STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

(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 03/25/2024, with information gathered through 03/27/2024, Surveyor conducted a verification visit, complaint investigation, and standard survey at Long Lake House. Ten deficiencies identified. Five deficiencies were repeat violations from Statement of Deficiency (SOD) #HGN912, dated 02/07/2019. The complaint was unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 7	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess 2 of 2 residents (Resident 7 and Resident 8) reviewed for resident's needs,	N 381		

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

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N 381	Continued From page 1	N 381		

abilities, and physical and mental condition before admitting the person to the facility and at least annually. There was no evidence of a completed assessment for Resident 7 and Resident 8.

This is a repeat deficiency. See Statement of Deficiency (SOD) HGN912, dated 02/07/2019.

Findings include:

The facility is licensed as an AA facility for 8 residents with programs in emotionally disturbed/mental illness, developmentally disabled, alcohol/drug dependent, physically disabled, and traumatic brain injury.

On 03/25/2024, Surveyor reviewed Resident 7's and Resident 8's record and identified the following.

Resident 7
Resident 7 was admitted to the facility on 09/13/2020 with diagnoses including developmental disability, anemia, alcohol and other drug abuse (AODA), bipolar disorder, and atypical psychosis. There was no written documentation in Resident 7's record to indicate Resident 7 was assessed prior to admission and at least annually to determine Resident 7's needs, abilities, and physical and mental condition.

Resident 8
Resident 8 was admitted to the facility on 12/03/2021 with diagnoses including Asperger's Syndrome, attention-deficit/hyperactivity disorder (ADHD), and bipolar disorder. There was no written documentation in Resident 8's record to indicate Resident 8 was assessed prior to admission to determine Resident 8's needs, abilities, and physical and mental condition.

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N 381	Continued From page 2 On 03/25/2024 at 9:45 AM, Surveyor interviewed Licensee A. Licensee A could not locate a pre-admission assessment or annual assessments for Resident 7 and Resident 8. Licensee A stated the house manager was responsible for completing the assessments and s/he would have to check with them. Surveyor asked to have information sent by 03/26/2024 at 8:00 AM. As of 03/27/2024 at 4:00 PM, no evidence of a pre-admission assessment or annual assessment completed for Resident 7 and Resident 8 was received.	N 381		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written temporary service plan was prepared upon admission to meet the immediate needs of 2 of 2 residents (Resident 7 and Resident 8.) This is a repeat deficiency. See Statement of Deficiency (SOD) HGN912, dated 02/07/2019. Findings include: The facility is licensed as an AA facility for 8 residents with programs in emotionally	N 385		

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N 385	Continued From page 3 disturbed/mental illness, developmentally disabled, alcohol/drug dependent, physically disabled, and traumatic brain injury. On 03/25/2024, Surveyor reviewed Resident 7's and Resident 8's record and identified the following: Resident 7 Resident 7 was admitted to the facility on 09/13/2020 with diagnoses including developmental disability, anemia, alcohol and other drug abuse (AODA), bipolar disorder, and atypical psychosis. There was no evidence of a completed temporary service plan in Resident 7's record. Resident 8 Resident 8 was admitted to the facility on 12/03/2021 with diagnoses including Asperger's Syndrome, attention-deficit/hyperactivity disorder (ADHD), and bipolar disorder. There was no evidence of a completed temporary service plan in Resident 8's record. On 03/25/2024 at 9:45 AM, Surveyor interviewed Licensee A. Licensee A could not locate a temporary service plan for Resident 7 and Resident 8. Licensee A stated the house manager was responsible for completing the temporary service plans and s/he would have to check with them. Surveyor asked to have information sent by 03/26/2024 at 8:00 AM. As of 03/27/2024 at 4:00 PM, no evidence of a temporary service plan completed for Resident 7 and Resident 8 was received.	N 385		

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N 387	Continued From page 4	N 387		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have the resident or resident's legal representative sign the Individual Service Plan (ISP) acknowledging their involvement in, understanding of, and agreement with the plan for 2 of 2 resident records reviewed. Residents 7's and 8's ISPs did not have signatures. This is a repeat deficiency. See Statement of Deficiency (SOD) HGN912, dated 02/07/2019. Findings include: The facility is licensed as an AA facility for 8 residents with programs in emotionally disturbed/mental illness, developmentally	N 387		

