| 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 _____ | R-C 05/21/2025 |

| 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<br><br>On 05/19/2025, Surveyor conducted two (2) verification visits at LakeHouse Cedarburg for Statement of Deficiencies (SOD) TXMN11 and XCCR11. Additional information was gathered through 05/21/2024. Four deficiencies were identified. Four of 4 deficiencies were repeat deficiencies identified in the following SODs:<br><br>TXMN11, dated 04/21/2025- N415 83.37(2)(d) and Y3244 50.09(1)(L) were repeat deficiencies.<br><br>XCCR11, dated 02/25/2025- N310 83.29(2) and N558 83.48(8)(b) were repeat deficiencies.<br><br>Four of 4 deficiencies will be cited a 2nd time.<br><br>Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 25 | {N 000} | | |
| {N 310} | 83.29(2) Admission agreement include services, charges<br><br>The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for | {N 310} | | |

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

| 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 _____ | R-C 05/21/2025 |

| 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 310} | Continued From page 1<br>resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not have an Admission Agreement for 9 of 25 residents providing information regarding services and accommodations available including charges for services.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) XCCR11, dated 02/25/2025.<br><br>Findings include:<br><br>The facility is licensed to provide services for up to 65 residents who may be advanced aged, physically disabled and/or irreversible dementia/Alzheimer's. The census at time of survey was 25. | {N 310} | | |

| 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 _____ | R-C 05/21/2025 |

| 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 310} | Continued From page 2<br><br>On 05/19/2025 at 12:12 PM, Surveyor requested admission agreements for the residents residing prior to the change of ownership from Executive Director (ED) A. ED A stated s/he did not do new admission agreements as upper management stated they were honoring the previous admission agreement from the previous licensee. Nine of 15 residents cited under SOD XCCR11 remain in the facility without an admission agreement from LakeHouse Cedarburg.<br><br>The provider did not have an Admission Agreement for 9 of 25 residents providing information regarding services and accommodations available including charges for services. | {N 310} | | |
| N 415 | 83.37(2)(d) Documentation of medication administration.<br><br>Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation and interview, the provider did not ensure that the person administering residents' medications or | N 415 | | |

| 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 _____ | R-C 05/21/2025 |

| 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 415 | Continued From page 3 | N 415 | | |

treatments initialed the medication administration record (MAR) after administration.

This is a repeat deficiency. See Statement of Deficiency (SOD) TXMN11, dated 04/21/2025.

Findings include:

On 05/19/2025 at 10:53 AM, Surveyor interviewed Resident 9. Resident 9 confirmed staff bring him/her his/her medication. Surveyor observed a med cup with a number of pills on the table next to Resident 9's chair. Resident 9 stated some staff observe him/her take medications, but other staff bring medications in, set them on the table and leave. Resident 9 confirmed s/he had not taken the morning medications yet and pointed to the cup of medications sitting on the table next to him/her. Resident 9 got up and walked to the refrigerator to get a bottle of juice. Resident 9 returned to his/her chair and took the medications at 10:56 AM. Resident 9 confirmed s/he receives noon meds.

On 05/19/2025 at 11:07 AM, Surveyor interviewed Caregiver (CG) E. CG E acknowledged s/he gave Resident 9 his/her meds. CG E stated Resident 9 was in bed and didn't want to get up, so s/he left the medications by Resident 9's chair. CG E confirmed Resident 9 receives noon meds. Surveyor shared findings that Resident 9 took his/her morning meds at 10:56 AM. CG E was unsure of the window morning meds should be taken. CG E acknowledged that s/he had signed the morning meds out, and that they were short staffed.

