STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020660	A. BUILDING: _____ B. WING _____	R-C 10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN VALLEY LUXEMBURG	143 SCHOOL CREEK TRAIL LUXEMBURG, WI 54217

(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 10/09/2025 with additional information gathered through 10/13/2025, Surveyor conducted a verification visit and complaint investigation at Sun Valley Luxemburg. As a result, 1 of 1 previous deficiencies were corrected. Two (2) of 2 complaints were substantiated and 1 deficiency was identified. Under statutory provisions of WI 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 2 of 2 residents reviewed received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 2 did not receive Hydralazine 10 mg tablets as prescribed. Resident 3 did not receive Mounjaro 10 mg/0.5 ml pen as prescribed. Findings include: On 07/21/2025 and 07/29/2025, the Department	N 352		

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

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N 352	Continued From page 1 received complaints alleging residents were not receiving medications as ordered. On 10/09/2025, Surveyor conducted a verification visit and 2 complaint investigations. A sample of residents was selected including Resident 2 and Resident 3. RESIDENT 2: On 10/09/2025 at 9:30 AM, Surveyor reviewed Resident 2's record to include his/her face sheet, individual service plan (ISP), July 2025 medication administration record (MAR), observation notes, physician orders and emergency department (ED) summary. The following was identified: Resident 2 admitted to the facility on 09/11/2020 with diagnoses to include but not limited to, diabetes, dementia, depression, chronic kidney disease, hypertension and hyperlipidemia. Resident 2 is his/her own decision maker and has a managed care organization (MCO). Resident 2's ISP, signed 04/08/2025, identified staff administer his/her medications. Observation notes from 07/01/2025 to 07/31/2025 read in part: 07/25/2025, 8:15 PM: "Resident had issues with high blood pressure today, Dr office instructed to send resident to ER. Resident returned from ER around 8:15 pm. Has been put on new medication hydralazine, sent to [Pharmacy L] to start tomorrow but the pharmacy is closed. [Family K] left [his/her] phone number incase anyone needs to be called. Order states start Monday start date." Author: Caregiver G.	N 352		

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07/27/2025, 2:00 PM: "Resident went for a walk outside, had a good day, no concerns. FOLLOW UP from residents outing to er for blood pressure being high, resident had a blood pressure medication added to med list, will be ready Monday 7/27/25 Follow up with PCP in 3-5 days." Author: Caregiver H.

Review of an emergency department (ED) summary dated 07/25/2025 reflected Resident 2 was seen in the ED for high blood pressure. The summary included a diagnosis of uncontrolled hypertension with the following instructions: "Start new medication. Take as prescribed. Follow-up with PCP (Primary Care Physician) for recheck of blood pressure in 3-5 days. If blood pressure continues to be elevated they may recommend increasing the dose of your new medication. Pick up these medications at [Pharmacy L]: Hydralazine. Start taking on: July 26, 2025." (Surveyor note: Pharmacy L is in close proximity to the facility (next door) and within walking distance.)

A physician order dated 07/25/2025 indicated, "Hydralazine HCl 10 mg oral tablet. Take 1 tablet (10 mg total) by mouth four times daily. Start date: 7/26/2025."

Review of Resident 2's July 2025 MAR reflected: "Hydralazine 10 mg. Take one tablet by mouth four times daily. Scheduled for 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM." The MAR documented staff administered the first tablet of Hydralazine on 07/28/2025 at 12:00 PM.

On 10/09/2025 at 10:25 AM, Surveyor interviewed House Manager (HM) A who stated Resident 2 went to the ED on 07/25/2025 due to high blood pressure and returned to the facility

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the same day with a new medication order for Hydralazine. HM A reported the new medication order was faxed to Pharmacy L. S/he stated, "I was not aware the order was faxed to [Pharmacy L] and then on Saturday (07/26/2025) they close early. No one picked it up and on Sunday (07/27/2025) they are closed." HM A reported Caregiver G who is no longer employed at the facility was working the evening of 07/25/2025 when Resident 2 returned to the facility. HM A stated Caregiver G should have followed up with him/her after reviewing the ED summary and seeing the after-visit instructions for the new medication. HM A reported, "I first became aware of the new medication on Monday (07/28/2025) and it not being here." HM A also stated, "During an emergent situation like this and when a new medication is ordered, families can use any pharmacy they choose, but they would need to pick it up and bring it to the facility." S/he confirmed s/he was uncertain if Resident 2's family or any other families were aware of this.

On 10/09/2025 at 11:30 AM, Surveyor interviewed Caregiver H who confirmed s/he passes medications and worked the AM shift on 07/26/2025. Caregiver H verified they did not call [Pharmacy L] and stated, "They close at 11:00 AM on Saturday. There were only 2 staff working and we can't leave only 1 staff in the building." Caregiver H also confirmed they did not receive any messages for them to reach out to the family. S/he stated, "If there was a message, I would have notified the family to pick up the new medication."

During an interview with Caregiver N on 10/13/2025 at 12:40 PM, s/he confirmed s/he passes medications and recalled working on 07/26/2025. Caregiver N reported, "I was not told

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anything about a new medication for [Resident 2]. If I would have known I would have followed up and went to the pharmacy to pick it up. I didn't even know [s/he] went to the hospital." Caregiver N stated, "The communication is not the greatest."

