STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018443	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE TOMAH CENTER	321 BUTTS AVENUE TOMAH, WI 54660

(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 11/25/2024, Surveyor conducted a complaint investigation at Lake Tomah Center. Data collection continued through 12/10/2024. The complaint was substantiated. Two deficiencies were identified. Census: 38	N 000		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the	N 404		

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
	0018443	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE TOMAH CENTER	321 BUTTS AVENUE TOMAH, WI 54660

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N 404	Continued From page 1	N 404		

provider did not ensure that at least annually, the CBRF (community based residential facility) had a physician, pharmacist, or registered nurse (RN) conduct an on-site review of the CBRF's medication storage system.

Findings include:

The provider is licensed to care for 62 residents within the following client groups: advanced aged, physically disabled, terminally ill, emotionally disturbed/mental illness, developmentally disabled, alcohol/drug dependent, traumatic brain injury and irreversible dementia/Alzheimer's disease.

On 09/27/2024, the department received a complaint alleging the provider was administering medications that were inconsistent with resident medication orders.

On 11/25/2024, at approximately 11:45 AM, Surveyor interviewed Administrative Assistant (AA) A. When asked about medication auditing and review practices, AA A stated managers would audit medications daily during administration times.

On 12/03/2024, Surveyor emailed AA A and requested the provider's annual medication regimen review documentation.

On 12/04/2024, Surveyor received an email from AA A requesting an extension regarding the medication review documentation. Surveyor approved extension until 12/05/2024 at 10:00 AM.

On 12/10/2024, at 7:23 AM, Surveyor received an email from AA A stating s/he looked back and realized a fax related to the medication review did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018443	A. BUILDING: _____ B. WING _____	C 12/10/2024

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LAKE TOMAH CENTER	321 BUTTS AVENUE TOMAH, WI 54660

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N 404	Continued From page 2 not go through. At 7:33 AM, Surveyor received an email attachment from AA A related to the medication review. The document titled, "Pharmacist Medication Regimen Review," was identified to be Resident 1's 30-Day Review and dated 07/06/2022. At 9:00 AM, Surveyor interviewed AA A and Licensee H via Microsoft Teams meeting. When asked if the provider had evidence an annual medication review was completed in 2023, Licensee H stated s/he assumed they did not have it. AA A stated they did not have documentation of an annual medication review for 2023. Cross Reference N0432 DHS 83.38(1)(h) Medication Administration	N 404		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018443	A. BUILDING: _____ B. WING _____	C 12/10/2024

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N 432	Continued From page 3 provider did not ensure residents received medications as appropriate to the resident's needs and as ordered. Findings include: The provider is licensed to care for 62 residents within the following client groups: advanced aged, physically disabled, terminally ill, emotionally disturbed/mental illness, developmentally disabled, alcohol/drug dependent, traumatic brain injury and irreversible dementia/Alzheimer's disease. On 09/27/2024, the department received a complaint alleging the provider was administering medications that were inconsistent with resident medication orders. On 11/25/2024, at approximately 11:45 AM, Surveyor interviewed Administrative Assistant (AA) A. When asked about any recent resident hospitalizations, AA A stated Resident 1 was in and out of the emergency room (ER) and passed away recently. When asked if s/he was aware of any medication errors related to Resident 1, AA A stated s/he was not aware of any. When asked to describe how medication orders and changes are received and processed, AA A stated Resident 1's medical provider would have sent orders to the pharmacy and the pharmacy would have updated the changes in the provider's electronic medication record. When asked about Resident 1's Lisinopril orders, AA A stated that in their system, Lisinopril 10 MG was started on 8/05/2022 and stopped on 09/23/2024. AA A stated Resident 1 was receiving Lisinopril 10 MG until 9/23/2024. AA A stated Resident 1 had a second order of Lisinopril, for 20 MG, which was ended on 8/24/2024.	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018443	A. BUILDING: _____ B. WING _____	C 12/10/2024

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N 432	Continued From page 4 At approximately 11:50 AM, Surveyor reviewed Resident 1's medication administration record (MAR) for August 2024 and September 2024. The August 2024 MAR identified the following: -Lisinopril Tab 10 MG, Take 1 Tablet by Mouth Once Daily, ordered by Prescriber B. Start date 8/09/2023; End date 9/23/2024. The medication was signed as administered on 8/01/2024, 8/02/2024, 8/03/2024, 8/04/2024, 8/06/2024, 8/07/2024, 8/08/2024, 8/09/2024, 8/13/2024, 8/14/2024, 8/15/2024, 8/20/2024, 8/21/2024, 8/29/2024, and 8/30/2024. The remainder of the days included a no pass entry with the following notations: 8/05/2024: Out 8/10/2024: Out 8/11/20254: Out 8/12/2024: Out 8/16/2024: Out of building 8/17/2024: Refused by resident 8/18/20254: No med available 8/19/2024: Refused by resident 8/22/2024 - 8/28/2024: Hospitalization 8/31/2024: Out of med -Lisinopril 20 MG Tablet, Take 1 Tablet by Mouth Every Day, ordered by Prescriber C. Start date 7/17/2024; End date 8/28/2024. The medication was signed as administered on 8/01/2024, 8/02/2024, 8/03/2024, 8/04/2024, 8/06/2024, 8/07/2024, 8/08/2024, 8/09/2024, 8/13/2024, 8/14/2024, 8/17/2024, 8/20/2024, and 8/21/2024. The remainder of the days included a no pass entry with the following notations: 8/15/2024: Blank 8/16/20204: Out of building 8/18/2024: No med available	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018443	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE TOMAH CENTER	321 BUTTS AVENUE TOMAH, WI 54660

