STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018785	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER LAKE MANOR	**N2641 17TH LANE WAUTOMA, WI 54982**

(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
U 000	INITIAL COMMENTS On 11/03/2025 with information gathered through 11/05/2025, Surveyor conducted a complaint investigation and standard survey at Silver Lake Manor, a Residential Care Apartment Complex (RCAC) in Wautoma, WI. One deficiency identified. Complaint unsubstantiated. Census: 11	U 000		
U 188	89.27(4) SERVICE AGREEMENT REVIEW AND UPDATE. The service agreement shall be reviewed when there is a change in the comprehensive assessment or at the request of the facility or at the request or on behalf of the tenant and shall be updated as mutually agreed to by all parties to the agreement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Tenant 1's service agreement was reviewed when there was a change in the comprehensive assessment, and updated as mutually agreed to by all parties to the agreement. Findings include: On 10/29/2025, the Department received a complaint regarding tenant care. On 11/03/2025, Surveyor requested to review Tenant 1's record and identified the following: Tenant 1 had an admission date of 03/01/2023.	U 188		

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

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U 188	Continued From page 1 Staff charted the following observations between 10/10/2025 and 10/29/2025: -"10/10/2025: 6:50 AM, staff went into resident's room to wash [him/her] up, resident slurred [his/her] speech and proceeded to tuck [him/herself] into bed. Staff went to pull blankets down and resident yanked blanket back up and proceeded to ignore staff. 8:30 AM, staff went to give resident 8 AM meds and resident ignored staff, 10 min later resident came out of room for breakfast and took [his/her] meds perfectly. -10/13/2025: Resident could not follow commands while performing cares. Was able to wash top half, but not bottom. Resident got slightly agitated. -10/19/2025: 8 PM, Resident was in the hallway and two other residents were in the hallway and s/he was swearing at them, saying they needed to be quiet. Resident was going into the med cart as staff was getting meds out. 8 PM, Resident very agitated tonight staff tried to redirect but resident was just getting more upset. -10/21/2025: 8:12 AM, Admin came in at 8:00 AM to staff reporting that resident was in [his/her] room on the floor and non-responsive. When admin came into room, resident was lying on [his/her] back, snoring and not responding to stimuli. Resps 18, temp 97.9, pulse 88. Staff was getting BP when EMTs arrived. Per EMT lactose level was 9. Resident was starting to grip hands and trying to pull pants when transferring to gurney. Resident being transported to Berlin for evaluation. Per staff, resident was assisted in cares at about 5:30 AM. Staff went back to get resident out for breakfast around 7:45 AM, when they found [him/her]. -10/22/2025: Resident kept trying to stand up in living room and kept falling over. Staff unable to redirect [him/her]. Tried to use EZ stand to	U 188		

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U 188	Continued From page 2	U 188		

transfer [him/her] to recliner and [s/he] was unable to do so. Wouldn't stand up. When staff came out of another resident's room, [Resident 1] was asleep in [his/her] bed. Staff went to check on [him/her] 15 min later and resident had blood on face and hands. Gash on right eyebrow. When staff tried to apply compress to wound, resident became combative. Resident was sent to ER. Ambulance personnel checked lactic acid, stated it was elevated and "something is definitely going on with [him/her]".
-10/23/2025: 4:30PM, this writer went to assess resident in Wild Rose Hospital. Resident was alert and responsive. [S/he] was talking but words were not corresponding with what this staff was saying, which is residents current baseline. Resident would not get up to walk but nursing staff and PT/OT notes gait is steady. Nurse reported resident transferred and ambulated self and with contact guard with no difficulties. Nursing reports resident would do things "when and if [s/he] felt like it" but has not been aggressive or combative at all. Nurse did note s/he had been receiving [his/her] notes from [his/her] visit to Berlin ER and had been given 2 mg of Ativan prior to MRI and [his/her] discharge which could have been factor in unsteadiness prior. Resident has hearing for guardianship on 10/24 and will be discharged back to facility after.
-10/27/2025: 6:40 AM, staff was coming out of another residents room when resident was coming out of [his/her] room, swearing and agitated. Resident seemed to be trying to give staff a hug and once [s/he] got [his/her] arms around staff, resident started aggressively, trying to throw staff side to side, feet came off the ground. Staff went and got other staff as resident threw [his/her] water cup lid at staff. Both staff got resident back into [his/her] room. Very agitated trying to tell us something we couldn't

