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June 10, 2025

ELECTRONIC MAIL
SOD #GKY111

NOTICE OF NONCOMPLIANCE

COMPLIANCE REQUIREMENT

Kelly Wickert
517 Luco Road
Fond du Lac, WI 54935

C/O Operator: Fond du Lac AL LLC

Re: LakeHouse Fond du Lac (0019851)
517 Luco Road
Fond du Lac, WI 54935

Dear Kelly Wickert:

This letter is a NOTICE of NONCOMPLIANCE on the registrant of LakeHouse Fond du Lac located at 517 Luco Road, Fond du Lac, WI 54935. This regulatory action is taken by the Department of Health Services (Department) pursuant to Wis. Stat. § 50.034, and Wis. Admin. Code ch. DHS 89.

NOTICE OF NONCOMPLIANCE

On April 14, 2025, a compliance visit was concluded for LakeHouse Fond du Lac by the Division of Quality Assurance, Bureau of Assisted Living, to verify that the above-referenced facility was in compliance with Wis. Stat. ch. 50 or Wis. Admin. Code ch. DHS 89, or both, which set forth requirements for the administration and operation of a registered residential care apartment complex (RCAC). The Statements of Noncompliance are as follows:

Statement of Noncompliance #1:

Wis. Admin. Code § DHS 89.23(2)(b)1 requires staff to meet tenant needs. The number, assignment and responsibilities of staff shall be adequate to provide all services identified in the tenants' service agreements.

Based on interview and record review, the provider did not ensure the number, assignment and responsibilities of staff were adequate to provide services to tenants to meet their identified and assessed needs.

Interviews with 2 staff, 5 tenants and 1 family member consistently indicated the number of direct care staff and dietary staff were insufficient to meet tenant needs. Tenants experienced long wait times for meals and tenants who had identified needs for medication, transfer, bathing and toileting assistance experienced long wait times to have their needs met in those areas. Call light logs on 04/06/2025 confirmed Tenant 8 waited 50 minutes after activating his/her call light and Tenant 9 waited 1.5 hours.

Findings include:

The Department received a complaint tenants were not receiving adequate care due to insufficient numbers of staff.

During the onsite visit on 04/07/2025, Surveyor observed the facility is expansive. It consists of two buildings, both two stories and connected by a walkway. According to the tenant roster provided by Licensed Practical Nurse (LPN) B at 1:45 PM, the facility was home to 76 tenants.

On 04/07/2025, Surveyor interviewed two caregivers and both reported concerns with low staffing levels impacting tenant care.

•Surveyor interviewed Caregiver Q at 2:31 PM and asked how s/he likes working at the facility. S/he said, "Ever since we switched to new people (owners), it's been kinda [sic] worse....There are not enough staff. I am burned out...Yesterday was a [expletive] show...only 2 of us (were working.)" Caregiver Q said frequently there are only 2 caregivers when s/he works 1st shift which doesn't allow enough time for showers and tenants wait for daily cares. Caregiver Q also said mediations are administered late because s/he needs to administer to approximately 27 tenants, using 3 different medication carts to apartments throughout both buildings. Caregiver Q said tenants are unhappy about wait times and the impact on their care.
•Surveyor interviewed second shift Lead Caregiver R at 2:55 PM. Caregiver R said in the past they operated with 5 direct care staff and added, "It's a big building. Even though it's an RCAC...we need...2 med techs [caregivers trained to administer medications] and 3 caregivers." Caregiver R said about half the time they are operating with only 2 caregivers; 1 to administer medications and 1 to provide cares. Caregiver R said there are 2 tenants (including Tenant 11) who need 2 staff to transfer and when they are short staffed, s/he transfers those tenants alone.

On 04/07/2025, Surveyor interviewed five tenants and one family member. All six interviews indicated there were not enough staff to meet tenant needs.

•Surveyor interviewed Tenant 7 at 3:30 PM. S/he volunteered, "Right now they are having a bit of a problem with getting enough people to take care of us. They're all doing two and a half times what they should be...Every day is tough, they have just a minimum of people to handle what a maximum should take care of." Tenant 7 described tenant frustrations during mealtimes, "...because we have to wait. There's just so many people....that need to eat. They can only take care of a few at a time. You get water. Then you have to wait. [Tenants] are being very hostile...I feel sorry for the [staff] ...they catch it from so many people."

