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 01/09/2024

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 01/03/2024, Surveyor conducted a complaint investigation and verification visit at Lake Shore Assisted Living Lake Tomahawk. Data collection continued through 01/09/2024. The complaint was unsubstantiated. 10 deficiencies were identified. Four of 10 deficiencies were repeat violations. See statement of deficiency (SOD) EWS511, dated 06/14/2023. Under statutory provisions of Wis. Stat.Ch. 50, a $200 revisit fee is being assessed. Census: 13	{N 000}		
{N 219}	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by:	{N 219}		

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

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{N 219}	Continued From page 1 Based on record review and interview, the provider did not ensure a criminal background check was conducted and documented for 1 of 3 caregivers reviewed. This is a repeat deficiency. See statement of deficiency (SOD) EWS511, dated 06/14/2023. 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. On 01/04/2024 at 8:42 AM, Surveyor contacted Administrator A via email and requested hire dates and caregiver background checks for Assistant Director (AD) B, Caregiver C and Caregiver G. On 01/05/2024 at 4:01 PM, Surveyor received background checks via email for Caregiver C and Caregiver G. Administrator A reported AD B's date of hire was 06/23/2022. Administrator A noted, "I cannot find [AD B's] BiD [sic] (background information disclosure). S/he (AD B) states s/he filled one out but I have nothing in his/her file or one that has been run." On 01/09/2024 at 3:00 PM, Surveyor interviewed Administrator A. Administrator A confirmed that Administrator A could not find a background or BID for AD B. Administrator A reported, "I just ran a background check for [AD B]."	{N 219}		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan	N 386		

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N 386	Continued From page 2 Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not develop an individual service plan (ISP) for Resident 1 within 30 days of admission. Findings include: On 11/08/2023, the Department received a complaint alleging lack of administrator oversight facility and the provider was unstaffed (for an undetermined amount of time) on 10/31/2023. 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. On 01/03/2024, Surveyor reviewed Resident 1's record and ISP book. Resident 1 was admitted on 07/23/2023. Resident 1's record and ISP book did not contain an ISP.	N 386		

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N 386	Continued From page 3 On 01/03/2024 at 2:15 PM, Surveyor interviewed Caregiver C and requested Resident 1's ISP. Caregiver C stated, "If it's not in the ISP book, I don't think we have one." On 01/03/2024 at 2:20 PM, Surveyor interviewed Assistant Director (AD) B. Surveyor asked AD B if Resident 1 had an ISP. AD B reported, "I don't think so; I don't believe I have an ISP for Resident 1." AD B confirmed Resident 1 was admitted on 07/23/2023. AD B commented, "We need organization, structure and more staff." AD B informed Surveyor that s/he works a lot of extra shifts on the floor and does not have a lot of time to keep up with resident paperwork.	N 386		
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: Based on record review and interview, the provider did not update Resident 4's individual	N 389		

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N 389	Continued From page 4 service plan (ISP) when there was a change in Resident 4's needs, abilities and mental condition. 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. On 01/03/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 06/23/2021. Resident 1's (undated) ISP stated, "Resident displays no harmful behaviors towards self" and "Resident suffers from dementia." On 01/03/2024 at 10:00 AM, Surveyor interviewed Assistant Director (AD) B. AD B reported, "We have challenging residents and they like to touch things. [Resident 4] wanders into the kitchen and into other people's rooms." Surveyor asked AD B what staff do to assist Resident 4. AD B stated staff redirect Resident 4 and residents shut their doors. On 01/03/2024 at 1:07 PM, Surveyor interviewed Caregiver F. Caregiver F stated, "We do have a resident, [Resident 4], that likes to wander." Caregiver F reported that Resident 4 "drank paint last Spring (2023)." Caregiver F stated, "It's concerning about chemicals being left out because [Resident 4] could eat or drink something that's toxic." Caregiver F noted, "I feel ISPs are not up to date." The provider did not update Resident 4's ISP when there was a change in Resident 4's needs, abilities and mental condition.	N 389		

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N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Surveyor: Calhoun, Lonny C. Based on observation, record review and interview, the provider did not prepare weekly written menus and did not make menus available to residents. 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. On 01/03/2024, Surveyor toured the facility. Surveyor did not see a daily or weekly menu posted. On 01/03/2024, Surveyor reviewed provider records for daily/weekly menus. Daily/Weekly menus were not available. On 01/03/2024 at 12:30 PM, Surveyor interviewed Resident 2. Surveyor asked Resident 2 about meals and if menus were available to residents. Resident 2 stated, "The food is good." Resident 2 indicated menus were not available to	N 450		

