

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Geneva Lake Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision to prevent an elopement from occurring for 1 of 3 residents at risk for elopement out of a sample of 12 (R1). R1 has a history of elopement and is at risk of wandering. The facility failed to implement care planned interventions and failed to ensure exits were secured resulting in R1 being able to exit the facility through an exit door without staff knowledge. The facility's failure to supervise a resident and implement care planned interventions allowed R1 to elope from the facility. This created a finding of immediate jeopardy that began on 7/10/26. Surveyor notified Administrator, Director of Nursing (DON), Director of Operations, and the Chief Nursing Officer of the immediate jeopardy on 7/14/26 at 4:10 PM. The immediate jeopardy was removed and corrected on 7/10/26; the deficient practice is being cited as past noncompliance. Findings include: Review of the facility's policy titled, Elopements and Wandering Residents, dated 07/22/25, indicates .The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. R1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia with behavioral disturbance, and ground-level fall. The admission Minimum Data Set with an Assessment Reference Date of 06/30/26 revealed a Brief Interview for Mental Status score of 9 out of 15 indicating R1 was moderately cognitively impaired. R1 was assessed for exhibiting the behavior of inattention and disorganized thinking and wandering occurring daily. R1's Care Plan, dated 06/26/26, included a category of Wander Risk, Elopement Risk. I demonstrate movement behavior that may be interpreted as wandering, pacing, roaming, and/or elopement related to diagnosis of: Alzheimer's. I am unaware of my surroundings and often search for my spouse. I need gentle approach and redirection frequently. Approaches: Validate function of wander device (Code (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
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Alert) every 24 hours on day shift. One to one companion staff 24/7 to monitor resident whereabouts until determined that supervision can be reduced. (of note: R1 uses a walker as an assistive device) R1's Progress Notes, dated 07/10/26 at 7:58 AM, stated, Resident eloped at 6:30AM this morning. At 6:20AM writer was notified resident was not in his room. Writer is working on another zone and was receiving report. Writer then had staff check all rooms and bathrooms. As CNAs (Certified Nurse Assistants) were checking another resident notified [sic] that they saw resident going towards rehab exit door. Writer then had staff start to check outside the building. Writer then contacted Assistant Director of Nursing (ADON).then contacted 911. Writer gave description around 6:40AM of resident and where he was last seen. Staff continued to look for the resident. Resident found by law enforcement around 7:20AM. Resident brought back to facility. Resident had no injuries. On 07/14/26 at 10:36 AM, Surveyor spoke with RN1 (Registered Nurse), who was on duty at the time of R1's elopement. RN1 stated about 6:00 AM she had seen R1 awake and wandering near the men's locker room and time clock. RN1 stated she escorted R1 back to the common area. (Of note: RN1 escorted R1 back to the common area and did not provide 1:1, when he was to have 1:1 companion staff 24/7 to monitor resident's whereabouts. The CNA assigned to provide supervision, did not provide supervision to R1) Review of the facility-reported incident (FRI,) submitted on 07/10/26 at 9:12 PM, stated, The Administrator was informed at approximately 6:46 AM that resident (R1) was missing. Staff conducted a comprehensive search. R1's responsible party, attending physician, case worker, and local law enforcement were notified. R1 was found with no injury noted. Upon his return the resident was immediately assessed by licensed nursing staff, with no injuries noted, and was placed one-to-one supervision. Review of the facility's undated Timeline for R1 provided by the facility as part of their investigation revealed the following: -On 07/10/26 at 5:45 AM, CNA1 entered R1's room and observed him in bed. -At 6:05 AM, R1's assigned night shift nurse, RN1, last observed R1 walking near the men's locker room by the time clock. -At 6:25 AM, LA (Laundry Aide), a housekeeping staff member, reported seeing a resident walking eastbound outside the facility. -At 6:35 AM, RN2 discovered the resident was missing, searched the resident's room, and began asking staff if anyone had seen him. -Approximately 6:35 AM, Code [NAME] was initiated. Staff immediately began searching the interior and exterior of the facility. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	He stated as soon as he arrived at the facility, he started checking all exit doors and alarms. Mnt D stated he found that the rehabilitation unit exit door was programmed wrong, so the alarm would not have been activated. During an interview on 07/14/26 at 12:43 PM, the Laundry Aide (LA) stated she had gone out to the employee parking lot and was sitting in her vehicle around 6:00 AM -7:00 AM when she saw a man walking across the yard next to the road with a walker in street clothes walking on sidewalk. LA was asked why she had not reported seeing this man as soon as she re-entered the facility. LA stated she saw a lot of people out walking at that time and did not realize he was a facility resident. The facility's failure to supervise a resident who was to be on 1:1 supervision and failure to ensure all door alarms were working properly allowed R1 to elope from the facility. This created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The facility removed the immediate jeopardy and corrected the deficiency on 7/10/26 when it completed the following: Corrective Actions Resident was immediately assessed by a licensed physician following his return to the facility no in (no injury) The resident's