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	510330	A. BUILDING: _____ B. WING _____	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MANOR	119 E 4TH ST N LADYSMITH, WI 54848

(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 04/02/2024, Surveyor conducted a complaint investigation at Lake Manor. Data collection continued through 04-11-2024. The complaint was substantiated. One deficiency was identified. Census: 16	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Surveyor: Calhoun, Lonny C. Based on observation, record review, and interview, the provider did not safeguard residents from environmental hazards to which it was likely the residents would be exposed, including both conditions that were hazardous to anyone and conditions that were hazardous to the resident because of the resident's conditions or disabilities. Resident 1 eloped on 03/27/2024 and was found deceased outside the facility on 03/27/2024. The provider's doors were alarmed. Resident 1 had a	N 358		

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

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history of entering the door code and successfully opening the doors at the facility since being admitted.

Findings include:

The provider is licensed to care for 20 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease.

The Department received a complaint on 03/27/2024, indicating Resident 1 was found outside the building of the provider deceased (frozen in the snow) on 03/27/2024.

The Department received a self-report on 03/29/2024, indicating Resident 1 eloped during the overnight (NOC) shift 03/26/2024 to 03/27/2024 and was found deceased on the provider's property at approximately 8:03 AM on 03/27/2024. The report read, in part: "NOC shift reported last seeing resident (Resident 1) physically (not covered by blanket) at 2:33 AM on 03/27/2024, and covered in bed (not seeing a face) at 4:15 AM on 03/27/2024. AM Caregiver and NOC Caregiver did shift change at around 6:00 AM on 03/27/2024, where AM Caregiver peeked into the resident's room at 6:10 AM [sic] 03/27/2024 [sic] and it appeared [s/he] was sleeping. Around 7:45 AM - 8:00 AM, AM Med Tech [sic] noticed resident was not in [his/her] bed and thought to first check [his/her] bathroom; however, [s/he] was not there. Afterwards, AM Med Tech [sic] checked all communal areas and resident rooms - not found. At that point, AM Med Tech [sic] followed procedure of missing resident. Facility believes resident may have wandered outside the building between 2:33 AM and 7:45 AM on 03/27/2024, where during those minutes/hours inbetween [sic] that time stamp,

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staff were unable to report physically seeing the resident's face."

The self-report also read, in part: "Historically, the resident (Resident 1) was not an exit seeker at first choice or chance, regardless of [his/her] current state of mind. [S/he] enjoyed [his/her] walks outside utilizing [his/her] front-wheeled walker w/staff, and during warmer weather [s/he] would demand (in a friendly-sassy kind of way) to be walked outside. [S/he] refused to walk alone outside always wanting someone with [him/her].Over the course of the two years resident was at [Provider], [s/he] was aware of the sequence of numbers to input the door alarm system, because [s/he] would vocally say the numbers occasionally to staff and [his/her] [daughter/son] [Family Member (FM) C], upon visit; however, not very often to staff or [FM C]. Of the current staff, only one staff reported the resident inputting the code once. [Provider] Door Alarms - there are six doors that lead directly to outside at [Provider]. All six doors that lead to exits have alarms in place. Two of the six outside exit doors (we deem the main exits) have wander guard strips on them that signal to transmitters when in proximity of one another and alarm when attempting to exit. With that said, all six doors regardless of wander guard strips or not, will trigger an alarm that requires a sequence of codes to disarm, otherwise it will continue to sound an alarm that does not time out or stop."

On 04/02/2024 at 9:30 AM, Surveyor toured the facility with Director A. Surveyor observed six doors that exited to the outside and one door that led to the basement. All 7 doors were alarmed. Two of the six doors that led outside had WanderGuard alarms in addition to door alarms. Surveyor observed Director A open all 7 doors

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one at a time. All 7 door alarms sounded and required Director A to enter a sequence of numbers to turn the door alarms off. The doors appeared to be working as designed. The basement door led to facility storage and laundry.

On 04/02/2024 at 9:30 AM, Surveyor interviewed Director A. Director A reported that s/he tested all of the door alarms with Police Officer (PO) D on 03/27/2024. Director A reported that all of the door alarms worked on 03/27/2024. Director A reported Resident 1 was found deceased in the snow with his/her walker, outside on 03/27/2024. Director A stated that Resident 1's WanderGuard was on his/her walker and the WanderGuard was tested and the WanderGuard worked.

