STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525625	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Health Care Ctr	1922 Cty Rd Nn Elkhorn, WI 53121

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525625	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Health Care Ctr	1922 Cty Rd Nn Elkhorn, WI 53121

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that 1 (R1) of 1 allegations of potential abuse/neglect were reported immediately, but not later than 2 hours after the allegation is made.*On 6/23/2025, R1 received medication that was not prescribed to R1, which resulted in R1 going to the emergency room. Facility staff did not report the incident in a timely manner and did not report the potential neglect/abuse to the administrator and/or law enforcement. Findings include:The facility's policy dated 9/2024 and titled Freedom from Abuse, Neglect & Exploitation documents: Procedure: Internal Reporting: a. Employees, and contracted employees will receive orientation and education on the facility abuse policy and reporting requirements. Staff must always report any abuse or suspicion of abuse immediately to the Administrator and Director of Nursing.R1 was admitted to the facility on [DATE] with diagnoses that include Heart Failure, Renal Insufficiency, Dementia and Paroxysmal Atrial Fibrillation.R1's admission Minimum Data Set (MDS), dated [DATE], documented a brief interview mental status (BIMS) score of 13, indicating that R1's cognition was intact. Section B documented that R1 is understood and understands. The facility's self-reported incident dated 7/1/2025 documented: Registered Nurse (RN)-H gave R1 three medications that belonged to another resident. Attached documents from Certified nursing assistant (CNA)-L, documented that Registered Nurse (RN)-H stated to CNA-L that R1 did not have orders for tizanidine, cyclobenzaprine, and Diphenhydramine, that the medications would help R1 sleep. It is documented that on 6/23/2025, at 11:53 AM, DON-B was updated on incident via phone call from CNA-L regarding R1 receiving medications that were not prescribed. Surveyor noted that the self-report documented that nursing staff education did not immediately notify Nursing Home Administrator (NHA)-A or Director of Nursing-B within the reported time frames of the potential abuse and or neglect. The self-report investigation documents that only nursing staff were provided education on reporting from abuse, neglect and misappropriation. Surveyor could not locate education to other departments regarding reporting potential abuse and or neglect.On 7/7/2025, at 10:40 AM, Surveyor interviewed Food Service Aide-J, who stated that there was no recent education or training related to reporting abuse and or neglect. On 7/7/2025, at 10:42 AM, Surveyor interviewed House Keeping-K, who stated that there was no recent education or training on reporting abuse. On 7/7/2025, at 11:50 AM, Surveyor interviewed Director of Nursing (DON)-B, who indicated that only nursing staff was educated on reporting abuse and or neglect. DON-B stated that it was nursing staff that did not report R1's potential neglect incident to NHA-A and DON-B in a timely manner and that's why the facility limited the education to only the nursing department. DON-B indicated that other staff in the building would also report abuse if abuse were observed by those staff members, and that they should also be included in the training and that they will start the education with all departments right away.On 7/7/2025, at 1:50 PM, Surveyor informed Nursing Home Administrator (NHA)-A, of the concern of reporting abuse and or neglect was not done within the designated time frames, as NHA-A and DON-B were not immediately notified of the potential neglect/abuse when R1 was administered the wrong medication. No additional information was provided as to why the facility did not ensure allegations of potential abuse/neglect were reported immediately, but not later than 2 hours after the allegation is made.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525625	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Health Care Ctr	1922 Cty Rd Nn Elkhorn, WI 53121

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525625	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Health Care Ctr	1922 Cty Rd Nn Elkhorn, WI 53121