•Surveyor interviewed Tenant 8 at 3:30 PM. S/he told Surveyor s/he recently had several surgeries due to a fractured elbow. Surveyor observed his/her right arm bandaged bicep to wrist. Tenant 8 said there are not enough caregivers. Tenant 8 said, "Yesterday was Sunday which is my bath day. I can't take a shower because of my arm, so I need a good bed bath. And I was in my pajamas still at 3:00 PM and nobody did my cares yesterday." Tenant 8 said that same day his/her arm was hurting and s/he pressed the call light around 12:00 PM for prescribed oxycodone pain medication. Tenant 8 said s/he talked to a 1st shift caregiver before they left at 2:00 PM and they said they would tell 2nd shift. Tenant 8 s/he didn't get the medication until approximately 8:00 PM. Tenant 8 said long wait times happen often and said, "You can wait an hour." Tenant 8 said s/he needs staff assistance with transfers, but "I'm just doing it myself now and not waiting. Because nobody comes." Tenant 8 said s/he is very unhappy living at the facility and added, "I pay for the care, a lot."
•Surveyor interviewed Tenant 9 at 4:36 PM. Just prior to the interview, Surveyor observed Tenant 9 rely on staff assistance with propelling his/her wheelchair. Tenant 9 said s/he moved in on 03/14/2025 and s/he does not like living at the facility. Tenant 9 explained, "I'm not getting the care I'm paying for. I'm keeping a daily log." Tenant 9 referred to a notebook and described an incident shortly after admission. Tenant 9 said s/he was having frequent diarrhea and used the call light for transfer assistance to the bathroom. Tenant 9 said no one came so "I managed to get myself on the toilet." Tenant 8 said 57 minutes passed between when s/he first called and when a caregiver finally arrived and added, "I could have called rescue, they would have gotten here sooner." Tenant 9 said a similar incident happened on 04/06/2025 when s/he waited 1.5 hours for toileting assistance. S/he again self-transferred, waited on the toilet until his/her legs got numb, and then self-transferred back to the wheelchair and then the recliner. Tenant 9 said there are "definitely not" enough staff.
•Surveyor interviewed Tenant 10 at 5:40 PM. Tenant 10 stated the facility is "Very short staffed. The [caregivers] try their best. [Caregiver Q]...was in tears this morning, [s/he] was so overwhelmed."
•Surveyor interviewed Tenant 11 and Family N at 6:19 PM. Surveyor observed Tenant 11 used a wheelchair for ambulation and Tenant 11 said s/he relies on staff assistance with transfers using a mechanical lift. Tenant 11 said they are supposed to use 2 staff for transfers, but due to staffing issues they frequently transfer with only 1. S/he said, "Between the kitchen aids and [caregivers] on day shift, they used to have 7 people. Now they are lucky if they have 4 all in with kitchen and caregivers...meals are pretty late." Tenant 11 said there are times s/he waits "half an hour to 45 minutes and you're stuck in your wheelchair waiting to go the bathroom or waiting for help to get off the toilet. That's a long time." Family N said, "It's really sad. If we could help it, [Tenant 11] wouldn't be here. But I work and [s/he] needs help during the day."

During an interview with LPN B on 04/07/2025 at 5:04 PM, s/he confirmed staffing shortages on 1st shift which sometimes resulted in only 2 caregivers for 74 tenants. LPN B said s/he was in the process of hiring 1 new caregiver. Surveyor conducted a follow up interview with LPN B on 04/14/2025 at 2:00 PM. S/he confirmed 27 tenants receive assistance with medications and on 04/06/2025, two caregivers worked first shift.

On 04/07, 04/08 and 04/09/2025, Surveyor reviewed tenant records, shower schedules, call light logs, mechanical lift policy and staffing schedules.

•"Use of Mechanical Lifts" policy dated 06/10/2024 read, "Always have (2) Care Managers [sic] assisting during the transfer of a resident using a mechanical lift."
•Tenant 8: an assessment dated 03/05/2025, indicated s/he relied on staff assistance with medication administration. Surveyor reviewed 2 forms used to document administration of oxycodone on 04/06/2025, however the records were not complete or consistent, making it unclear when the medication was administered. The 04/06/2025 call light log showed Tenant 8 called for assistance at 12:49 PM and waited 50 minutes 39 seconds and called again at 1:53 PM and waited 10 minutes 45 seconds. Surveyor noted these times aligned with Tenant 8's statements that s/he first requested pain medication around 12:00 PM and spoke with 1st shift about the request again prior to 2:00 PM. Shower schedules showed 28 tenants relied on assistance with showers, and Tenant 8's showers were scheduled on Thursdays and Sundays. Daily charting did not indicate Tenant 8 received his/her scheduled shower on 04/06/2025.
•Tenant 9: an assessment dated 03/14/2025, indicated s/he relied on staff assistance for transferring, toileting and dressing. The 04/06/2025 call light log showed Tenant 9 called for assistance at 2:45 PM and waited 1 hour and 36 minutes.

Cross Reference:
DHS 89.23(4)(a)3 Services
DHS 89.23(4)(b)1 Services
DHS 89.34(15) Tenant Rights

Statement of Noncompliance #2:

Wis. Admin. Code § DHS 89.23(4)(a)1 requires nursing services and supervision of delegated nursing services shall be provided consistent with the standards contained in the Wisconsin nurse practice act. Medication administration and medication management shall be performed by or, as a delegated task, under the supervision of a nurse or pharmacist.

Based on interview and record review, the provider did not ensure medication administration and medication management was performed by or, as a delegated task, under the supervision of a registered nurse or pharmacist.

Regional Registered Nurse M (RN M) had responsibilities for supervision of the facility's medication management and administration systems. RN M had not been onsite at the facility since the end of February 2025 and was unaware of concerns with medication availability, accurate documentation or unresolved tenant concerns with their medication regime. In addition, the provider did not maintain records to confirm caregivers were administering medications as a trained and delegated task.

Findings include:

The Department received complaints management was not adequately overseeing resident care, including medication administration.

On 04/07/2025 at 2:55 PM, Surveyor interviewed Lead Caregiver R who reported concerns with the availability of medications. Surveyor asked if RN M had been involved in trying to resolve issues and s/he replied, "I can't answer that. I don't speak to [RN M], that is a [LPN B] question. I don't know if [LPN B] has reached out to [RN M]." Caregiver R also said s/he was not trained or delegated to pass medications by RN M.

On 04/07/2025 at 2:00 PM, Surveyor interviewed Caregiver Q who also reported concerns with medication management systems. Caregiver Q said for example, Tenant 9 had been refusing a stool softener scheduled daily because it was giving him/her diarrhea and s/he wanted it switched to PRN (as needed.) Caregiver Q said the situation has not been resolved and the medication remains scheduled daily. Caregiver Q went on to describe a potential medication error during night shift over the weekend with a different tenant, but said s/he did not report it to management. Caregiver Q said s/he would feel bad calling LPN B for something like that. Surveyor asked about RN M's role at the facility and Caregiver Q replied, "We don't see [him/her.] The last time we saw [RN M] was at beginning of the year and that's it. I haven't seen [him/her] since."

