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LAKE SHORE ASSISTED LIVING CEDAR COTTAGE	12440 WARPATH LN MINOCQUA, WI 54548

(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 08/29/2023, Surveyor conducted a verification visit and complaint investigation at Lake Shore Assisted Living Cedar Cottage. On 09/06/2023, Surveyor received an additional complaint. Data collection continued through 09/14/2023. All deficiencies identified in Statement of Deficiency (SOD) F80Q12, dated 01/26/2023, were corrected. One of 2 complaints was substantiated. Five deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 12	{N 000}		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify Resident 5's legal representative when there was a significant change in Resident 5's physical condition.	N 169		

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

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N 169	Continued From page 1 Findings include: On 09/06/2023, the Department received a complaint alleging a resident had significant weight loss and a significant decline in health and the provider did not have an "oximeter" to monitor the resident's condition. This facility is licensed to serve up to 15 residents in the client groups developmentally disabled, irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, advanced aged and physically disabled. On 09/11/2023, Surveyor reviewed Resident 5's record. Resident 5 was admitted on 06/06/2023. Resident 5 was admitted with a guardian in place, Guardian J. Resident 5 was sent to the emergency room/hospital on 08/18/2023 (discharged: 08/20/2023) and on 08/27/2023 (discharged: 08/27/2023). On 09/12/2023 at 11:00 AM, Surveyor interviewed Guardian J. Guardian J confirmed, "[Resident 5] was admitted (to the emergency room/hospital) on 08/18/2023 with nausea, diarrhea and dehydration. No one called me. [S/He] was discharged 08/20/2023. I did not know about this hospital stay until 08/21/2023 when [Named Home Health Agency] contacted me about home health care for [Resident 5]. [S/He] was also admitted (to the emergency room) on 08/27/2023 and again I was not notified by [Provider] or [hospital] that [s/he] was there. On 09/14/2023 at 2:30 PM, Administrator A confirmed Guardian J was not notified about Resident 5's emergency room/hospital visits on 08/18/2023 and 08/27/2023. Administrator A informed Surveyor that "some retraining has been	N 169		

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N 169	Continued From page 2 conducted" and staff are now aware they need to notify guardians, powers of attorney (POA) and family members when required.	N 169		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure all residents were free from mistreatment. Findings include: On 07/19/2023, the Department received a complaint alleging a caregiver was "verbally abusing residents" and residents were afraid of the caregiver. This facility is licensed to serve up to 15 residents in the client groups developmentally disabled, irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, advanced aged and physically disabled. On 08/29/2023 at 2:05 PM, Surveyor interviewed Caregiver D. Caregiver D reported s/he had worked at the facility for over five months.	N 348		

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N 348	Continued From page 3 Surveyor asked Caregiver D if there were any concerns about resident care or treatment of residents. Caregiver D reported, "[Caregiver F] yelled at [Resident 1] and [Resident 4]." Caregiver D indicated that s/he reported Caregiver F's behavior to Administrator A. Caregiver D reported, "[Caregiver F] would push [Resident 1] in a wheelchair and yell at him/her. [Resident 1] would pee himself/herself on purpose (and) [Caregiver F] would tell [Resident 1] you don't belong here - you need to be in a skilled nursing facility." Caregiver D noted, "[Resident F] raised his/her voice and basically screamed at residents." Caregiver D indicated Caregiver F was transferred to the provider's other licensed facility in Lake Tomahawk in early August 2023. On 08/29/2023 at 2:30 PM, Surveyor interviewed Resident 4. Surveyor asked Resident 4 if s/he had any concerns about interactions with staff. Resident 4 reported, "[Caregiver F] could be an [expletive]. S/He always raised his/her voice." Surveyor asked Resident 4 if s/he reported any concerns to management. Resident 4 responded, "I don't tattletale." Resident 4 stated, "[Caregiver F] told me I was too big to be here". Resident 4 commented, "I am a big person - what can I do about that?" Surveyor asked Resident 4, "How did [Caregiver F] interact with other residents?" Resident 4 told Surveyor that Caregiver F yelled at him/her and other residents and Caregiver F was loud all the time. Resident 4 reported that Caregiver F was no longer at the facility and "We have good staff right now." On 08/29/2023 at 2:40 PM, Surveyor interviewed Administrator A. Surveyor asked Administrator A if there were any concerns about caregiver interactions with residents. Administrator A reported that s/he recently received and	N 348		

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N 348	Continued From page 4	N 348		

investigated a complaint about Caregiver F yelling at a resident and a staff member. Administrator A commented, "It came down to he said/she said and [Caregiver F] was transferred to our facility in Lake Tomahawk on 08/16/2023." Administrator A commented, "I heard from staff [Caregiver F] is doing well at Lake Tomahawk."

