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 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT COVENTRY VILLAGE	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 03/11/2026, the bureau of assisted living southern regional office conducted 2 verfication visits at The Terraces at Coventry Village a CBRF located in Madison, WI. As a result of this survey, 1 violation of DHS Chapter 83 was identified. One of 2 violations from previous statement of deficiency (SOD) Z1LL16 dated 09/18/2025 was corrected. One of 1 violation from previous SOD 63R911 dated 10/17/2025 was corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 34	{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, record review and interview, the provider did not ensure residents received all prescribed medication in the dosage and at intervals prescribed by their practitioner. From 11/20/2025 to 03/05/2026, Resident 16 was not administered 55 doses of polyethylene glycol	{N 352}		

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

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{N 352}	Continued From page 1 as prescribed. From 02/10/2026 to 03/11/2026, Resident 17 was not administered approximately 68 puffs of his/her Symbicort inhaler as prescribed. From 01/29/206 to 03/11/2026, Resident 18 was not administered 18 capsules of his/her CREON 36000UNT with meals as prescribed. This is a repeat from previous 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 and SOD ZILL16 dated 09/18/2025. FINDINGS INCLUDE: On 03/11/2026, Surveyors arrived at facility for a verification visit. OBSERVATION & INTERVIEW: On 03/11/2026 at approximately 10:30 AM, Surveyor observed the contents of the memory cart medication cart with Caregiver CCC. Surveyor opened the top drawer of the medication cart and found 2 prescription bottles of CREON (Pancrelipase) 36000unit capsules. Surveyor picked up the bottles of CREON and asked Caregiver CCC to acknowledge the first bottle's prescription label had a dispense date of 01/23/2026 and original quantity was 100 capsules (Picture 6). Surveyor opened the bottle of CREON dispensed in January and counted 4 capsules remaining in the bottle (Picture 5). Surveyor showed Caregiver CCC the contents of the CREON bottle and acknowledged 4 capsules remained in the bottle. Surveyor picked up the second bottle of CREON and asked Caregiver	{N 352}		

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{N 352}	Continued From page 2 CCC to acknowledge the prescription label on outside of the bottle had a dispense date of 02/19/2026 and original quantity was 100 capsules (Picture 4). Surveyor removed the cap and observed the CREON bottle dispensed in February 2026 and found the aluminum sealed was unbroken (Picture 4). Caregiver CCC acknowledged the second CREON bottle remained sealed with the original quantity of 100 capsules. Surveyor observed Resident 17's inhaler had an original quantity of approximately 120 doses (puffs) of medication and the dial on the dosage counter was at approximately 80 puffs remaining inside the inhaler (Picture 2). Surveyor reviewed the pharmacy bag with the inhaler's prescription order. A pharmacy sticker that documented, "DATE OPENED: 02/10/2026 ..." and an order for," BUDES/FORMOT AER 160-4.5 ...SYMBICORT ...02/04/26 ...INHALE 2 PUFFS BY MOUTH TWICE DAILY FOR CHRONIC WIDENING OF LUNG AIR PASSAGES ..." (Picture 3). Surveyor calculated with Caregiver CCC that Resident 17's inhaler originally contained 30 days' worth of medication (4 puffs X 30 days = 120 puffs). Surveyor with Caregiver CCC calculated that 30 days from the date the inhaler was opened on 02/10/2026, was 03/13/2026. Caregiver CCC acknowledged that had Resident 17's inhaler been administered as prescribed daily the inhaler should only have approximately 8-12 puffs of medication left. Caregiver CCC acknowledged the inhaler had approximately 80 puffs left in it. Surveyor picked up Resident 16's bottle of Polyethylene Glycol, the prescription label documented a dispense date of 11/17/2025 and an order to administer 17gm once daily. Surveyor opened the bottle of polyethylene glycol and observed it to be 50 % filled with powder. Surveyor asked Caregiver CCC to observe the inside of the polyethylene	{N 352}		

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{N 352}	Continued From page 3	{N 352}		

glycol bottle and acknowledge the bottle of 50% full. Caregiver CCC reported that Resident 16's bottle of polyethylene glycol was about a month supply and didn't know why s/he still had a bottle dispensed in November 2025.