On 04/07/2025 at 4:36 PM, Surveyor interviewed Tenant 9. Tenant 9 said shortly after admission on 03/14/2025, s/he started having diarrhea. Tenant 9 suspected it was due to a medication and said, "I questioned it right away, the 2nd day I was here I was going to the bathroom non-stop." Tenant 9 said s/he eventually discovered they were administering a stool softener daily. Tenant 9 s/he did not think s/he was prescribed the medication every day, but regardless, s/he wanted it switched to "as needed." Surveyor reviewed portions of Tenant 9's record (received 04/07/2025 at 5:00 PM and 04/09/2025 at 8:57 AM.) Tenant 9 relied on staff assistance for medication management and the medication administration records (MARs) documented s/he refused the daily dose of prescribed senna (stool softener) 03/21, 03/24, 03/29, 03/30 and every day 04/01-04/07. On 04/15/2025, LPN B emailed Surveyor documentation of a fax dated 04/07/2025 to Tenant 9's physician, noting his/her request to have senna changed to PRN and a progress note stating the order was changed as requested on 04/09/2025.

On 04/07/2025 at 3:53 PM, Surveyor interviewed Tenant 8. Tenant 8 said s/he relies on facility staff to manage and administer medications and s/he's been having problems with medications being available. S/he also reported a delayed response to requests for oxycodone pain medication on 04/06/2025. Tenant 9 said s/he received oxycodone at 6:00 AM, requested another dose at approximately 12:00 PM but did not receive it until 8:00 PM. Surveyor requested and reviewed portions of Tenant 8's records on 04/07 and 04/08/2025. The documentation consisted of the April 2025 MAR and the controlled substance daily proof of use documentation. The documents did not align with Tenant 8's report and the two records were inconsistent with each other. The MAR documented administration of oxycodone twice; once at 3:00 PM and a second time at 11:00 PM. However, the controlled substance form documented administration three times; 1 administration with the time left blank, and then 3:00 PM and 11:00 PM.

On 04/07/2025 at 6:19 PM, Surveyor interviewed Tenant 11 and Family D. Tenant 11 said s/he is independent with administering and managing his/her medications but recalled, "One day [Caregiver L] came in here and said, 'It's time for your shot.' I'm like, 'No I do not take shots, you got the wrong person.' I had to insist to [Caregiver L] I don't get a shot, [s/he] kept trying. Then on Saturday (again) [s/he] said, 'I'll be right back with your shot.'" Tenant 11 and Family D questioned whether Caregiver L was trained and capable to administer medications and said they were concerned for tenants who were less able to advocate for themselves. On 04/08/2025, in response to Surveyors request for any written grievances, LPN B send a grievance form dated 04/08/2025. The form documented a grievance from Tenant 11, reporting the same concerns about Caregiver L. The response section indicated Caregiver L "did not confirm or deny the incident" and s/he was "taken off med passing, until med retraining has been complete."

On 04/07/2025 at 5:04 PM, Surveyor interviewed LPN B. LPN B reported feeling overwhelmed with all his/her responsibilities at the facility. LPN B said there is a nurse (RN M) assigned to the facility and his/her contact with RN M has involved weekly phone calls. Surveyor asked what RN M's role has been with oversight of medication administration and management. LPN B said s/he has not asked for or received assistance from RN M to resolve any concerns with medication management and said s/he tries to "trouble shoot" on his/her own.

On 04/08/2025 at 5:51 PM, Surveyor sent an email to LPN B and RN M requesting documentation of training in medication administration and delegation for Caregivers R and L. On 04/09/2025, LPN B relied via email, "I am unable to find documentation on the med training for [Caregiver R] and [Caregiver L]."

On 04/09/2025 at 10:30 AM, Surveyor interviewed RN M:

- RN M said s/he is the regional director of resident care and oversees the clinical department for a total of 20 facilities in multiple states. RN M said s/he was last present at the facility at the end of February 2025, which was also the last time s/he conducted an audit of the medication systems.
- During the interview, Surveyor shared concerns with medications for multiple tenants, including Tenant 8 and Tenant 9. RN M said s/he was not familiar with the medication regimes for those tenants or of any potential concerns.
- Surveyor shared the concerns with Tenant 8's senna and requests to have the medication changed to PRN due to side effects. RN M said they need to improve their current system to better monitor refusals. This would allow them to follow with residents about why they are refusing and facilitate communication with medical providers.
- Surveyor next shared the concerns with Tenant 9's oxycodone. RN M had familiarity with Tenant 9 and said s/he is an accurate reporter. RN M said the discrepancy in Tenant 9's reports versus the documentation was concerning, especially because oxycodone is a controlled substance.
- RN M said s/he was "taken aback" after learning of the medication concerns from Surveyor. S/he stated, "I feel responsible. I could have been more responsive. These issues are all encompassing in medication management in general. All need to be dealt with better and better oversight will fix most of these problems."

•Surveyor asked about training. RN M said their process is for him/her to directly train and delegate medication administration tasks to caregivers before they administer medications. Surveyor asked about LPN B's email response regarding training records for Caregivers R and L. RN M said s/he trained and delegated both caregivers, and the records should be at the facility.

On 04/14/2025 at 2:00 PM, Surveyor conducted an interview with LPN B, RN M and other managers. Surveyor asked if the training records had been located and RN M responded, "I'm not even in the same state, so I can't locate them." LPN B confirmed s/he looked diligently for the records and could not find them. RN M s/he planned to be at the facility on Thursday, 04/17/2025 to try to address medication systems and provide training. Surveyor asked RN M if s/he investigated the concern with Tenant 9's oxycodone reviewed by Surveyor on 04/09/2025. RN M replied s/he had not and said, "I can not look into that from here, that's an investigation I'm going to do on Thursday. I don't understand what the problem is there."

