STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525319	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook Lakeside	2115 E Woodstock Pl Milwaukee, WI 53202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on record review, interview, and facility policy review, the facility failed to ensure one (Resident (R)2) out of five reviewed for medications received ordered medications upon admission. This had the potential for the resident to have unmet care and health needs. Findings include: Review of the Census tab of the electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE] at 5:45 PM. Review of the Diagnosis tab located in the EMR revealed diagnoses of presence of right artificial knee joint, end stage renal disease, and kidney transplant status. Review of R2's Medication Administration Record (MAR) for December 2023 with the Director of Nursing (DON) revealed the following physician ordered medications were not given as ordered the evening of 12/21/23 or 12/22/23 due to not being available and there was no evidence the physician was notified the medications were not available: 1. Belsomra Oral tablet 10 MG [milligrams] 1 tablet at bedtime for insomnia to be given at 8:00 PM. A Nursing Note dated 12/21/23 and timed 8:37 PM and located in the Nursing Notes tab of the EMR revealed stated awaiting on med from pharmacy. 2. Prednisone oral tablet 5 mg 1 tablet by mouth one time a day for anti-rejection [kidney transplant]. The medication was noted to be scheduled to be given at 9:00 AM on 12/22/23. The medication was coded with a 9 indicating it was not given. A Nursing Progress Note dated 12/22/23 and timed 9:44 AM revealed the medication was not available. According to the DON the pharmacy was notified the medication was unavailable. Review of the hospital discharge papers the resident last received the medication on 12/21/23 at 8:52 AM. 3. Apixaban [anticoagulant] oral tablet 2.5 MG every 12 hours. The medication was scheduled to be given at 8:00 AM and 8:00 PM. It was not administered on 12/21/23 at 8:00 PM. A Nursing Note dated 12/21/23 and timed 8:37 PM and located in the Nursing Notes tab of the EMR revealed awaiting on med from pharmacy. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Calcium Acetate oral capsule 667 mg 3 capsules by mouth with meals related to end stage renal disease and kidney transplant status. The medication was scheduled to be given on 12/22/23 at 8:00 AM, 12:00 noon, and at 5:00 PM. It was coded on the MAR to indicate it was not given at 12:00 PM and 5:00 PM. The code in the 12:00 PM block was a 9 indicating to see the Nursing Progress Notes. The notes were silent to why this medication was not administered at 12:00 PM. The code in the 5:00 PM block was an 18 indicating it was not available from the pharmacy. Review of the Nursing Progress Notes were reviewed for 12/21/23 and 12/22/23 and were silent to the physician being notified that the medications were not available and were not given. Review of a document titled After Visit Summary-External Facility Transfer with a printed date of 12/21/23 contained a list of the medications and medication orders. Review of the document revealed the above doses of medications were not administered prior to the resident being transferred from the hospital to the nursing facility. During an interview on 03/28/24 at 2:30 PM the DON verified the medications were documented as not being administered and there were no progress notes to indicate the physician was notified that the medications were not available and not given. She stated the nurses are supposed to notify the physician when a medication is not given or is not available and it should be documented it in the progress notes. Review of the facility policy titled Administering Medications with a revision date of 01/22/24 revealed medications were to be administered in accordance with physician's orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 03115 Based on record review, interview, and facility policy review, the facility failed to administer one (Resident (R) 1) out of five residents insulin in a timely manner, in accordance with the physician's order. This had the potential for the resident to have unmet health care needs. Findings include: Review of R1's Medication Administration Record (MAR) located in the Orders tab of the electronic medical record (EMR) revealed an order for insulin Regular Human Injection solution Pen-injector 100 UNITS/ML. Inject as per sliding scale. The order included how much insulin she should receive depending on the results of her finger stick [blood sugar]. According to MAR at 7:30 AM the resident's blood sugar was 215 and she received three units of the insulin and at 11:30 AM her blood sugar was 234 and she received three units of insulin. During an interview on 03/25/24 with R1 at 12:30 PM revealed her lunch tray was on the overbed table. Some of her food was gone and she stated she had finished eating. During the interview she was asked if she received her medications in a timely manner and she stated that she often receives her morning medications late. She stated she just now received her insulin injection, and she was supposed to receive it before meals she stated she also received her morning insulin after she ate breakfast, and she was supposed to get it before breakfast. During an interview on 03/25/24 at 1:05 PM Registered Nurse (RN)2 revealed she administered both the morning dose and the afternoon dose of insulin to R1 and stated she obtained the resident's finger stick blood sugar prior to her eating breakfast however she did not administer the insulin until after she ate because she was afraid of what would happen if the resident did not eat. She said she gave the insulin at around 9:40 AM. She stated it was late because she was dealing with a problem on the floor. She stated it should have been given between 8:00 AM and 9:00 AM. She stated she obtained the residents blood sugar level via finger stick before she received her noon meal and she gave R1 her noon insulin at about 12:55 PM right after she finished eating lunch. She verified the order stated for the insulin to be administered before meals, but she usually gave the insulin after meals to make sure the residents eat. During an interview on 03/25/24 at 2:51 PM the Director of Nursing (DON) was informed of R1's insulin not being given before the meal. Review of the MAR confirmed R1's insulin was administered on 03/25/24 at 9:37 AM and on 03/25/24 at 12:25 PM. She verified both doses were administered after the meal and not before the meal as ordered by the physician. Review of the facility policy titled Administering Medications with a revision date of 01/22/24 revealed medications shall be administered per the physician's written orders upon verification of the right medication, dose, route, time, and positive verification of the resident's identity.