STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	R-C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST 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 04/22/2025, Surveyor conducted a standard survey, verification visit and complaint investigation at Lilac Springs Assisted Living LLC, a community-based residential facility (CBRF) located in Lake Mills, WI. As a result of the survey, 3 deficiencies were identified. Three (3) were repeat deficiencies and 5 previous deficiencies from statement of deficiency (SOD) ZOLI13, dated 09/27/2025 were substantially corrected. The complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 18	{N 000}		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by:	{N 389}		

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
	0019044	A. BUILDING: _____ B. WING _____	R-C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST 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 389}	Continued From page 1 Based on record review and interview, the provider did not update Resident 14's individual service plan (ISP) to include elopement, physical and verbal aggression to staff and residents and methods for delivering the needed care/interventions. This is a repeat deficiency. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023, SOD ZOLI11, dated 01/23/2024, SOD ZOLI12, dated 05/30/2024, and SOD ZOLI13, dated 09/27/2024. Findings include: On 04/22/2025, Surveyor reviewed Resident 14's record. Resident 14 was admitted to the provider on 08/29/2024 with diagnoses including Alzheimer's disease. Resident 14's progress notes from March and April 2025, which document the following: 03/02/2025, "Resident used 115's toilet and [s/he] got mad when we came into the bathroom and we saw [him/her] in there." 03/06/2025, "Resident tried to leave with a visitor today. [S/he] has tried to do this a couple times now. [S/he] will follow the visitors out unless someone is watching and stops [him/her]." 03/06/2025, "I was letting someone out and [s/he] was trying to leave with [him/her] and I stopped [him/her] and [s/he] grabbed my arm and pushed me and [s/he] stated I was trying to go with [him/her s/he] wants me to go with [him/her] and I told [him/her] that the weather was too cold outside and that we should stay inside and then [s/he] said you don't even know [him/her]. And then [s/he] threatened to call the police and then [s/he] walked away from me." 03/07/2025, "Resident tried to leave building with random people multiple times."	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	R-C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST 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 389}	Continued From page 2 03/07/2025, "Resident is still, frequently trying to follow anyone who is leaving the building so eyes on when resident is actively up." 03/08/2025, "Resident kept going in residents rooms staff asked [him/her] to come out of 109 [s/he] pushed staff and punched staff in arm, staff did follow resident around till[sic] [s/he] got tired, also [s/he] kept telling staff [s/he] was going to call the police on us. Resident did cry a lot today while walking around and said that staff kicked in the in [expletive] and resident kept going in the office and finally it got locked." 03/08/2025, "Writer was in 102 getting resident ready for bed, [Resident 14] came in room writer asked resident to leave because it was someone else's room resident then stayed in the room well writer asked [him/her] to leave writer had to close the door to get resident out then 5 minutes later [Resident 14] was back in the room and was not leaving writer then had to walk resident out well[sic] resident was still trying to get into the room writer had to close door on resident and lock it." 03/09/2025, "Resident was caught breaking into other residents rooms so writer told resident it wasn't residents room and resident got mad and started yelling at writer but eventually left." 03/09/2025, "Writer tried to grab some items resident stole from other residents rooms and resident started to yell, hit, spit, kick, and slap writer. Right after writer managed to grab some items resident started yelling at writer saying 'your[sic] going to jail for stealing' then writer walked away and left resident alone in living room." 03/09/2025, "Resident was trying to go into employees break room and writer told resident they are not aloud[sic] to go in that room and resident turns around and threatens writer saying 'when I get to you I will hurt you'."	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	R-C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST 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 389}	Continued From page 3 03/12/2025, "Was attacking staff and other resident tonight and calling names and stated 108 and [his/her] family was here to kill [him/her] and [s/he] stated [s/he] had to kill them first, also [s/he] was in and out of rooms and angry when asked to leave." 03/13/2025, "Was caught trying to leave the building behind our [staff personnel]..." 03/15/2025, "Resident managed to follow someone out the door and escaped for about 1 minute. Resident was brought in by worker and then watched to make sure resident didn't leave again." 03/16/2025, "Resident was walking into other resident room staff corrected with letting resident know where their room was. Resident persisted all morning to afternoon staff locked resident's doors upon their request." 03/16/2025, "Resident had some visitors to see [him/her] however [s/he] didn't seem happy to see them. [S/he] began to act out when they got here, trying even harder to get into other rooms and when asked to leave room 109 as it wasn't [his/hers s/he] began to scratch and claw staff and trying to kick staff. When staff got away [s/he] was seeking staff out to continue with [his/her] behavior and tore staff shirt broke staffs name tag and left many scratched." 03/18/2025, "[S/he] snuck out the building, we need to watch [him/her] when anyone comes in or out." 03/18/2025, "Resident walked out door and tried getting into another car, working was in another residents room and seen[sic] resident get into car workers ran outside and got [him/her] to come in resident did not fight and came in easily. 03/21/2025, "Resident has grabbed several items that are not [his/hers]and we did get stuff back but [s/he] tried to hurt staff by punching and scratching and staff had let [him/her] be so [s/he]	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	R-C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST 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 389}	Continued From page 4	{N 389}		

