STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525565	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Lake Manor	211 S Curtis St Lake Geneva, WI 53147

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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility did not ensure their abuse policy and procedure was implemented for 1 of 8 employees reviewed for 4-year background checks potentially affecting a portion of the 47 residents.Dietary Aide (DA)-P did not have an up to date background check completed within the four year time frame.Findings include:The facility policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program from (C)MED-PASS dated 2001 revised 4/2021 documents: 4. Conduct employee background checks and not knowingly employ or otherwise engage any individual who has: a. been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law .On 11/6/2025, Surveyor requested from Nursing Home Administrator (NHA)-A the personnel files for eight employees to review for the required background checks.DA-P was hired on 4/27/2021. The Background Information Disclosure (BID) form, the Department of Justice (DOJ) letter, and the Interagency Border Inspection System (IBIS) form were completed on 4/27/2021. Four years had lapsed since the background check information had been submitted. On 11/6/2025 at 2:15 PM, Surveyor shared with Director of Nursing (DON)-B DA-P's background check forms were completed upon hire on 4/27/2021 and need to be completed every four years so the background check should have been completed by 4/27/2025. DON-B stated DON-B would talk to Human Resources (HR) to see if there is a more recent background check.In an interview on 11/6/2025 at 2:30 PM, HR-O stated HR-O does the background checks for all employees. HR-O stated HR-O would check and see if there was a more recent background check for DA-P and if not, HR-O would complete the background check immediately.On 11/6/2025 at 2:55 PM, NHA-A brought Surveyor the background check forms for DA-P. Surveyor noted the background check forms were dated that day, 11/6/2025, and DA-P was also listed as being an Activity Aide. NHA-A confirmed DA-P worked as both a dietary aide and an activity aide. Surveyor shared with NHA-A the concern DA-P's background check was completed that day and not within the four year time frame. NHA-A agreed it should have been done earlier.

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) based on their comprehensive assessment for 1 (R1) of 3 residents reviewed.On 9/3/2025, R1 experienced a change of condition with increased lethargy, not wanting to eat, having a small emesis, and no bowel movement for three days. No documentation of an assessment by facility staff including vital signs, was found with the change of condition. No assessment or documentation was found from facility nursing staff of R1 having multiple emesis. No assessment or documentation was found from facility nursing staff indicating R1 had received medication to relieve constipation, what medication was administered, and the results from receiving the medication. No documentation was found from facility staff indicating R1 had a COVID-19 test administered on 9/03/2025 or the results of that test. R1 was seen by Nurse Practitioner (NP)-D on 9/3/2025 who referenced these details in their note and ordered lab work. R1's laboratory results with elevated white blood count of 19.9 were not reported to the NP or attending physician. No documentation was found indicating R1 was monitored each shift for a decline in condition; facility nursing staff did not assess or document vital signs, the general appearance of R1 and the overall health status of R1. On 9/4/2025, 911 was called and R1 was transferred to the hospital. R1 was admitted to the hospital with initial diagnoses of septic shock due to a urinary tract infection, acute hypoxic respiratory failure, and cardiogenic shock. No documentation was found in R1's record prior to R1 being transferred to the hospital of the circumstances as to why 911 needed to be activated for R1.The facility's failure to monitor and assess R1 while R1 was experiencing a change in condition created a finding of immediate jeopardy that began on 9/3/2025. Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the immediate jeopardy on 11/4/2025 at 3:26 PM. The immediate jeopardy was removed on 11/5/2025, however, the deficient practice continues at a scope and severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.Findings include:According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process:(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.(b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis.(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants.(d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis.According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider .(b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient .(e) Perform the following other acts when applicable:1. Assist with the collection of data.2. Assist with the development and revision of a nursing care plan.3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction.4. Participate with other health team members in meeting basic patient needs.R1 was admitted to the facility on [DATE] with diagnoses of Diabetes Mellitus, Parkinson's Disease, and Gastroesophageal Reflux Disease. R1's Quarterly Minimum Data Set (MDS) dated [DATE] documents R1 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 05. R1 required extensive to total assistance from staff with activities of daily living (ADLs) including toileting, dressing, and bathing. R1 had an activated Power of Attorney (POA).On 8/29/2025 at 1:57 PM, R1's vital signs were as follows: temperature 98.0 degrees, pulse 64, respirations 16, blood pressure 120/82, and oxygen saturation 97%.On 9/1/2025 at 8:25 PM in the progress notes, nursing documented R1's POA signed the fluoxetine (antidepressant Prozac) consent form on 8/29/2025.No documentation was found in R1's progress notes from 9/1/2025 until 9/3/2025.On 9/3/2025 on the food intake record, R1 had a decline of meal percentage eaten; for the three meals, R1 ate 26-50%. Normal intake for R1 ranged from 50-100%.R1's medical record includes a progress note e-signed as an imported record, dated 9/3/2025 at 8:42 PM from NP-D. The chief

