STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016400	A. BUILDING: _____ B. WING _____	R-C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 07/17/2024, Surveyor conducted a verification visit (x2) and complaint investigation (x2) at Lake Shore Assisted Living Cedar Cottage for Statement of Deficiency (SOD) F80Q14 and SOD SOB312. Data collection continued through 07/18/2024. The complaints were unsubstantiated. One deficiency was identified. The deficiency is cited for the third time. See SOD F80Q13, dated 09/14/2023 and SOD SOB311, dated 12/21/3023. Three of 4 deficiencies identified in SOD SOB311 were corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 11	{N 000}		
{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	{N 397}		

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

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{N 397}	Continued From page 1 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 record review and interview, the provider did not ensure at least one qualified resident care staff was present in the facility during multiple shifts in June 2024 and July 2024. This is cited for the third time. See statement of deficiency (SOD) SOB311, dated 12/21/2023 and SOD F80Q13, dated 09/14/2023. Findings include: On 05/24/2024 and 06/24/2024, the Department received complaints alleging a staff member was not accurately documenting blood sugars and the facility was understaffed at times. The 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 07/17/2024 at 10:00 a.m., Surveyor interviewed Administrator A. Surveyor asked	{N 397}		

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{N 397}	Continued From page 2	{N 397}		

Administrator A about work schedules, medication administration and training. Administrator A reported that all staff, except for Caregiver B, were trained to pass medications. Administrator A reported that when Caregiver B was scheduled to work alone, Assistant Director (AD) C would be "on call" to come in and dispense "PRN (as needed) medications" if needed.

On 07/17/2024, Surveyor reviewed the facility's work schedule for May 2024, June 2024 and July 2024. According to the June 2024 schedule, Caregiver B worked alone (7:00 PM to 7:00 AM) on the following days in June: 3, 5, 8, 16, 17, 18, 21, 22, 23, 26 and 27. On the days Caregiver B worked, the schedule noted to contact the "on Call Med (medication) Passer." According to the July 2024 schedule, Caregiver B worked alone (7:00 PM to 7:00 AM) on the following days in July: 1, 2, 5, 6, 7, 10, 11, 15 and 16. The July 2024 schedule noted, "Call [AD C] for PRN 7 PM/7AM."

On 07/17/2024 at approximately 2:15 PM, Surveyor interviewed Administrator A. Administrator A reported that caregivers worked 12-hour shifts (7 AM to 7 PM, 7 PM to 7 AM). Administrator A reported that medications were given between 7:00 AM and 7:00 PM. Administrator A stated that Caregiver B worked the second 12-hour shift (7 PM to 7 AM) and was not trained to administer medications. Administrator A indicated that if a resident needed a PRN medication, [Caregiver B] would have to call [AD C] to administer the medication after 7:00 PM. Administrator A confirmed that Caregiver B was hired on 05/31/2024 and worked shifts alone since starting. Administer A admitted that "the situation was not ideal" and the facility was

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{N 397}	Continued From page 3 working on hiring additional staff and getting Caregiver B trained to pass medications. On 07/18/2024 at approximately 9:55 AM, Surveyor interviewed AD C. AD C verified the following information: Caregiver B started on 05/31/2024 and Caregiver B was not trained to pass medications. AD C confirmed that Caregiver B had worked alone (7:00 PM to 7:00 AM) since starting. AD C reported that AD C was the "on call medication passer" when Caregiver B worked because Caregiver B was not trained to administer medications. AD C reported that the last round of medications were given by the day shift and were given by 7:00 PM. AD C stated, "I am the PRN medication passer when [Caregiver B] works." AD C noted that AD C has not been contacted to administer a PRN medication since Caregiver B started. AD C stated, "We are working on getting more staff and [Caregiver B] will be trained to pass medications." On 07/18/2024 at approximately 12:26 PM, Surveyor interviewed Caregiver B. Caregiver B confirmed s/he started on 05/31/2024. Caregiver B stated that s/he had worked several shifts (7:00 PM to 7:00 AM) alone since his/her start date. Caregiver B reported that s/he was not trained to administer medications. Surveyor asked Caregiver B about the procedure to administer medications when Caregiver B worked alone. Caregiver B stated that s/he would have to call [AD C] to administer medications during his/her shift if needed. Caregiver B indicated, "I want to get trained in passing medications and I plan to become certified to pass medications soon." Caregiver B denied having to call AD C to administer medications since beginning employment.	{N 397}		