STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019034	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD AT KEWAUNEE (THE)	**625 4TH ST KEWAUNEE, WI 54216**

(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
U 000	INITIAL COMMENTS On 01/27/2025 with additional information gathered through 01/30/2025, Surveyor conducted a standard survey and complaint investigation at Concord of Kewaunee (The). As a result of the survey, 1 deficiency was identified and the complaint was unsubstantiated. Census: 13	U 000		
U 118	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure nursing services, specifically medication management were provided. Tenant 1 and Tenant 2's medication and medications to be destroyed were not properly stored when they were left unsecured in	U 118		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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U 118	Continued From page 1 Executive Director (ED) A's office. Findings include: DHS 89.13(22) "Medication management" means oversight by a nurse, pharmacist, or other healthcare professional to minimize risks associated with use of medications. Medication management includes proper storage of medications; preparation of a medication organization or reminder system; assessment of the effectiveness of medications; monitoring for side effects, negative reactions and drug interactions; and delegation and supervision of medication administration. On 01/27/2025 at approximately 10:20 AM, Surveyor entered the facility and observed the door to ED A's office was unsecured and the room was dark. Surveyor observed as Caregiver B was in the medication room. At 10:45 AM, Surveyor observed a white 4 cube horizontal shelving unit on the back wall of ED A's office. In 2 of the 4 cubes, Surveyor observed several medication blister packs belonging to Tenant 1 and Tenant 2. One of the cubes was labeled with "Tenant 1's" name and contained approximately 44 blister packs. Another cube had "Tenant 2's" name and approximately 14 blister packs. Surveyor also observed approximately 20 opened blister packs in a tray on top of the shelving unit belonging to several other residents. In addition, Surveyor observed a rolling cart with 6 drawers next to the shelving unit and there were 2 of 6 drawers with Tenant 1 and Tenant 2's names. The drawers contained medication pill bottles for Tenant 1 and Tenant 2. At 11:30 AM, Surveyor interviewed Caregiver B	U 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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U 118	Continued From page 2 who identified s/he was the medication technician working on this day. Surveyor asked about the medications on the shelving unit. Caregiver B reported the opened blister packed medications on the tray were medications that needed to be destroyed. S/he stated they were just put in the tray this morning and s/he was waiting on another staff to come in to assist with destruction of those medications. Caregiver B stated Tenant 1 and Tenant 2 receive a 3-month supply of their medication and the medication in the cube were "extra ones." Caregiver B reported there is not enough room in their medication cabinet in the medication room as one side of the cabinet is broken. When Surveyor explained the door to ED A's was open upon Surveyor's arrival, Caregiver B stated "That was my doing. I brought the medications that needed to be destroyed in the office this morning." Caregiver B also reported Tenant 1 and Tenant 2's medication have been in the office for about 6 months. At approximately 11:45 AM, Surveyor interviewed ED A who acknowledged Surveyor's findings. S/he reported the office door is normally closed, so s/he was not sure why it was open. The provider did not ensure nursing services, specifically medication management were provided.	U 118		