STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015333	A. BUILDING: _____ B. WING _____	R-C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBRING ASSISTED CARE RESIDENCE	7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719

(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 09/18/2025, Surveyor conducted 1 verification visit and1 complaint investigation at Sebring Assisted Care Residence. Two deficiencies were identified. Both deficiencies were repeat violations. See Statement Of Deficiency (SOD) 62US12, dated 12/19/2019, SOD KSK211 dated 06/02/2023, SOD ZILL12 dated 02/20/2024, SOD ZILL13 dated 07/09/2024, SOD Z1LL15, dated 05/21/2025. Seven of 8 deficiencies from SOD Z1LL15, dated 05/21/2025 were substantially corrected. The complaint was unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 39	{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 the resident right to receive all prescribed medication in the dosage and at intervals prescribed by their practitioner.	{N 352}		

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

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{N 352}	Continued From page 1 Two of 2 of 3 residents reviewed had not received all prescribed medications as ordered by their practitioner. This is a repeat deficiency. See Statement Of Deficiency (SOD) KSK211 dated 06/02/2023, SOD ZILL12 dated 02/20/2024, SOD ZILL13 dated 07/09/2024, SOD Z1LL15 dated 05/21/2025. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 81 residents within the client groups of irreversible dementia/Alzheimer's and advanced age. On 09/18/2025 at 12:05 PM, Surveyor inspected medication carts and reviewed Resident 15's and Resident 13's records. Example 1- Resident 15 On 09/18/2025 at 12:05 PM, Surveyor inspected the northwest medication cart with Caregiver CCC. Surveyor observed Resident 15's 11:00 PM bubble packs. Pharmacy label identified: Carbidopa/Levodopa 25-100 MG Take 1 tablet 7 times daily at 3:00 AM, 7:00 AM, 11:00 AM, 2:00 PM, 5:00 M 8:00 PM and 11:00 PM for Parkinson's disease. Dispensed 08/27/2025 1 tablet remained in the 09/15/2025 slot (Photo 2). Carbidopa//Levodopa 50-200 MG Take 1 tablet 6 times daily at 7:00 AM, 11:00 AM, 2:00 PM, 5:00 PM, 8:00 PM, and 11:00 PM for	{N 352}		

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{N 352}	Continued From page 2	{N 352}		

Parkinson's disease.
Dispensed 08/27/2025
1 tablet remained in the 09/15/2025 slot (Photo 3).

Resident 15 was admitted 08/06/2025. Diagnoses included Parkinson's disease.
Physician orders included carbidopa/levodopa 25-100 MG take 1 tablet 7 times daily at 3:00 AM, 7:00 AM, 11:00 AM, 2:00 PM, 5:00 M 8:00 PM and 11:00 PM and carbidopa//levodopa 50-200 MG take 1 tablet 6 times daily at 7:00 AM, 11:00 AM, 2:00 PM, 5:00 PM, 8:00 PM, and 11:00 PM both for Parkinson's disease.

Medication Administration Record (MAR):
On 09/15/2025 staff documented administration of 11:00 PM carbidopa/levodopa 25-100 MG and carbidopa//levodopa 50-200 MG.

Observation notes dated 09/01/2025- 09/18/2025 did not address why carbidopa/levodopa was documented as administered when left in bubble packs.

Individual service plan (ISP) dated 08/12/2025:
In the area of Medication Administration:
" ...I will receive medications safely and as prescribed ...I request the staff to administer my medications to me ..."

Example 2- Resident 13
On 09/18/2025 at 12:12 PM, while inspecting the east wing medication cart with Caregiver I, Surveyor observed Resident 13's morning metformin bubble pack.