On 08/29/2023 at 3:00 PM, Surveyor interviewed Caregiver E. Surveyor asked Caregiver E if there were any concerns about caregiver interactions with residents. Caregiver E stated, "When [Caregiver F] worked here, s/he was verbally abusive with some of the residents." Caregiver E commented that Caregiver F was "loud and argumentative" when talking to the residents. Caregiver E stated that Resident 1 and Caregiver F did not get along and Caregiver F was "not patient sometimes when assisting or transferring residents." Caregiver E stated, "I heard [Caregiver F] tell [Resident 4] 'You are too big to be here... You are getting too big from all of the junk food (and) it's getting hard for us to move you.'" Caregiver E indicated that s/he reported the concern of Caregiver F yelling at residents to Administrator A. Caregiver E stated, "[Caregiver F's] demeanor was unacceptable and aggressive at times and some residents did not want [Caregiver F] to help them."

On 08/29/2023 at 3:30 PM, Surveyor interviewed Resident 1. Surveyor asked Resident 1 how s/he was doing. Resident 1 responded, "Pretty good right now." Surveyor asked Resident 1, "What do you mean right now?" Resident 1 informed Surveyor there was a caregiver that was not nice and that caregiver was gone. Resident 1 stated, "[Caregiver F] was not always nice to me." Resident 1 indicated Caregiver F was transferred to Lake Tomahawk. Resident 1 stated,

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"[Caregiver F] was loud and mean and s/he made me anxious and nervous."

On 08/30/2023 at 11:30 AM, Surveyor interviewed House Manager (HM) B. HM B indicated that s/he worked with Caregiver F several times. HM B stated, "[Caregiver F] would take some things personal and raised his/her voice and it would upset the residents." HM B reported that Caregiver F acted this way over the past few months and had since been transferred to Lake Tomahawk in August 2023. HM B stated that s/he reported an incident to Administrator A on 08/15/2023. The incident involved Caregiver F calling HM B on the telephone to ask about a resident's medications. While on the telephone with Caregiver F, HM B could hear Caregiver F yelling at the resident and a staff member in the background. HM B indicated s/he instructed Caregiver F to walk away and find another caregiver to help the resident. HM B stated, "I told [Caregiver F] you cannot talk to the residents and staff like that."

On 08/31/2023, Surveyor reviewed a "Disciplinary Action" dated, 08/16/2023. According to the "Disciplinary Action," Administrator A gave Caregiver F a "First Warning" for an argument that occurred between Caregiver F, a resident, and a staff member on 08/15/2023.

On 08/31/2023 at 11:19 AM, Administrator A verified giving Caregiver F a warning for Caregiver F arguing with a resident and another caregiver on 08/15/2023.

On 09/12/2023 at 1:30 PM, Surveyor interviewed Caregiver I. Surveyor asked Caregiver I if there were any concerns about caregiver interactions with residents. Caregiver I reported that s/he had

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N 348	Continued From page 6 worked at the facility since May 2023. Caregiver I stated that Caregiver F was "loud and yelled at residents." Caregiver I also indicated that Caregiver F would take things away from residents and would make derogatory comments to the residents. Caregiver I stated that Caregiver F works in a different building now (in Lake Tomahawk).	N 348		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure at least one qualified	N 397		

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N 397	Continued From page 7	N 397		

resident care staff was present in the facility during the overnight (NOC) shift on 08/30/2023.

Findings include:

On 09/06/2023, the Department received a complaint alleging a resident had significant weight loss and a significant decline in health and the provider did not have an "oximeter" to monitor the resident's condition.

This facility is licensed to serve up to 15 residents in the client groups developmentally disabled, irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, advanced aged and physically disabled.

Wis. Admin. Code § DHS 83.02(42) states: "Qualified resident care staff" means an employee who has successfully completed all of the applicable training and orientation under subch. IV."

On 09/12/2023 at 11:00 AM, Surveyor interviewed Guardian J. Guardian J reported, "[Resident 5] was admitted (to the emergency room/hospital) on 08/18/2023 with nausea, diarrhea and dehydration...[S/He] was also admitted (to the emergency room) on 08/27/2023..." Guardian J noted that on 08/30/2023, Guardian J received a message from Caregiver I. Caregiver I's message indicated Resident 5 had asked for pain medication on 08/30/2023 (during the NOC shift - around 11:00 p.m.), that Caregiver I was not trained to administer medication, and Caregiver I was the only staff available on 08/30/2023 during the NOC shift.

