

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Cedar Lake Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5595 Cty Rd Z West Bend, WI 53095	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review, and policy review, the facility failed to investigate an allegation of resident-to-resident abuse for 2 residents (R) (R4 and R3) of 3 residents reviewed for abuse.</p> <p>Findings include:</p> <p>Review of R4's Face Sheet located in the electronic medical record (EMR) revealed R4 was re-admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD).</p> <p>Review of R4's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/1/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 was cognitively intact.</p> <p>Review of R3's Face Sheet located in the EMR revealed R3 was re-admitted to the facility on [DATE] with diagnoses which included major depressive disorder.</p> <p>Review of R3's Quarterly MDS assessment, with an ARD of 3/13/25, revealed a BIMS score of 12 out of 15 which indicated R3 was moderately cognitively impaired.</p> <p>Review of the facility's summary of incident, dated 5/13/25, revealed on 5/13/25 at approximately 4:30 PM, Medication Aide (MA) 1 went in R3's room to administer medication. R3 stated R3's roommate (R4) was often in an angry mood and when R4 entered the room a few minutes earlier, R4 stated, You better watch out because you are next.</p> <p>Review of the facility's investigation, dated 5/20/25, revealed the only resident interviewed was R3. There were no interviews with other cognitively intact residents, including R4.</p> <p>During an interview on 6/12/25 at 1:07 PM, Registered Nurse Manager (RN) 1 confirmed there were no other residents interviewed during the investigation. RN 1 indicated the Social Worker spoke with R4 but not about what R4 allegedly said to R3. RN 1 agreed the investigation was lacking and other residents, including R4, should have been interviewed.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review, and policy review, the facility failed to ensure the medical record was complete, accurate, and readily accessible for 1 resident (R) (R1) of 10 sampled residents. This failure had the potential for staff not to have knowledge about the resident and/or other residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the facility's Documentation-Guidelines policy, revised 1/2025, revealed: .2. Record the services or care given to the resident and his reaction to it as an assurance of quality care. 3. Record the resident's condition and progress shown. 4. Serves as a source of legal protection against libel, fraudulent charges, or claims. 5. Serves as a source of information for statistics, chart audit, and research. 6. Provides a basis for planning resident care. Enter time care was provided in note. 2. Chart only the services you have given, a) Each licensed nurse and nursing assistant are responsible for his/her own acts and documentation of the same. Follow through from shift to shift is extremely important, a) This provides for continuity in total resident care.</p> <p>Review of R1's undated admission Record located in the electronic medical record (EMR) indicated R1 was admitted to the facility on [DATE] with a diagnosis of need for assistance with personal care.</p> <p>Review of a facility incident report, dated 5/29/25, revealed R1 had an unwitnessed fall when attempting to get to the bathroom. R1 had a skin tear on the elbow and hit R1's head. Range of motion varied, but discomfort was noted. A Nurse Practitioner was notified of the fall. Because R1 hit R1's head and was on Eliquis, an order was given to send R1 to the Emergency Department (ED) for evaluation.</p> <p>Review of toileting documentation in R1's EMR revealed no documentation that R1 was toileted on 5/28/25 after 7:21 PM through 5/29/25 at 5:00 AM.</p> <p>During an interview on 6/11/25 at 4:14 PM, Registered Nurse (RN) 1 said staff must offer R1 the bed pan frequently because R1 will not call for assistance and will try to get up on R1's own. RN 1 said on the night of 5/28/25 through the morning of 5/29/25, RN 1 provided toileting twice for R1. RN 1 said R1 didn't want the bed pan the first time so RN 1 checked R1's brief and pad. RN 1 said when RN 1 saw R1 later, R1 used the bed pan and voided. RN 1 stated RN 1 forgot to document the toileting in the Certified Nurse Aide (CNA) task section of R1's medical record.</p> <p>During an interview on 6/12/25 at 12:55 PM, RN 2 stated staff do not have to chart every time they toilet a resident, but should chart/document at least once per shift and more if able. RN 2 stated RN 2 did not know if anyone spoke with RN1 about not documenting any toileting during RN 1's shift, however, all nursing staff should have been reeducated on the expectation to document.</p> <p>During an interview on 6/12/25 at 1:20 PM, Director of Nursing (DON) B stated staff should offer toileting or use of the bed pan every two to two and half hours. DON-B stated staff do not have to document every encounter, but should document at least once per shift unless something unusual or uncommon occurs.</p>		