STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015624	A. BUILDING: _____ B. WING _____	C 11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW BROOKE POINT SENIOR LIVING CBF	1800 BLUEBELL LN STEVENS POINT, WI 54481

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N 000	Initial Comments On 11/12/2025, Surveyors conducted an investigation into 2 complaints at Willow Brooke Point Senior Living CBRF. One (1) of 2 complaints were substantiated and 2 deficiencies were identified. Census: 44	N 000		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not maintain accurate proof-of-use records for scheduled II drugs. On 11/12/2025, Resident 2's proof-of-use documentation for Tramadol was not accurate and Resident 3's proof-of-use record for oxycodone was incomplete. Findings include: The Department received a complaint alleging concerns with the provider's proof-of-use records. On 11/12/2025 at 10:15 AM, Surveyor and	N 409		

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

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N 409	Continued From page 1 Caregiver C observed the first of two medication storage carts. Caregiver C explained each cart has a drawer for storing narcotic medications. At the time of narcotic administration, caregivers are supposed to sign the medication out in two places; the electronic medication administration record (MAR) and a paper form titled "Controlled Drug Record" (CDR). The CDR maintains a balance of the amount of pills left in each medication card. At the time of each shift change (6:00 AM, 2:00 PM and 10:00 PM) one staff member from each shift is to compare the number of pills in the medication card with the number of pills documented on the CDR, and the numbers should match. Then, each shift member signs a form titled "Narcotic Reconciliation/Card Count" to attest the counts match. Surveyor and Caregiver C compared the balances documented on the CDRs with the number of pills in the narcotic medication cards in cart 1. Resident 2 had a medication card containing 19 pills of Tramadol. The CDR noted the total was 18. Caregiver C said s/he did not have first hand knowledge of the discrepancy, but noted Caregiver A signed out the medication twice on the CDR on 11/11/2025 during 2nd shift. Caregiver C looked in the MAR and noted it was only documented as administered once. Caregiver C said if the MAR was accurate and if Caregiver A made a mistake by signing the medication out twice on the CDR, that would account for the discrepancy. Caregiver C acknowledged the discrepancy should have been caught during the count at shift change from 2nd to 3rd shift and again at shift change from 3rd	N 409		

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N 409	Continued From page 2 shift to 1st shift, but it was not. Caregiver D was in the medication room at the time and explained to Surveyor at the start of 1st shift today, s/he did the "narc count" with Caregiver E who worked 3rd shift. While they counted, Caregiver E said "there were a few things missed" when s/he counted with Caregiver A the night before at the start of 3rd shift, and one of the things was the discrepancy with Resident 2's Tramadol count. Surveyor then moved to cart 2 and along with Caregiver D, and compared the balances on the CDRs with the number of pills in the narcotic medication cards. Resident 3 had a medication card containing 25 pills of oxycodone to be administered every 4 hours as needed for pain. The CDR also recorded a balance of 25 pills. However, the CDR documentation of administration during 2nd shift on 11/11/2025 was incomplete. An entry was made with the date of 11/11/2025 but the corresponding prompts on the CDR for the time, amount, and signature of staff who administered the medication were left blank. In the margin to the right of the prompts, was Caregiver A's first name. Caregiver D and Surveyor reviewed the MAR and noted the medication was also not documented as administered in that record. Caregiver D acknowledge neither record documented the medication was administered on 11/11/2025 and s/he believed Caregiver E (3rd shift) wrote Caregiver A's name in the margin to reconcile the count. On 11/12/2025 at 3:30 PM, Surveyor reviewed a	N 409		

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N 409	Continued From page 3	N 409		

form titled "Narcotic Reconciliation/Card Counts" for both medication carts. At shift change from 2nd into 3rd on 11/11/2025 and 3rd into first on 11/12/2025, two staff members signed the forms attesting the counts were verified for each cart. Neither form identified the discrepancy with Resident 2 and Resident 3's records and medication balances.

On 11/12/2025 at 3:04 PM, Surveyor interviewed Caregiver A. Caregiver A described the same process for proof-of-use records for schedule II drugs as Caregiver C did.

Caregiver A said the night prior, s/he signed out Resident 2's medication twice on the CDR in error, but s/he was positive s/he only administered it once. Therefore, the balance on the CDR should have been 19 to align with the 19 pills remaining in the card.

Caregiver A confirmed s/he did not document the date or time of Resident 3's oxycodone administration on 11/11/2025. Caregiver A said during the shift change narcotic count with Caregiver E, s/he told Caregiver E s/he administered the medication to Resident 3 and said, "I thought [Caregiver E] would fix it on the sheet" so the counts would match. Caregiver A explained the reason s/he did not document the administration in the MAR was because s/he was having login problems.

Caregiver A also acknowledged caregivers are "rushing through" the shift change narcotic counts to "get out of here" and there have been times when counts don't happen at all. Caregiver A said this has been ongoing "for a while" and acknowledged it occurred dating back to July 2025. Caregiver A said the former administrator,

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N 409	Continued From page 4 Administrator F, did not double check the counts which allowed the problem to persist. Cross Reference: N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 409		
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 ensure the person who administered medications recorded the name, dosage, date and time of administration. On 07/22/2025, Caregiver A documented administration of four medications to Resident 1 that s/he did not administer. Findings include: The Department received a complaint alleging concerns with medication administration causing	N 415		

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N 415	Continued From page 5 negative resident outcome. On 11/12/2025 at 1:20 PM, Surveyor reviewed Resident 1's facility record. Resident 1 had an activated power of attorney for health care, relied on facility staff to administer medications and had diagnoses to include schizophrenia. On 07/22/2025, Caregiver A documented in the electronic medication administration record (MAR), that s/he administered all of Resident 1's "HS" (bedtime) medications which included: --Depakote 250 mg for schizophrenia --Clonazepam for anxiety --omeprazole 20 mg for GERD --multivitamin On 11/12/2025 at 3:04 PM, Surveyor interviewed Caregiver A. Caregiver A recalled medication administration during the evening of 07/22/2025. Caregiver A said s/he was training Caregiver B. Caregiver A recalled for four residents including Resident 1, s/he (Caregiver A) prepared the medications by popping them from the medication cards into a pill cup, and then gave the pill cup to Caregiver B to administer to residents. Caregiver A specifically recalled Resident 1's administration and said s/he waited outside the door when Caregiver B administered the medications and s/he did not observe the medication administration. Caregiver A said s/he then documented in the MAR that s/he (Caregiver A) was the one who administered the medications when in fact it was Caregiver B. Caregiver A acknowledged in hindsight, s/he did not know for certain if the medications were given to Resident 1 because s/he did not witness the administration. Cross Reference:	N 415		

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N 415	Continued From page 6 N0409 DHS 83.27(1)(j) Proof-Of-Use Record	N 415		