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N 432	Continued From page 5	N 432		

8/19/2024: No med available
8/22/2024 - 8/28/2024: Hospitalization
8/28/2024-8/31/2024: Blank

The August 2024 MAR indicated Resident 1 received both doses of Lisinopril 15 days in the month of August.

The September 2024 MAR included the 10 MG order of Lisinopril ordered by Prescriber B. It was signed as administered on 9/3/2024, 9/6/2024, 9/11/2024, 9/13/2024, 9/14/2024, and 9/17/2024. The remainder of the days included a no pass entry with the following notations:
9/01/2024: Out
9/02/2024: Out
9/04/2024: Refused by resident
9/05/2024: Refused by resident
9/07/2024: Refused by resident
9/08/2024: Out
9/09/2024: Out of med
9/10/2024: Out
9/12/2024: Refused by resident, out of med.
9/15/2024: Not in med cart
9/16/2024: Not in cart

Surveyor reviewed Resident 1's hospital discharge summary, dated 8/28/2024. The orders instructed Resident 1 to stop taking Lisinopril 20 MG. Lisinopril 10 MG did not appear under the current medication list.

At approximately 12:00 PM, Surveyor interviewed AA A regarding the medication charting. AA A stated there was a possible recordkeeping issue due to the inconsistent charting. AA A stated s/he was questioning if the Lisinopril was in the medication pack and if staff were signing off on it when it was not there. AA A stated managers would audit the medication records when

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	0018443	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE TOMAH CENTER	321 BUTTS AVENUE TOMAH, WI 54660

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N 432	Continued From page 6	N 432		

administering medications. When asked about the multiple Lisinopril orders, AA A stated the Lisinopril 20 MG ended in August, but the Lisinopril 10 MG continued to appear in their system into September 2024, and continued to be signed as administered. Caregiver D and Caregiver E's initials appeared on the MARs as caregivers who signed off on the Lisinopril medication.

At approximately 12:27 PM, Surveyor interviewed Caregiver E. Caregiver E stated s/he was a medication passer and did not usually work on Resident 1's side of the building. Caregiver E stated s/he did not recall any issues with Resident 1's medications. Caregiver E stated s/he did not recall the medication being unavailable. Caregiver E stated that if s/he signed it off in the MAR, it was in house and administered to Resident 1.

At approximately 12:35 PM, Surveyor interviewed Caregiver D. Caregiver D stated s/he was not aware of any issues with Resident 1's medications. Caregiver D stated s/he only gave Resident 1 his/her medication a couple of times and did not recall the medication being unavailable. Caregiver D stated that if s/he signed them as administered, they were in house and administered.

On 11/26/2024, at 1:40 PM, Surveyor interviewed Pharmacy Representative (PR) F. PR F stated Resident 1's 10 MG Lisinopril was discontinued on 12/27/2023 and was last filled in December 2023. PR F stated Resident 1 should have only been given the 20 MG Lisinopril after 12/27/2023. PR F stated the 20 MG Lisinopril was put on hold on 7/22/2024 by Prescriber C. PR F stated it was put on hold pending Resident 1 being seen by his/her primary care provider. PR F stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018443	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE TOMAH CENTER	321 BUTTS AVENUE TOMAH, WI 54660

(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 432	Continued From page 7	N 432		

pharmacy resent the cycle with those changes and took back the other medications to ensure accuracy. PR F stated that as of 7/22/2024, Resident 1 should not have been receiving either dose of Lisinopril. PR F stated s/he did not see an order for Lisinopril 10 MG ordered by Prescriber B. PR F stated s/he would refer Surveyor to the pharmacist.

At 3:01 PM, Surveyor requested additional records from AA A via email for Resident 1 including MARs for January through July 2024.

On 11/27/2024, Surveyor received additional records for Resident 1 that included the following:
-Lisinopril 10 MG was signed as administered and a scheduled medication between January 2024 and July 2024.
-Lisinopril 20 MG was signed as administered on 7/23/2024, 7/24/2024, 7/25/2024, 7/26/2024, 7/31/2024. On 7/27/2024, 7/28/2024, 7/29/2024 and 7/30/2024, it was marked a no pass, with notations indicating the medication was out or not in the medication pack.

On 12/03/2024, Surveyor emailed AA A and requested dates and documentation of Resident 1's primary care visits that took place between July 2024 and September 2024.