On 04/02/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 10/07/2021 and expired on 03/27/2024. Resident 1 was diagnosed with dementia. Resident 1's Individual Service Plan (ISP), dated 10/25/2023, noted for ambulation: "To assist me [sic] I use a walker [sic] I require supervision [sic] one caregiver [sic] occasionally to go for walks outside." The ISP noted, for Personal/Social, dated 06/09/2022: "When staff have down time [sic] please offer to take me out for a walk, I enjoy being outdoors. I may ask shortly after I return but I am easily redirected and if I need to wait for staff to complete a task in order to take me [sic] I will wait."

On 04/02/2024 at 11:30 AM, Surveyor interviewed Registered Nurse (RN) B. RN B reported that Resident 1 was a "fall risk" and was on 2-hour toileting checks.

On 04/02/2024 at 11:45 AM, Surveyor interviewed Caregiver E. Caregiver E stated that s/he started

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work at 6:00 AM on 03/27/2024. Caregiver E reported, "I went down to [Resident 1's] room around 7:30 AM because another resident had a call light on. I looked in [Resident 1's] room. [S/he] was not in [his/her] room. I checked [his/her] bathroom; [S/he] was not there. I checked everywhere. I conducted a full facility search. I spoke to my co-worker, [Caregiver F]. [Caregiver F] went outside to check the alleyway. I went outside on the porch. I called [Director A] around 8:02 AM. While I was on the phone with Director A, [Caregiver F] called me on the walkie-talkie and reported [s/he] found [Resident 1] outside in the snow. I called 911 and around 8:07 AM, I called [Resident 1's] [daughter/son]." Caregiver E noted, "[Resident 1] may have been looking for the bathroom and somehow got outside." Caregiver E stated that Resident 1 was found with his/her walker next to him/her and Resident 1's WanderGuard was on his/her walker. Surveyor asked Caregiver E if Resident 1 knew the door code or ever entered the door code to disable the door alarms. Caregiver E stated, "I saw [Resident 1] enter the door code once." Caregiver E noted that Resident 1 entered the door code "a long time ago." Surveyor asked Caregiver E if Resident 1 was on checks. Caregiver E indicated that Resident 1 was on 2-hour toileting checks. Caregiver E informed Surveyor that the door alarms had always worked and "you need to enter a code to disable the alarms."

On 04/02/2024 at 12:25 PM, Surveyor interviewed Caregiver F. Caregiver F reported that s/he worked until 10:20 PM on 03/26/2024 and 6:00 AM to 1:30 PM on 03/27/2024. Caregiver F stated, "I worked at 6:00 AM on 03/27/2024 to 1:30 PM on 03/27/2024. On 03/27/2024, I walked through the facility with

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Caregiver G at approximately 6:10/6:15 AM. Caregiver G had documented last checking on [Resident 1] around 4:15 AM - 4:30 AM on 03/27/2024." Caregiver F noted that s/he was not sure if Caregiver G had actually made "visual contact" with Resident 1 around 4:15 AM - 4:30 PM on 03/27/2024. Caregiver F stated, "While doing rounds with Caregiver G on 03/27/2024, I glanced through [Resident 1's] door. The bed looked like [Resident 1] was in it. I did not physically go in the room." Caregiver F reported, "[Caregiver E] came to me at 7:30 a.m. on 03/27/2024 and asked if I saw [Resident 1]. We started searching the building and I went outside and checked the grounds. I found [Resident 1] outside by the Lake House next to the facility. [His/her] face was buried in the snow and s/he was on top of his/her walker. I am pretty sure the WanderGuard was on the walker. I radioed [Caregiver E] when I found [Resident 1] outside. Caregiver E brought me a blanket for [Resident 1]. [Caregiver E] called Director A, 911 and [Resident 1's] family." Caregiver F indicated that Resident 1 was deceased (frozen) when s/he located Resident 1 on 03/27/2024. Caregiver F reported that the door alarms had been working and there were no known issues with them. Caregiver F stated that the door alarms turned off by entering a code. Surveyor asked Caregiver F if Resident 1 knew the door code or if Caregiver F ever witnessed Resident 1 punch in the door code. Caregiver F indicated that s/he was unaware if Resident 1 knew the door code or ever punched in the door code.