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 2 (CNA-J, MT-E) of 3 nursing staff reviewed had appropriate competencies and skills sets to assure resident safety and respond to resident needs. This has the potential to affect a total of approximately 25 residents who currently reside in zone 2 and the rehab zone in which certified nursing assistant (CNA)-J and med tech (MT)-E are typically assigned. *CNA-J stated they assessed vitals for R1 while R1 was experiencing a change of condition without proof of competency to collect vitals and without a comprehensive assessment being performed by a registered nurse or monitoring by a licensed practical nurse (LPN)*MT-E did not have evidence of completing required pharmacy education for the last 3 calendar years and did not have evidence of certification to perform blood draws defined under State regulations.Findings include:The facility job description for job title certified nursing assistant documents the CNA will provide patient/resident care as required under the direct supervision of the licensed nurse . completes assigned tasks to ensure timely, efficient, and safe patient/resident care . ability to observe and report patient/resident status . provides direct patient/resident care and reports condition and changes to Registered Nurse (RN) or Licensed Practical Nurse (LPN) . The facility job description for job title certified nursing assistant/med tech documents under the supervision and direction of a licensed nurse, the medication assistant administrators (sic) and records select oral, nasal, transdermal and rectal, inhalant and ophthalmic scheduled medications to residents . trained to measure and record blood pressure, radial pulse, and blood glucose readings by way of a finger stick . must have successfully completed the State of Wisconsin Medication Assistant Training Program . must be a Certified Nursing Assistant in Wisconsin; in good standing . reports to nurse when coming on duty and going off duty . obtains assignments and specific directions from Unit Nurse or RN supervisor . knowledgeable of medication actions, medication effects on body systems and side effects, especially in the geriatric population . R1 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Parkinson's Disease and Gastroesophageal Reflux Disease. R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 6/30/25 documents R1 had a Brief Interview for Mental Status (BIMS) score of 05, indicating R1 had severe cognitive impairment related to daily decision making. R1 required extensive to total assistance from staff with activities of daily living (ADLS) including toileting, dressing and bathing. On 10/8/25, at 1:15 PM, a Surveyor conducted an interview with LPN-C via telephone. A Surveyor asked if LPN-C recalled any changes in R1's health status on 9/3/25. LPN-C recalled on 9/3/25 at approximately 1:15 PM it was reported by R1's family member to LPN-C that R1 had a small emesis (vomiting episode) and was experiencing increased fatigue and weakness. LPN-C notified Nurse Practitioner-D at this time regarding R1's small emesis and increased fatigue and weakness. Nurse Practitioner-D was at the facility at this time and assessed R1. LPN-C told a Surveyor a COVID-19 test was conducted for R1 at this time with a negative result. Nurse Practitioner-D gave orders to LPN-C for laboratory work for R1 including a Complete Blood Count (C.B.C.), Basic Metabolic Panel (B.M.P), Vitamin D level and Vitamin B-12 level. MT-E collected the blood samples from R1 at this time and faxed the facility's contracted laboratory to pick up R1's blood specimens. On 10/8/25, at 1:30 PM, a Surveyor conducted an interview with Agency LPN-H, who worked the night shift at the facility on 9/3/25 into the morning of 9/4/25. Agency LPN-H stated that prior to R1 going out to the hospital on the morning of 9/4/25, they did not recall R1 ever having any serious medical issues. A Surveyor asked Agency LPN-H if they had taken R1's vital signs or conducted any assessments of R1 on night shift 9/3/25 into 9/4/25. Agency LPN-H told a Surveyor they did not recall taking any vital signs or performing an assessment for R1.On 11/3/25, at 2:20 PM, Surveyor interviewed CNA-J who worked with R1 during the night shift on 9/3/25 into 9/4/25. CNA-J stated R1 was a night shift get up, and when CNA-J got R1 up, CNA-J noted R1 transferred onto the toilet normally with a Sara Steady transfer device but then could not get up from the toilet and was weaker than normal. CNA-J stated CNA-J kept R1 on the toilet, reported to the nurse on duty, and then obtained R1's vital signs. CNA-J stated CNA-J wrote the vital signs on a piece of paper and gave them to the NOC (night) shift nurse, Agency LPN-H. Surveyor reviewed R1's electronic medical record and did not locate any nursing assessments or vital signs documented on 9/3/25 or 9/4/25. On 11/3/25, at 3:18 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding the process for blood draws. NHA-A stated the facility does not have a phlebotomist and MT-E does all the blood draws for the facility. Surveyor requested evidence that MT-E is certified to perform blood draws. On 11/3/25, at 3:35 PM, NHA-A informed Surveyor