STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525465	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Lake Health and Rehab Center	5595 Cty Rd Z West Bend, WI 53095

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure allegations of abuse/neglect were reported to the State Agency (SA) for 1 resident (R) (R1) of 1 resident in a sample of 4 residents.R1 and their family filed a grievance with the facility on 3/26/26 that involved allegations of abuse/neglect. The facility did not report the allegations of abuse/neglect to the SA.Findings include:The facility's Patient Abuse, Neglect, Mistreatment, Misappropriation of Property and Exploitation policy, dated 3/2026, indicates: Alleged Violation: is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, or other but has not been investigated .Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Reporting/Response: 1. Report all alleged violations to the Administrator, Nursing Administrator on-call, State Agency (Division of Quality Assurance (DQA)/Office of Caregiver Quality (OCQ)) .no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. R1 was admitted to the facility on [DATE] for rehab following hospitalization for a fall. R1 had diagnoses including multiple fractures of the pelvis with stable disruption of the pelvic ring, unspecified fracture of the sacrum resulting in pubic rami, and right sacral ala fracture. R1 also had diagnoses including spinal stenosis, lumbar region, age-related osteoporosis with current pathological fracture, cognitive communication deficit, and unspecified dementia. R1's Minimum Data Set (MDS) assessment, dated 4/7/26, stated R1 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment. R1 and their family filed a grievance with the facility on 3/26/26. The grievance indicated sometime during the night, R1 called out in pain and someone closed the door without checking on them. R1 also said staff did not apply cream the last 3 days which made their pain worse. A family member stated they went to the nurses' station on (3/23/26), (3/24/26), and (3/25/26) at approximately 7:00 PM to tell them they were leaving and R1 wanted to get into bed. The family member was told by a Certified Nursing Assistant (CNA) that they would not put R1 to bed because R1 would keep the CNA up all night with their call light. The CNA had worked with R1 and knew they used their call light frequently. The CNA also said there was no way they could put R1 to bed at that time because they were taking care of 10 residents and were short staffed. The grievance also indicated staff told R1 when they were newly admitted that they should not use their call light so much because it would wear out. The comment upset R1, made them feel like a nuisance, and made them fearful to use their call light. On 6/24/26, Surveyor reviewed the facility's investigation and staff education and noted the facility did not report the allegation of abuse/neglect to the SA. On 6/24/26 at 2:59 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. DON-B indicated the facility's initial investigation was completed within 24 hours. The facility determined there was no abuse/neglect so the allegation was not reported. Surveyor informed NHA-A and DON-B that all allegations should be reported to the SA and the facility's investigation should be submitted with their 5-day report. Surveyor also informed (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NHA-A and DON-B that some of the investigatory interviews were completed after the 24-hour window and the date of resolution was listed as 4/1/26.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure care was provided in accordance with physician orders for 1 resident (R) (R2) of 4 sampled residents. R2's hospital discharge summary contained follow-up instructions for a right upper quadrant (RUQ) and left internal/external biliary drain to be flushed with 10 milliliters (ml) of saline twice daily. R2's medical record contained orders for a biliary drain and did not accurately reflect the orders. In addition, orders from an after visit summary on 5/4/26 indicated R2's biliary tube was attached to a bag after a tube exchange and the physician would tell them when to remove the bag and cap the drain. The orders were not transcribed into R2's medical record, were not clarified, and were not implemented. Findings include: The facility's Transcribing Physician Orders policy indicates: To ensure complete and accurate follow through on practitioners' orders .All orders transcribed by the Health Unit Coordinator (HUC), Medication Assistant, or Nurse Extern/trained designee must be checked and co-signed by a licensed nurse .Key Steps: 1. Check order against current practitioner's order to avoid conflicting orders .5. Send copy/notify appropriate departments of new orders .6. Check off completed order with first initial, last name, and title. 