STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019881	A. BUILDING: _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE CEDARBURG	W56 N225 MCKINLEY BLVD CEDARBURG, WI 53012

(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 11/15/2024, Surveyor conducted two (2) complaint investigations at LakeHouse Cedarburg. Additional information was gathered through 11/25/2024. As a result of the survey, 1 deficiency was identified, 2 complaints were substantiated. Census: 27	N 000		
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 review and revise the individual service plan (ISP) annually or on change of condition for two (2) of 2 resident reviewed. Findings include: On 11/15/2024, Surveyor conducted 2 complaint investigations with concerns Resident 1 was left unattended without his/her oxygen on the	N 389		

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

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N 389	Continued From page 1 overnight of 09/06/2024 into morning of 09/07/2024, and Resident 2 had cognitive deficits and history of alcohol consumption. Surveyor requested Resident 1 and Resident 2's record from Executive Director (ED) A. Resident 1 was admitted to the facility on 06/28/2024. Resident 2 was admitted to the facility on 06/22/2019. Resident 1: Resident 1's ISP was completed on 07/07/2024 by Caregiver (CG) C. Review of Resident 1's ISP did not reflect Resident 1 was on oxygen. ED A provided his/her investigation into the concerns Resident 1 did not have on his/her oxygen. ED A stated s/he talked to hospice and hospice explained, "Resident is able to take off [his/her] oxygen but struggles with the ability to place it back on." ED A provided the letter dated 09/09/2024, from Family D. Family D stated s/he received a call from Resident 1. Resident 1 was extremely distressed. Resident 1's exact words were "no air" which s/he would say when not connected to his/her oxygen. Family D stated Resident 1 was sitting on the edge of his/her chair gasping for breath when Family D entered room. Surveyor requested oxygen policy from ED A. The oxygen policy stated under procedure #3 - "Resident unable to self-administer oxygen will be assisted by care staff qualified according to state regulation or have the oxygen administered by a licensed professional." On 11/15/2024 at 10:45 AM, Surveyor interviewed Director of Health and Wellness (DHW) B. DHW B stated s/he received the oxygen order the end of August. Surveyor reviewed resident hospice nursing notes and physician orders: 08/13/2024 - "[Resident 1] was sitting outside on	N 389		

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N 389	Continued From page 2	N 389		

bench upon arrival. [S/he] walked with writer to the lobby. [Resident 1] c/o SOB during assessment. . . [Resident 1] stopped several times to catch [his/her] breath. . . put oxygen on, [s/he] is on 2L. . . [S/he] was feeling better after a few minutes. [Resident 1] states [his/her] SOB has increased and [s/he] is using oxygen more often."
08/16/2024 - "[Resident 1] now uses 2L O2 nearly continuously. [S/he] stated [his/her] oxygen came off in the night and [s/he] had to call for help in order to have it placed back on. [S/he] needs help with this as [s/he] cannot feel [his/her] fingertips."
08/21/2024 - "[Resident 1] now needs O2 continuously, education provided to staff to assist [Resident 1] with keeping the O2 on." Hospice writer noted "collaborated with [DHW B, ED A and Family D]."
08/23/2024, Physician Orders - "O2 via nasal cannula 2L when at reset, 4L when walking. Use the tanks when the batteries on portable run out. Check frequently throughout day and night to replace nasal cannula as [Resident 1] is not able to do this."
DHW B confirmed the ISP did not address Resident 1 having PRN oxygen from hospice. DHW B acknowledged the ISP was not updated when Resident 1's oxygen orders for continuous oxygen, 2L at rest and 4L when walking, was received on 08/23/2024.

Resident 2:
Resident 2's ISP was completed on 07/07/2024 by CG C. Resident 2's ISP documented Resident 2 is oriented to person, place and time; can communicate independently; is independent in life enrichment and socialization activities; can smoke independently in designated areas; is independent in mobility; is continent of bowel and bladder and manages independently; and

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N 389	Continued From page 3 requires employee assist/administer medications. Resident 2's ISP did not document Resident 2 had a history of alcohol abuse. On 11/15/2024 at 11:00 AM, Surveyor interviewed ED A. ED A stated concerns in complaint were while Resident 2 was drinking. ED A stated Resident 2's family has been more involved and Resident 2 seems to be doing better with family involvement. ED A confirmed Resident 2 does drink, however family are trying to stop and limit Resident 2's alcohol consumption. ED A acknowledged Resident 2's drinking alcohol was not identified in Resident 2's ISP. The provider did not review and revise ISP on change of condition due to shortness of breath and needing oxygen continuously for Resident 1 and did not identify Resident 2's alcohol consumption or interventions in place for staff when Resident 2 was drinking.	N 389		