Pharmacy label identified
Metformin 500 MG ER
Take 2 tablets twice daily at mealtime for diabetes

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{N 352}	Continued From page 3 mellitus. Dispensed 08/27/2025 Two tablets remained in the 09/04/2025 slot (photo 1). Resident 13 was admitted 08/22/2024. Diagnoses included type 2 diabetes mellitus. Physician orders included metformin 500 MG 2 tablets twice daily (start 06/14/2025). MAR: On 09/04/2025, staff documented administration of AM metformin 1000 MG. Observation notes dated 09/01/2025-09/18/2025 did not address why staff documented metformin was administered when it remained in the bubble pack. ISP dated 03/13/2025: In the area of Medication Administration " ...I will receive medications safely and prescribed ...I request staff to administer my medications to me ..." On 09/18/2025 at 12:12 PM, Surveyor interviewed Caregiver I who stated the September 2025 medication cycle started 09/04/2025. (Note: Cycle start date is the 1st day medication is administered from the pharmacy bubble pack.) On 09/18/2025 at 1:12 PM, Surveyor interviewed Resident 15 who stated staff could administer medication within 1 hour prior to 1 hour after scheduled administration time. Resident 15 stated occasionally staff administered 11:00 PM carbidopa/levodopa late or not at all because PM	{N 352}		

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{N 352}	Continued From page 4 and night shift staff did not coordinate which shift would administer it, since it could be administered from 10:00 PM- midnight. Resident 15 stated s/he requested staff prioritize administration of his/her carbidopa//levodopa due to its wearing off effects which s/he described as "disastrous." Resident 15 stated s/he experienced hot flashes, burning sensation on skin, itching, painful feet and ankles, and fast, heavy breathing when the medication wore off when administered late or not at all. On 09/18/2025 at 1:45 PM, Surveyor discussed concerns of medication administration with Administrator WW and Health and Wellness Director RR. Health and Wellness Director RR stated s/he was unsure why the medications were not administered especially since all medication passers were retrained on medication administration after they received the last SOD (SOD Z1LL15, dated 05/21/2025 and issued by the Department on 07/11/2025). On 09/18/2025 at 5:28 PM, Surveyor interviewed Pharmacy Tech DDD who stated pharmacy delivered Resident 13's metformin 500 MG and Resident 15's carbidopa/levodopa 50-200 MG and 25-100 MG to facility on 09/02/2025. Cross Reference: N0415 83.37(2)(d) Documentation Of Medication Administration	{N 352}		
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	N 415		

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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 staff accurately documented time of medication administration in the resident record.

Staff did not accurately document time of medication administration for Resident 15.

This is a repeat deficiency. See Statement Of Deficiency (SOD) 62US12, dated 12/19/2019 and SOD KSK211, dated 06/02/2023.

Findings include:
On 09/18/2025, Surveyor reviewed Resident 15's record. S/he was admitted 08/22/2024.

Physician orders included:
-carbidopa-levodopa 25-100 MG 1 tablet 6 times daily for Parkinson's disease (start 08/05/2025)
Scheduled administration times: 7:00 AM, 11:00 AM, 2:00 PM, 5:00 PM, 8:00 PM and 11:00 PM

-carbidopa-levodopa ER 50-200 MG 1 tablet 6 times daily for Parkinson's disease (start date 08/05/2025)
Scheduled administration times 7:00 AM, 11:00 AM, 2:00 PM, 5:00 PM, 8:00 PM and 11:00 PM

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N 415	Continued From page 6 -ascorbic acid 500 MG 2 tablets twice daily (start 08/05/2025) scheduled administration times 8:00 AM and 8:00 PM -docusate sodium 50 MG1 tablet once daily (start date 08/05/2025) scheduled administration time 8:00 AM -lactobacillus 1 tablet once daily (start 08/05/2025) scheduled administration time 8:00 AM -metoprolol succinate ER 25 MG 1 tablet once daily (start date 08/05/2025) scheduled administration time 8:00 AM -sennosides 17.2 MG 1 tablet twice daily (start date 08/05/2025, discontinued 09/03/2025) and 2 tablets twice daily (start date 09/03/2025) scheduled administration times 8:00 AM and 8:00 PM -ginger root 500 MG 1 capsule 3 times daily (start 08/05/2025) scheduled administration times 8:00 AM, 12:00 PM and 5:00 PM -multivitamin with minerals 1 tablet once daily (start date 08/06/2025) scheduled administration time 8:00 AM -azelastine nasal solution 0.15% spray 2 sprays in both nostrils twice daily (start date 08/05/2025) scheduled administration times 8:00 AM and 8:00 PM -mirabegron ER 25 MG 1 tablet once daily (start date 08/05/2025) scheduled administration time 8:00 AM	N 415		