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N 387	Continued From page 5 disabled, alcohol/drug dependent, physically disabled, and traumatic brain injury. On 03/25/2024, Surveyor reviewed Resident 7's and Resident 8's record and identified the following: Resident 7 Resident 7 was admitted to the facility on 09/13/2020 with diagnoses including developmental disabilities, anemia, alcohol and other drug abuse (AODA), bipolar disorder, and atypical psychosis. Resident 7 had a legal guardian. Resident 7's ISPs dated December 2020, September 2021, and September 2022 had no signature from his/her legal guardian. Resident 8 Resident 8 was admitted to the facility on 12/03/2021 with diagnoses including Asperger's Syndrome, attention-deficit/hyperactivity disorder (ADHD), and bipolar disorder. Resident 8 had a legal guardian. Resident 8's most current ISP dated 12/06/2021 had no legal guardian or facility staff signatures. On 03/25/2024 at 9:45 AM, Surveyor interviewed Licensee A. Licensee A stated the house manager would responsible for completing the ISPs and involving residents' legal guardians in care plan review and having them acknowledge by signing off. Licensee A stated s/he would have to check with house manager about this. Surveyor asked to have information sent by 03/26/2024 at 8:00 AM. As of 03/27/2024 at 4:00 PM, no evidence of a signed ISP for Resident 7 and Resident 8 was received.	N 387		

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N 389	Continued From page 6	N 389		
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 Individual Service Plans (ISP) annually for 2 of 2 resident records reviewed. Residents 7's and 8's records did not include annual ISP updates. Findings include: The facility is licensed as an AA facility for 8 residents with programs in emotionally disturbed/mental illness, developmentally disabled, alcohol/drug dependent, physically disabled, and traumatic brain injury. On 03/25/2024, Surveyor reviewed Resident 7's and Resident 8's record and identified the following: Resident 7	N 389		

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N 389	Continued From page 7	N 389		

Resident 7 was admitted to the facility on 09/13/2020 with diagnoses including developmental disability, anemia, alcohol and other drug abuse (AODA), bipolar disorder, and atypical psychosis. Resident 7 had a legal guardian. Resident 7 had ISPs dated December 2020, September 2021, and September 2022, which had no signature from his/her legal guardian. There was no evidence of an ISP completed for 2023.

Resident 8
Resident 8 was admitted to the facility on 12/03/2021 with diagnoses including Asperger's Syndrome, attention-deficit/hyperactivity disorder (ADHD), and bipolar disorder. Resident 8 had a legal guardian. Resident 8's most current ISP dated 12/06/2021 had no legal guardian or facility signatures. There was no evidence of an ISP completed for 2022 and 2023.

On 03/25/2024 at 9:45 AM, Surveyor interviewed Licensee A. Licensee A stated the house manager would be in charge updating the ISPs annually and involving residents' legal guardians in care plan review and having them acknowledge by signing off. Licensee A stated s/he would have to check with house manager about this. Surveyor asked to have information sent by 03/26/2024 at 8:00 AM.

As of 03/27/2024 at 4:00 PM, no evidence of an ISP for Resident 7 for 2023 and no evidence of an ISP for Resident 8 in 2022 and 2023 was received.

CROSS REFERENCE
DHS 83.35(2) N0385 Temporary Service Plan
DHS 83.35(3)(b) N0387 Service Plan Development: Parties Involved

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N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was maintained in a safe, clean, comfortable, and homelike environment. The facility did not have sufficient heat. There were cleaning needs identified and repairs to walls, flooring, and fixtures which needed to be completed. This is a repeat deficiency. See Statement of Deficiency (SOD) HGN912, dated 02/07/2019. Findings include: The facility is licensed as an AA facility for 8 residents with programs in emotionally disturbed/mental illness, developmentally disabled, alcohol/drug dependent, physically disabled, and traumatic brain injury. On 03/25/2024, Surveyor conducted a tour of the facility, Surveyor observed the following: Occupied Resident Room with Patio Door Four cobwebs areas in corners of ceiling about 1-inch by 4-inches. Four cobwebs hanging from ceiling about 1-inch by 4-inches. Four brown stains about 1-inch by 2-inches on	N 481		

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N 481	Continued From page 9	N 481		

wall by toilet.
Multiple black scuff marks on wall by toilet paper holder.

