Wisconsin Department of Health Services

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 _____	R-C 05/28/2025

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 05/28/2025, Surveyor conducted a complaint investigation and verification visit at Lake Tomah Center. The complaint was substantiated. One deficiency was identified. This is a repeat violation. See Statement of Deficiency (SOD) 5MN311, dated 12/10/2024. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 39	{N 000}		
{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 provider did not ensure residents received medications as appropriate to the residents' needs and as ordered. This is a repeat deficiency. See Statement of	{N 432}		

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

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{N 432}	Continued From page 1 Deficiency (SOD) 5MN311, dated 12/10/2024. 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 03/13/2025, the department received a complaint alleging a resident received the wrong medication. On 05/28/2025, at approximately 11:30 AM, Surveyor interviewed Administrative Assistant (AA) A. When asked about any recent medication errors, AA A stated that on 03/11/2025, Caregiver B administered the wrong medications to Resident 1. AA A stated another resident had interrupted Caregiver B during the medication preparation and Caregiver B grabbed the wrong medication. Resident 1 received Resident 2's medications by mistake. Poison Control was called and it was advised Resident 1 be sent to the emergency room (ER). Resident 1's scheduled medications were held because of the medication error and guidance from poison control. AA A stated Caregiver B received coaching after the incident and had a lot of performance issues prior to the medication error. Caregiver B was terminated and his/her last day of employment was 04/23/2025. Surveyor requested Resident 1's records, including his/her most recent individual service plan (ISP), medication administration record (MAR), and the medication error report.	{N 432}		

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{N 432}	Continued From page 2 Resident 1 was admitted on 05/11/2022 and had a corporate guardian. Resident 1 required staff assistance with medication administration. The medication error report, dated 03/11/2025, read, in part, "Staff was getting medications ready and another resident walked by and [s/he] asked [him/her] to wait as [s/he] had [his/her] medication and grabbed the wrong pack and gave them to [Resident 1]. [S/he] was given Cetirizine 10mg, Melatonin 3mg, Cranberry 450mg, Divalproex ER 205mg, Gabapentin 100mg, Metoprolol ER 25 mg, Quetiapine 200mg and Trazodone 100mg. Staff called poison control immediately and explained what happened and the doses and they expressed that [s/he] needed to go to the local ER (emergency room) to be evaluated as the doses were high sleeping medication ...Staff called for an update and was told they were going to keep [him/her] overnight for observation. Resident returned on 3/12 at about 2pm." Resident 1's March 2025 MAR indicated the following medications were not administered because Resident 1 was out of the building: 03/11/2025 Eliquis 5 MG Tablet at 7:00 PM Melatonin 3 MG Tablet at 7:00 PM Acetaminophen 500 MG Caplet at 7:00 PM The provider did not ensure residents received medications as appropriate to the residents' needs and as ordered when Resident 1 received the wrong medications and was sent to the ER for observation.	{N 432}		