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 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING LAKE TOMAH	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 04/04/2026, Surveyor conducted a verification visit and complaint investigation (x4) at Lake Shore Assisted Living Lake Tomahawk. Data collection continued through 04/06/2026. Seven of 8 deficiencies identified in Statement of Deficiency (SOD) D8Q413 were corrected. Two of 4 complaints were substantiated. Two deficiencies were identified. The deficiencies were repeat deficiencies, cited for the 2nd time, see SOD D8Q413, dated 01/08/2026 and SOD 54NQ11, dated 10/07/2021. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
{N 158}	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form	{N 158}		

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

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{N 158}	Continued From page 1 provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report an incident of abuse to the Department on a form provided by the Department within 7 calendar days from the date the provider knew or should have known about the abuse. The deficiency is cited for the 2nd time, see Statement of Deficiency (SOD) D8Q413, dated 01/08/2026. 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. Between 02/25/2026 and 03/04/2026, the Department received 4 complaints alleging concerns with abuse and staffing. On 05/04/2026 at approximately 10:00 AM, Surveyor interviewed House Manager (HM) A. Surveyor requested records pertaining to grievances and abuse investigations since February 2026. HM A provided Surveyor with a 2-page written investigation (undated) written by Former Director (FD) C. According to FD C's investigation, FD C noted,	{N 158}		

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{N 158}	Continued From page 2 "On Friday [sic] February 20th (2026), at 1:30 PM, I was greeted in the entryway at Edgewater Main RCAC side by Moments Hospice Social Worker (HSW) [HSW B]. [S/He] asked if I was the director. I told [him/her] yes. [S/He] said that there was an incident at the Lake Tomahawk facility with a resident and a staff member and [s/he] will be reporting it to adult protective services as [s/he] is a mandated reporter and already called them. I questioned [him/her] about what happened. [S/He] said, [Caregiver D], who is a caregiver(,) was in the dining room with [Resident 1]. [S/He] was just about (to) leave the building when [s/he] heard [Caregiver D] yelling and went back to see if things were ok. The Social Worker [sic] witnessed [Caregiver D] actively yelling at the resident and telling [him/her] [s/he] was going to 'take [him/her] outside and kick [his/her] [expletive].' [S/He] then said, 'I should just stab you.' And '[s/he] was going to [expletive] shoot [Resident 1].' The Social Worker [sic] intervened and was yelled at by the staff member also. At this time, another resident's family [Resident 3] were visiting and overheard the yelling also. The Power [sic] of attorney for [Resident 3](,) [Family Member E] went over to [Caregiver D] and talked to [him/her]. While this happened(,) [Resident 3] overheard what [Caregiver D] was saying and became scared to be living there. They then had to take the resident (Resident 3) to [his/her] room and calm [him/her] down..." FD C's investigation indicated that Caregiver D was suspended and ultimately terminated. On 05/04/2026 at approximately 11:50 AM, Surveyor interviewed HM A. HM A verified that FD A investigated Caregiver D in February 2026 and substantiated abuse. HM A confirmed that Caregiver D was terminated. Surveyor asked HM A if Caregiver D was reported to the Department	{N 158}		

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{N 158}	Continued From page 3 for abuse. HM A reported that there was "no paperwork or record" of Caregiver D being reported to the Department. On 05/04/2026 at approximately 2:30 PM, Surveyor interviewed HSW B. Surveyor asked about an abuse concern involving Resident 1 and Caregiver D in February 2026. HSW B reported that HSW B heard Caregiver D swear and yell at Resident 1 on 02/20/2026. HSW B indicated that HSW B reported the incident to FD C. HSW B stated that HSW B heard Caregiver D say the following things to Resident 1 on 02/20/2026: "I wish I could stab [him/her];" "I will run [him/her] over with my car." HSW B commented that Caregiver D's behavior was aggressive and Caregiver D had threatened to take Resident 1 outside and lock him/her outside. On 05/05/2026 at approximately 12:38 PM, Surveyor interviewed Family Member (FM) E via e-mail. FM E verified being at the facility on 02/20/2026 for Resident 3's admission. FM E indicated that during Resident 3's admission, FM E heard a commotion and people shouting but at that time was unaware of the arguing parties or who was involved. FM E indicated that Resident 3 stated, "I don't want to be out there when there is yelling." FM E indicated that FM E spoke to Caregiver D on 02/20/2026 and Caregiver D made the following comments about Resident 1: "I'm going to stab [him/her]. I want to run [him/her] over with my car and stab [him/her] with a knife." On 05/05/2026, Surveyor reviewed Department records. Department records did not contain evidence of the provider reporting Caregiver D to the Department for abuse since the incident occurred on 02/20/2026.	{N 158}		

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{N 158}	Continued From page 4 On 05/06/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 01/30/2026. Resident 1 was discharged on 05/04/2026. Resident 1's diagnoses included peripheral neuropathy, dementia, bipolar disorder, and anxiety disorder. On 05/06/2026 at approximately 1:00 PM, Surveyor interviewed HM A and Interim Director (ID) F via telephone. Both HM A and ID F verified that the provider substantiated abuse involving Caregiver D and Resident 1 on February 20, 2026. HM A and ID F verified that Caregiver D was not reported to the Department. Both HM A and ID F agreed that Caregiver D needed to be reported to the Department for caregiver abuse and the provider would be reporting Caregiver D to the Department. The provider did not report an incident of abuse to the Department on a form provided by the Department within 7 calendar days from the date the provider knew or should have known about the abuse.	{N 158}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition.	N 169		

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N 169	Continued From page 5	N 169		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 2's physician and legal representative were notified after s/he had multiple falls in February 2026.

The deficiency is cited for the 2nd time, see Statement of 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.

Between 02/25/2026 and 03/04/2026, the Department received 4 complaints alleging concerns with care and staffing.

On 05/04/2026, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 02/09/2026 and was discharged on 03/03/2026. Resident 2's diagnoses included ischemic stroke, paroxysmal atrial fibrillation and memory deficit. According to incident reports, Resident 2 fell on the following dates: 02/24/2026, 02/22/2026, 02/20/2026, 02/16/2026 and twice on 02/11/2026. Records indicated that Resident 2 sustained bruising to his/her left hip, elbow and shoulder. Records did not contain evidence that Resident 2's physician or legal representative were notified after the falls.

On 05/04/2026 at approximately 12:45 PM, Surveyor interviewed House Manager (HM) A. HM A's date of hire was 03/31/2026. Surveyor

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N 169	Continued From page 6 asked about Resident 2's falls. HM A verified that Resident 2 fell on the following dates: 02/24/2026, 02/22/2026, 02/20/2026, 02/16/2026 and 02/11/2026. On 05/05/2026 at approximately 2:00 PM, Surveyor interviewed HM A via telephone. Surveyor asked if Resident 2's physician and legal representative were notified after Resident 2 fell multiple times in February 2026. HM A stated, "I have no idea." HM A commented that there appears to be no documentation about reporting the falls to Resident 2's physician or legal representative. On 05/06/2026 at approximately 1:00 PM, Surveyor interviewed HM A and Interim Director F via telephone. Surveyor asked if the provider had any additional information or records to provide surveyor regarding notifications for Resident 2. HM A confirmed that there were no additional records to provide and Resident 2's physician and legal representative were not notified after Resident 2 fell multiple times in February 2026. The provider did not ensure Resident 2's physician and legal representative were notified after s/he had multiple falls in February 2026.	N 169		