Occupied Resident Room by Front Entrance
Window blinds were bent.
Window was rotting out and window could not be opened otherwise window would fall out.
Wall paint was peeling.

First floor bathroom
The ceiling fan had an accumulation of dust.
The sink fixture was dirty.
The wall behind the toilet had peeling paint.
The floor vent was rusted and dusty.
Walls were stained and marked with black and brown marks.
The caulk lining by the bathtub and flooring was coming off.

Kitchen
The island drawers were dirty and had food spills.
There were brown stains on the counter.
Outdated bread was on the counter with a best by date of 03/04/2024.
There was half eaten cake on the counter with no date.
The refrigerator door had a broken handle with tape wrapped around it.

Basement Living Room with access to all residents
The flooring was uneven and lifting in multiple areas, which created a potential trip hazard.

Basement bathroom
The corner piece by the shower was rotting and had a black substance, consistent with mold on it.
Walls were dirty.
Shower rod was rusted.

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N 481	Continued From page 10 Wet dirty towels were laying on the ground. Toilet seat was stained brown and dirty. On 03/25/2024, at 9:45 AM, Surveyor interviewed Licensee A. Licensee A confirmed there were concerns in the home which needed to be fixed.	N 481		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and 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 ensure cleaning compounds and toxic substances were stored in a secure area. Cleaning supplies and toxic compounds were observed in an unlocked cabinet in the laundry room. This is a repeat deficiency. See Statement of Deficiency (SOD) HGN912, dated 02/07/2019. Findings include: The facility is licensed as an AA facility for 8 residents with programs in emotionally disturbed/mental illness, developmentally disabled, alcohol/drug dependent, physically disabled, and traumatic brain injury. On 03/25/2024, Surveyor conducted a tour of the facility, Surveyor observed the following: The laundry room led from the dining room and exited into the facility's attached garage. The door	N 499		

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N 499	Continued From page 11 between the laundry room and dining room was not lockable. In the laundry room, there were cabinets above the dryer. The cabinets had a locking mechanism but were not locked and Surveyor was able to independently access the cabinet. Residents were moving around freely in the facility. Surveyor observed the following chemicals in the cabinet: 1 spray bottle multi-purpose disinfecting cleaner 2 spray bottles Clorox all purpose cleaner, with the label stating, "Store out of reach of children or persons unfamiliar with its use...Caution: Causes moderate eye irritation..." 2 spray bottles Lysol cleaner, with the label stating, "Warning: Causes substantial but temporary eye injury. Do not get in eyes, on skin or on clothing..." 6 canisters of Clorox wipes 1 spray bottle of Raid insect spray 1 spray bottle of oven cleaner 1 spray bottle of ammonia 1 spray bottle of Windex 2 spray bottles of Lysol disinfecting cleaner 1 Glade air fresher spray, with the label stating, "Warning: Use only as directed. Intentional misuse by concentrating and inhaling the contents can be harmful or fatal..." 1 Xtra laundry detergent On 03/25/2024, at 9:45 AM, Surveyor interviewed Licensee A. Licensee A stated staff should have kept the cabinet locked at all times. Licensee A was unaware why the cabinet was unlocked.	N 499		
N 502	83.46(1)(a) Comfortable and safe temperatures A CBRF shall maintain comfortable and safe	N 502		

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N 502	Continued From page 12	N 502		

temperatures. The CBRF shall provide tempered air at all times to eliminate cold air drafts. The heating system shall be capable of maintaining temperatures of 74º F. in areas occupied by residents.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure a comfortable and safe temperature was maintained in the facility for 7 of 7 residents. The facility did not maintain a temperature of 74 degrees Fahrenheit (F) in areas occupied by residents.

Findings include:

On 03/25/2024 at approximately 9:00 AM, Surveyor conducted a tour of the facility and identified the thermostat read 61 degrees F.

On 03/25/2024 at approximately 9:02 AM, Surveyor interviewed Resident 8. Resident 8 stated the heater was not working and it had been very cold in the facility, especially at night. Resident 8 stated the heater had been out for about a week now. Resident 8 stated another resident in the home was lucky because s/he had an electric fireplace TV stand, so his/her room was a little warmer than all the other rooms.