On 05/19/2025 at 12:31 PM, Surveyor reviewed Resident 9's chart and medication administration

| 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 _____ | R-C 05/21/2025 |

| 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 415 | Continued From page 4 | N 415 | | |

record (MAR). Resident 9 was admitted to the provider on 02/12/2015 with diagnoses including hypertension, depression bipolar disorder and diabetes. Surveyor reviewed Resident 9's May 2025 MAR. Resident 9 received the following oral medications in the morning:
Amphet/Dextr 30 MG Tab, Baclofen 10 MG Tab, Calcium / D 600 MG-400IU, Cetirizine 10 MG Tab, Dalfampridin 10 MG Tab, Diltiazem ER 180 MG Cap, Docusate SOD Cap 100 MG Cap, Escitalopram 20 MG Tab, Ferosul 325 MG Tab, Linzess 72 MMCG Cap, Metformin 500 MG ER Tab, Myrbetriq 50 MG Tab, Omeprazole 40 MG Cap, Oxycod/APAP 5-325 MG Tab, Vitamin D3 2000 Unit Cap, and Xarelto 10 MG Tab. Surveyor observed on 05/19/2025 morning meds were signed as given. Surveyor observed AMPHET/DEXTR 30 MG Tab - morning - signed as an exception for 05/01/2025, 05/02/2025, 05/03/2025, 05/04/2025, 05/05/2025, 05/6/2025, 05/07/2025, 05/08/2025, 05/09/2025, 05/10/2025, 05/11/2025 and 05/12/2025, Reason - "Med Not Available." On 2nd page of MAR Surveyor observed AMPHET/DEXTR 30 MG Tab with 1st dose given 05/12/2025 and 05/13/2025 marked as an exception. Review of exception/notes - no documentation for 05/13/2025 why Resident 9 didn't receive AMPHET/DEXTR 30 MG Tab. Surveyor observed Lidocaine Pad 5% - Apply topically every day for 12 hours, then leave off for 12 hours. Lidocaine was documented as "Refused" in the morning on 05/05/2025, 05/06/2025, 05/10/2025, 05/11/2025 and 05/16/2025, however was signed off at bedtime.

On 05/19/2025 at 12:45 PM, Surveyor reviewed Resident 9's individual service plan (ISP): Medication/Treatments - "Requires employees assist/administer medications up to 3x[sic] per day with more than 4 medications per pass."

| 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 _____ | R-C 05/21/2025 |

| 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 415 | Continued From page 5<br><br>On 05/19/2025 at 1:12 PM, Surveyor interviewed Team Lead (TL) F. TL F stated morning meds should be passed between "8am - 10am." TL F confirmed caregiver should not let medications in resident rooms and that caregivers should observe residents take the medication. TL F acknowledged Resident 9's AMPHET/DEXTR 30 MG Tab was out and they needed to get a new script.<br><br>On 05/19/2025 at approximately 2:30 PM, ED A confirmed staff were re-educated on med pass. ED A acknowledged RN G reeducated caregiver on med pass and medications should not be left in resident rooms.<br><br>The provider did not ensure the person administering residents' medications or treatments initialed the MAR after administration. | N 415 | | |
| {N 558} | 83.48(8)(b) Sprinkler system installation and maintenance<br><br>Installation and maintenance. 1. All sprinkler systems shall be installed by a state licensed sprinkler contractor. All sprinkler systems shall be maintained, inspected and tested at least annually or at intervals determined by the requirements in NFPA 25. 2. In facilities with sprinklers, sprinkler heads shall be placed at the top of each linen or trash chute and in the rooms where the chutes terminates. 3. The sprinkler system flow alarm shall be connected to the CBRF ' s fire alarm system.<br><br>This Rule is not met as evidenced by:<br>Based on record review and staff interview, the provider did not ensure the sprinkler system was | {N 558} | | |