On 09/12/2023 at 1:30 PM, Surveyor interviewed Caregiver I. Caregiver I reported that s/he had

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N 397	Continued From page 8 worked at the facility since May 2023. Caregiver I admitted that Resident 5 asked for pain medication a few weeks ago (08/30/2023) and Caregiver I could not give Resident 5 pain medication because Caregiver I was not trained to administer medication. Caregiver I indicated s/he worked alone on 08/30/2023 and Resident 5 did not get pain medication on 08/30/2023. Caregiver I stated s/he notified Guardian J about not being able to administer medication to Resident 5 on 08/30/2023. Caregiver I also indicated that s/he had worked alone several times over the past few weeks. On 09/13/2023, Surveyor reviewed the facility's 08/30/2024 work schedule. The schedule noted Caregiver I worked on 08/30/2023, during the NOC shift. On 09/14/2023 at 11:20 AM, Surveyor interviewed House Manager (HM) B. HM B verified Caregiver I worked alone during the NOC shift on 08/30/2023 and Caregiver I was not trained to administer medications. HM B stated that HM B did not work during the NOC shift on 08/30/2023 but would have been available to assist Caregiver I with medications if Caregiver I would have called HM B. HM B confirmed that Caregiver I did not call HM B during Caregiver I's NOC shift on 08/30/2023. On 09/14/2023 at 2:30 PM, Surveyor interviewed Administrator A. Administrator A confirmed Caregiver I worked alone during the NOC shift on 08/30/2023 and Caregiver I was not trained to administer medications.	N 397		
N 419	83.37(3)(c) Medication storage: locked cabinet.	N 419		

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N 419	Continued From page 9 Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not keep medicine cabinets locked and the key available only to personal identified by the community based residential facility (CBRF). Findings include: This facility is licensed to serve up to 15 residents in the client groups developmentally disabled, irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, advanced aged and physically disabled. On 08/30/2023 at 10:45 AM, Surveyor observed a small, unlocked refrigerator on the floor near a medication cart in close proximity to the kitchen and dining room area (accessible to all staff and residents). Surveyor observed multiple insulin pens inside the refrigerator. On 08/30/2023 at 10:45 AM, Surveyor interviewed House Manager (HM) B. HM B confirmed the small, unlocked refrigerator contained insulin for two residents (Resident 1 and Resident 2) in the CBRF and one tenant (Person C) who lived in the provider's attached licensed Residential Care Apartment Complex (RCAC). HM B indicated the unlocked refrigerator had been in its current location for the past several months.	N 419		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents	N 432		

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N 432	Continued From page 10 the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure staff provided medication administration to meet the needs of 2 residents (Resident 3 and Resident 1). Resident 3 was given Lisinopril when his/her systolic blood pressure was 120 - Per Resident 3's medication administration record (MAR), Lisinopril should be held if Resident 3's systolic blood pressure is less than 130. Resident 1's insulin pen was not labeled with an open date. Findings include: "All insulin's must be stored with care to ensure that they remain safe and effective. Improper storage could result in the breakdown of insulin, affecting its ability to effectively and predictably control your blood sugar level... Once you open a new vial (meaning once you stick a needle in the vial) or pen, use a Sharpie to note the date you opened it right on the packaging. This will help you remember when to stop using it. Throw the insulin away 28 days after opening it. (Source:	N 432		

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Harvard Health Blog, Safe and Effective Use of Insulin Requires Proper Storage, 12/04/2018, https://www.health.harvard.edu/blog/safe-and-effective-use-of-insulin-requires-proper-storage-2018120415486, retrieved 05/10/2022.)

On 08/29/2023 at 11:50 AM, Surveyor observed a medication pass for Resident 3. House Manager (HM) B checked Resident 3's blood pressure. Resident 3's systolic blood pressure was 120. HM B gave Resident 3 Lisinopril.

On 08/29/2023, Surveyor reviewed Resident 3's MAR. Resident 3's MAR read, in part:

"Blood Pressure and Pulse
Take blood pressure each morning and document.
Hold Lisinopril if systolic pressure is less than 130
For: Hypertension (HTN)"

On 08/29/2023, Surveyor interviewed HM B. HM B confirmed that s/he should have held Resident 3's Lisinopril because Resident 3's systolic blood pressure was 120. HM B reported the medication error to the facility nurse, Registered Nurse (RN) G.

On 08/29/2023 at 12:25 PM, Surveyor observed a medication pass for Resident 1. HM B administered insulin to Resident 1. Resident 1's insulin pen was not labeled with an open date.

On 08/29/2023 at 12:25 PM, Surveyor interviewed HM B. HM B confirmed Resident 1's insulin pen was not labeled with an open date. HM B commented, "It looks like a date was written but it must have wiped off." Surveyor asked HM B about the expectation of using

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N 432	Continued From page 12 insulin pens and dating the insulin pens when opened. HM B responded, "Insulin pens should be labeled with an open date and the insulin would expire after 28 days after being opened." HM B informed Surveyor that s/he would speak to RN G about finding a "better way" of labeling insulin pens so the dates don't "wipe off."	N 432		