could calm down. [S/he] also has a pager and wont give it back."
03/23/2025, "Resident keeps going into rooms and taking stuff that's not [his/hers]..."
03/24/2025, "Resident was found by writer multiple times going into other residents rooms."
03/26/2025, "Resident has been saying some not nice things to staff like 'you should die' 'I hate you' and hitting at staff. Then a quick turn where resident is all of a sudden crying stating everyone has just beak [him/her] bloody and how [s/he's] dead."
03/26/2025, "Resident handed writer one of residents dolls saying 'it's going to die so it can die with you'."
03/26/2025, "Resident tried going in everyone's room then continued to get upset when resident couldn't get managements door."
04/02/2025, "During dinner resident went into another residents room..."
04/04/2025, "...there was a living baby in the living room. [Resident 14] comes around the corner and grabs both of the babies arms and states that this was [his/her] baby. [Person] is able to remove [his/her] grip from the baby and take [him/her] to a different room while [Caregiver] tried to calm [Resident 14] down. The baby's mother was notified along with [Administrator Y]."
04/08/2025, "Resident has been going into other residents rooms claiming that the other rooms are also residents."
04/08/2025, "Staff found resident in other rooms several times, when staff asked [him/her] to please stay out of rooms [s/he] got mad and called staff [expletive] and walked away."
04/09/2025, "Resident was trying to get out of the building. Stated that '[s/he] wanted to go home'..."
04/09/2025, "Resident wants to leave and go to [his/her] other home."
04/09/2025, "Resident tried leaving the building to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	R-C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST 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 389}	Continued From page 5 go take a look at residents own car outside." 04/09/2025, "Resident tried going into another residents room because resident thought resident heard guys laughing and thought there was a party going on." 04/10/2025, "Resident claimed that residents doll was possessed and that the doll would attack all of us." 04/15/2025, "Resident had tried going into other rooms earlier in the day." 04/16/2025, "Resident has tried going into other residents rooms a few times today since shift change." 04/17/2025, "Resident has been trying to go into other residents rooms." 04/19/2025, "Resident is stealing table clothes and going into other residents rooms." Surveyor reviewed Resident 14's current ISP, which documented: -Under a "Safety" heading, "Resident has a history of wandering but has had no occurrences of elopement." -Under a "Behavior" heading, "Resident has difficulties expressing wants and needs. [S/he] can only communicate with vague descriptions." -Under a "Self Direction & Communication" heading, "Resident required staff assistance/intervention to maintain positive interactions with others. Resident has a positive attitude with others at the community. Resident has a positive self-concept." At 10:24 a.m., Surveyor interviewed Caregiver AA. Caregiver AA stated that Resident 14 tries to elope often. S/he stated that Resident 14 is aggressive towards staff and residents. Caregiver AA has been slapped in the face by Resident 14. At 12:36 p.m., Surveyor reviewed the above	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	R-C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST 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 389}	Continued From page 6 concerns with Administrator Y and Assistant Administrator Z. Administrator Y stated that s/he understand the concern and that s/he and Assistant Administrator Z have only been in place since March. Assistant Administrator Z stated s/he is in the process of updating ISPs.	{N 389}		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plans (ISP) for 1 of 1 resident reviewed with a prescription for as-needed (PRN) psychotropic medication included a rationale for use and a detailed description of the behaviors indicating	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	R-C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST 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 408	Continued From page 7	N 408		

