

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/20/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE  1016 Lakeshore Dr Rice Lake, WI 54868	
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 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.  (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview, record review, and facility document review and policy review, the facility failed to submit an initial report of an allegation of misappropriation to the state survey agency within 24 hours and failed to notify law enforcement for 1 (Resident #1) of 4 residents reviewed for misappropriation. Specifically, the facility failed to report an allegation of a missing wallet and identification cards for Resident #1 to the state agency within the required time for reporting and failed to notify the law enforcement of the allegation. Findings included: A facility policy titled, Abuse Prevention Policy, revised 11/04/2024, indicated, Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The policy also specified, 6. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the state agency. All reports will be investigated after reporting and finalized, then submitted to the State Agency within 5 working days. An admission Record revealed the facility admitted Resident #1 on 04/09/2024. According to the admission Record, Resident #1 had a medical history that included diagnoses of Alzheimer's disease, unspecified psychosis, and hallucinations. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/12/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderately impaired cognition. An email dated 09/02/2025 at 3:12 PM from Resident #1's Responsible Party (RP) to the Social Services Director (SSD) indicated that Resident #1's wallet and social security card were missing. The email revealed that the RP asked the SSD if these items were given to her. The email indicated Resident #1 had reported to family that people were going into rooms and taking stuff over the weekend. The email indicated that these documents were needed to complete insurance paperwork. A Monthly Grievance Log dated 09/2025 indicated a formal grievance was filed on behalf of Resident #1 on 09/03/2025 with a resolution for items to be replaced. The Monthly Grievance Log revealed the complainant was notified of the resolution on 09/11/2025. A Complaint/Grievance Report dated 09/11/2025 indicated the wallet had not been located. The report indicated Resident #1 had been interviewed and denied having a wallet at the facility stating an alternate family member had the wallet. The report indicated Resident #1's RP was notified during a care conference on 09/11/2025 that the wallet had not been located and the facility offered to assist with replacement of the resident's social security card and provided Resident #1's RP the needed social security number. An untitled handwritten document dated 09/03/2025 written by the SSD revealed an interview completed with Resident #1 on 09/03/2025 which Resident #1 denied having the wallet at the facility and indicated the resident identified a specific family member had the wallet and checkbook. An Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report was submitted to the state survey agency on 09/12/2025 at 5:25 PM by the Administrator (ADM). The report indicated that a family member had reported that Resident #1's wallet was missing. The report revealed the resident's family member had indicated there was no cash in the wallet, but there was a state identification card and social security card in the wallet. A Misconduct Incident Report submitted to the state survey agency on 9/19/2025 at 10:33 AM indicated the facility was notified that Resident #1 was missing a wallet that included a state identification card and a social security card. The report and investigation indicated that facility staff had searched for the wallet but had not located the wallet. The report indicated that law enforcement had not been contacted or involved. During an interview on 10/20/2025 at 1:58 PM, the SSD stated investigating allegations of abuse, neglect, or misappropriation was a group effort. The SSD stated that anything that could be reportable should be reported to the ADM and Director of Nursing (DON). During a follow-up interview on 10/20/2025 at 3:05 PM, the SSD stated if someone reported missing money she would report it as an allegation of misappropriation, but missing money is managed differently than other missing items that were not necessarily reportable. The SSD stated it was the ADM who determined if something was reportable. The SSD stated that Resident #1 was sometimes cognitively aware but became confused later in the day. During an interview on 10/20/2025 at 3:16 PM, the ADM confirmed that she was the Abuse Coordinator for the facility. The ADM stated that the SSD notified her of missing items. The ADM stated if it was clothing or candy or something that was easily replaceable she replaced these types of items. The ADM stated that if money was missing she reported it</p>		

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<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>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview, record review, and facility document and policy review, the facility failed to complete a thorough investigation for 1 (Resident #1) of 4 residents sampled for allegations of misappropriation. Specifically, the facility failed to conduct interviews and/or obtain statements from staff regarding Resident #1's missing wallet and identification cards. Findings included: A facility policy titled, Abuse Prevention Policy, revised 11/04/2024, indicated, Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The policy revealed, Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern, as a minimum: e. The development of investigative protocols governing resident abuse, theft/misappropriation of resident property, resident-to-resident abuse and resident-to-staff abuse; f. Timely and thorough investigations of all reports and allegations of abuse. An admission Record revealed the facility admitted Resident #1 on 04/09/2024. According to the admission Record, Resident #1 had a medical history that included diagnoses of Alzheimer's disease, unspecified psychosis, and hallucinations. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/12/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderately impaired cognition. An email dated 09/02/2025 at 3:12 PM from Resident #1's Responsible Party (RP) to the Social Services Director (SSD) indicated that Resident #1's wallet and social security card were missing. The email revealed that the RP asked the SSD if these items were given to her. 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An untitled handwritten document dated 09/03/2025 written by the SSD revealed an interview completed with Resident #1 on 09/03/2025 which Resident #1 denied having the wallet at the facility and indicated the resident identified a specific family member had the wallet and checkbook. An Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report was submitted to the state survey agency on 09/12/2025 at 5:25 PM by the Administrator (ADM). The report indicated that a family member had reported that Resident #1's wallet was missing. The report revealed the resident's family member had indicated there was no cash in the wallet, but there was a state identification card and social security card in the wallet. A Misconduct Incident Report submitted to the state survey agency on 09/19/2025 at 10:33 AM indicated the facility was notified that Resident #1 was missing a wallet on that included a state identification card and a social security card. The report and investigation indicated that facility staff had searched for the wallet but had not located the wallet. The investigation included interviewing Resident #1, searching for the wallet, and interviews with additional residents. Further review revealed no interviews with staff who cared for Resident #1 were included in the investigation report. During an interview on 10/20/2025 at 10:46 AM, Licensed Practical Nurse (LPN) E confirmed that she had worked with Resident #1. LPN E stated she was not aware of Resident #1 having a missing wallet. LPN E stated Resident #1 had not reported a missing wallet to her, and no one had asked her about a missing wallet. During an interview on 10/20/2025 at 11:00 AM, Certified Nurse Aide (CNA) A confirmed she had worked with Resident #1. CNA A stated she was not aware that Resident #1 had a missing wallet. CNA A stated that no one had asked her about a missing wallet. During an interview on 10/20/2025 at 11:03 AM, CNA B confirmed she had worked with Resident #1. CNA B stated she had never seen Resident #1 with a wallet, and Resident #1 had not reported a missing wallet to her. CNA B stated that no one had asked her about a missing wallet. During an interview on 10/20/2025 at 11:10 AM, CNA C confirmed that she had worked with Resident #1. CNA C stated Resident #1 had never complained about missing wallet. CNA C stated no one ever interviewed her about a missing wallet. During an interview on 10/20/2025 at 11:14 AM, Trained Medication Aide (TMA) D confirmed she had worked with Resident #1</p>		