| 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 _____ | R-C 05/21/2025 |

| 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 558} | Continued From page 6<br>maintained by the requirements in NFPA 25.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) XCCR11, dated 02/25/2025.<br><br>Findings include:<br><br>On 05/19/2025 at 1:52 PM, Surveyor requested sprinkler repairs from Executive Director (ED) A. ED A provided a binder with corrections from previous statement of deficiency (SOD) #XCCR11.<br>Surveyor observed a Fire Protection System NFPA-25 Deficiency Repair Proposal dated 05/08/2025. Sticky note stating "all signed & scheduling for repair - AP 5/14/25" ED A acknowledged repair was approved, however work was not completed and ED A was unable to provide a date repair would be completed.<br>Surveyor observed a 2nd Fire Protection System Work Order Service Proposal dated 03/25/2025 for "compressor." Sticky note stated "Received [sic] 4-29-25 sent to [Person H] getting approval. Signed & sent to Ahern 5-13-25 [sic]."<br>Surveyor observed Quarterly Sprinkler Inspection dated 04-25-2025:<br>Equipment Summary North Side identified:<br>Auxiliary Drain - "Failed"<br>Dry Valve - "Failed"<br>Flow Alarm Switch - "Passed 1, Failed 1"<br>Control Valve - "Passed 1, Failed 3"<br>Sticky on page "Sprinkler Inspection Quotes?"<br><br>1 - Control Valve<br>Is valve provided with the appropriate identification signs? No<br>Deficiency Authority NFPA 25-2011 Section: 13.3.2.2<br>"The valve inspection shall verify that the valves are in the following condition: (1) In the normal | {N 558} | | |

| 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 _____ | R-C 05/21/2025 |

| 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 558} | Continued From page 7<br>open or closed position. (2) Sealed, locked, or supervised. (3) Accessible. (4) Provided with appropriate wrenches. (5) Free from external leaks. (6) Provided with appropriate identification.<br><br>CV00002 - Control Valve<br>Is valve provided with the appropriate identification signs? No<br>Deficiency Authority NFPA 25-2011 Section: 13.3.2.2<br>"The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position. (2) Sealed, locked, or supervised. (3) Accessible. (4) Provided with appropriate wrenches. (5) Free from external leaks. (6) Provided with appropriate identification.<br><br>CV00005 - Control Valve<br>Is valve provided with the appropriate identification signs? No<br>Deficiency Authority NFPA 25-2011 Section: 13.3.2.2<br>"The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position. (2) Sealed, locked, or supervised. (3) Accessible. (4) Provided with appropriate wrenches. (5) Free from external leaks. (6) Provided with appropriate identification.<br><br>DVR00002 - Dry Valve<br>Dry valve free from physical damage, trim valves in appropriate open or closed position, and no leakage from intermediate chamber? No<br>Tech Notes: "Quick opening device out of service, compressor is currently down, temporary compressor installed, but is cycling every two minutes. Leak investigation should be done on dry system before new compressor is installed."<br>Deficiency Authority NFPA 25-2011 Section: 13.4.4.1.4 | {N 558} | | |

| 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 _____ | R-C 05/21/2025 |

| 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 558} | Continued From page 8<br>"The dry pipe valve shall be externally inspected monthly to verify the following: (1) The valve is free of physical damage. (2) All trim valves are in appropriate open or closed position. (3) The intermediate chamber is not leaking."<br><br>DVR00002 - Dry Valve<br>Did air pressure supervisory alarm pass functional test? Yes<br>Tech Notes: "Low air alarm comes in as a supervisory tamper alarm on the panel."<br>Deficiency Authority NFPA 25-2011 Section: 13.4.4.2.6<br>"Low air pressure alarms, if provided, shall be tested quarterly in accordance with the manufacturer's instruction."<br><br>DVR00002 - Dry Valve<br>Did the Quick Opening Device pass its operational test? No<br>Tech Notes: "Device out of service"<br>Deficiency Authority NFPA 25-2011 Section: 13.4.4.2.4<br>"Quick-opening devices, if provided, shall be tested quarterly."<br><br>Low Points - Auxiliary Drain<br>Was the auxiliary valve drained: No<br>Deficiency Authority NFPA 25-2011 Section: 13.4.4.3.2<br>"Auxiliary drains in dry pipe sprinkler systems shall be drained after each operation of the system, before the onset of freezing weather conditions, and thereafter as needed."<br><br>SPRKR QUES00002- Sprinkler Questions<br>Hydraulic nameplate (calculated systems only) securely attached to riser and legible? No<br>Deficiency Authority NFPA 25-2011 Section 5.2.6<br>"The hydraulic nameplate for hydraulically | {N 558} | | |

