despite being within parameters for holding) - 09/23/2024 (8:00 a.m.): Systolic blood pressure recorded as 123, staff documented administering midodrine (despite being within parameters for holding) - 09/26/2024 (3:00 p.m.): Systolic blood pressure recorded as 113, staff documented holding midodrine due to vitals outside of parameters (despite being within parameters for administration) - 09/27/2024 (3:00 p.m.): Systolic blood pressure recorded as 121, staff documented administering midodrine (despite being within parameters for holding) - 09/28/2024 (8:00 a.m.): Systolic blood pressure recorded as 131, staff documented administering midodrine (despite being within parameters for holding) - 10/08/2024 (3:00 p.m.): Systolic blood pressure recorded as 116, staff documented holding midodrine due to vitals outside of parameters (despite being within parameters for administration) - 10/10/2024 (3:00 p.m.): Systolic blood pressure recorded as 120, staff documented holding midodrine due to vitals outside of parameters (despite being within parameters for administration) At approximately 11:50 a.m., Surveyors interviewed Director of Wellness U and Resident Care Coordinator V and reviewed the above errors. Director of Wellness U reported that the provider had implemented measures such as medication audits, medication pass observations,	N 352		

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N 352	Continued From page 4	N 352		

and staff trainings specifically on the interpretation of blood pressure parameters to minimize medication administration errors. Director of Wellness U reported that s/he had started doing MAR audits on 10/09/2024 but was not aware of the error that had occurred on 10/10/2024 for Resident 5's midodrine.

Example 2 - Resident 11

On 10/16/2024, at approximately 8:55 a.m., Surveyors reviewed the medication cart with Caregiver J, who reported s/he was the medication passer that day. Surveyors observed 1 container of polyethylene glycol 3350 powder prescribed to Resident 11. The manufacturer's label indicated that the container contained 30 once-daily doses. The pharmacy label on the container documented that it was dispensed on 03/28/2024 (approximately 7 months prior to the survey) and the instructions were to, "Mix 17 grams (fill cap to line) in 4-8 oz liquid, stir well and drink once daily for constipation (hold for loose stool)." The container was observed to be nearly completely full (Photos 1, 2, and 3). Surveyor interviewed Caregiver J, who reported that Resident 11 was known to typically take his/her polyethylene glycol daily and not refuse it.

On 10/16/2024, Surveyor reviewed Resident 11's record. Resident 11 was admitted to the provider on 11/17/2021 with diagnoses including unspecified dementia and mild cognitive impairment. Resident 11's prescriptions included polyethylene glycol 3350 powder with instructions to, "Mix 1 packet in adequate liquid and drink once daily for constipation. Hold of loose stools." The start date of the prescription was documented as 08/23/2024. Surveyor reviewed Resident 11's MARs from 08/29/2024 -

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N 352	Continued From page 5 10/16/2024 and observed that staff documented administering daily doses of his/her polyethylene glycol to him/her throughout the entire review period, for a total of 49 administrations. At approximately 11:25 a.m., Surveyor interviewed Caregiver J again. Caregiver J reported s/he was unaware of Resident 11 ever having polyethylene glycol packets that staff administered to him/her and that s/he was only aware of administering Resident 11's polyethylene glycol from his/her container. Upon being asked if there were any other containers staff were utilizing to administer Resident 11's polyethylene glycol, Caregiver J showed Surveyor 1 container of polyethylene glycol 3350 powder with a pharmacy label indicating that it was prescribed to Resident 11 and dispensed on 02/05/2024. The seal was still intact on the bottle, indicating that it had not been opened yet. Caregiver J reported s/he was unaware of any other polyethylene glycol containers that staff were using to administer Resident 11's polyethylene glycol. Caregiver J reported s/he could not recall having recently opened a container of polyethylene glycol for Resident 11. When Surveyor discussed the discrepancy between staff's documented administration of Resident 11's polyethylene glycol versus the observed amount of powder on hand, Caregiver J stated, "Oh," but said nothing further. At approximately 11:27 a.m., Surveyor interviewed Caregiver F. Caregiver F reported his/her duties also included routine medication administration. Caregiver F reported s/he did not recall having recently opened a new container of polyethylene glycol for Resident 11 but reported that s/he always administered it during his/her medication passing shifts.	N 352		

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N 352	Continued From page 6 At approximately 11:50 a.m., Surveyors interviewed Director of Wellness U and Resident Care Coordinator V. Director of Wellness U reported that on 08/01/2024 the provider had switched pharmacies and with Resident 11's polyethylene glycol order having started on 08/23/2024, the new pharmacy would have sent new polyethylene glycol for him/her. Director of Wellness U reported that the provider's current pharmacy was Pharmacy W and the provider's previous pharmacy was Pharmacy X. At approximately 3:40 p.m., Surveyor interviewed Pharmacy Technician Y from the provider's current pharmacy. Pharmacy Technician Y reported that the pharmacy has had a prescription for Resident 11's polyethylene glycol since 07/16/2024 but staff had never requested it. Pharmacy Technician Y confirmed that the pharmacy had never dispensed polyethylene glycol (in either packets or containers) for Resident 11. At approximately 3:45 p.m., Surveyor interviewed Pharmacist Z from the provider's last pharmacy. Pharmacist Z confirmed that they had stopped servicing the provider around June of 2024, with the last cycled medications for Resident 11 having been sent out on 06/28/2024 with a start date of 07/04/2024 and thus anticipated to have lasted until the beginning of August 2024. Pharmacist Z confirmed that the last time the pharmacy dispensed Resident 11's polyethylene glycol was on 03/28/2024 in a container that contained 30 once-daily doses. Pharmacist Z confirmed that this container should have only lasted for approximately 1 month and that no refill requests were made since that bottle was dispensed.	N 352		