Cross Reference:
DHS 89.23(2)(b)1 Services
DHS 89.23(4)(b)1 Services
DHS 89.34(15) Tenant Rights

Statement of Noncompliance #3:

Wis. Admin. Code § DHS 89.23(4)(b)1 requires each residential care apartment complex shall have a designated service manager who shall be responsible for day-to-day operation of, including ensuring that the services provided are sufficient to meet tenant needs and are provided by qualified persons; that staff are appropriately trained and supervised; that facility policies and procedures are followed; and that the health, safety and autonomy of the tenants are protected. The service manager shall be capable of managing a multi-disciplinary staff to provide services specified in the service agreements.

Based on interview, observation and record review, the provider did not ensure the designated service manager was overseeing day to day operations to ensure the services provided were sufficient to meet tenant needs and to ensure the health, safety and autonomy of tenants were protected.

Executive Director (ED) A was the manager responsible for oversight of the facility prior to 03/17/2025. Tenants reported s/he was inaccessible and concerns weren't resolved. Licensed Practical Nurse (LPN) B assumed responsibility for oversight on 03/17/2025. LPN B was not knowledgeable about policies, was not trained in the responsibilities of the role and concerns persisted.

As of 04/07/2025, Tenant 8, Tenant 9 and Tenant 10 expressed concerns about management and reported unresolved issues with care, medication, billing and apartment maintenance. In addition, LPN B did not ensure medication and health monitoring orders received 03/28/2025 from Tenant 7's medical provider were promptly addressed.

Beginning on or before 02/20/2025 and continuing through 04/07/2025, the facility did not have a functioning main phone line. Neither ED A nor LPN B ensured proactive communication to tenants, family members, legal decision makers or medical providers to inform them of the situation or provide an alternate means of communicating with the facility. This resulted in barriers for medical providers trying to coordinate care for tenants.

Findings include:

The Department received a complaint about lack of effective oversight at the facility, including inoperable phone lines impacting the ability to coordinate tenant care.

Prior to conducting the onsite visit, Surveyor reviewed records. Executive Director (ED) A was listed as the facility administrator.

On 04/07/2025, Surveyor conducted interviews with Licensed Practical Nurse (LPN) B at 1:33 PM and 5:04 PM. LPN B said ED A was on leave, had not been at the facility since 03/17/2025 and s/he did not know an anticipated return date. LPN B said s/he was hired at this facility in the role of LPN on 02/02/2025 and s/he has been overseeing day to day operations in ED A's absence. ED A said s/he received some support 3 days during the preceding week from regional staff but overall s/he felt overwhelmed commented, "I feel like I'm drowning...I am not an ED."

While discussing staffing needs for tenants that use mechanical lifts, LPN B said s/he did not know if the provider had a policy about transfers. S/he said, "I would imagine we do" and agreed to find out. The following day, LPN B emailed Surveyor the policy.

Surveyor inquired about the phone lines. LPN B acknowledged the main phone lines had not been functional for at least a month and it was impacting the coordination of care with medical providers. LPN B said s/he did not have information from the corporate office about when the phone system would be repaired or replaced. LPN B stated neither s/he nor anyone else has provided proactive communication to tenants, families, legal decision makers or medical providers to inform of them the phones weren't working or to provide an temporary way to communicate until a permanent solution could be implemented.

While discussing facility operations, LPN B described responsibilities for hiring, onboarding, medication management, tenant grievances and tenant assessments. LPN B said s/he has received "no training" on the interim manager role.

TENANT 8, TENANT 9 AND TENANT 10

On 04/07/2025 Surveyor conducted interviews with Tenants 8, 9 and 10. The interviews identified concerns with ED A's oversight prior to his/her absence beginning 03/17/2025, lack of communication about the designated manager since 03/17 and concerns about LPN B's ability to effectively manage day to day operations in ED A's absence.

Tenant 8: Surveyor interviewed Tenant 8 at 3:53 PM. S/he expressed overall unhappiness with his/her care. Tenant 8 said s/he tried to get ED A to "help with a situation about not having enough staff to take me to the bathroom. I wanted to talk to [him/her] and [s/he] never came up to talk to me. That was a couple of months ago. I told the staff I wanted to talk to [ED A]. I was very mad about what happened. I told everybody. They left [ED A] notes." Tenant 8 also said, "My medical doctor tried to call the front desk...for discharge (instructions) from surgery last Friday and nobody answered the phone in the main office."

Tenant 9: Surveyor interviewed Tenant 9 at 4:36 PM. Tenant 9 (admitted 03/14/2025) expressed concerns with medication management and maintenance. S/he told Surveyor the kitchen sink faucet will not move between the sinks and said, "They said they'd fix it, but they haven't." (Surveyor observed the faucet as Tenant 9 described.) Surveyor asked who is in charge at the facility and s/he replied, "I have no idea." Tenant 9 said in addition to medication and maintenance concerns s/he has billing concerns and said, "They billed me for things I paid for and I don't know who to get in contact with to resolve it. [ED A] is on...leave or something" Tenant 9 said a week ago s/he gave [LPN B] "a long list of concerns" but s/he has not received a response. Tenant 9 commented, "I'm pretty easy going believe or not. I feel bad complaining. I'm glad I had this opportunity to talk to you. I didn't know what to do. Especially the medication concerns bother me a lot."

On 04/14/2025 at 2:00 PM, Surveyor interviewed LPN B and asked if s/he remembered Tenant 9 providing a written list of concerns. LPN B replied, "Not off top of my head. I will look maybe it's on my desk or something." On 04/14/2025 at 6:29 PM, Surveyor sent an email to LPN B and asked if s/he located the list and if so, to send information to show the efforts to resolve the concerns. LPN B replied to the email (which included unrelated requests) but did not acknowledge the request regarding Tenant 9's concerns.