On 10/09/2025 at 2:50 PM, Surveyor interviewed Family M who stated Family K brought Resident 2 back to the facility on 07/25/2025 after the emergency department visit. S/he stated Family K provided the ED summary to the staff that was working that evening and discussed the new medication for Hydralazine. Family M stated, "[Family K] was told they would ensure the new medication was taken care of and no one said anything to [him/her] about picking it up from [Pharmacy L]." Family M reported Resident 2 still didn't have the new medication on Sunday (07/27/2025) when s/he went to the facility to visit. Family M stated, "I called [Pharmacy L] on Monday (07/28/2025) who confirmed no one called them from the facility, so I asked them to fill it. I picked it up that morning and brought it to the facility. [Resident 2] got [his/her] first dose of Hydralazine at 12:00 PM." Family M reported, "I talked with [HM A] on Monday and was told they are short staffed on the weekends, and they didn't have someone available to pick up the medication. If I would have known this, we could have picked it up earlier."

During an interview with Pharmacy Technician (PT) O on 10/09/2025 at 3:25 PM, s/he confirmed they received an electronic prescription order for Resident 2 on 07/25/2025 at 7:06 PM after the pharmacy was closed. PT O verified the order was for Hydralazine 10 mg tablets with instructions to take 1 tablet by mouth four times daily with a start date of 07/26/2025. PT O

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confirmed the pharmacy closes at 5:30 PM on Fridays and are open 9:00 AM to 2:00 PM on Saturdays, and they are closed on Sundays. S/he stated Resident 2's order for Hydralazine was filled and ready for pick up by 9:20 AM on Saturday, 07/26/2025. PT O stated they do not close earlier than 2:00 PM on Saturdays and they do not keep record of any phone calls they receive. S/he also confirmed Resident 2's medication was picked up on 07/28/2025 at 10:41 AM.

RESIDENT 3:

On 10/09/2025 at 11:00 AM, Surveyor reviewed Resident 3's record to include his/her face sheet, individual service plan (ISP), July 2025 medication administration record (MAR), observation notes, incident reports and physician orders. The following was identified:

Resident 3 admitted to the facility on 12/17/2024 with diagnoses to include but not limited to, diabetes, hypertension, peripheral vascular disease, acute kidney failure, cognitive communication deficit, muscle weakness and heart disease. Resident 3 is his/her own decision maker and has an MCO. Resident 3's ISP, signed 09/26/2025, identified staff administer his/her medications.

Review of a physician visit report from 07/09/2025 reflected Resident 3 was seen by his/her primary care physician (PCP) for a diabetes recheck. Resident 3 received a discontinue order for Trulicity and a new order to start Mounjaro 10 mg once weekly.

Review of Resident 3's July 2025 MAR reflected: "Mounjaro 10 mg/0.5 ml pen. Inject 10 mg into

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the skin every 7 days for Type 2 Diabetes" at 8:00 AM. The MAR documented staff administered a 10 mg injection of Mounjaro 4 days in a row, 07/14/2025, 07/15/2025, 07/16/2025 and 07/17/2025. On 07/18/2025, the MAR reflects a Mounjaro injection was not administered due to "Other" and "Not [his/her] scheduled day."

Review of an observation note from 07/18/2025 at 6:15 PM by Caregiver H stated, "PCP contacted due to getting too much of a medication. Recommendations are to monitor especially for the next week. Please monitor blood sugars daily and watch for signs and symptoms of hypoglycemia such as feeling tired and weak, dizziness, abdominal pain, fast heartbeat, change in eyesight, feeling anxious or slurred speech. Send out if resident does not respond to standard interventions of correcting blood sugars. House manager and RN are also aware. Medication error has been corrected in system."

An incident report dated 07/18/2025 reflected, "A new insulin was prescribed to resident. When the medication was checked into the system it was not set up for once a week which is how this new insulin is to be administered. The new insulin was administered for 4 days in a row 7/14, 7/15, 7/16, 7/17, on 7/18 the med error was caught. PCP was contacted along with house manager." The incident report indicated Resident 3's PCP was notified on 07/18/2025 at 8:20 AM along with House Manager (HM) A.

On 10/09/2025 at 11:10 AM, Surveyor interviewed HM A who confirmed there was a medication error and Resident 3 received a Mounjaro injection 4 days in a row on 07/14/2025, 07/15/2025, 07/16/2025 and 07/17/2025 when it

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N 352	Continued From page 7 should have been administered weekly. HM A stated when a previous caregiver checked the medication in from pharmacy, s/he did not compare the medication orders and did not change the medication from daily to weekly on the electronic MAR. HM A stated once they became aware of the medication error, Resident 3's physician was notified and extra daily precautions and monitoring was added to his/her care plan and task administration record. HM A also confirmed all staff have been re-educated. On 10/13/2025 at 3:15 PM, Surveyor interviewed HM A and Executive Director (ED) B who acknowledged Surveyor's concerns regarding Resident 2's missed doses of Hydralazine starting on 07/26/2025 and that Resident 3 received a Mounjaro injection daily from 07/14/2025 to 07/17/2025 instead of weekly as prescribed. ED B reported s/he was not aware Resident 3 received the Mounjaro injection 4 days in a row. ED B also acknowledged a call should have been made to Resident 2's family regarding his/her medication. S/he stated s/he will ensure re-education is provided to all staff. The provider did not ensure Resident 2 and Resident 3 received all prescribed medications in the dosage and at intervals prescribed by a practitioner.	N 352		