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N 352	Continued From page 7 Surveyor observed that the reports from Pharmacy Technician Y and Pharmacist Z were consistent with Surveyor's observation of Resident 11's polyethylene glycol labels. Example 3 - Resident 14 On 10/16/2024, at approximately 8:55 a.m., Surveyors reviewed the medication cart with Caregiver J, who reported s/he was the medication passer that day. Surveyors observed a box containing 1 bottle fluticasone propionate 50 mcg nasal spray, prescribed to Resident 14. The pharmacy label on the box documented that it was dispensed on 08/26/2024 and had prescriptions instructions to, "Use 1 spray in each nostril twice daily for asthma." The manufacturer's label on the bottle documented that the bottle contained 120 metered sprays. Handwritten in marker on the bottle was "8/31/24" (5 days after the bottle was dispensed). Caregiver J reported that s/he thought the handwritten date was the date staff opened and began using the bottle for Resident 14. Surveyor observed that from the number of sprays the bottle contained, compared to Resident 14's prescription, that Resident 14 was prescribed 4 sprays daily (1 spray per nostril, twice daily). Based on this, routine administration of Resident 14's fluticasone would indicate that the bottle contained 30 days worth of his/her dosing supply. The bottle was observed to be approximately 75% full (Photos 4, 5, 6, 7). At approximately 9:55 a.m., Surveyor interviewed Caregiver J, who reported that Resident 14 was known to typically take his/her fluticasone spray daily and not refuse it.	N 352		

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N 352	Continued From page 8 On 10/16/2024, Surveyor reviewed Resident 14's record. Resident 14 was admitted to the provider on 08/06/2016. Resident 14's prescriptions included fluticasone propionate 50 mcg nasal suspension with instructions of, "1 spray in each nostril two times a day for asthma..." The start date of the medication was 07/01/2024. Surveyor reviewed Resident 14's MARs from 09/01/2024 (approximately 1 day after what appeared to be the "open" date of Resident 14's current fluticasone bottle) through 10/15/2024. Surveyor observed that staff documented administering all twice daily doses of his/her fluticasone to him/her throughout the entire review period, for a total of 45 daily administrations. At approximately 11:50 a.m., Surveyors interviewed Director of Wellness U and Resident Care Coordinator V. Director of Wellness U confirmed understanding of Surveyor's concern that staff could not have administered all of Resident 14's doses of fluticasone to him/her based on how many sprays-worth the bottle contained and that it still appeared approximately 75% full. Director of Wellness U reported that management had been doing observations of medication passes with staff to verify medication administration compliance but had not been checking on-hand amounts of non-tablet/capsule medications to verify compliance with administration. Example 4 - Resident 18 On 10/16/2024, Surveyor reviewed Resident 18's record. Resident 18 was admitted to the provider on 03/25/2021 with diagnoses including essential hypertension. Resident 18's prescriptions included the following:	N 352		

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N 352	Continued From page 9 - Amlodipine bedylate 5 mg tablet with instructions to, "Give 1 tablet by mouth one time a day...if blood pressure <100/50 or pulse <55, hold medication..." - Metoprolol tartrate 25 mg tablet with instructions to, "Take 1 tablet by mouth twice a day...if blood pressure <100/50 or pulse <55, hold medication..." On 09/30/2024 at approximately 4:30 p.m., the hold parameters changed to, "...Hold for [systolic blood pressure] less than 120." Surveyor reviewed Resident 18's MARs from 09/01/2024 - 10/16/2024 and observed the following 4 discrepancies between Resident 18's recorded blood pressure values and staff's holding versus administration of his/her amlodipine and metoprolol: - 09/07/2024 (morning administration): Blood pressure recorded as 131/57, no pulse recorded. Staff documented administering metoprolol but not his/her amlodipine (despite having the same hold parameters at this time). - 09/10/2024 (evening administration): Pulse recorded as 54 (within hold parameters), staff documented administering metoprolol - 09/22/2024 (morning administration): Pulse recorded as 52 (within hold parameters). Staff documented administering both metoprolol and amlodipine - 09/26/2024 (morning administration): Blood pressure recorded as 138/59, pulse recorded as 70. Staff documented holding both metoprolol and amlodipine. At approximately 11:50 a.m., Surveyors interviewed Director of Wellness U and Resident Care Coordinator V and reviewed the above errors. Director of Wellness U confirmed that on	N 352		

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N 352	Continued From page 10 the 09/07/2024 administration, s/he could not find that staff recorded a pulse value which would have indicated whether the amlodipine and metoprolol were both supposed to have been held or administered. Director of Wellness U reported s/he thought a couple occasions of administration errors were just documentation errors, but confirmed with Surveyor s/he had no evidence of this. Director of Wellness U reported that the provider had implemented measures such as MAR audits, medication pass observations, and staff trainings specifically on the interpretation of blood pressure parameters to minimize medication administration errors.	N 352		