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N 415	Continued From page 7 -coenzyme Q10 1 capsule once daily (start date 08/05/2025) scheduled administration time 8:00 AM -cyanocobalamin 500 MCG 500 MCG 1 tablet once daily (start date 08/05/2025) scheduled administration time 8:00 AM -cholecalciferol 1 tablet once daily (start date 08/05/2025) scheduled administration time 8:00 AM -turmeric 500 MG 1 tablet once daily (start date 08/05/2025) scheduled administration time 8:00 AM -polyethylene glycol 3350 17 grams twice daily (start date 08/05/2025) scheduled administration times 09:00 AM and 5:00 PM Medication Administration Audit Report dated 09/01/2025-09/18/2025 identified: -09/01/2025 - 7:00 AM, 8:00 AM, and 9:00 AM medications were documented as administered at 11:19 AM and 11:20 AM; 11:00 AM and 12:00 PM medications were documented as administered at 2:06 PM. -09/03/2025- 11:00 AM medications were documented as administered at 2:21 PM. -09/05/2025- 5:00 PM medications were documented as administered at 8:05 PM. -09/06/2025- 5:00 PM medications were documented as administered at 7:43 PM. -09/07/2025- 5:00 PM medications were	N 415		

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documented as administered at 6:41 PM.

-09/08/2025- 7:00 AM, 8:00 AM, and 9:00 AM medications were documented as administered at 10:20 AM; and 5:00 PM medications were documented as administered at 6:45 PM.

-09/09/2025- 9:00 AM medication was documented as administered at 12:25 PM.

-09/10/2025- 8:00 AM, 9:00 AM, 11:00 AM and 12:00 PM medications were documented as administered at 1:50 PM and 1:51 PM.

-09/11/2025- 5:00 PM medications were documented as administered at 8:00 PM.

-09/12/2025- 5:00 PM and 8:00 PM medications were documented as administered at 10:28 PM.

-09/13/2025- 11:00 AM, 12:00 PM, and 2:00 PM medications were documented as administered at 7:34 PM; and 5:00 PM medications were documented as administered at 7:37 PM.

-09/14/2025- 7:00 AM, 8:00 AM, and 9:00 AM medications were documented as administered at 10:42 AM; 12:00 PM and 2:00 PM medication were documented as administered at 3:08 PM; and 5:00 PM medications were documented as administered at 6:58 PM and 7:01 PM.

-09/16/2025- 7:00 AM and 8:00 AM medications were documented as administered at 9:10 AM; 11:00 AM and 12:00 PM medications were documented as administered at 1:31 PM; and 8:00 PM medications were documented as administered at 10:12 PM.

-09/17/2025- 11:00 AM and 12:00 PM

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N 415	Continued From page 9 medications were documented as administered at 1:15 PM; 5:00 PM and 8:00 PM medications were documented as administered at 10:17 PM and 10:18 PM. On 09/18/2025 at 1:45 PM, Surveyor reviewed the September 2025 Medication Administration Audit Report and discussed concerns of medication administration with Administrator WW and Health and Wellness Director RR. Health and Wellness Director RR stated staff administered the medications at correct times but waiting to document medication passes all at once. Health and Wellness Director RR stated they recently retrained staff on medications including administration documentation. Cross Reference: N0352 83.32(3)(h) Rights Of Residents: Receive Medication	N 415		