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 2 (R3 & R1) of 3 residents were free of significant medication errors.* On 6/30/25, R3 received R2's medication which consisted of Hydralazine 50 mg (milligrams) and Ropinirole 0.5 mg.* On 6/23/25, R1 received another resident's medication.Findings include:The facility's policy titled, Medication Administration Guidelines and last revised 7/2025 under Purpose documents Compliance with current professional standards of practice, Lakeland Health Care Center maintains a medication administration process to safely prepare, administer and store resident medication. Under Procedure for Safety documents 1. Resident will be identified prior to medication administration by asking the resident their name. Whether the resident can state their name or not, the residents' phone in PCC (pointclickcare) will be used to verify the correct resident. Under Medication Pass guidelines documents .5. Follow the 6 rights of medication administration: Right Resident, time, route, medication, dosage and dosage form.1.) R3's diagnoses includes Chronic Obstructive Pulmonary Disease (group of lung diseases that block airflow and make it difficult to breathe), diabetes mellitus (high blood sugar), dementia (loss of cognitive function that interferes with a person's daily life & activities), atrial fibrillation (irregular and rapid heart beat) and chronic kidney disease (characterized by progressive damage and loss of kidney function).R3's admission MDS (minimum data set) with an assessment reference date of 7/1/25 has a BIMS (brief interview mental status) score of 7 which is moderate cognitive impaired.R3's nurses note dated 6/30/25, at 1345 (1:45 p.m.), written by Registered Nurse/Nurse Manager (RN/NM)-E documents: This resident inadvertently given the wrong medications by LPN (Licensed Practical Nurse): Hydralazine 50 and Ropinirole 0.5 at approximately 1330 (1:30 p.m.). Provider [Name] NP (Nurse Practitioner) notified and ordered every 2 blood pressure checks x (times) 8 hours and push fluids. Orders noted.Hydralazine is used to treat high blood pressure & heart failure. Ropinirole is used to treat Parkinson's Disease and Restless Leg Syndrome.R3's nurses note dated 6/30/25, at 1409 (2:09 p.m.), written by LPN-D documents: [Name] POA/HC (Power of Attorney/Healthcare) in facility and made aware of administration of Hydralazine and Ropinirole on 6/30/25. Daughter is in agreement with plan of care.R3's nurses note dated 6/30/25, at 14:17 (2:17 p.m.), written by RN-F documents: Writer assessed patient. Vital signs WNL (within normal limits). Patient denied dizziness, nausea, headache when asked.R3's nurses note dated 6/30/25, at 2229 (10:29 p.m.), written by RN-G documents: 24 hour board monitoring BP (blood pressure) . BP stable. No adverse reactions seen.On 7/7/25, at 11:38 a.m., Surveyor showed Director of Nursing (DON)-B the two pieces of paper, #1775 Medication Error and Supervisor Coaching Note dated 6/30/25 Surveyor was provided for R3 and asked if there is any additional information such as an investigation, staff statements, education, etc. DON-B looked at the Medication Error report and said this is what they did referring to the immediate action taken. DON-B informed Surveyor she would look and get back to Surveyor.Surveyor reviewed #1775 Medication Error dated 6/30/25 at 13:30 (1:30 p.m.). Under the section Incident Description for Nursing Description documents Inadvertently administered wrong medication to wrong resident. Received Hydralazine 50 mg (milligrams) and Ropinirole 0.5 mg @ (at) 1330 (1:30 p.m.). Resident Description documents Resident unable to give description. Under the section Immediate Action Taken documents Description: ADON (Assistant Director of Nursing) made aware. MD (Medical Doctor) notified Per RN Nurse Manager. New orders received to check B/P (blood pressure) every 2 hours for the next 8 hours.The Supervisor Coaching Note dated 6/30/25 for describe the nature of the incident documents Gave wrong medication to [room number]. For Rule/Policy Violated documents 5 rights of medication: RIGHT PATIENT, right drug, right dose, right route, right time. Expectations going forward documents Perform the 5 rights of medication with every medication administration.On 7/7/25, at 12:01 p.m., Surveyor interviewed RN/NM-E regarding R3 receiving R2's medication on 6/30/25. RN/NM-E explained [Name], the Assistant Director of Nursing (ADON)-C came and got me. ADON-C was on the unit doing wound rounds with the wound NP and the floor nurse (LPN-D) told ADON-C. ADON-C came and got her as ADON-C was in the middle of wound rounds. RN/NM-E informed Surveyor she went down and spoke with the LPN that made the error. RN/NM-E informed Surveyor LPN-D didn't have a real good explanation why she gave R3 another resident's medication. RN/NM-E informed Surveyor she called [Name] NP to let her know what happened and got orders to monitor blood pressure every two hours for eight hours and push fluids. RN/NM-E informed Surveyor they have a coaching note which is not a write up per se which she (LPN-D) needs to do, the five

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525625	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Health Care Ctr	1922 Cty Rd Nn Elkhorn, WI 53121

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) R1 was admitted to the facility on [DATE] with diagnoses that include Heart Failure, Renal Insufficiency, Dementia and Paroxysmal Atrial Fibrillation. R1’s admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview Mental Status (BIMS) score of 13, indicating R1’s cognition is intact. Section B documented that R1 is understood and understands. The facility’s self-reported incident dated 7/1/2025 documented: Registered Nurse (RN)-H gave R1 three medications that belonged to another resident. Attached documents from Certified nursing assistant (CNA)-L, dated 6/24/2025 documented that Registered Nurse (RN)-H, stated to CNA-L, that R1 did not have orders for Tizanidine, Cyclobenzaprine, and Diphenhydramine, that the medications would help R1 sleep. Time of concern that was witnessed was at 1:00 AM on 6/23/2025, It is documented that on 6/23/2025, at 11:53 AM, DON-B was updated on incident via a phone call from CNA-L regarding R1 receiving medications that were not prescribed. R1’s progress note dated 6/23/2025, at 1:26 AM, documented: Resident calling out this shift. Other residents on unit complaining about sleep disruptions due to resident’s continuous outbursts throughout the night. Surveyor reviewed R1’s medical record and could not locate any physician orders for the administration of the medications Tizanidine, Cyclobenzaprine and Diphenhydramine. On 7/7/2025, at 11:50 AM, Surveyor interviewed Director of Nursing (DON)-B regarding the facility’s self-reported incident involving R1 being administered the wrong medication on 7/1/25. DON-B informed Surveyor that medication administration education was started on 7/3/2025 and DON-B stated the nursing staff are still being provided education. DON-B indicated that the names of staff that have not received medication remain unsigned and that all staff will be educated prior to their return to work. Surveyor reviewed #1778, Medication Error form, dated 6/23/2025, at 1:00 AM, which documented: Nursing description: Resident became increasingly lethargic, hard to arouse with cares, and combative with cares, more than baseline. R1’s vitals were stable. Documented under: Immediate Action Taken, sent to emergency department for eval. Surveyor reviewed discharge paperwork from the Emergency Department, dated 6/23/2025, this visit was documented as, unclear whether there was an accidental ingestion today. Labs drawn and intravenous fluids (Normal Saline) 0.9% bolus 1000 milliliters were administered. On 7/7/2025, at 1:50 PM, Surveyor informed Nursing Home Administrator (NHA)-A, of the concern of R1 being administered medication that was not prescribed to R1. R1 had to be sent out to the ER for labs and intravenous fluids. No additional information was provided to Surveyor regarding R1 receiving medications that were not ordered for R1.