| 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 _____ | R-C 05/21/2025 |

| 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 558} | Continued From page 9<br>designed systems shall be inspected quarterly to verify that it is attached securely to the sprinkler riser and is legible."<br><br>SPRKR QUES00002- Sprinkler Questions<br>Alarm devices free from mechanical damage? No<br>Tech Notes: "Low air for dry system comes in as a supervisory tamper valve on panel. Wet system not tied into panel, no signals received but local bell works. See previous reports"<br>Deficiency Authority NFPA 25-2011 Section 5.2.5<br>"Waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage."<br><br>WFA0004 - Flow Alarm Switch<br>Was alarm test performed? Yes<br>Tech Notes: "No signal received that panel, local Bell only"<br>Deficiency Authority NFPA 25-2011 Section 5.3.3.2<br>"Vane-type and pressure switch type waterflow devices shall be tested semiannually."<br><br>Technician Comments: "Ahren will be contacting you shortly to discuss how we may help you create an action plan to correct deficiencies identified in this inspection."<br><br>Surveyor observed Quarterly Sprinkler Inspection dated 04-25-2025:<br>Equipment Summary South Side identified:<br>Fire Department Connection - "Failed 1"<br><br>Tech Notes: No ball drip at riser<br>Deficiency Authority NFPA 25-2011 Section 13.7.1<br>"Fire department connections shall be inspected quarterly. The inspection shall verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels | {N 558} | | |

| 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 _____ | R-C 05/21/2025 |

| 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 558} | Continued From page 10<br>are not damaged and rotate smoothly. (6) The check valve is not leaking."<br><br>Technician Comments: "Ahren will be contacting you shortly to discuss how we may help you create an action plan to correct deficiencies identified in this inspection."<br><br>On 05/19/2025 at 2:27 PM, Surveyor interviewed ED A. ED A stated s/he will talk with Maintenance Director (MD) D to ensure the work is scheduled and completed.<br><br>The provider did not ensure the sprinkler system was maintained in accordance with NFPA 25. | {N 558} | | |
| Y3244 | 50.09(1)(L) Care<br><br>(1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to<br><br>(l) Receive adequate and appropriate care within the capacity of the facility. | Y3244 | | |

| 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 _____ | R-C 05/21/2025 |

| 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 |
|---|---|---|---|---|
| Y3244 | Continued From page 11 | Y3244 | | |

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure adequate and appropriate care was provided within the capacity of the facility for 6 out of 6 residents reviewed (Resident 9, Resident 10, Resident 11, Resident 12, Resident 15 and Resident 16).

This is a repeat deficiency. See Statement of Deficiency (SOD) TXMN11, dated 04/21/2025.

Findings include:

The provider is licensed as a class CNA (non-ambulatory) to provide care for up to 65 residents in the following client groups: advanced age, irreversible dementia/Alzheimer's, and physically disabled.

On 05/19/2025 at 10:53 AM, Surveyor interviewed Resident 9. Resident 9 stated "staff keep changing and you get to know them and poof they are gone." Resident 9 stated response time depends who and how many are working and how busy they are. Resident 9 acknowledge some staff are snippy and do not want to help. Resident 9 stated s/he had concerns with the wait time when s/he pushes his/her pendant.