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N 450	Continued From page 6 residents. On 01/03/2024 at 2:20 PM, Surveyor interviewed Assistant Director (AD) B and asked about menus. AD B reported, "I prepare a menu daily with [Caregiver D]. I tell residents what's for breakfast and lunch when I work. We don't post daily or weekly menus."	N 450		
N 495	83.45(1)(d) Hazards. Hazards. The CBRF shall maintain each building in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain the kitchen in good repair and free of hazards. 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. On 01/03/2024, Surveyor toured the facility. Surveyor observed the following in the kitchen: The kitchen had two separate sinks (side by side). One of the sink faucets dripped water. There was black and gray discoloration underneath the sink cabinets. The bottom shelf in the sink cabinet was falling down (caused by water damage). The black and gray discoloration appeared to be mold. There were no handles on the cabinets. Two cabinets underneath the countertop were missing doors. The drywall	N 495		

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N 495	Continued From page 7 around the inside of the kitchen door was unfinished. A dirty, dusty fan was circulating air (dust was hanging off the fan). Chemicals (cleaning chemicals and disinfectant sprays) were not secured. Resident 4 tried entering the kitchen throughout the morning and was redirected by staff. On 01/03/2024 at 2:20 PM, Surveyor interviewed Assistant Director (AD) B. AD B reported the kitchen had been unfinished for over a year. AD B stated that the sink leaks and there was mold underneath the sinks and the cabinet shelf was falling down. AD B reported that the kitchen cabinets do not have handles and sometimes the floor floods when you use the sink and dishwasher together. On 01/04/2024 at 10:40 AM, Surveyor interviewed Caregiver D. Caregiver D reported, "There are no handles on the kitchen cabinets. We have to use our feet or fingers to pry the doors open." Caregiver D noted that the cabinets were missing trim and the sink leaked if the dishwasher and sink were used at the same time. On 01/04/2024 at 1:07 PM, Surveyor interviewed Caregiver F. Caregiver F stated, "It would be nice if the kitchen cabinets were finished. The sink leaks and sometimes the floor gets flooded when you use the sink while the dishwasher is running." Caregiver F reported, "The owner and management have known about the kitchen sink leaking since this summer."	N 495		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and	N 499		

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N 499	Continued From page 8 toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not secure cleaning compounds and toxic substances. 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. On 01/03/2024, Surveyor toured the facility. Surveyor observed the following: cleaning compounds and toxic substances were not secure in two bathrooms, the laundry room and the kitchen. Residents walked by these rooms. On 01/03/2024 at 10:00 AM, Surveyor interviewed Assistant Director (AD) B. Surveyor asked AD B about the provider's expectation for storing chemicals and toxic substances. AD B stated, "Chemicals need to be secured." AD B confirmed the presence of chemicals in two bathrooms (used by staff and residents), the laundry room and the kitchen. AD B commented, "We have challenging residents and they like to touch things that they shouldn't be touching." AD B reported, "[Resident 4] wanders into the kitchen and into other people's rooms." On 01/04/2024 at 10:40 AM, Surveyor interviewed Caregiver D. Caregiver D stated, "All cleaners and chemicals should be locked up in the laundry room. "Caregiver D noted that s/he	N 499		

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N 499	Continued From page 9 routinely sees chemicals left out in the bathrooms, kitchen and laundry room. On 01/04/2024 at 10:53 AM, Surveyor interviewed Caregiver E. Caregiver E indicated, "Chemicals should be locked up and secured in the laundry room and locked up in the kitchen." On 01/04/2024 at 1:07 PM, Surveyor interviewed Caregiver F. Caregiver F stated, "Chemicals are supposed to be secured in the laundry room. The cleaning supplies and chemicals in the kitchen should also be locked up."	N 499		
{N 504}	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain the heating system in a safe and properly functioning condition. This is a repeat deficiency. See statement of deficiency (SOD) EWS511, dated 06/14/2023.	{N 504}		