responsible party, case worker, and attending physician were notified. A comprehensive investigation was conducted. Staff interviews were completed. PHQ-9 monitoring was initiated for 72 hours, as appropriate. A BIMS assessment was completed. The resident's elopement risk assessment was reviewed and updated. The resident's person-centered care plan was revised to reflect individualized behaviors, triggers, risks, and interventions. All residents identified as being at risk for wandering or elopement were audited. Wander Guard devices were verified for proper placement and functionality. Door alarm audits were completed on all shifts. Elopement drills were conducted on 7/10/26 and 7/13/26 Staff scheduling practices were reviewed and reinforced to ensure employees do not independently change assignments involving residents requiring continuous supervision without authorization from (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nursing leadership. Education was provided to all staff, including agency personnel, on :1. 1. Elopement and Wandering Resident Policy (reviewed/revised 7/10/26) 2. Door alarm procedures and response expectations 3. Resident-specific care plan updates 4. Appropriate interventions when a resident is observed outside the building or on facility grounds 5. Schedule expectations 6. Abuse Prevention and Reporting Policy 7. Expectations regarding one-to-one supervision assignments and the requirement that assigned safety interventions must not be altered without approval from nursing leadership 8. Staff were re-educated that they must never assume a resident belongs outside the facility or is visiting someone. Any resident observed outside the building or on facility grounds must be approached immediately, safely redirected back into the facility when appropriate, and reported to the charge nurse for assessment. 9. Ongoing monitoring through supervisory rounds and routine audits has been implemented. Ongoing monitoring of door alarms and Wander Guard functionality. Audits of implementation of care plan interventions for residents at risk of elopement. Ongoing education and competency validation for all staff, including agency personnel. Review audit findings during QAPI meetings and monitor for sustained compliance. Ongoing audits to verify the effectiveness of corrective actions and identify any additional opportunities for improvement. All interventions were verified as completed on 07/15/26 by 4:20 PM.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility did not complete a performance review of CNAs (Certified Nursing Assistants) at least every 12 months for 5 of 5 CNAs reviewed. This has the potential to affect all 45 residents.CNA3, CNA4, CNA5, CNA6, and CNA7 did not have a yearly performance review completed. This is evidenced by:The facility's policy Job Descriptions and Performance Evaluations, dated 9/20, includes: Performance evaluations measure the standards against job performance. The objectives of our job descriptions and performance evaluations are to: d. aid management in analyzing and improving the facility's services and structure of its organization; e.and to improve the quality of work performance; CNA3 has a hire date of 2/16/25. CNA3 does not have a yearly performance review completed in the last 12 months. CNA4 has a hire date of 9/21/09. CNA4 does not have a yearly performance review completed in the last 12 months.CNA5 has a hire date of 5/23/25. CNA5 does not have a yearly performance review completed in the last 12 months CNA6 has a hire date of 1/13/20. CNA6 does not have a yearly performance review completed in the last 12 months.CNA7 has a hire date of 12/31/97. CNA7 does not have a yearly performance review completed in the last 12 months.On 7/27/26 at 12:40 PM, Surveyor interviewed NHA A (Nursing Home Administrator). NHA A indicated the facility did not have yearly performance reviews for the CNAs. NHA A indicated the facility should have completed a yearly performance review for the CNAs but did not.		

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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 record review and interviews the facility failed to report an allegation of abuse to the state agency (SA) for one of three residents (R8) reviewed for abuse out of 12 sampled residents. R8 reported an allegation of abuse to the NHA (Nursing Home Administrator) this allegation was not reported to the state agency. Findings include: Review of the facility's policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 06/23/26, revealed The Administrator or designee will notify the appropriate agencies immediately: as soon as possible, but no later than 2 hours after discovery of the incident. Review of R8's undated Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab revealed R8 was admitted to the facility on [DATE] with a readmission on [DATE] with diagnoses including major depressive disorder, intellectual disabilities, and anxiety. Review of R8's five day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/21/26, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R8 was cognitively intact. Review of the facility's Incident Report dated 01/19/26 and provided by the facility, revealed This Administrator was notified of potential abuse allegation reported by [R8] on 01/19/26. The initial report indicated that the resident stated an employee, described as African American, tall, skinny and had pinched her on the upper arm on Tuesday 01/13/26. Further review of the facility's soft file on R8's incident report, provided by the facility, revealed that although the facility contacted the local police enforcement, and conducted a thorough investigation, the allegation of physical abuse was not reported to the State Agency. During an interview conducted with the current Administrator on 07/15/26 at 1:07 PM, the Administrator was questioned if R8's allegation of abuse should have been reported. Administrator stated Yes, I would have reported it.		