STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016401	A. BUILDING: _____ B. WING _____	R-C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING LAKE TOMAHAWK	6416 FLICKER RD LAKE TOMAHAWK, WI 54539

(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 07/30/2025, Surveyor conducted a verification visit and complaint investigation (x2) at Lake Shore Assisted Living Lake Tomahawk. Data collection continued through 07/31/2025. The deficiencies identified in statement of deficiency (SOD) D8Q411 were corrected. One of 2 complaints was substantiated Two deficiencies were identified. One of 2 deficiencies was a repeat deficiency. See Statement of Deficiency (SOD) 54NQ11, dated 10/07/2021. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 10	{N 000}		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the department within 3 working days after Resident 1 fell and was treated for a head injury. This is a repeat deficiency. See Statement of	N 165		

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
	0016401	A. BUILDING: _____ B. WING _____	R-C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING LAKE TOMAHAWK	6416 FLICKER RD LAKE TOMAHAWK, WI 54539

(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 165	Continued From page 1	N 165		

Deficiency (SOD) 54NQ11, dated 10/07/2021.

Findings include:

The provider is licensed to serve up to 16 residents in the following client groups: advanced aged, traumatic brain injury, terminally ill, physically disabled and irreversible dementia/Alzheimer's disease.

On 07/01/2025, the Department received a complaint alleging staffing, resident care, and maintenance concerns. The complaint also alleged a resident fell in May 2025 and was hospitalized for a head injury. The resident died shortly after falling and the fall was not reported to the Department.

On 07/30/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 02/01/2024. Resident 1 died on 05/14/2025. According to an incident report, dated 05/02/2025, "Resident was coming out of bathroom in bed room [sic] and fell [sic] hit [his/her] head on heater on boarder [sic] of the wall."

The incident report noted that Resident 1 sustained a "head injury" and was taken to the emergency department. According to observation notes, dated 05/02/2025 (7:45 AM), "Resident fell forward hitting head on heater on boarder [sic] of the wall [sic] resident yelled help. resident [sic] has a gash by forehead [sic] Any concerns or changes will be updated.

Observation notes, dated 05/02/2025 (2:15 PM) noted, "Resident was admitted to hospital. updates [sic] will be added." On 05/09/2025 (12:30 PM), an observation note indicated, "Resident is back at facility, [s/he] is on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016401	A. BUILDING: _____ B. WING _____	R-C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING LAKE TOMAHAWK	6416 FLICKER RD LAKE TOMAHAWK, WI 54539

(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 165	Continued From page 2 hospice...any concerns staff needs to call hospice." On 07/30/2025 at approximately 11:00 AM, Surveyor interviewed House Manager (HM) A. Surveyor asked about Resident 1's fall on 05/02/2025. HM A stated that Resident 1 fell and "cracked [his/her] head open." HM A reported that Resident 1 was hospitalized and received treatment for a head injury. Surveyor asked HM A if Resident 1's fall was investigated and reported to the Department. HM A responded, "I don't know." On 07/31/025, Surveyor reviewed Department records. Department records did not contain a self-report for Resident 1's fall on 05/02/2025. 07/31/2025 at approximately 3:18 PM, Surveyor interviewed HM A via telephone. HM A verified Resident 1 fell on 05/02/2025, and sustained a head wound and fractured left hand, and the fall was not reported to the Department	N 165		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility.	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016401	A. BUILDING: _____ B. WING _____	R-C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING LAKE TOMAHAWK	6416 FLICKER RD LAKE TOMAHAWK, WI 54539

(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
Y3244	Continued From page 3	Y3244		

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure all residents received adequate and appropriate care within the capacity of the facility.

Findings include:

The provider is licensed to serve up to 16 residents in the following client groups: advanced aged, traumatic brain injury, terminally ill, physically disabled and irreversible dementia/Alzheimer's disease.

On 07/01/2025, the Department received a complaint alleging staffing and resident care concerns.

On 07/30/2025 at approximately 9:15 AM, Surveyor observed House Manager (HM) A and Caregiver B in Resident 2's room. Resident 2 was lying in bed. HM A and Caregiver B were assisting Resident 2 with cares. Caregiver B rolled a Hoyer lift (mechanical lift) closer to Resident 2's bed. The Hoyer lift, with plug in cord, pulled a glass shelf down to the floor and several glass items shattered on the floor. HM A and Caregiver B proceeded to clean up the floor and then transferred Resident 2 from his/her bed via Hoyer lift to Resident 2's Broda chair (specialized wheelchair). Resident 2 was wheeled into the dining room area. Caregiver B continued to clean

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016401	A. BUILDING: _____ B. WING _____	R-C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING LAKE TOMAHAWK	6416 FLICKER RD LAKE TOMAHAWK, WI 54539

(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
Y3244	Continued From page 4	Y3244		

up Resident 2's room. During this observation, both HM A and Caregiver B were using personal wheeled walkers to walk around the facility.