RECORD REVIEW:

EXAMPLE 1: Resident 16

On 03/11/2026, Surveyor reviewed Resident 16's face sheet. Resident 16 was admitted to the facility on 12/13/2023. Resident 16 was diagnosed with but not limited to: dementia, psychotic disturbance, mood disturbance, anxiety, and major depressive disorder. Resident 16 had a legal guardian.

On 03/11/2026, Surveyor reviewed Resident 16 individualized service plan (ISP). Resident 16's ISP was signed on 02/03/2026. Resident 16's ISP documented facility staff were to administer all of Resident 16's medications.

On 03/11/2026, Surveyor reviewed Resident 16's physician orders. The polyethylene glycol was ordered as, "MIX 17 GRAMS (FILL CAP TO LINE) IN 4 TO 6 OZ LIQUID STIR WELL AND DRINK ONCE DAILY FOR CONSTIPATION."

On 03/11/2026, Surveyor reviewed Resident 16's November 2025 medication administration record. Surveyor counted from 11/20/2025 to 11/30/2025, there were 11 doses of polyethylene glycol documented as administered.

On 03/11/2026, Surveyor reviewed Resident 16's December 2025 MAR. Surveyor counted from 12/01/2025 to 12/31/2025, there were 25 doses of polyethylene glycol documented as

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{N 352}	Continued From page 4 administered. On 03/11/2026, Surveyor reviewed Resident 16's January 2026 MAR. Surveyor counted from 01/01/2026 to 01/30/2026, there were 19 doses of polyethylene glycol documented as administered. On 03/11/2026, Surveyor reviewed Resident 16's February 2026 MAR. Surveyor counted from 02/01/2026 to 02/28/2026, there were 26 doses of polyethylene glycol documented as administered. On 03/11/2026, Surveyor reviewed Resident 16's March 2026 MAR. Surveyor counted from 03/01/2026 to 03/05/2026, there were 5 doses of glycol documented as administered. EXAMPLE 2: Resident 17 On 03/11/2026, Surveyor reviewed Resident 17's facesheet. Resident 17 was admitted to the facility on 02/20/2024. Resident 17 was diagnosed with but not limited to: type 2 diabetes mellitus and mild cognitive impairment. On 03/11/2026, Surveyor reviewed Resident 17's ISP. Resident 17's ISP was signed on 02/25/2026. Resident 17's ISP documented facility staff were to administer all of Resident 17's medications. On 03/11/2026, Surveyor reviewed Resident 17's physician orders. The Symbicort inhaler was ordered as, "INHALE 2 PUFFS BY MOUTH TWICE DAILY FOR CHRONIC WIDENING OF LUNG AIR PASSAGES (RINSE MOUTH AFTER EACH USE) *WAIT 1 MINUTE BETWEEN PUFFS."	{N 352}		

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{N 352}	Continued From page 5 On 03/11/2026, Surveyor reviewed Resident 17's February 2026 MAR. Surveyor counted from 02/10/2026 to 02/28/2026, there were 68 puffs documented as administered. On 03/11/2026, Surveyor reviewed Resident 17's March 2026 MAR. Surveyor counted from 03/01/2026 to 03/11/2026, there were 40 puffs documented as administered. EXAMPLE 3: Resident 18 On 03/11/2026, Surveyor reviewed Resident 18's facesheet. Resident 18 was admitted to the facility on 08/22/2024. Resident 18 was diagnosed with but not limited to: dementia. Resident 18 had an activated power of attorney. On 03/11/2026, Surveyor reviewed Resident 18's ISP. Resident 18's ISP was signed on 01/27/2026. Resident 18's ISP documented facility staff were to administer all of Resident 18's medications. On 03/11/2026, Surveyor reviewed Resident 18's physician orders. The order for CREON 36,0000 DR-H was, "TAKE BY MOUTH 1 CAP WITH BREAKFAST, 1 CAP WITH LUNCH, 1 CAP WITH DINNER." On 03/11/2026, Surveyor reviewed Resident 18's January 2026 MAR. Surveyor counted from 01/29/2026 to 01/31/2026, there were 8 capsules of CREON 36000UNT documented as administered. On 01/31/2026 at 5:00 PM, staff documented "not on hand ..." On 03/11/2026, Surveyor reviewed Resident 18's February 2026 MAR. Surveyor counted from	{N 352}		