On 05/19/2025 at 11:07 AM, Surveyor interviewed Caregiver (CG) E and CG I. CG E acknowledged they were short staff. CG E stated RN G worked the weekend because there was no staff. CG E stated the schedule for 05/19/2025 only had 2 staff on the schedule, 3rd spot was open. CG E stated they try to get to everything, but you must keep moving. CG E stated Maintenance Director (MD) D was cooking lunch as there was no cook 05/19/2025. CG E acknowledged response times may be longer with 2 staff and that with 3 staff

| 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 _____ | R-C 05/21/2025 |

| 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 |
|---|---|---|---|---|
| Y3244 | Continued From page 12 | Y3244 | | |

they would be more prompt. CG E confirmed Resident 13 is a sit to stand and should be a 2 person. CG I stated s/he has done Resident 13 by his/herself when s/he is the only caregiver with 1 med passer. CG I stated when there is 3 staff Resident 13 is done as a 2 person.

On 05/19/2025 at 11:24 AM, Surveyor reviewed the schedule. The schedule for 5/19/2025 reflected 2 staff 7a-3p, 2 staff 3p-11p and 2 staff 11p-7a.

On 05/19/2025 at 11:39 AM, Surveyor interviewed Resident 6. Resident 6 stated this facility is not well managed and not what it used to be. Resident 6 stated there are no improvements to make place better. Resident 6 acknowledged s/he is fairly independent. Resident 6 had concerns with staff at night. Resident 6 stated caregivers come in to pass med's while on the phone. Resident 6 stated last week s/he missed her glaucoma med as s/he was waiting for the med prior to going to bed and fell asleep waiting, so s/he never received. Resident 6 stated s/he does not use his/her pendant.

On 05/19/2025 at 12:25 PM, Surveyor reviewed resident records and call wait times:

RESIDENT 9

Resident 9 was admitted to the provider on 02/12/2015 with diagnoses including hypertension, depression bipolar disorder and diabetes. Resident 9's individual support plan (ISP) dated 05/01/2025, noted s/he needs assistance of 1 care staff with bilateral lower extremity and some assistance may be needed with top; assist with showering twice a week; resident will call for assistance if needed with

| 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 _____ | R-C 05/21/2025 |

| 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 |
|---|---|---|---|---|
| Y3244 | Continued From page 13 | Y3244 | | |

managing incontinence care; resident will call for assistance with ambulation to prevent falls; med passers will administer medications 3 x/day. Surveyor reviewed the Alarm Response Report for Resident 9's pendant usage from 05/01/2025 through 05/19/2025. Surveyor noted several instances when Resident 9 waited over 20 minutes for a response from caregivers. The dates and times are as follows:
05/01/2025: Initiated at 5:08 PM Wait Time 2 hours 17 minutes
05/04/2025: Initiated at 3:54 PM Wait Time 47 minutes
05/05/2025: Initiated at 5:34 AM Wait Time 39 minutes
05/05/2025: Initiated at 6:42 AM Wait Time 43 minutes
05/05/2025: Initiated at 12:15 PM Wait Time 48 minutes
05/06/2025: Initiated at 3:21 PM Wait Time 36 minutes
05/12/2025: Initiated at 10:19 AM Wait Time 1 hour 11 minutes
05/15/2025: Initiated at 4:19 PM Wait Time 1 hour 17 minutes
05/18/2025: Initiated at 10:01 AM Wait Time 25 minutes
05/18/2025: Initiated at 6:35 PM Wait Time 30 minutes