Tenant 10: Surveyor interviewed Tenant 10 at 5:40 PM. S/he said the caregivers try hard, but there are concerns with management. Tenant 10 said [s/he] has tried to talk to ED A about concerns, "but I have not had very good luck...[S/he] didn't attend resident counsel meetings. One time we were told [s/he] was on a phone call....Then the following month we were told [s/he] was busy. To me, it's like [s/he] was avoiding the meetings...I haven't seen [him/her] or heard anything from [him/her] for a month or better. It's been a long time" Tenant 9 said s/he's been trying to resolve maintenance concerns with drafty windows and a cracked transition strip on the floor (Surveyor observed both concerns), but the issues are unresolved. Tenant 10 said s/he has not been informed of who to talk to in ED A's absence, but it appears to be LPN B.

Surveyor conducted an interview with Regional Registered Nurse (RN) M, LPN B and other management staff on 04/14/2025 and discussed tenant dissatisfaction with care and management oversight. RN M said, "Management has been lacking...it has been building tension with tenants."

TENANT 7

Surveyor interviewed Lead Caregiver R at 2:55 PM. S/he confirmed ED A was on leave. Surveyor asked who was currently in charge and Caregiver R said, " I guess we would say [LPN B]...[s/he] tries, but [s/he] is in over [his/her] head." Surveyor inquired about the phone lines. Caregiver R said it's been "months" they have been operating without a functional phone. S/he added, "If someone is to fall and we need to call non-emergency, we need to use our own personal cell phones." Caregiver R said tenants' medical providers have expressed concerns about their inability to reach staff to coordinate care. Caregiver R said Tenant 7's nurse practitioner's office ultimately sent someone in person after being unable to reach facility staff and 2-3 other tenants' medical providers have done the same.

Surveyor interviewed Tenant 7 at 3:30 PM. S/he said his/her family lives out of state has tried to call the facility, but "sometimes it won't ring or it will ring and quit, there is no answer. There is a defect in the equipment." Surveyor asked how his/her physician's coordinates things like new medications. Tenant 7 said s/he did not know and s/he also didn't who at the facility s/he could contact to resolve concerns.

Surveyor received email correspondence from RN J, on dates to include 04/10/2024. RN J said s/he works with Tenant 7's Nurse Practitioner (NP K) and described an inability over the course of a month (beginning 02/20/2025) to reach facility staff by phone or mail. RN J explained they were "trying to give orders, coordinate/schedule a follow up with [NP K] & schedule a neurology referral." On 03/25/2025, at the request of Tenant 7's family member, RN J went to the facility in person and spoke with Lead Caregiver R. Caregiver R "acknowledged the phones hadn't been working for approximately a month & neither was the fax." Caregiver R provided RN J with a temporary fax number and ED A's phone number. RN J indicated s/he called ED A and left a detailed voice mail with the concerns and need to coordinate Tenant 7's care but "never received a call back." RN J said eventually s/he obtained LPN B's cell number and informed him/her of a forthcoming order for fasting labs, medications, vitals monitoring and the need to assist Tenant 7 with scheduling a neurology appointment. RN J noted s/he sent a fax on 03/28 with the aforementioned orders, however as of 04/10 s/he had not receive confirmation the orders were satisfied and was concerned Tenant 7 was not receiving the new medications.

Surveyor sent an email to LPN B on 04/08/2025, and requested the following for Tenant 7, "Most recent signed and dated medication list/orders. Documentation of blood pressure and pulse checks... Does s/he have an appointment with neurology and a fasting lab draw scheduled? If so when were those scheduled and when are they scheduled for?"

LPN B replied and attached documentation dated 02/19/2025 confirming Tenant 7 needed assistance with medication management and an order dated 03/24/2025 from NP K which listed diagnoses to include, "cognitive impairment" and "moderate dementia." The email included another order from NP K's office was sent via fax on 03/28/2025. The order requested assistance from facility staff for 8 tasks including scheduling of labs and a neurology appointment and monitoring blood pressure/pulse. The order also included a new prescription for Coenzyme Q10, 50 mg daily.

LPN B also provided medication administration records (MARs) and progress notes. A note dated 03/28/2025 confirmed LPN B received the aforementioned faxed orders. The next noted dated 04/08/2025 (10 days later and after Surveyor's visit), documented LPN B scheduled the lab and neurology appointments. Tenant 7's MARs 03/28/205 - 04/07/2025 did not indicate the prescribed Coenzyme Q10 was administered and LPN B did not provide documentation of blood pressure/pulse monitoring.

LPN B stated the following during the aforementioned interview on 04/14/2025:
--S/he "missed" the orders for blood pressure/pulse monitoring listed on the 3/28 fax and the vitals had not been monitored.
--Tenant 7 did not receive prescribed Coenzyme Q10 between 03/28 - 04/07/2025. LPN B placed blame on the pharmacy, but did not provide information to indicate the facility sent, or otherwise confirmed the pharmacy received, the 03/28/2025 order for the medication.

SURVEY FINDINGS

During the course of this survey, the Department investigated 3 complaints, all of which were substantiated. A total of 5 deficiencies were identified, including this one. Deficient practices included:
- There were not sufficient numbers of staff to meet tenants needs for bathing, transfer and toileting assistance.
- Tenants were not clearly informed of the costs associated with the care they were receiving.
- Medication administration, management and staff training was not supervised by a registered nurse.
- Medications were not administered as prescribed.

Cross Reference:
DHS 89.23(2)(b)1 Services
DHS 89.23(4)(a)3 Services
DHS 89.25(2) Schedule Of Fees For Services
DHS 89.34(15) Tenant Rights

Statement of Noncompliance #4:

Wis. Admin. Code § DHS 89.25(2) requires the schedule of fees for services shall be presented in language and a format that make it possible for tenants to readily identify the cost of the components of the service agreement and to be able to make informed choices about the services they receive.

