STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525727	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Years of Lake Geneva	611 Harmony Drive Lake Geneva, WI 53147

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** 11599 Based on record review and interviews, the facility failed to ensure one of five residents (Resident (R) 1) reviewed received his pain medications as ordered creating the potential for increased discomfort. Findings include: Review of the facility's 2024 policy titled, Pain Assessment and management revealed The care team will respect and support every patient's right to optimal pain relief through education, initial and ongoing assessment, and effective and appropriate pain management. Review of the Face Sheet located under the Demographics tab in the electronic medical record (EMR) revealed R1 was admitted on [DATE] with diagnoses including unilateral primary osteoarthritis, left knee; open wound of lower back and pelvis without penetration into retroperitoneum; non-pressure chronic ulcer of other part of right foot limited to breakdown of skin. Review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 10/06/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 was cognitively intact. Review of the October 2024 Physician Orders located under the Orders tab in the EMR noted R1 had an order for pregabalin -Schedule V (controlled substance) capsule; 25 mg (milligram); amt (amount): 25 mg/1capsule; oral Once A Day AM with a Start Date of 10/02/24. Review of the Informed Consent for Medication, form, located in the Documents tab in the EMR, dated 10/01/24, was signed by R1 and a facility nurse. The form identified the medication, for consent, as Pregabalin for pain. Review of the October 2024 Medication Administration Orders (MARS) provided by the Director of Nursing (DON), revealed from 10/03/24 through 10/15/24, that the Pregabalin was not administered with the reason noted as not administered: drug/item unavailable. The MAR did not identify why the medication was not administered on 10/02/24. (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
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes located under the Resident tab in the EMR, dated 10/16/24, Script sent for Pregabalin to (Pharmacy). Pharmacy Query completed. The notation was written by the Nurse Practitioner. During an interview on 01/08/25 at 11:45 AM, the family of R1 (F1) said the resident could have been much more comfortable. F1 stated, I was told they ran out of the Pregabalin, for his pain, and didn't get it reordered. During an interview, on 01/09/25 at 3:20 PM, with R1's Nurse Practitioner (NP), also the facility DON, the NP stated, I am in the building Monday-Friday and see the majority of the residents. I saw R1 almost every day because of his care needs. When (F1) asked about the Pregabalin, that he was used to taking at home, I sent a script. I don't know what happened with the escribe (electronic prescription) order. In our state, narcotic prescriptions have to go directly to the pharmacy. The DON/NP said she was not informed by the nurses that the Pregabalin was unavailable. In an interview on 01/09/25 at 5:00 PM, neither the Administrator nor the DON/NP said they had a policy regarding escribes to ensure all medications are ordered as intended.