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U 188	Continued From page 3	U 188		

make sense of but somehow seemed to be talking a bit clearer. Kept pointing at the ceiling and asking staff, 'Do you know?' Resident is laying in bed til breakfast.
-10/27/2025: Resident was out in common area very agitated. When a staff member walked past [him/her], [s/he] took off running after [him/her]. Resident went after another resident. Pushing [him/her] to the ground in hallway. Resident continued down the hall and is trying to get into other resident rooms.
-10/27/2025: 10:32 AM Resident outside the building, walking back and forth in parking lot, attempting to go towards the road. Staff providing one-on-one time. 911 called. Officers arrived and crisis management called. New corporate guardian called as well.
-10/27/2025: At supper resident was confused and put [his/her] food on [his/her] placemat and ate off placemat. Resident was agitated. After supper staff discussed moving [him/her] to table near nurses station to staff could assist [him/her].
-10/28/2025: 4:01 PM-Resident not exhibiting aggressive behaviors but started wandering and exit seeking behaviors. Staff providing one on one. PCP seen today recommends neurology follow up as well as PT/OT evaluation. Staff to continue to monitor behaviors. This writer had discussion with guardian regarding alternative placement.
-10/28/2025: 4:15PM-Activity director was providing one on one time with resident due to restlessness s/he called facility stating resident was headed towards highway 21 and would not turn around. 911 called for police assistance.
-10/28/2025: 4:21PM- Activity Director stayed with resident until police arrived at scene. Resident and staff had walked almost to 152. Talked with crisis management and police. Crisis management suggested evaluation at Neenah.

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U 188	Continued From page 4 EMS called. Admin will meet Resident at Neenah ED. -10/29/2025: 8:44 AM, Resident was protectively placed at Thedacare through APS while alternative placement is found. Family and care team have been updated." Tenant 1's Individual Service Plan dated 08/19/2025 stated the following: -"Behavior Patterns, Behavioral Supervision: N/A" On 11/03/2025 at approximately 12:00 PM, Surveyor interviewed Administrator A and Licensee D. Administrator A stated there were so many changes with Tenant 1 within a short amount of time that s/he did not get to update the ISP. Administrator A stated Tenant 1 returned on a Friday and s/he was off so the ISP was not updated. Licensee D stated s/he would be in charge of updating the ISP if Administrator A was off and s/he acknowledged Tenant 1's ISP should have been updated due to his/her behavioral changes. On 11/05/2025, Surveyor reviewed police report dated 10/28/2025, which stated the following: On Monday 10/27/2025 at approximately 09:38 hours, Deputy B and Deputy C responded to a citizen assist complaint at Silver Lake Manor. It was reported that [Tenant 1] was confused and wandering, wearing sweatpants and a white t-shirt. Before arrival, Officers from the Wautoma Police Department (PD) advised they were outside with Tenant 1. Deputy B and Deputy C arrived to find officers out with [Tenant 1] sitting on a bench wearing a black t-shirt. Wautoma PD told Deputy B and Deputy C [Tenant 1] was walking down the hall with [his/her] arms out. A caregiver approached [Tenat 1] and gave	U 188		

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U 188	Continued From page 5 [him/her] a hug. [Tenant 1] then picked up the caregiver and shook [him/her] from side to side. Once caregiver was free from [his/her] hold, [Tenant 1] ran down the hallway into another caregiver. Wautoma PD advised that [Tenant 1] was not very verbal. Deputy C had been near [Tenant 1] and stated that it didn't appear that [Tenant 1] was fully comprehending what was going on. Deputy B tried to ask [Tenant 1] what was going on and [s/he] made some motions with [his/her] hands and mumbled something that I couldn't understand. Administrator A came out of the building. Administrator A stated that [Tenant 1] has experienced a steep decline in [his/her] mental cognition over the last 2 weeks. Administrator A said that [Tenant 1] had been in the hospital twice the week before and put through tests but nothing serious found. Administrator A said that this was the first time that [Tenant 1] had been physical with anyone. Administrator A said that they don't have the staff to do one to one with [Tenant 1] to stay at the facility. Deputy B advised Administrator A to call Human Services and get them involved." Tenant 1's service agreement was not updated when there was a change in Tenant 1's behavior patterns.	U 188		