the need for administration of the PRN medication.

Resident 4's ISP did not include rationales for use or detailed descriptions of behaviors indicating the need for his/her prescribed PRN Clonazepam or his/her PRN Lorazepam tablets.

This is a repeat deficiency. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023.

Findings include:

On 04/22/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 06/08/2023 with diagnoses including dementia, anxiety, schizophrenia, bipolar, and obsessive-compulsive disorder. Resident 4's prescriptions included the following:

- Lorazepam 1 mg tablet: "Take 1/2 tablet orally once daily as needed. Reason for use, anxiety"
- Clonazepam 0.5 mg tablet: "Take (1) tablet orally once daily as needed for anxiety or restless legs"

Surveyor reviewed Resident 4's current ISP, which, under a "Psychotropic Medication" heading, details that resident has a scheduled/PRN prescribed psychotropic medications, but does not identify which medications. There was no evidence of detailed descriptions of behaviors indicating the need for administration of his/her Lorazepam or his/her Clonazepam.

Surveyor reviewed Resident 4's medication administration record (MAR) for April 2025. Resident 4 was administered his/her prn Lorazepam 1 mg on 04/12/2025 and his/her prn

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	R-C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST 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 408	Continued From page 8 Clonazepam 0.5 mg on 04/16/2025. At 12:36 p.m., Surveyor reviewed the above concerns with Administrator Y and Assistant Administrator Z. Administrator Y stated that s/he understand the concern and that s/he and Assistant Administrator Z have only been in place since March. Assistant Administrator Z stated s/he is in the process of updating ISPs.	N 408		
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 observation, record review and interview, the provider did not ensure the person administering medication documented the medication that was administered to Resident 4 accurately in his/her medication administration record (MAR). Resident 4's Metoprolol Succ ER 25 MG was documented as administered throughout the month of April, although it was not available.	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	R-C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST 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 415	Continued From page 9 This is a repeat deficiency. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023 and SOD ZOLI11, dated 01/23/2024. Findings include: On 04/22/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 06/08/2023 with diagnoses including dementia, anxiety, schizophrenia, bipolar, and obsessive-compulsive disorder. Resident 4's prescriptions included the following: - Metoprolol Succ ER 25 MG: "Take (1) tablet orally once daily in the morning" Surveyor reviewed Resident 4's MAR for April 2025. Resident 4's Metoprolol was documented as "not passed" on 04/13/2025 with documentation stating, "not in med cart". Resident 4's Metoprolol was documented as not in the medication cart on: 04/14/2025; 04/15/2025; 04/18/2025; 04/21/2025; 04/22/2025. Resident 4's Metoprolol was documented as administered on: 04/16/2025; 04/17/2025; 04/19/2025; 04/20/2025. At 12:14 p.m., Surveyor observed the medication cart and asked Caregiver V, who was administering medications that day, if Resident 4's Metoprolol was available for administration. Caregiver V looked in the medication cart and then stated, according to documentation, this medication has been out since 04/13/2025. At 12:36 p.m., Surveyor reviewed the above concerns with Administrator Y and Assistant Administrator Z. Administrator Y stated that s/he was just finding out about the medication and will	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	R-C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST 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 415	Continued From page 10 ensure staff are only documenting the administration of medications that are available and administered to residents.	N 415		