STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Country Health Services	2195 North Summit Village Way Oconomowoc, WI 53066

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on record review and interviews, the facility failed to honor a resident's advanced directive of do not resuscitate for 1 (R1) of 4 residents reviewed for advanced directives and resident's rights. R1 has a State Do Not Resuscitate (DNR) form signed by R1's Power of Attorney (POA), and an active Medical Doctor (MD) order documenting DNR. On [DATE], R1 became unresponsive and was pulseless. Facility staff did not check R1's advanced directives before performing Cardiopulmonary Resuscitation (CPR) compressions on R1. R1's pulse returned. After receiving compressions, R1 complained of pain as high as 10 out of 10 and required an added MD order for Morphine to control R1's pain. The facility's failure to honor R1's DNR wishes led to facility staff completing chest compressions through the act of cardiopulmonary resuscitation (CPR) that caused R1 to be resuscitated, despite the formulation of an advanced directive to decline such measures and which led to R1 experiencing extreme pain post resuscitation. This situation created a finding of immediate jeopardy that began on [DATE]. Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Nurse Consultant-C, and [NAME] President of Success (VP)-D were notified of the immediate jeopardy on [DATE] at 2:36 PM. The immediate jeopardy was removed on [DATE]. The deficient practice continues at a scope and severity (s/s) of an E (potential for harm/pattern) as the facility continues to implement their action plan. Findings include: The facility policy titled, Cardiopulmonary Resuscitation (CPR) with a review date of [DATE], documents, in part: It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation (CPR) . The facility will follow current American Heart Association (AHA) guidelines regarding CPR. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and: a. In accordance with the resident's advance directives, or b. In the absence of advance directives or a Do Not Resuscitate order; and c. If the resident does not show obvious signs of clinical death . CPR certified staff will be available at all times. (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: 525702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1 was admitted to the facility on [DATE] with diagnoses that include Cerebrovascular disease, Dementia, Hypertension, Atrial Fibrillation, Pacemaker, and Type 2 Diabetes. R1's Significant change Minimum Data Set (MDS) assessment dated [DATE] documents that R1 is severely cognitively impaired and requires partial to moderate assist for toileting, mobility, and transfer. R1 has an activated Power of Attorney. Surveyor located multiple signed State DNR forms in R1's electronic medical record. The most recent State DNR form, signed by R1's POA, is dated [DATE]. R1's active MD order dated [DATE], documents: DNR. R1's Advanced Directive Care plan initiated [DATE] documents: Resident's advanced directive is: DNR. Goal: Resident's wishes will be honored. Pertinent Interventions include: Follow advanced directive per MD orders. Refer to MD orders for code status. Follow facility protocol for identification of code status . On [DATE] at 9:15 AM, R1's Physician Assistant (PA) documents in a progress note, in part: Updated by staff that patient was woken up early this morning to receive a shower. However following shower reported by staff that she has had significant increased fatigue and weakness from baseline including knocking over her utensils at breakfast and inability to feed herself, as well as slurred speech . Cares are discussed with POA regarding change in condition who is requesting no workup or ED evaluation, however request for hospice consult instead for comfort measures . goal of care remaining comfort only. R1's progress note dated [DATE] at 11:49 AM, documents in part: [R1] appeared to be weakened and coordination off. [R1] speech slightly slurred and not able to smile. [R1] able to move all extremities. Writer and PA . spoke with . POA who wants [R1] to be kept comfortable . POA agreed for hospice to evaluate for services. R1's Initial plan of care completed by the Hospice company, dated [DATE] documents, in part: Advanced Directives: Do Not Resuscitate . Surveyor noted R1 was started on hospice services on [DATE] with the goal of comfort measures. R1's Hospice Care plan dated [DATE], documents the following intervention: Honor advanced directives. R1's progress note dated [DATE] at 1:22 PM, documents in part: [R1] . coughing while eating and drinking. Appetite poor . Respiratory panel results are back and [R1 is] positive with Influenza A. Hospice nurse aware and new order to start Mucinex . R1's progress note dated [DATE] entered by R1's PA at 11:15 AM documents in part: [R1] has completed isolation precautions for recent influenza with resolution in symptoms noted. [R1] denies any further [upper respiratory symptoms], fevers/chills, shortness of breath or uncontrolled pain . (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:40 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E. LPN-E stated that LPN-E worked on [DATE]. LPN-E stated that LPN-E was very familiar with R1. LPN-E stated that R1 had returned to R1's baseline after the diagnosis of Influenza A and LPN-E did not have any concerns regarding R1 on [DATE]. Surveyor asked what R1's advanced directive status was. LPN-E stated that R1 was a DNR. LPN-E stated that LPN-E knew all her residents' code status. LPN-E stated that R1 wore a DNR bracelet on R1's left wrist all the time. Surveyor asked where a staff member would look for advanced directives/code status. LPN-E stated that LPN-E would look in the electronic medical record. LPN-E stated that code status is seen when you open a resident's chart. On [DATE] at 1:14 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-I. CNA-I stated that CNA-I cared for R1 on [DATE] starting at 6 AM. CNA-I stated that R1 was acting normal and per R1's usual. R1 ate normally and followed R1's normal routine. R1's