7. Nurse transcribing or co-signing to document in progress note. R2 was admitted to the facility on [DATE] with diagnoses including biliary acute pancreatitis and intraoperative complications of digestive system resulting in two drains being placed in their abdomen. R2's Minimum Data Set (MDS) assessment, dated 5/28/26, stated R2's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating intact cognition. R2 was discharged home on 6/1/26.A hospital Discharge summary, dated [DATE], included the following instructions:~ Drain Follow-up:~ Faculty Owner: Medical Doctor (MD)-G~ Location: Right Upper Quadrant (RUQ)~ Drain Type: 12 Fr (French, size) to gravity bag~ Drain Placed By: (unknown initials)~ Drain Maintenance: Flush drain with 10 ml normal saline (NS) twice daily (BID)~ Faculty Owner: MD-G~ Drain Location: Left internal/external biliary drain~ Drain Type: 10.2 Fr to gravity bag~ Drain Placed By: Interventional Radiology (IR)~ Drain Maintenance: Flush drain with 10 ml NS BID~ Discharge instructions: Drain care: Continue drain care as instructed. Monitor and record drain output and bring the information to clinic follow-up: 0.9% sodium chloride (NaCl) syringe administer 10 ml once daily. Flush biliary drain once daily with 10 ml saline. (Of note: This instruction indicated to flush once daily versus the instruction above to flush BID).R2's Treatment Administration Record (TAR) included the following orders:~ Flushing biliary drain: Flush drain with 10 mls of NS BID for biliary drain maintenance (started: 3/21/26; discontinued: 4/10/26) ~ Biliary drain: Document output every shift (started: 3/21/26; discontinued 4/21/26)~ Biliary drain dressing change: Gauze dressing to be changed every other day or as needed if it becomes soiled. Use split gauze and secure with tape. It is okay to clean insertion site with NS and mild soap and water. Once daily (started: 3/22/26; discontinued: 4/21/26)~ Flushing biliary drains: Flush drains with 10 mls of 0.9% NS BID (started: 4/10/26; discontinued: 4/21/26) ~ Flushing both biliary drains: Flush drains with 10 mls NS BID (started: 4/22/26; discontinued 4/28/26)~ Document drain output each shift three times daily (TID) (started 4/23/26; discontinued 5/8/26)~ Flushing both biliary drains: Flush drains with 10 mls of 0.9% NS BID (started: 4/28/26; discontinued 4/29/26)~ Flushing both biliary drains: Flush drains with 10 mls of 0.9% NS BID. Flush the drains slowly. This will avoid abdominal pressure and the inability to breathe. BID (started 4/29/26; discontinued 5/4/26)~ Flushing biliary drain: Flush drain with 10 mls of 0.9% NS daily. Flush the drains slowly. This will avoid abdominal pressure and the inability to breathe. Once daily (started 5/5/26, discontinued: 5/26/26)~ Change dressing to biliary drain site/removal site once daily every 3 days (started: 5/7/26; discontinued 5/26/26)~ Empty drain bag each shift, document amount removed. TID (started: 5/7/26; discontinued 5/26/26)~ Biliary drain: Record drainage amounts each shift every shift (started: 5/26/26; discontinued 6/1/26)~ Flush biliary drain with 10 mls of 0.9% NS daily. Flush drain slowly. This will avoid abdominal pressure and the inability to breath. Once daily (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(started 5/27/26; discontinued 6/1/26)After comparing the discharge summary with R2's TAR, the following inconsistencies were identified:~ Two drains were identified in the discharge summary: RUQ 12 Fr to gravity bag and a left internal/external biliary 10.2 Fr to gravity bag. ~ One drain was identified on the TAR as a biliary drain to flush from 3/21/26 through 4/10/26. On 4/10/26, the order changed to flush both drains. A progress note on 4/6/26 indicated the biliary drains were flushed. (This was the first indicator in R2's progress notes and TAR that two drains were flushed.) ~ On 4/9/26, Advanced Practice Nurse Practitioner (APNP)-H ordered to continue to flush BOTH (upper case and underlined) drains daily with 10 mls of 0.9% NS each and record drain output daily. ~ The discharge summary stated both drains were attached to drainage. According to R2's TAR, staff documented drainage for the biliary drain. There was no documentation to indicate the facility contacted the discharging provider to clarify the discharge instructions which stated both drains were attached to drainage. ~ A progress note on 4/12/26 indicated the capped drain and the left drain with bag attached were flushed. (This was the first indicator in R2's progress notes or TAR that one of the drains was capped.) ~ Orders were entered in R2's TAR to change the biliary drain dressing from 3/22/26 through 4/21/26. Between 4/22/26 and 5/7/26, the TAR did not contain orders to change dressings for the drain(s). A progress note on 4/26/26 indicated both dressings were changed during a time dressing changes were not on R2's TAR. The next note on 5/8/26 indicated dressings were changed to BL (possible bilateral) biliary drains. The left drain