Based on interview and record review, the provider did not ensure the schedule of fees for services identified in the service agreement, was presented in language and in a format that made it possible for tenants to readily identify the care and services associated with each level of the fee schedule.

The schedule of fees documented in service agreements included 6 care levels and charges for each level. The schedule of fees in the service agreements did not clearly or readily identify the services that would be provided in connection with each care level or the points based system used to determine the care levels/costs.

--Tenant 9 had concern s/he was not receiving the care s/he was being billed for. As a result, s/he made a written request for more information about the fee schedule but a week had passed and s/he did not receive the information.
--Tenant 10 said s/he was confused about the process for determining the level of care s/he was paying for and felt s/he was being billed too much based on the services s/he received.
--Tenant 11 stated the process for determining his/her level of care was unfair and not directly connected with the services s/he was receiving.

Findings include:

The Department received a complaint alleging concerns with how the provider was determining and communicating levels of care and associated fees.

TENANT 9
Surveyor conducted an interview with Tenant 9 at 4:36 PM. Tenant 9 said last week s/he asked LPN B to provide "a print out of what the different levels of care consist of. They have me at a (level) 5 and I'm paying over $7,000/month (note: for base rent and care level) and I'm not getting that kind of care here. I want to know the different levels." Tenant 9 said s/he had not yet received the requested information.

Surveyor interviewed Licensed Practical Nurse (LPN) B on 04/14/2025 at 2:00 PM and asked if Tenant 9 submitted a written concern about billing. LPN B said s/he didn't remember and would look. On 04/15/2025, Surveyor sent a 2nd request via email for the information, along with any response LPN B may have provided in response to the concerns. LPN B did not respond that portion of Surveyor's email.

TENANT 10
Surveyor conducted an interview with Tenant 10 on 04/07/2025 at 5:40 PM. S/he volunteered concerns about the process used to determine the care level s/he pays for. Tenant 10 said LPN B recently did an assessment and, based on what s/he has heard about an assessment point system, s/he should only be charged an extra $300 on top of the base rent but s/he is being charged $600. Tenant 10 said s/he is independent with all activities of daily living and fully manages and administers his/her own medications. Tenant 10 said s/he does not receive any daily care or monitoring services from caregivers. Tenant 10 described other problems s/he has had with billing errors and the requirement to pay via automatic bank deduction. Surveyor observed Tenant 10 begin to cry. Tenant 10 said, "I don't like to complain. I'm not asking for anything I'm not entitled to. The anxiety and frustration keeps building."

Surveyor sent an email to LPN B on 04/08/2025 at 10:12 AM and requested portions of Tenant 10's record and "The facility's Schedule of Fees as defined in DHS 89.25 (1) " ...written schedule of fees for services which includes all of the following: (a) Separately identified charges for rent, meals and services. The schedule of fees for services shall clearly identify those services which are included in any base service rate or rates and those for which there will be separate charges."

Surveyor reviewed the requested documentation, received on 04/08/2025 at 2:07 PM and 04/09/2025 at 8:57 AM.

SCHEDULE OF FEES:
Care Level Points
Level 1: 0-5=Care Coordination Fee
Level 1: 6-15
Level 2: 16-35
Level 3: 36-55
Level 4: 56-75
Level 5: 76-100
Level 6: 101-125
Level 6+: 126+=ancillary charge *RDO (not defined on the document)

Care Level Fees
Level 1: $300.00
Level 1: $600.00
Level 2: $1200.00
Level 3: $1800.00
Level 4: $2395.00
Level 5: $2995.00
Level 6: $3595.00
Level 6+: ancillary charge *RDO

Invoices dating back to January 2025 included "Recurring - Level of Care" charge of $600/month, in addition to the monthly rate of $3,424.00. (They also included the unrelated billing error Tenant 10 mentioned during the interview.)

Tenant 10's service agreement signed and dated upon admission on 12/15/2023:
- Identified "core services...included in the Monthly Rate". Core services included, "Staff/associates are available 24-hours a day, seven days a week," "Emergency Care...Our associates will assist in obtaining emergency medical care 24-hours a day by calling 9-1-1" and access to an "Emergency Call System" consisting of call pendants and pull cords for emergencies.
- An addendum tilted, "RATE SCHEDULE" identified 6 care levels and the cost associated with each, to be billed in addition to the monthly rate. This section noted, "these are the current Level of Care charges at the time of your move-in...Should your level of care and/or associated points change, you will be charged the then associated amount in place at that time, whether higher or lower."

•The rate schedule did not include the "Care Level Point" system used to determine the "Care Level Fees" as documented in the aforementioned schedule of fees provided to Surveyor.

Tenant 10's record included a document title, "Service Description Full." It was signed and dated 03/20/2025 and assigned a total of 5 points; 4 points were for his/her medical diagnoses and 1 point was because s/he is prescribed PRN (as needed) medications. Surveyor noted the point assignments were not directly related to the care or services Tenant 10 received.

During an interview with Regional Registered Nurse (RN) M on 04/09/2025 at 10:30 AM, s/he confirmed the care levels within the schedule of fees are determined by the assessment based point system and documented on the form titled, "Service Description Full.". Surveyor noted Tenant 10 was recently assessed 5 points placing him/her in the $300 fee range, and asked why Tenant 10 was paying the $600 monthly fee. RN M explained the following:
•When Tenant 10 moved in, all of level 1 was $600/month and Tenant 10 signed a service agreement agreeing to the $600 fee.
•Tenant 10 moved in while the current ownership was functioning as the management company. After the change of ownership on 04/25/2024, a new service agreement was not signed.
•Subsequent to the new license being issued, a "new fee structure" was implemented and offered the 0-5 point, $300 range as "a courtesy." However, anyone assessed between 0-15 points could be billed $600. Once a tenant was assessed in the $600 range, they would not lower to the $300 range, even if their assessed points drop and they require fewer services. (Note: this conflicted with the language in Tenant 10's service agreement.) RN M stated this could create a situation where tenants try to lower their points to pay less, even if they need the service.
•RN M said, "We don't talk in terms of points and levels. We don't give them anything that gives them the points and levels and fees associated with it."