RESIDENT 10

Resident 10 was admitted to the provider on 01/30/2025 with diagnoses including hypertension, atrial fibrillation, chronic kidney disease and diabetes. Resident 10'S ISP dated 01/31/2025, noted Resident 10 requires assistance with dressing and grooming; requires physical assist with shower; requires regular employees assistance in managing bowel and/or

| 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 _____ | R-C 05/21/2025 |

| 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 |
|---|---|---|---|---|
| Y3244 | Continued From page 14<br><br>bladder care; and requires employees to escort or push wheelchair because of a physical limitation. Surveyor reviewed the Alarm Response Report for Resident 10's pendant usage from 05/01/2025 through 05/19/2025. Surveyor noted several instances when Resident 10 waited over 20 minutes for a response from caregivers. The dates and times are as follows:<br>05/02/2025: Initiated at 10:08 PM Wait Time 39 minutes<br>05/04/2025: Initiated at 4:52 PM Wait Time 33 minutes<br>05/11/2025: Initiated at 10:26 PM Wait Time 21 minutes<br>05/12/2025: Initiated at 4:56 PM Wait Time 22 minutes<br>05/12/2025: Initiated at 11:03 PM Wait Time 45 minutes<br>05/13/2025: Initiated at 8:36 PM Wait Time 23 minutes<br>05/14/2025: Initiated at 11:43 PM Wait Time 22 minutes<br>05/15/2025: Initiated at 11:44 AM Wait Time 27 minutes<br>05/15/2025: Initiated at 3:35 PM Wait Time 36 minutes<br><br>Resident 11<br><br>Surveyor reviewed Alarm Response Report for Resident 11's pendant usage from 05/01/2025 through 05/19/2025. Surveyor noted several instances when Resident 11 waited over 20 minutes for a response from caregivers. The dates and times are as follows:<br>05/01/2025: Initiated at 7:52 AM Wait Time 44 minutes<br>05/01/2025: Initiated at 12:06 PM Wait Time 21 minutes<br>05/01/2025: Initiated at 3:34 PM Wait Time 30 | Y3244 | | |

| 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 _____ | R-C 05/21/2025 |

| 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 |
|---|---|---|---|---|
| Y3244 | Continued From page 15<br>minutes<br>05/01/2025: Initiated at 4:56 PM Wait Time 1 hour 45 minutes<br>05/01/2025: Initiated at 10:31 PM Wait Time 40 minutes<br>05/02/2025: Initiated at 12:58 AM Wait Time 5 hours 2 minutes<br>05/02/2025: Initiated at 9:42 AM Wait Time 37 minutes<br>05/02/2025: Initiated at 12:12 PM Wait Time 1 hour 9 minutes<br>05/02/2025: Initiated at 5:21 PM Wait Time 35 minutes<br>05/02/2025: Initiated at 6:34 PM Wait Time 56 minutes<br>05/03/2025: Initiated at 7:05 AM Wait Time 30 minutes<br>05/03/2025: Initiated at 7:38 AM Wait Time 1 hour<br>05/03/2025: Initiated at 12:13 PM Wait Time 37 minutes<br>05/03/2025: Initiated at 1:34 PM Wait Time 25 minutes<br>05/03/2025: Initiated at 8:42 PM Wait Time 21 minutes<br>05/04/2025: Initiated at 7:48 AM Wait Time 1 hour 18 minutes<br>05/04/2025: Initiated at 3:38 PM Wait Time 36 minutes<br>05/04/2025: Initiated at 7:56 PM Wait Time 1 hour 8 minutes<br>05/05/2025: Initiated at 12:42 PM Wait Time 36 minutes<br>05/05/2025: Initiated at 8:20 PM Wait Time 1 hour<br>05/06/2025: Initiated at 7:00 AM Wait Time 25 minutes<br>05/08/2025: Initiated at 7:02 AM Wait Time 23 minutes<br>05/08/2025: Initiated at 9:00 AM Wait Time 31 | Y3244 | | |