On 07/30/2025 at approximately 11:30 AM, Surveyor interviewed HM A. Surveyor asked HM A about Resident 2's cares. HM A stated that Resident 2 required the assistance of two staff with cares and transfers via Hoyer lift. HM A reported that two staff worked AM shift (7:00 AM to 7:00 PM) and got Resident 2 in and out of bed. HM A reported that one staff worked PM/NOC (overnight) shift (7:00 PM to 7:00 AM) and Resident 2 stayed in bed and was changed in bed from 7:00 PM until the next morning. HM A stated that Resident 2 was a "2 person assist" and required a Hoyer lift for all transfers. HM A reported that HM A was working with "restrictions" since having a knee surgery. HM A stated that HM A used a wheeled walker at times to ambulate.

On 07/30/2025, Surveyor requested the provider's schedule for May 2025 through July 2025. The schedule noted that two caregivers consistently worked daily, 7:00 AM to 7:00 PM, and one caregiver consistently worked daily, 7:00 PM to 7:00 AM.

On 07/30/2025, Surveyor observed a caution sticker on Resident 2's Hoyer lift. The caution sticker read, in part,"

1. This equipment is designed to lift and transfer users between bed and wheelchair and other objects.
Transportation of users on this equipment over distance is prohibited.
2. This equipment shall be operated by trained caregivers only.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016401	A. BUILDING: _____ B. WING _____	R-C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING LAKE TOMAHAWK	6416 FLICKER RD LAKE TOMAHAWK, WI 54539

(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
Y3244	Continued From page 5 3. Whenever possible, two caregivers should be present during lifting and transferring. 4. To ensure its safety, frequent inspections of this equipment and its accessories should be performed by qualified maintenance staff to detect wears and tears. Replace worn parts before use. 5. For details of operation of this equipment, please refer to your Owner's Manual. On 07/31/2025 at approximately 8:50 AM, Surveyor interviewed Caregiver C via telephone. Surveyor asked about staffing, resident care, and residents who required the assistance of two caregivers. Caregiver C reported that Resident 2 required the assistance of two caregivers with Hoyer lift transfers. Caregiver C stated, "I am comfortable transferring [Resident 2] by myself, but it is recommended to have two people." Caregiver C reported that Resident 2 did not usually ask to get out of bed when Caregiver C worked (7:00 PM to 7:00 AM). Caregiver C verified that Caregiver C worked alone during his/her shift from 7:00 PM to 7:00 AM. On 07/31/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 02/25/2025. Resident 2's care plan noted the following: - Ambulation - Full Assistance Status: Resident does not ambulate. - Positioning - Staff Assistance Instructions: Reposition every 4 hours or PRN (as needed). You may reposition by getting each side of [his/her] butt cheek up off the mattress and rotating every 4 hours from side to side. Status: Resident requires staff assistance with all positioning needs.	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016401	A. BUILDING: _____ B. WING _____	R-C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING LAKE TOMAHAWK	6416 FLICKER RD LAKE TOMAHAWK, WI 54539

(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
Y3244	Continued From page 6 - Transferring - Mechanical Lift Status: Resident requires a mechanical lift for transfers. Resident uses a Hoyer lift for all transfers. On 07/31/2025 at approximately 10:14 AM, Surveyor interviewed Caregiver D via telephone. Surveyor asked Caregiver D about staffing, resident care, and residents who required the assistance of two caregivers. Caregiver D reported that Caregiver D worked alone from 7:00 PM to 7:00 AM. Caregiver D stated, "[Resident 2] should be a two-person (lift); I can't get [him/her] out of bed by myself (and) [Resident 2] was hard to change and reposition by myself." Caregiver D stated that Resident 2 needed a Hoyer lift for all transfers and it was recommended to have two people to assist with transfers. Caregiver D reported, "[Resident 2] doesn't ask to get out of bed when I work because [s/he] knows it is just me (working)." Caregiver D stated that on at least three occasions since Resident 2 was admitted, Resident 2's family had to help Caregiver D get Resident 2 back into bed at night. In regard to another resident, Caregiver D noted that Resident 3 wandered at night, became aggressive at times, and was an elopement risk. Caregiver D commented, "It would be nice to have two staff during the night shift (7:00 PM - 7:00 AM) for rounding and dealing with resident behaviors." On 07/31/2025 at approximately 2:25 PM, Surveyor interviewed Family Member (FM) E. FM E reported that Resident 2 was a two-person transfer and "a lot of times there was only one person working." FM E confirmed having to assist staff in the past with transferring Resident 2 back to bed because "One person works the overnight shift."	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016401	A. BUILDING: _____ B. WING _____	R-C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING LAKE TOMAHAWK	6416 FLICKER RD LAKE TOMAHAWK, WI 54539

(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
Y3244	Continued From page 7 On 07/31/2025 at approximately 3:18 PM, Surveyor interviewed HM A via telephone. HM A verified the May 2025 through July 2025 schedule. HM A stated that Resident 2 needed two people to assist with transfers and there was not always two people working. The provider did not ensure all residents received adequate and appropriated care within the capacity of the facility.	Y3244		