STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018891	A. BUILDING: _____ B. WING _____	C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERWOOD LODGE LAKE MILLS	510 OWEN STREET LAKE MILLS, WI 53551

(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 02/22/2024, Surveyor conducted 2 complaint investigations at Timberwood Lodge, a CBRF located in Lake Mills, WI. As a result of the investigation, 2 violations of Chapter DHS 83 were issued. Both complaints were substantiated. Census: 10	N 000		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure accurate documentation of medication administration. There were numerous entries in Resident 2's Medication Administration Record (MAR) that were missing documentation related to the administration of medications. Findings include:	N 415		

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

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N 415	Continued From page 1 On 02/22/2024, Surveyor reviewed Resident 2's medical record. Resident 2 was admitted 12/30/2022 with diagnoses that include but are not limited to: schizophrenia, hypertension, GERD, and obesity. Surveyor reviewed Resident 2's MAR for the months of January 2024 and February 2024. The following dates in Resident 2's MAR did not have documentation of administration: 01/02/2024 Potassium Chloride ER Furosemide Spironolactone Lisinopril Lidocaine 4% Patch 01/03/2024 Potassium Chloride ER Furosemide Spironolactone Lisinopril 01/04/2024 Potassium Chloride ER Furosemide Spironolactone Lisinopril Lidocaine 4% Patch 01/05/2024 Potassium Chloride ER Furosemide Spironolactone Lisinopril Lidocaine 4% Patch	N 415		

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N 415	Continued From page 2 01/06/2024 Potassium Chloride ER Furosemide Spironolactone Lisinopril Lidocaine 4% Patch 01/08/2024 Potassium Chloride ER Furosemide Spironolactone Lisinopril 01/09/2024 Furosemide 01/10/2024 Furosemide Lidocaine 4% Patch On 02/22/2024 at 11:00 AM, Surveyor interviewed Administrator A who stated that there was a glitch in their system and caregivers must not have gone back and documented that the medication was administered. Administrator A stated s/he would review this concern with staff.	N 415		
N 423	83.37(3)(g) Medication storage: controlled substances. Controlled substances. The CBRF shall provide separately locked and securely fastened boxes or drawers or permanently fixed compartments within the locked medications area for storage of schedule II drugs subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats.	N 423		

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N 423	Continued From page 3 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that controlled substances were secured using a 2 lock system. The medication room was open and the medication cart was unlocked. Findings include: On 02/12/2024, the Department received a complaint that alleged the facility did not secure schedule II medications using a double lock system. on 02/22/2024, Surveyor observed the physical environment. On 02/22/2024 at 9:15 AM Surveyor observed that the medication room door was unlocked and opened. Surveyor observed that the medication cart was unlocked and was able to open drawers in the medication cart. There was a sign on the door to the medication room that read, "Please keep door closed and locked." On 02/22/2024 at 9:30 AM, Surveyor observed Administrator A walk in to the medication room and exit without locking the medication cart or closing and locking the door to the medication room. On 02/22/2024 at 9:45 AM Surveyor observed that the medication room door was unlocked and opened. Surveyor observed that the medication cart was unlocked and was able to open drawers in the medication cart. On 02/22/2024 at 10:00 AM, Surveyor observed Administrator A walk in to the medication room and exit without locking the medication cart or	N 423		

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N 423	Continued From page 4 closing and locking the door to the medication room. On 02/22/2024 at 10:15 AM Surveyor observed that the medication room door was unlocked and opened. Surveyor observed that the medication cart was unlocked and was able to open drawers in the medication cart. On 02/22/2024 at 11:00 AM, Surveyor interviewed Administrator A. Administrator A acknowledged that the medication room door was opened and unlocked. Administrator A acknowledged that the medication cart was unlocked. Administrator A acknowledged that 3 residents (Resident 1, Resident 2 and Resident 3) are prescribed medications that are considered controlled substances. Resident 1 was prescribed Hydrocodone and the medication was stored in the medication cart. Resident 2 was prescribed Clozapine and the medication was stored in the medication cart. Resident 3 was prescribed Tramadol and the medication was stored in the medication cart. On 02/22/2024 at 11:30 AM, Surveyor discussed the above concern with Administrator A. Administrator A acknowledged that controlled substances are required to be secured using a double lock system.	N 423		