| 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 _____ | R-C 05/21/2025 |

| 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 |
|---|---|---|---|---|
| Y3244 | Continued From page 16<br>minutes<br>05/08/2025: Initiated at 11:15 AM Wait Time 51 minutes<br>05/09/2025: Initiated at 11:26 AM Wait Time 45 minutes<br>05/09/2025: Initiated at 5:32 PM Wait Time 39 minutes<br>05/09/2025: Initiated at 8:42 PM Wait Time 43 minutes<br>05/12/2025: Initiated at 1:09 AM Wait Time 1 hour 8 minutes<br>05/12/2025: Initiated at 7:00 AM Wait Time 28 minutes<br>05/12/2025: Initiated at 10:00 AM Wait Time 3 hours 41 minutes<br>05/12/2025: Initiated at 6:32 PM Wait Time 32 minutes<br>05/12/2025: Initiated at 8:32 PM Wait Time 42 minutes<br>05/16/2025: Initiated at 5:16 AM Wait Time 58 minutes<br>05/16/2025: Initiated at 8:35 PM Wait Time 23 minutes<br>05/16/2025: Initiated at 11:32 PM Wait Time 23 minutes<br>05/17/2025: Initiated at 4:47 PM Wait Time 26 minutes<br>05/18/2025: Initiated at 6:58 AM Wait Time 26 minutes<br>05/18/2025: Initiated at 10:11 AM Wait Time 27 minutes<br>05/18/2025: Initiated at 3:34 PM Wait Time 24 minutes<br><br>Resident 12<br><br>Surveyor reviewed Alarm Response Report for Resident 12's pendant usage from 05/01/2025 through 05/19/2025. Surveyor noted several instances when Resident 12 waited over 20 | Y3244 | | |

| 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 _____ | R-C 05/21/2025 |

| 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 |
|---|---|---|---|---|
| Y3244 | Continued From page 17<br>minutes for a response from caregivers. The dates and times are as follows:<br>05/01/2025: Initiated at 9:15 AM Wait Time 1 hour 5 minutes<br>05/01/2025: Initiated at 6:00 PM Wait Time 39 minutes<br>05/02/2025: Initiated at 5:25 AM Wait Time 27 minutes<br>05/02/2025: Initiated at 7:43 PM Wait Time 22 minutes<br>05/03/2025: Initiated at 5:22 PM Wait Time 42 minutes<br>05/04/2025: Initiated at 12:41 PM Wait Time 30 minutes<br>05/04/2025: Initiated at 5:46 PM Wait Time 34 minutes<br>05/06/2025: Initiated at 2:02 PM Wait Time 28 minutes<br>05/07/2025: Initiated at 7:45 AM Wait Time 2 hour 9 minutes<br>05/08/2025: Initiated at 7:43 AM Wait Time 1 hour<br>05/08/2025: Initiated at 6:00 PM Wait Time 28 minutes<br>05/09/2025: Initiated at 7:26 AM Wait Time 25 minutes<br>05/10/2025: Initiated at 5:47 PM Wait Time 27 minutes<br>05/11/2025: Initiated at 5:56 PM Wait Time 25 minutes<br>05/12/2025: Initiated at 6:04 PM Wait Time 24 minutes<br>05/13/2025: Initiated at 11:01 AM Wait Time 29 minutes<br>05/13/2025: Initiated at 5:59 PM Wait Time 24 minutes<br>05/14/2025: Initiated at 7:51 AM Wait Time 21 minutes<br>05/14/2025: Initiated at 5:59 PM Wait Time 48 minutes | Y3244 | | |