site was crusty with no active drainage, redness or warmth, and there was 50 cubic centimeters (ccs) of green bile drainage from the bag. The left site was healed, no opening noted, slight pinkness with no drainage. ~ Two progress notes indicated two dressings were changed: A progress note on 3/22/26 indicated dressings to biliary drain remain (clean, dry, intact). A progress note on 4/16/26 indicated dressings were changed. ~ A progress note on 5/5/26 at 8:31 AM by Registered Nurse (RN)-F indicated R2 had a drain procedure on 5/4/26 and the right drain was removed. The center drain was replaced and had a drainage bag. A handwritten physician progress note, dated 3/30/26 and written by MD-G, indicated: IR to pull the capped drain if appropriate then record RUQ (biliary) drain output. Make follow-up appointment for MD-G to remove biliary drain when output less than 30 ccs per day for 2 days.MD-G signed handwritten orders on 3/30/26 that stated: .record daily intake/output from biliary drain daily; after capped drain removed, call to make an appointment with MD-G for biliary drain removal. MUST have intake/outputs recorded prior to removal. Will only pull when less than 30 ccs per day for 2 days.From 3/21/26 through 3/31/26, the daily drain output was documented between 7 mls and 35 mls. From 4/1/26 through 4/21/26, the daily drain output was documented between 1 ml and 150 mls. R2 was hospitalized from [DATE] through 4/22/26 for pneumonia. From 4/23/26 through 5/8/26, the daily drain output was documented between 0 ml and 645 mls: ~ 4/23/26: 10 mls (NOC shift)~ 4/24/26: 17.5 mls~ 4/25/26: 2 mls~ 4/26/26: 3.5 mls~ 4/27/26: 3 mls (AM and NOC shifts)~ 4/28/26 and 4/29/26: 0 ml~ 4/30/26: 20 mls~ 5/1/26: 10 mls (NOC shift)~ 5/2/26: 20 mls~ 5/3/26: 2 mls~ 5/4/26: 350 mls~ 5/5/26: 500 mls (AM and NOC shifts)~ 5/6/26: 575 mls (AM and NOC shifts)~ 5/7/26: 645 mls~ 5/8/26: 250 mls (This day had duplicate documentation on another order in the TAR. The amount is for the AM and PM shifts.)From 5/7/26 through 5/26/26, the daily drain output was documented between 150 mls and 900 mls: ~ 5/7/26: 500 mls (PM and NOC shifts)~ 5/8/26: 600 mls (This day had duplicate documentation on another order in the TAR. The amount is for the AM, PM, and NOC shifts.) ~ 5/9/26: 900 mls ~ 5/10/26: 850 mls~ 5/11/26: 450 mls (PM and NOC shifts)~ 5/12/26: 625 mls ~ 5/13/26: 750 mls~ 5/14/26: 330 mls (PM and NOC shifts)~ 5/15/26: 250 mls (AM and NOC shifts)~ 5/16/26: 250 mls ~ 5/17/26: 500 mls ~ 5/18/26: 425 mls (PM and NOC shifts)~ 5/19/26: 405 mls (PM and NOC shifts)~ 5/20/26: 300 mls (AM and NOC shifts)~ 5/21/26: 150 mls (AM shift; Went to hospital at 8:15 PM)R2 was hospitalized from [DATE] at approximately 8:15 PM through 5/26/26 at approximately 4:30 PM for a urinary tract infection (UTI), sepsis, and acidosis.From 5/26/26 through 6/1/26, the daily drain output was documented between 0 ml and 357.5 mls:~ 5/26/26: 5 mls (Returned from hospital at approximately 4:30 PM)~ 5/27/26: 20 mls~ (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/28/26: 10 mls (AM shift not documented)~ 5/29/26: 357.5 mls~ 5/30/26: 155 mls ~ 5/31/26: 0 ml~ 6/1/26: No documented drain output. (R2 discharged home.)The following progress notes indicate a change in condition for R2 prior to hospitalization on 5/21/26:A nurses' note on 5/17/26 at 7:42 PM indicated R2 had increased confusion and weakness. Vital signs were stable. There were no other symptoms or changes in condition noted. R2 was independent in their room with cares but was encouraged to call for help due to weakness. The on-call MD was updated and orderd a urinalysis (UA) with culture and sensitivity (C&S) and other labs.A nurses' note on 5/18/26 at 6:37 AM indicated the Nurse Practitioner (NP) was updated on R2's lab results. The NP ordered to hold Lasix and potassium for 1 day, and hold gabapentin for 1 dose.A nurses' note for physician communication on 5/21/26 at 10:18 PM indicated R2 had increased weakness, decreased appetite, overall decline, and a chole tube (in left abdomen) for pancreatitis. R2 also had a UTI and complicated gastrointestinal (GI) issues. R2 complained of nausea and feeling like they were hit by a bus. R2 declined to get out of bed, looked pale, and complained of body aches. R2 had been receiving antibiotics for over 48 hours, however, they continued to decline with increased drainage from the chole tube, blood pressure trending down, and heart rate trending up. R2 was transferred to the hospital to rule out sepsis.On 6/24/26 at 11:25 AM, Surveyor interviewed R2 who stated there were communication issues with orders the hospital had given the facility after R2 had one of two drains removed during a pre-scheduled procedure. R2 indicated staff continued to empty the drainage bag from the remainin drain 4 to 5 times per day, however, the drain was supposed to be capped after the procedure on 5/4/26. After R2 discharged from the facility