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{N 352}	Continued From page 6 02/01/2026 to 02/28/2026, there were 75 capsules of CREON 36000UNT documented as administered. On 02/03/2026 at 5:04 PM, staff documented, "not in cart." On 02/05/2026 at 5:36 PM, staff documented, "not on hand." On 02/10/2026 at 8:18 AM, staff documented, "not on hand." On 02/10/2026 at 11:49 AM, staff documented, "not on hand." On 02/11/2026 at 4:36 PM, staff documented, "not on hand." On 02/17/2026 at 5:12 PM, staff documented, "no in cart." On 02/25/2026 at 8:24 AM, staff documented, "none." On 03/11/2026, Surveyor reviewed Resident 18's March 2026 MAR. Surveyor counted from 03/01/2026 to 03/11/2026, there were 31 capsules of CREON 36000UNT documented as administered. INTERVIEWS: On 03/11/2026 at 11:30 AM, Surveyor asked Nurse RR if facility had a system for monitoring if capsules from pill bottles were being administered as prescribed. Nurse RR requested clarification. Surveyor asked if Nurse RR had a system for knowing how many capsules remained in Resident 18's CREON bottles. Nurse RR explained Resident 18's CREON was delivered from a special pharmacy in California and s/he had some issues getting a bottle in January. Nurse RR stated Resident 18's was the only resident with medications stored in a prescription pill bottle. Nurse RR denied having any special system for staff to follow when administering medication from prescription pill bottles. On 03/11/2026 at 12:30 PM, Surveyors discussed the above concerns with Nurse RR and Administrator EEE. Surveyor explained that from	{N 352}		

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{N 352}	Continued From page 7 01/29/2026 until 03/11/2026 there had been 104 capsules of CREON documented as administered, and 8 capsules documented as not being available for administration. Nurse RR agreed that staff had access to Resident 18's CREON capsules from 01/29/2026 to 03/11/2026 for administration, and acknowledged staff didn't administer the 8 capsules documented as "not being available" as prescribed. Surveyor explained that Resident 18 had 104 capsules remaining in the 2 bottles observed during the medication cart audit, and that 114 capsules had been documented as administered on the MAR since 01/29/2026. Nurse RR and Administrator EEE acknowledged Resident 18 didn't receive 10 of the 114 capsules documented as administered on the MARs. Surveyor explained Resident 17's inhaler was opened on 02/10/2026 with an original quantity of 120 puffs. Surveyor explained that from 02/10/2026 to 03/11/2026, staff had documented 108 puffs as administered in Resident 17's MAR. Surveyor explained that during the medication cart audit Resident 17's inhaler had approximately 80 puffs remaining. Nurse RR and Administrator EEE acknowledged that if Resident 17's inhaler been administered as documented from 02/10/2026 to 03/11/2026 then there would only be approximately 12 puffs remaining, and that Resident 17 didn't receive approximately 68 puffs as prescribed. Surveyor explained that Resident 16's polyethylene glycol was found in the medication cart to be half full of a dispense date of 11/17/2025, and that Resident 16 had an order for 17gm of polyethylene glycol to be administered once daily. Surveyor explained that from 11/20/2025 to 03/05/2026, staff had documented 85 administrations of polyethylene glycol to Resident 16 and that the bottle only had a 30-day supply of medication. Nurse RR nor Administrator EEE did not know why staff had	{N 352}		

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{N 352}	Continued From page 8 documented 55 administrations beyond the original supply in the polyethylene glycol bottle.	{N 352}		