| 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 _____ | R-C 05/21/2025 |

| 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 |
|---|---|---|---|---|
| Y3244 | Continued From page 18<br><br>05/15/2025: Initiated at 5:59 PM Wait Time 27 minutes<br>05/16/2025: Initiated at 6:01 PM Wait Time 32 minutes<br>05/18/2025: Initiated at 11:25 AM Wait Time 35 minutes<br>05/19/2025: Initiated at 5:00 AM Wait Time 26 minutes<br><br>On 05/19/2025 at 1:41 PM, Surveyor interviewed Resident 14. Resident 14 stated there is room for improvements. Resident 14 acknowledged some staff are good, some staff bad. Resident 14 expressed concerns for the residents needing assistance, stating they are often short staffed and wait times can be long. Resident 14 confirmed some staff bring medications and watch you take and others leave them for you to take independently.<br><br>On 05/19/2025 at 2:00 PM, Surveyor interviewed Resident 15. Resident 15 stated some staff are good, some are not helpful. Resident 15 stated response time depend on time of day and staffing. Resident 15 acknowledged s/he waits over 15 - 20 minutes at times. Resident 15 stated s/he had no concerns except having to wait for staff.<br><br>On 05/19/2025 at 2:10 PM, Surveyor tried to interview Resident 11. Surveyor knocked on door, no answer and door was locked.<br><br>On 05/19/2025 at 2:15 PM, Surveyor interviewed Resident 16. Resident 16 confirmed s/he uses his/her pendant. Resident 16 stated response depends on staff, sometimes s/he waits over 30 minutes. Resident 16 expressed concerns with staffing and stated they could use more. | Y3244 | | |

| 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 _____ | R-C 05/21/2025 |

| 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 |
|---|---|---|---|---|
| Y3244 | Continued From page 19<br>On 05/19/2025 at 2:30 PM, Surveyor reviewed call wait times for Resident 15 and Resident 16:<br><br>Resident 15<br><br>Surveyor reviewed Alarm Response Report for Resident 15's pendant usage from 05/16/2025 through 05/19/2025. Surveyor noted several instances when Resident 15 waited over 20 minutes for a response from caregivers. The dates and times are as follows:<br>05/16/2025: Initiated at 8:56 AM Wait Time 34 minutes<br>05/16/2025: Initiated at 12:10 PM Wait Time 1 hour 20 minutes<br>05/16/2025: Initiated at 4:57 PM Wait Time 1 hour 1 minute<br>05/17/2025: Initiated at 8:57 AM Wait Time 44 minutes<br>05/17/2025: Initiated at 7:59 PM Wait Time 39 minutes<br>05/17/2025: Initiated at 9:45 PM Wait Time 33 minutes<br>05/18/2025: Initiated at 7:57 AM Wait Time 39 minutes<br><br>Resident 16<br><br>Surveyor reviewed Alarm Response Report for Resident 16's pendant usage from 05/16/2025 through 05/19/2025. Surveyor noted several instances when Resident 16 waited over 20 minutes for a response from caregivers. The dates and times are as follows:<br>05/16/2025: Initiated at 10:22 AM Wait Time 1 hour<br>05/16/2025: Initiated at 3:45 PM Wait Time 35 minutes<br>05/16/2025: Initiated at 8:31 PM Wait Time 24 minutes | Y3244 | | |

| 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 _____ | R-C 05/21/2025 |

| 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 |
|---|---|---|---|---|
| Y3244 | Continued From page 20<br>05/17/2025: Initiated at 4:18 PM Wait Time 24 minutes<br>05/17/2025: Initiated at 6:13 PM Wait Time 1 hour 13 minutes<br>05/17/2025: Initiated at 8:16 PM Wait Time 42 minutes<br>05/18/2025: Initiated at 3:53 PM Wait Time 33 minutes<br>05/18/2025: Initiated at 4:36 PM Wait Time 33 minutes<br>05/18/2025: Initiated at 6:04 PM Wait Time 35 minutes<br>05/18/2025: Initiated at 7:51 PM Wait Time 39 minutes<br><br>On 05/19/2025 at approximately 2:45 PM, Surveyor interviewed Executive Director (ED) A. ED A stated s/he realized staff bring residents to meals without resetting their pendants. ED A stated s/he has heard the system beeping and when s/he goes to look residents are in the dining. Surveyor shared finding with wait times and ED A stated s/he will look at the response times. ED A acknowledged s/he is currently hiring staff for all 3 shifts.<br><br>The provider did not ensure adequate and appropriate care was provided within the capacity of the facility. | Y3244 | | |