Surveyor conducted a follow up interview with LPN B, Regional RN M, Regional ED O and Division Director (DD) P on 04/14/2025 at 2:00 PM.

DD P further explained, even if a tenant is assessed 0 points and is completely independent, they will pay a $300 "care coordination fee." S/he said this $300 minimum fee is for the coordination of care that goes on "behind the scenes" to include 90 day assessments and the costs to "live in the building with 24/7 care services." S/he explained a tenant "may not be care planned [sic] for falls, but if they fall we will help them up." S/he also explained points can be assessed in categories like medications even when a tenant administers their own medications and medical diagnoses because certain comorbidities can make a tenant prone to need emergency care. The managers stated the "Service Description Full" document served as both the assessment tool and the "care plan." The mangers did not describe any other documentation used to communicate with tenants the services they were receiving in connection with the care levels.

Surveyor asked for confirmation the "core services" outlined in the service agreement were billed as part of the base monthly rate, and these core services included call systems for emergencies and staff available 24/7 to respond. ED O acknowledged it did. ED O also acknowledged Tenant 10 has an unresolved billing error that s/he was working to correct.

TENANT 11

Surveyor conducted an interview with Tenant 11 on 04/07/2025 at 6:19 PM and 04/14/2025 at 8:35 AM. Tenant 11 said s/he is completely independent with all activities of daily living, manages his/her own medications and has had no recent changes in condition. Tenant 11 said s/he only receives assistance with transfers and assistance putting on socks. Tenant 11 said s/he was very frustrated with an assessment LPN B conducted on 04/08/2025, because based on the assessed points s/he was being moved from a level 3 to a level 5 resulting in an increase of nearly $1200/month. Tenant 11 said s/he did not think the assessment was a fair way to calculate the cost of his/her care because it assigned points for services s/he does not actually receive. Tenant 11 said for example, the assessment included language like, "may need assistance" with oral care. Tenant 11 said, "They don't even know where my toothbrush is" and said s/he did not want to pay for assistance, or the potential for assistance, with oral care.

Surveyor asked if s/he was provided the schedule of fees with the care levels and associated points. Tenant 11 replied, "No. I had to ask, then I was only told verbally. I kept pushing, they really did not want to tell me. I got the sense they do it verbally so they don't have something set in stone." Tenant 11 said during the assessment s/he expressed his/her concerns to LPN B who said s/he would talk to his/her supervisors. Tenant 11 said s/he/e followed up with LPN B at least once, but as of the morning of 04/14 s/he had not receive a response. Tenant 11 said s/he was worried about a potential increase and said, "You can't fight you with anything because you must do automatic deduction. There is no way to recover our money when (they) over bill" and Tenant 11 said s/he already has unresolved billing concerns dating back to his/he admission in August 2024.

Surveyor reviewed Tenant 11's service agreement signed 07/30/2024. The service agreement identified 6 care levels and the cost associated with each, but it did not identify the care or services that would be provided with each level or the assessment based point system used to determine the levels.

During the aforementioned management interview on 04/14/2025 at 2:00 PM, LPN B confirmed Tenant 11 had concerns about his/her recent assessment and the impact on his/her monthly fee, as well as an unrelated and unresolved billing issue.

IN CONCLUSION

The provider utilized a two-part schedule of fees for services. Part 1 identified 6 levels of care and the associated costs and part 2 identified the points based system used to determine the level of care.

In the "RATE SCHEDULE" section of the service agreements, tenants were only informed the levels/costs but were not informed about the point system used to calculate the levels.

Tenants 9, 10 and 11 stated they were not informed about the schedule of fees in a format that made it possible for them to readily identify the services they were paying for.

Cross Reference:
DHS 89.23(4)(b)1 Services
DHS 89.25(2) Schedule Of Fees For Services

Statement of Noncompliance #5:

Wis. Admin. Code § DHS 89.34 requires a tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse medication unless there is a court order.

Based on record review and interview, the provider did not ensure tenants who relied on staff assistance for medication administration and management received all prescribed medications in the dosages and intervals prescribed.

Tenant 8 was prescribed alprazolam on an as needed basis, up to three times daily for anxiety. Tenant 8 experienced increased pain and heightened anxiety after a surgery. The medication was unavailable for four days from 04/05/2025 through 04/08/2025 during which time Tenant 8 was asking for the medication. In addition, Tenant 8 was prescribed furosemide daily for congestive heart failure and s/he did not receive the medication for at least 6 days from 04/01/2025 - 04/07/2025.

Tenant 9 was prescribed warfarin due to a heart condition and did not receive it for five days between 03/31/2025 and 04/07/2025.

Both tenants relied on assistance from staff for medication management and administration.

Findings include:

The Department received a complaint alleging concerns tenants were not receiving medications.

TENANT 8

On 04/07/2025 at 2:55 PM, Surveyor interviewed 2nd shift Lead Caregiver R who said there are concerns with medications which include problems with re-orders. Caregiver R explained their medication system is electronic but does not allow for reorders to be requested in the computer so caregivers must call or fax. S/he said, "We are down staff, so by the time I can do that, the places are closed, but I (try to) get the faxes out...for example [Tenant 8], before I left on Saturday (04/04) I sent out a fax and reorder for alprazolam. [S/he] just had 5 surgeries on [his/her] elbow. This (medication) is for anxiety and [his/her] anxiety is high (right now because) [s/he]'s in pain, and [s/he] has not received it."