On 04/02/2024 at 1:15 PM, Surveyor interviewed Caregiver H. Caregiver H reported s/he worked on 03/26/2024 from 1:00 PM to 9:00 PM. Caregiver H reported that the door alarms worked and there were no issues with the door alarms on

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N 358	Continued From page 6 03/26/2024. Caregiver H stated, "I saw [Resident 1] around 8:00 PM on 03/26/2024 by the dining room. [Resident 1] seemed to be alert but had periods of confusion." Caregiver H worked on 03/27/2024 from 1:00 PM to 9:00 PM. Caregiver H stated that Resident 1 had been placed on "2-hour toileting checks" a few months ago and Resident 1 started using stool softeners in March 2024. Caregiver H indicated that once a door alarm gets activated, staff needed to go to the specific door and enter a code to turn off the alarm. On 04/02/2024 at 4:07 PM, Surveyor interviewed Director A. Director A reported, "[Resident 1] was independent with getting up." Director A stated that Resident 1 was on 2-hour toileting checks. Director A also noted Resident 1 had a bed alarm in place and "[Resident 1] knew how to turn off the bed alarm." On 04/03/2024 at 3:50 PM, Surveyor asked Director A via e-mail if Resident 1 knew the door code or ever successfully punched in the door code. On 04/03/2024 at 4:02 PM, Director A responded via e-mail, "Yes," per my initial report to DQA- "Over the course of the two years resident was at [Provider], [s/he] was aware of the sequence of numbers to input into the door alarm system, because [s/he] would vocally say the numbers occasionally to staff and [his/her] daughter, [FM C], upon visit; however, not very often to staff or [FM C]. Of the current staff, only one staff reported the resident inputting the code once. [Provider's] regular routine with the resident was to always input the code when we exited with said resident, because s[s/he] would not [sic] willing attempt and often times waited for us to	N 358		

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N 358	Continued From page 7 open the doors" On 04/03/2024 at 4:00 PM, Surveyor interviewed Caregiver I. Caregiver I reported working on 03/26/2024 from 6:00 AM to 3:00 PM. Caregiver I stated that Resident 1 was on 2-hour toileting checks due to "constipation issues." Caregiver I informed Surveyor that Resident 1 had a medical appointment on 03/20/2024 to address his/her constipation issues. Caregiver I stated that when Resident 1 was first admitted a few years ago (admitted on 10/07/2021), Resident 1 walked out of the facility and a WanderGuard was put in place. Surveyor asked Caregiver I if Resident 1 knew the door code or if s/he observed Resident 1 enter the door code. Caregiver I reported, "[Resident 1] learned the door code and punched the code in when [s/he] was first admitted. [S/he] knew the code when s/he was first admitted and pushed the door code a 'handful of times - at least one time a week' when [s/he] was first admitted. [Resident 1] would open the door and look outside. [Resident 1] knew the code. The door code was never changed. It has always been [code numbers]." Caregiver I reported that s/he did not know if management knew about Resident 1 knowing and/or using the door code in the past. Caregiver I indicated the door alarms worked during his/her shift on 03/26/2024. Caregiver I reported, "[Resident 1] could have had a 'lucid moment' and pushed the door code on 03/27/2024 because [s/he] knew the door code at one point." On 04/04/2024 at 7:10 AM, Surveyor interviewed Caregiver G. Caregiver G indicated s/he worked the NOC shift alone on 03/26/2024 (10:10 PM) to 03/27/2024 (6:10 AM). Surveyor asked Caregiver G about his/her NOC shift duties on 03/26/2024 into 03/27/2024. Caregiver G reported that s/he	N 358		

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did rounds, 2-hour toilet checks on residents (including Resident 1), and cleaned and did laundry throughout the night. Caregiver G reported that s/he liked to keep the same routine when s/he worked. Caregiver G indicated s/he usually did one or two loads of laundry during his/her shift and the laundry was located in the basement (downstairs). Caregiver G indicated that s/he was the main NOC shift worker. Caregiver G indicated that the washer and dryer were located downstairs and "you would not hear a door alarm if you were downstairs - doing laundry."