On 03/25/2024 at approximately 9:12 AM, Surveyor observed Resident 6 open the oven in the kitchen. Resident 6 stated House Manager B had told him/her to put the oven on and open it when s/he was cold because the heat was not

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N 502	Continued From page 13 working. Resident 6 stated the heat had not been working for at least a week now. On 03/25/2024 at approximately 9:16 AM, Surveyor interviewed Licensee A. Licensee A stated the heat was out and someone from the heating company would be coming out sometime between 11:00 AM and 1:00 PM. Licensee A stated s/he contacted them last night. Licensee A stated s/he was not sure how long the heat had been out, but s/he did not believe it was for a week. On 03/25/2024 at approximately 9:30 AM, Surveyor toured the basement where residents reside. Surveyor observed the thermostat reading 57 degrees F. On 03/25/2024 at approximately 10:00 AM, Surveyor reviewed furnace inspection reports. Furnace inspection report, dated 11/03/2021, stated "Recommend a new furnace soon." Furnace inspection report, dated 03/18/2024, stated, "Inducer motor noisy. Recommend replacing furnace. Furnace condition: Poor." On 03/25/2024 at approximately 1:30 PM, Surveyor observed heating company truck at the facility.	N 502		
N 511	83.46(3) Public water supply or well water test. Public water supply. The CBRF shall use a public water supply when available. If a public water supply is not available, the CBRF shall have a well that is approved by the state department of natural resources. The CBRF shall have the well water tested at least annually by the state laboratory of hygiene or other laboratory	N 511		

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N 511	Continued From page 14 approved under ch. HFS 165. The CBRF shall maintain documentation of annual testing results. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the well water was tested annually by the state laboratory of hygiene or other laboratory approved under ch. HFS 165. Findings include: On 03/25/2024, Surveyor requested the annual well water tests for 2023. Licensee A could not locate annual well water for 2023. On 03/25/2024 at 10:00 AM, Surveyor interviewed Administrator A. Administrator A confirmed the facility had a private well for water. Administrator A stated House Manager B was responsible for getting the water tested. Licensee A stated s/he would have to check with house manager about the testing. Surveyor asked to have information sent by 03/26/2024 at 8:00 AM. As of 03/27/2024 at 4:00 PM, no evidence of an annual well water test for 2023 was received.	N 511		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure the fire inspection by the	N 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE HOUSE	8208 RACINE AVE WIND LAKE, WI 53185

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N 530	Continued From page 15 local fire authority or certified fire inspector was completed for 1 of 1 calendar year (2023). Findings include: On 03/25/2024 at approximately 9:00 AM, Surveyor requested the annual fire inspection for calendar year 2023 from Licensee A. Licensee A gave Surveyor a binder which did not have the annual fire inspection for calendar year 2023. On 03/25/2024 at approximately 10:00 AM, Surveyor interviewed Licensee A. Licensee A stated s/he would have to reach out to the local fire department for the report. Surveyor requested information to be sent by 03/26/2024 at 8:00 AM. As of 03/26/2024 at 4:00 PM, Surveyor did not receive evidence of the annual fire inspection for calendar year 2023.	N 530		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure the fire detection system was inspected for 2 of 2 calendar years (2022 and 2023). Findings include:	N 538		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011322	A. BUILDING: _____ B. WING _____	R-C 03/27/2024

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N 538	Continued From page 16 On 03/25/2024 at approximately 9:00 AM, Surveyor requested from Licensee A the annual fire detection system inspection for calendar years 2022 and 2023. Licensee A gave Surveyor a binder which did not have the annual fire detection system inspection for calendar years 2022 and 2023. The most recent inspection was dated 08/15/2020. On 03/25/2024 at approximately 9:30 AM, Surveyor interviewed Licensee A. Licensee A stated s/he believed there was an inspection completed more recently but would have to contact the company for the report. Surveyor requested information to be sent by 03/26/2024 at 8:00 AM. As of 03/27/2024 at 4:00 PM, Surveyor did not receive evidence of the annual fire detection system inspection for calendar years 2022 and 2023. CROSS REFERENCE N0530 DHS 83.47(3) Fire Inspection	N 538		