and had a follow-up appointment, the radiologist informed R2 it was supposed to have stopped two weeks after the procedure. R2 stated it was disappointing. On 6/24/26 at 1:38 PM, Surveyor interviewed RN-C who completed discharge instructions with R2 and a family member on 6/1/26. RN-C stated R2 had one drain at the time of discharge but had two drains prior to that. RN-C educated R2 and their family member on how to flush and sanitize the port. RN-C stated nurses knew what to flush by reviewing the TAR. RN-C indicated R2 had one tube with sutures holding it in place and a bag attached to the tube. When RN-C flushed the tube, they detached the bag, sanitized, flushed, and reconnected the bag. RN-C stated they changed the dressing around the drain site every few days. RN-C did not recall any communication issues with the discharging hospital.On 6/24/26 at 2:44 PM, Surveyor interviewed Director of Nursing (DON)-B who reviewed R2's orders that did not differentiate the two separate drains for flushing, drainage amount, and dressing changes. R2's orders and medical record did not clearly define each drain. DON-B stated they would have RN-F (the manager for R2's unit) speak with Surveyor.On 6/24/26 at approximately 4:00 PM, Surveyor interviewed DON-B and Unit Manager RN-F. RN-F indicated if a HUC or Med Tech enters an order, a nurse double checks and signs off on the order; however, if a nurse enters an order, the order does not need to be double-checked. DON-B and RN-F could not provide evidence that both of R2's drains were flushed as ordered upon admission.On 6/24/26 at approximately 3:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who stated R2 had two drains when they were admitted . LPN-D stated initially only one of the drains was flushed then both drains were flushed twice daily. LPN-D stated when the flushes were done once daily, the AM shift completed the flushes. LPN-D stated R2 had one drainage bag and the other drain was capped. The capped drain was not being flushed until after a follow-up appointment. LPN-D could not recall dates. LPN-D stated when there is a new order, it is flagged for order entry and entered into the resident's medical record. If a nurse enters the order, another nurse does not have to double check the entry. Paper orders are put in a resident's paper chart after the nurse enters the orders and signs them. LPN-D did not recall any issues with R2's orders.On 6/25/26 at 2:29 PM, Surveyor interviewed Interventional Radiology (IR) RN-E who stated R2 and their family called the clinic on 6/5/26 and asked if 200 to 300 mls of fluid was normal to lose per day in the drainage bag. According to the IR notes, the provider stated the drainage bag should have been capped and not draining into a bag. The provider instructed the family to buy caps and cap the drain. RN-E stated they want to keep fluid from the drain in the body. RN-E stated the type of drain R2 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had is almost always capped so the fluid can be routed to the bowel. RN-E reviewed R2's IR clinic notes and indicated a provider note on 5/4/26 indicated to keep left biliary drain attached to drainage bag, cap in 24 hours, and return to the clinic in 3 weeks. An after visit summary, dated 5/4/26, included the directions: You will have your biliary tube attached to a bag after your exchange. Your doctor will tell you when to remove the bag and place a cap. Usually the next day. RN-E indicated R2 had a left internal/external biliary drain in place at the time of the interview. RN-E verified R2's notes indicated they should have only had a biliary drain at that time which should have been capped. RN-E stated it was rare to have a collection bag on that type of drain for the length of time that R2 did which was from 5/4/26 through 6/1/26 when they discharged from the facility.On 6/25/26 at 4:11 PM, Surveyor interviewed RN-F who provided additional pages of R2's 5/4/26 after visit summary that were not originally provided to Surveyor but were in R2's medical record. The additional pages contained a nursing note written by RN-F on 5/5/26 at 8:31 AM that indicated R2 was out of the facility on 5/4/26 for a drain procedure. The right (RUQ) drain was removed. The center drain (billiary drain) was replaced and had a drainage bag connected. RN-F verified they processed the after visit summary when R2 returned from the appointment on 5/4/26 and provided a copy of the first page to the HUC to schedule an appointment. RN-F put the after visit summary in R2's chart as flagged which meant the chart was standing up in the nurses' station with the after visit summary sticking out. RN-F did not know who processed or reviewed the after visit summary and verified R2's medical record did not contain orders or clarification related to contacting the provider or capping the drain. R2 continued to drain fluid into the drainage bag through discharge on [DATE].