Caregiver G reported that caregivers carry pagers and pagers work throughout the entire facility, including downstairs. Caregiver G noted, "When a resident pushes their call light, we get paged." Caregiver G reported that s/he went downstairs on two separate occasions during the NOC shift on 03/26/2024 - 03/27/2024. Caregiver G reported that s/he went downstairs around 11:00 PM on 03/26/2024 and around 3:30 AM on 03/27/2024 to do laundry and pick up supplies. Caregiver G stated that was downstairs for approximately 5 minutes at 11:00 PM (03/26/2024) and was downstairs for "not more than 15 minutes" at 3:30 AM (03/27/2024). Caregiver G reported that s/he did not hear a door alarm or bed alarm during his/her NOC shift. Caregiver G stated, "The last time I physically remember seeing [Resident 1] was around 2:30 AM on 03/27/2024 because I was finishing up my 2:00 AM rounds. [Resident 1] was coming out of another resident's room. [S/he] liked to visit with Resident 2. [Resident 1] went to [his/her] room by [himself/herself] around 2:30 AM. A few hours later, around 4:15 AM, I 'snuck' into [Resident 1's] room to deliver water. I was in and out of his/her room; it looked like [Resident 1] was in bed."

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Caregiver G noted that s/he did not actually see Resident 1 face to face or look directly at Resident 1's bed during the check at 4:15 AM. Surveyor asked Caregiver G if s/he heard any alarms during his/her shift. Caregiver G stated, "Not that I remember; one happened before my shift at 10:00 PM on 03/26/2024." Surveyor asked Caregiver G if Resident 1 knew the door code or ever entered the door code to open a door. Caregiver G reported, "Not that I know of." Caregiver G indicated that Resident 1 liked to wander around the facility but could be redirected and was on 2-hour bathroom checks (incontinence checks). Caregiver G reported, "The doors were alarmed and the alarms sound regardless of whether a resident was wearing a WanderGuard or not. The door alarm would continue to sound until the door code got entered. The next check was at shift change when Caregiver F came at 6:10 AM on 03/27/2024. We did rounds together. We went into Resident 3's room and Resident 4's room at 6:10 AM on 03/27/2024. We did not check [Resident 1's] room at 6:10 AM. The last time I was in [Resident 1's] room was to switch out waters at 4:15 AM. After shift change, I don't know what happened."

Surveyor asked Caregiver G if all of the door codes were the same and if it was possible Resident 1 knew how to enter the door code. Caregiver G stated that s/he believed all of the door codes were the same and as far as Resident 1 knowing how to enter the door code, Caregiver G stated, "I cannot honestly say yes or no to that question." Surveyor asked Caregiver G if the door alarms ever malfunctioned while s/he worked NOC shift in March 2024. Caregiver G reported, "To the best of my knowledge, the doors did not malfunction in March 2024." Surveyor

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asked Caregiver G about the behaviors of residents during a typical NOC shift. Caregiver G reported that s/he worked the NOC shift alone a few times a week and there had been times when Caregiver G would be toileting a resident and a door alarm would go off and Caregiver G would have to find the source of the alarm.

Caregiver G reported, "I have seen residents go outside while working and actually have gone outside after a door alarm sounded and a resident was outside. A few times per week, I have actually turned off door alarms by residents trying to get out of the building. In March 2024, I have caught [Resident 1] trying to leave before. I don't remember the exact dates but a few times [Resident 1] would try to push open a door and the alarm would go off. I would always get to [him/her] and [s/he] would never actually physically get outside." Caregiver G reported, There have been times, at least a few times a week, where I would be assisting one resident on the toilet and a wandering resident would set off a door alarm in another part of the facility. I would have to hurry and find which door was triggered and which resident triggered the door. I have seen residents go outside while working and actually have gone outside after a door alarm sounded and the resident was outside." Caregiver G reported that s/he had turned off the door alarms by residents trying to get out and in March 2024. Caregiver G had caught Resident 1 trying to leave before. Caregiver G could not recall the dates but it happened a "few times." Caregiver G commented that the times Resident 1 set off the door alarms in March 2024, Resident 1 was never able to get outside.