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{N 504}	Continued From page 10 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. On 01/03/2024, Surveyor toured the facility. The facility's thermostat read 73 degrees. Surveyor observed Resident 2 sitting in his/her room. Resident 2 was covered up with a few blankets and was wearing a stocking hat, scarf and gloves. On 01/03/2024 at 12:30 PM, Surveyor interviewed Resident 2. Resident 2 reported, "It's cold in my room. I have two blankets on and I have to wear a hat, scarf and gloves in my room." Resident 2 indicated that s/he had complained about the heat to staff and that his/her room has been "freezing" since October 2023. Resident 2 noted s/he has been putting on extra layers of clothes and using extra blankets for months. On 01/03/2024 at 12:45 PM, Surveyor interviewed Resident 3. Surveyor observed Resident 3 lying in bed with a blanket pulled up to his/her chin. Surveyor asked Resident 3 about the room temperature. Resident 3 stated, "My room is cold." Surveyor asked Resident 3 if s/he reported being cold to staff. Resident 3 confirmed staff know and have known for a while. On 01/03/2024 at 1:20 PM, Surveyor interviewed Assistant Director (AD) B. AD B reported, "The heat works occasionally in rooms [room numbers]." AD B noted that the heating system had been looked at by [Quality Heating] in November 2023. AD B indicated, "I told	{N 504}		

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{N 504}	Continued From page 11 Administrator A about the heat not working and Administrator A said we will hire someone else to look at the furnace."	{N 504}		
{N 525}	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct quarterly fire drills in 2023. This is a repeat deficiency. See statement of deficiency (SOD) EWS511, dated 06/14/2023. Findings include: The provider is licensed to serve up to 16 residents in the following client groups: advanced	{N 525}		

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{N 525}	Continued From page 12 aged, traumatic brain injury, terminally ill, physically disabled, and irreversible dementia/Alzheimer's. On 01/03/2024, Surveyor reviewed the provider's documentation of quarterly fire drills for 2023. There were no documented fire drills in 2023. On 01/03/2024 at 10:00 AM, Surveyor interviewed Assistant Director (AD) B. Surveyor asked AD B if fire drills were conducted and documented in 2023. AD B stated, "The last fire drill was sometime in August 2023." AD B could not remember having other fire drills in 2023. On 01/04/2024, Surveyor emailed Administrator A and asked Administrator A for fire drills conducted and documented in 2023. On 01/05/2024 at 4:01 PM, Surveyor received an email from Administrator A who stated, "I am unable to locate any information on fire drills and smoke detectors." On 01/09/2024 at 3:30 PM, Surveyor interviewed Administrator A. Administrator A confirmed s/he was unable to locate fire drills, evacuation drills or smoke detector tests in 2023.	{N 525}		
{N 526}	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct emergency or disaster	{N 526}		

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{N 526}	Continued From page 13 evacuation drills at least semi-annually in 2023. This is a repeat deficiency. See statement of deficiency (SOD) EWS511, dated 06/14/2023. 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. On 01/03/2024, Surveyor reviewed the provider's documentation of emergency and evacuation drills. There were no documented emergency or evacuation drills. On 01/03/2024 at 10:00 AM, Surveyor interviewed Assistant Director (AD) B. Surveyor asked AD B if emergency and evacuation drills were conducted and documented in 2023. AD B reported that s/he was unaware of emergency or evacuation drills being conducted in 2023. On 01/04/2024, Surveyor emailed Administrator A. Surveyor asked Administrator A if the facility conducted and documented fire drills, evacuation drills, and smoke detector tests in 2023. On 01/05/2024 at 4:01 PM, Surveyor received an email from Administrator A. Administrator A reported, "I am unable to locate any information on fire drills and smoke detectors." On 01/09/2024 at 3:30 PM, Surveyor interviewed Administrator A. Administrator A confirmed s/he was unable to locate fire drills, evacuation drills or smoke detector tests in 2023.	{N 526}		

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 01/09/2024

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

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N 535	Continued From page 14	N 535		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct smoke detector tests once every other month in 2023. 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. On 01/03/2024, Surveyor reviewed the provider's documentation of smoke detector tests. There were no documented smoke detector tests in 2023. On 01/03/2024 at 10:00 AM, Surveyor interviewed Assistant Director (AD) B. Surveyor asked AD B if staff tested the smoke detectors and documented the tests. AD B reported that s/he did not have any information or documentation of smoke detector tests.	N 535		

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 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 535	Continued From page 15 On 01/04/2024, Surveyor emailed Administrator A and asked for smoke detector tests in 2023. On 01/05/2024 at 4:01 PM, Surveyor received an email from Administrator A. Administrator A reported, "I am unable to locate any information on fire drills and smoke detectors." On 01/09/2024 at 3:30 PM, Surveyor interviewed Administrator A. Administrator A confirmed that s/he was unable to locate smoke detector tests in 2023.	N 535		