On 04/07/2025 at 3:35 PM, Surveyor interviewed Tenant 8. S/he stated, "I've been asking for [alprazolam] for 4 days and I still haven't gotten it and I'm very angry about that. I asked again today and I'm sure nothing was done. I need that medication for anxiety. They ran out, which shouldn't happen. They are in charge of getting refills, I pay them for it." Surveyor asked Tenant 8 said who s/he has talked to about the medication and s/he said, "All the med techs in the past 4 days, every one of them."

On 04/07/2025 at 5:00 PM, LPN B provided Surveyor Tenant 8's medication administration record (MAR):
- Alprazolam ".5 MG TAKE 1 TABLET BY MOUTH THREE TIMES DAILY AS NEEDED FOR ANXIETY." The medication was administered 04/01 and 04/02 once each day, and 04/03 and 04/04 twice each day. No administrations were documented after 04/04/2025.
- When LPN B provided Surveyor with the MAR, s/he added a post it note that read, "In process updating MD." This note was next to the medication prompt for "FUROSEMIDE 40 MG TAB TAKE 1 DAILY FOR CONGESTIVE HEART FAILURE." The MAR documented the medication was "Held/Omitted" from 04/01-04/07/2025.

On 04/14/2025 at 2:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B and Regional Registered Nurse (RN) M. They acknowledged Tenant 8 relies on staff assistance for medication management and was prescribed but was not receiving alprazolam or furosemide.
- Alprazolam - Neither LPN B nor RN M had information about why the medication was not available, but RN M said their process is to request a refill from the pharmacy for PRN medications prior to them running out. RN M checked the electronic MAR during the interview and said Tenant 9 started receiving the medication again on 04/09/2025.
- Furosemide - LPN B said prior to Surveyor's request for Tenant 8's MAR on 04/07/2025, s/he did not realize Tenant 8 was not receiving furosemide. LPN B gave conflicting information about why the medication was not administered. Initially s/he said s/he faxed the doctor a list of refusal dates and hadn't heard back. S/he subsequently said s/he did not have information about specific dates or a pattern of refusals and was unsure if s/he sent the fax. LPN B and RN M confirmed the MAR did not document any refusals and agreed to look into the situation.

On 04/14/2025 at 6:29 PM, Surveyor sent an email to LPN B and RN M and requested, "Documentation of the fax or communication with the prescriber regarding furosemide and documentation of efforts to obtain refills for PRN alprazolam."

On 04/15/2025, LPN B emailed Surveyor a "Fax Cover Sheet" dated 04/04/2025. The fax did not include a date/time stamp of transmittal or other indication it was successfully faxed. The fax was authored by Caregiver R, addressed to the pharmacy and read, "[Tenant 8] returned from [his/her] 5th surgery on [his/her] right arm and is need of [his/her] Alprazolam 0.5 mg tab for high anxiety. We have sent over several order's to refill this order but have not received the medication. Can we please fill the order for the Alprazolam RX#19198009 as soon as possible." [sic - all]

The email from LPN B did not include documentation of communication with Tenant 8's physician or pharmacy regarding Tenant 8's prescribed furosemide or include information about why the medication had not been administered.

TENANT 9

On 04/07/2025 at 4:36 PM, Surveyor interviewed Tenant 9 who said the facility manages his/her medications and s/he had concerns about missed doses of prescribed warfarin. Tenant 9 said sometimes the dosage of warfarin may change based on his/her INR blood test results, but s/he has only had 1 or 2 INRs since admission on 03/14/2025. Tenant 9 said s/he was very concerned about the missed medication.

On 04/07/2025 at 5:00 PM, LPN B provided Surveyor Tenant 9's MAR which confirmed Tenant 9 was prescribed warfarin for a heart condition, but did not receive the medication 5 consecutive days.

- 03/31 - not in med cart
- 04/01 - waiting on INR results, Resident will be having blood labs on 4/2/2025
- 04/02 - waiting on order to arrive, INR was done today
- 4/03 - waiting on medication to come in
- 04/04 - not administered, no reason documented

On 04/14/2025 at 2:00 PM, Surveyor interviewed LPN B and RN M. LPN B said Tenant 9 went without warfarin because there was the need for an INR to establish the appropriate dose. LPN B said normally with tenants admitted with the same physician Tenant 9 had, already have their next INR set up by that physician. However in Tenant 9's case, that did not happen and caregivers did not promptly report to LPN B the medication was not available which would have notified him/her of the need for follow up.

RN M acknowledged Tenant 9 did not receive prescribed warfarin. S/he said, "We should have been auditing those MARs...There was no communication to [LPN B] that medication was missing...There is an all med tech (caregivers trained to administer medications) in-service scheduled for Thursday. I will be onsite for going over all of these issues, to discuss medication management, and to communicate really how serious it is."

Cross Reference:
DHS 89.23(2)(b)1 Services
DHS 89.23(4)(a)3 Services
DHS 89.23(4)(b)1 Services

COMPLIANCE REQUIREMENT

According to Wis. Admin. Code § DHS 89.43(3), at any time, you shall be able to verify compliance with the applicable provisions of Wis. Stat. ch. 50, and Wis. Admin. Code ch. DHS 89. Various areas of noncompliance have been identified in this NOTICE, consequently, you should review the Statements of Noncompliance and make the necessary changes to your operation to ensure full compliance.

Please note the Statements of Noncompliance in this NOTICE do not affect the registration of LakeHouse Fond du Lac at this time; however, continued noncompliance may result in additional action, including registration revocation, jeopardizing the status of LakeHouse Fond du Lac as a registered RCAC.

* * *

If you have any questions about this letter, please contact Vicky Wittman, Assisted Living Regional Director, at (920) 448-4800.

Sincerely,

Kenneth Brotheridge, Assisted Living Director
Bureau of Assisted Living
Division of Quality Assurance

Enclosure
KB/CC