On 04/04/2024 at 8:50 AM, Surveyor interviewed Medical Examiner (ME) J. ME J reported,

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"[Resident 1] knew the door code and how to turn off the bed alarm." Surveyor asked ME J how s/he knew Resident 1 knew the door code and knew how to turn off the bed alarm. ME J stated Resident 1's son/daughter, FM C, told him/her that on "good days" Resident 1 knew the door code and entered it for family during visits and Resident 1 knew how to turn off his/her bed alarm. ME J reported that ME J was at the facility on 03/27/2024 at approximately 8:30 AM. ME J noted, "[Resident 1] was frozen solid and [s/he] had to be outside 4 to 6 hours after being seen at 2:30 AM on 03/27/2024 (per staff report). ME J indicated, "[Resident 1's] time of death will be reported around 4:30 AM on 03/27/2024." ME J commented, "Why not change the door code if residents know the code?"

On 04/04/2024 at 9:15 AM, Surveyor asked Director A via e-mail if the facility planned to change the door alarm codes.

On 04/04/24 at 4:07 PM, Director A responded, "At this time, we have not - we are still discussing internally."

On 04/05/2024 at 8:40 AM, Surveyor interviewed Police Officer (PO) D. PO D reported that Resident 1 was found outside by staff a little after 8:00 AM on 03/27/2024. PO D stated, "We got the call at approximately 8:10 AM that [s/he] was found." PO D indicated that s/he checked the door alarms with Director A on 03/27/2024. PO D noted, "The door alarms worked." PO D reported that Resident 1's WanderGuard was checked a few days after 03/27/2024 and the WanderGuard worked. PO D noted that Resident 1's WanderGuard battery expired in 2026. PO D reported, "[Resident 1's] [son/daughter, FM C] informed me [Resident 1] knew the door code

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510330	A. BUILDING: _____ B. WING _____	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MANOR	119 E 4TH ST N LADYSMITH, WI 54848

(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
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and had used it before to go outside." PO D commented that s/he was not too familiar with assisted living codes and PO D questioned how 1 person could watch 17 people that wander and have dementia.

On 04/08/2024 at 8:08 AM, Surveyor interviewed FM C. FM C stated, "[Resident 1] actually used the door code and let me out about 6 months ago or so. Usually, when [Resident 1] walked with me, I would punch in the code myself to leave the facility. I have seen [Resident 1] punch in the door code and successfully open the door on a few occasions since being admitted." FM C reported that the door code had not changed since Resident 1's admission in 2021.

According to accuweather.com (retrieval date - 04/09/2024), at the time Resident 1 eloped (after 2:30 AM on 03/27/2024), the outside temperature was 21 degrees. It had snowed and sleeted overnight. The facility is located in a downtown area across the street from a law enforcement center and courthouse. The facility is blocks away from a waterway (Ladysmith Flowage) and main highway that goes through the community.

On 04/09/2024, Surveyor reviewed ME J's provisional death report (ME 2024-1003). According to the provisional death report, Resident 1's date of death was 03/27/2024. Resident 1's cause of death was "Hypothermia due to exposure to cold" and the manner of death was "Accidental." The provisional death report read, in part, "[Resident 1], a 91 year old white [fe/male], was found outside [his/her] long term care facility dressed in a nightgown, light pants, and a sock. It had snowed and sleeted overnight. [S/he] was last known alive within the facility was unknown [sic]."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510330	A. BUILDING: _____ B. WING _____	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MANOR	119 E 4TH ST N LADYSMITH, WI 54848

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N 358	Continued From page 13 On 04/09/2024 at 8:06 AM, Surveyor asked Director A via e-mail, "Did Resident 1 know how to turn off his/her bed alarm? On 04/09/2024 at 2:41 PM, Director A responded via e-mail, "We established the bed alarm after [his/her] fall on 03/07/2024, Dr. and Guardian were notified of the fall and the intention for a bed alarm, when it was determined [s/he] fell near [his/her] bathroom door in [his/her] room. The bed alarm in [his/her] room, the actual alarm itself, was placed behind the headboard. With that said, staff do not believe [Resident 1] tried to turn [his/her] bed alarm off on [his/her] own whenever it did go off. However, [s/he] did have the capacity to push the button to do so; therefore, it was placed in an inconvenient spot on [his/her] bed." The provider did not safeguard Resident 1 from environmental hazards to which it was likely the resident would be exposed. Resident 1 knew the door code and entered it on a few occasions and exited the facility. The door code was not changed since Resident 1 was admitted. Resident 1 had a history of eloping and attempting to exit the facility during the NOC shift. The provider had just one caregiver during NOC shift to care for all the residents and do laundry in the downstairs (basement) area, where it would be difficult to hear door or WanderGuard alarms.	N 358		