STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525702	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Country Health Services	2195 North Summit Village Way Oconomowoc, WI 53066

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility did not ensure its medication error rate was below 5%. The facility error rate was 7.69% affecting 2 residents (R12 and R67) observed during medication pass. Findings include:The facility policy titled Medication Administration dated 5/7/25 documents (in part) .Staff will ensure each medication is safely administered per practitioner's orders.24. Staff will administer all medications following the Six Rights of Medication Administration: Right resident, right medication, right dose, right time, right route, right documentation. On 8/25/25, at 7:15 AM, Surveyor observed Registered Nurse (RN)-C prepare medications for R67. The following medications were prepared: Amlodipine Besylate 10 MG (milligram) 1 tablet, Baclofen 10 MG 1 tablet, Cetirizine HCL (Hydrochloride) 10 MG 1 tablet, Apixaban (Eliquis) 5 MG 1 tablet, Ferrous Sulfate 325 MG 1 tablet, Furosemide 40 MG 1 tablet, Lisinopril 10 MG 1 tablet, Oxybutynin Chloride 5 MG 1 tablet, Pantoprazole 40 MG Delayed Release 1 tablet, Polyethylene Glycol 3350 Powder for Oral Solution (Miralax)17 grams, Sertraline 50 MG 1 tablet, Tizanidine 2 MG 1/2 tablet, Tizanidine 2 MG 1 tablet, Fluticasone nasal spray 1 puff each nostril, Timolol Maleate 0.5 % 1 drop each eye.Surveyor verified the number of tablets with RN-C and the medications were administered to R67 whole with water.Surveyor reconciled the medications administered with R67's current (August 2025) MAR. R67's MAR documents: Cetirizine HCl Tablet 10 MG give 0.5 tablet by mouth one time a day for Allergy symptoms - start date 8/23/25. Surveyor noted R67 was administered a whole 10 MG tablet versus the 1/2 tablet as ordered. On 8/25/25, at 8:38 AM, Surveyor spoke with RN-C and asked to view the bottle of Cetirizine together. Surveyor advised RN-C that R67's MAR documents an order for 0.5 tablet (5 MG) but a whole tablet of 10 MG was given. RN-C looked at the bottle and stated, Your right she's supposed to get half a tablet. I'll call pharmacy and make sure we can break this in half; the tablet is scored. On 8/25/25, at 7:25 AM, Surveyor observed Registered Nurse (RN)-C prepare medications for R12. The following medications were prepared: Baclofen 20 MG (milligrams) 1 tablet, Gabapentin 100 MG 1 tablet, Metformin Hydrochloride 500 MG 1 tablet, Metoprolol Tartrate 25 MG 1/2 tablet, Amiodarone Hydrochloride 200 MG 1 tablet, Furosemide 20 MG 1 tablet, Citalopram 10 MG 1 tablet, Lisinopril 5 MG 1 tablet, Senna plus 1 tablet, Oxycodone Hydrochloride 5 MG 1 tablet, Insulin Glargine (Lantus) 100 unit/ml (milliliter) 20 units. RN-C prepared all medications, placed the tablets in a plastic medication cup and Surveyor verified number of tablets with RN-C. RN-C added applesauce to the tablets in the cup. RN-C then said she had to do them over because R12 likes his meds crushed. RN-C prepared all the above medications again, placing them in a plastic medication cup, except for Metoprolol Tartrate. Surveyor noted Metoprolol was not added to the medication cup. Surveyor verified number of tablets with RN-C, noting the number of tablets did not match the previous number, it was less the 1 tablet of Metoprolol. Surveyor advised RN-C that during the second observation, Metoprolol was not added to the medication cup, and the number of tablets was 1 less than previously observed. Surveyor and RN-C viewed R12's medication cards and MAR (Medication Administration Record) together. RN-C stated she must've forgot to punch out the Metoprolol and added it to the medication cup. The medications were then crushed and administered to R12 with applesauce. On 8/25/25, at 2:58 PM, Nursing Home Administrator (NHA)-A was advised of the above concerns and medication error rate. No additional information was provided.

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
	525702	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Country Health Services	2195 North Summit Village Way Oconomowoc, WI 53066

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility did not provide routine and emergency drugs and biologicals to meet the needs of each resident for 3 of 4 medications carts observed. Findings include:The facility policy titled Administration of Insulin with Insulin Pen dated [DATE] documents (in part) .Trained staff working under registered nurse delegation will safely and effectively administer insulin. It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge.3. Insulin pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date.10. Insulin pens should be disposed of after 28 days or according to the manufacturer's recommendations. The facility policy titled Administration of Eye Drops and Ointment dated [DATE] documents (in part) .Eye medications are administered as ordered by the physician and in accordance with professional standards of practice to lubricate the eye or treat certain eye conditions.d. Label new bottle with date opened and follow facility policy or manufacturer's instructions for when to discard and replace. On [DATE], 8:56 AM, Surveyor observed the Unit 400 medication cart. In the top drawer of the medication cart, Surveyor located the following: Two Lantus insulin pens belonging to R20, both were dated opened 7/5. Latanoprost 0.005% eye drops belonging to R5. The bottle was open and used but not dated when opened. Ketorolac Tromethamine 0.5% eye drops belonging to R5. The bottle was open and used but not dated when opened. Olopatadine HCL (Hydrochloride) 0.2% eye drops belonging to R49. The bottle was open and used but not dated when opened.Surveyor asked Registered Nurse (RN)-D how long insulin was good for once opened. RN-D reported she was not sure. Surveyor advised RN-D of the Lantus insulin pens dated opened 7/5. RN-C stated, We currently don't have anyone on insulin on this unit, so they probably should have been thrown out. Surveyor advised RN-D of the above eye drops not dated when opened. RN-D reported she was not sure how long eye drops are good for before expiring, but eye drops should be dated when opened. On [DATE], 2:28 PM, Surveyor observed the Unit 200 medication cart. In the top drawer of the medication cart, Surveyor located the following: Olopatadine HCL 0.1% eye drops belonging to R75. The bottle was open and used but not dated when opened. On [DATE], at 7:10 AM, during observation of medication pass with RN-C on the Unit 300 medication cart, Surveyor observed RN-C administer Timolol Maleate eye drops to R67. Surveyor noted the eye drops were not dated when opened. RN-C reported eye drops should be dated when opened and are good for 28 days.On [DATE], at 2:59 PM, Nursing Home Administrator (NHA)-A was advised of concerns regarding the expired insulin dated 7/5 and eye drops not dated when opened. No additional information was provided