On 12/04/2024, Surveyor reviewed progress notes and medication orders sent by AA A for primary care visits that took place on 8/1/2024 and 9/11/2024. AA A stated within the email that those were Resident 1's only primary care visits in that timeframe.

An original medication order, written and sent on 7/22/2024, included the following:
-Lisinopril 20 MG Tablet. Take 1 tablet by mouth

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	0018443	A. BUILDING: _____ B. WING _____	C 12/10/2024

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LAKE TOMAH CENTER	321 BUTTS AVENUE TOMAH, WI 54660

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N 432	Continued From page 8	N 432		

daily. "Hold until seen by PCP (Primary Care Provider) because [his/her] dose of diltiazem was increased."

The progress notes, dated 8/01/2024, indicated Resident 1 presented for routine hospital follow up after being admitted to the hospital on 7/17/2024 with a diagnosis of atrial fibrillation with rapid ventricular response. Resident 1 was discharged back to the provider on 7/22/2024. It stated, "Prior to today's visit, [Resident 1] was contacted by nursing staff to discuss and reconcile [Resident 1's] medications." Under the "Brief summary of hospitalization or nursing facility course" it read, in part, "Per hospital discharge summary ...[His/her] Lisinopril was held at discharge due to lower blood pressures on new oral medications." Under the "CHANGE how you take these medications" section, it stated Lisinopril 20 MG was held until primary care follow up. Under the "Concerns since discharge" section, it read, in part, "Medication list was reviewed with patient and care staff today. Upon review, there are several discrepancies noted, including use of ibuprofen which is not on current medication list from [Medical Provider], and lisinopril 30 mg daily which is also not on current medication list. The lisinopril was advised to be held until [s/he] followed with PCP (Primary Care Provider) for hospital discharge visit ...[His/her] blood pressure in office today is mildly elevated, despite use of lisinopril 30 mg ..."

The progress notes, dated 9/11/024, read, in part, " ...discontinue Lisinopril in favor of Losartan 25 mg daily ..."

On 12/04/2024, at 3:38 PM, Surveyor contacted Pharmacist G via phone. Pharmacist G stated Resident 1's 10 MG Lisinopril ended on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018443	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE TOMAH CENTER	321 BUTTS AVENUE TOMAH, WI 54660

(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 432	Continued From page 9	N 432		

12/27/2023, when it was increased to 20 MG. Pharmacist G stated they package the medications in strips and utilize electronic MARs. Pharmacist G stated anything that was discontinued should have rolled over into the provider's system. Pharmacist G stated that in January 2024, they swapped out the 10 MG Lisinopril with 20 MG Lisinopril, and Resident 1 should have been receiving the 20 MG Lisinopril since then. Pharmacist G stated the pharmacy would have discontinued the 10 MG Lisinopril in their system, which would have taken it off the provider's electronic medication system. Pharmacist G speculated someone may not have realized it was a 20 MG Lisinopril and re-entered it manually as a 10 MG Lisinopril. Pharmacist G stated Lisinopril 20 MG was put on hold on 7/22/2024, until Resident 1 was seen by his/her primary care provider.

On 12/10/2024, Surveyor interviewed AA A and Licensee H via Microsoft Teams meeting. Surveyor expressed concerns with the medication order discrepancies. AA A stated it was his/her guess that the new pharmacy did not get all the new orders because the orders were transferred. AA A stated they do not see orders they receive from the pharmacy. When asked if the issue of multiple orders of Lisinopril was ever investigated, AA A stated s/he did not recall having a conversation about it with any of the managers. Licensee H stated s/he could not speak to that. When asked if the Lisinopril was administered after 07/22/2024, AA A stated yes, and it was charted as given on multiple days. When asked if the provider noticed the original order stated it was to be held until Resident 1 was seen by his/her primary care provider, AA A stated that when s/he saw the original order, s/he did not see it was instructed to be held. AA A stated s/he did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018443	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE TOMAH CENTER	321 BUTTS AVENUE TOMAH, WI 54660

(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 432	Continued From page 10 not think it said that on the original order. When asked about the noted discrepancies on the progress report, AA A stated care staff should have let a manager on duty know about any medication changes or concerns. When asked about why the Ibuprofen was still appearing in the MAR despite not having an active order, AA A stated s/he did not notice it and it could have been an order from the previous pharmacy. AA A stated the pharmacy did not communicate to the provider that there was not a new prescription for it. The provider did not ensure Resident 1 received medications as appropriate to his/her needs and as ordered. Resident 1 had 2 orders of Lisinopril 10 MG in 2023. The Lisinopril was increased to 20 MG, at which point the 10 MG Lisinopril should have been discontinued. The pharmacy did not have an active order for Lisinopril 10 MG in 2024. Resident 1's 20 MG Lisinopril was held in July 2024, pending a visit with his/her primary care provider and records indicated staff were administering the medication when it was to be held. The Lisinopril was discontinued in August 2024 after Losartan medication was started. Lisinopril 10 MG continued to be signed as administered in September of 2024. Cross Reference N0404 DHS 83.37(1)(e) Medication Regimen, Administration Review	N 432		