progress note entered by Registered Nurse (RN)-F, dated [DATE] at 6:45 PM documents in part: Nurse called to resident's room by CNA who stated, Resident is not responding. CNA reports that [R1] was providing [bedtime] care when the resident became unresponsive. Upon entering the room and assessment, resident is slumped and limp in the wheelchair; unresponsive to verbal stimulation. Skin noted as cold and pale. Lips are blue-tinged and labored mouth breathing is noted. A weak pulse of 40 is noted to the internal carotid artery. Breathing is labored at 8 per minute. Vigorous sternal chest rub applied; ineffective. Jaw-chin [lift] applied; ineffective. CNA sent to get oxygen line and tank. Resident's condition declining quickly. Chest rise and fall is absent. Intermittent shallow breaths noted. Resident assessed for pulse to radial and the carotid artery - pulse is absent. This nurse is unable to ascertain the resident's code status at this time and situation. Resident lowered to the floor. Upon assessment, pulse is still absent - CPR initiated. CPR effective. Oxygen at 2 [liters per minute] provided for support. [Vital signs] [temperature] 97.3, [pulse] 79, [blood pressure] ,d+[DATE], [respiratory rate] 20, [Oxygen saturation] 98%, [Blood sugar] 331 . The express decision of [R1's POA] as follows: The resident to remain in the facility and NOT be sent out [for] evaluation and treatment. [Hospice staff] to see the resident tonight. Surveyor noted, RN-F initiated CPR without checking for R1's code status. R1's Hospice nurse note with a visit date of [DATE], documents, in part: Call received through triage that patient had become unresponsive, become pulseless, and CPR was initiated despite DNR status . [Patient] was experiencing a significant change in [R1's] level of pain. [R1] was rating pain at 7 out of 10 to R1's chest wall and ribs. [R1] stated that it was painful to take a deep breath . Morphine (a narcotic pain medication) and Lorazepam (an anti-anxiety medication) orders obtained . Surveyor noted R1 had a pain rating of 7 out of 10 and is now requiring a narcotic pain medication to control pain. R1's MD orders entered on [DATE] include the following: -Morphine Sulfate oral solution 100 milligrams(mg)/5 milliliters(ml). Give 0.25 ml by mouth every 2 hours as needed for pain; pain-moderate; pain-severe. -Lorazepam oral tablet 0.5mg by mouth every 4 hours as needed for anxiety, agitation or restlessness. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Complete and document a skin assessment every shift for 3 days. Every shift check skin for bruising injury. R1's progress note dated [DATE] at 12:03 AM documents in part: . CPR was done to [R1] on prior shift, [R1] [complains of] pain to chest/ribs 10 [out of] 10. R1's progress note dated [DATE] at 1:50 AM documents in part: . The current status is resident [complains of] pain ,d+[DATE] to [R1's] chest. [As needed] Morphine . given . Surveyor noted R1 had two pain assessments completed after R1 received compressions and in both assessments, R1 rated pain 10 out of 10. R1's progress note dated [DATE] at 3:18 AM documents, in part: . Resident [complains of] pain to chest/ribs. R1's progress note dated [DATE] at 5:03 AM documents, in part: [R1] continues to [complain of] pain to [R1's] chest/ribs, sleeping with hands folded on her breasts. Noted increased pain with movement. [As needed medications] utilized and effective. R1's progress note dated [DATE] at 10:15 AM, R1's PA documents in part: . Updated by staff that . [R1] was found to be unresponsive with no pulse and deterioration in respirations. CPR was initiated and [R1] received 16 compressions, which [R1] was revived following . Code status confirmed as DNR and Director of Nursing reports education will be carried out to staff as well as continued close monitoring of [R1] ongoing. [R1] currently states that [R1] has a headache and [R1's] back is sore. [R1] is requesting medication for pain . R1's progress note dated [DATE] at 11:55 AM, documents in part: . [R1] complaining of pain and discomfort, given [as needed] Morphine . R1's progress note dated [DATE] at 3:11 PM, documents in part: The current status is [R1] complained of pain of back and chest . R1's progress note dated [DATE] at 1:40 AM, documents in part: . Denies pain at rest. Facial grimacing and moaning out present with repositioning. [As needed Morphine] given prior to cares . R1's progress note dated [DATE] at 9:27 AM, documents in part: Resident is on follow up for chest compressions performed causing some pain and discomfort. R1's progress note dated [DATE] at 11:09 AM, documents in part: Writer reached to [Nurse Practitioner] and hospice for new orders for STAT [chest x-ray] post injury per family request and possible scheduled pain meds for pain medication. Resident has received [as needed Morphine every 2] hours since ,d+[DATE]. Resident in extreme pain and mobility has decreased . Surveyor noted the facility documented that R1 is in extreme pain. R1's progress note dated [DATE] at 4:12 PM documents in part: X-ray results negative for fracture. R1's progress note dated [DATE] at 5:58 AM documents: Pain to chest/ribs. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's progress note dated [DATE] at 11:15 AM, R1's PA documents in part: . Updated by staff that family requested chest x-ray following recent compressions due to resulting pain. Chest x-ray results are reported as negative. Continues on hospice for comfort measures. R1's MD order entered on [DATE] documents: Morphine Sulfate oral solution 20mg/5ml. Give 0.5ml by mouth every 2 hours for pain. Surveyor noted that R1's Morphine was changed to a scheduled medication to be given every 2 hours instead of every 2 hours as needed. R1's progress note dated [DATE] at 1:42 AM documents in part: Resident is on follow up for monitoring [status post] CPR done on [DATE] PM shift. The current status is [vital signs stable]. Scheduled Morphine given as ordered. Noted [positive] pain indicators continue . Surveyor noted that R1's scheduled medications were discontinued on [DATE] at 9:38 PM. R1 continued to receive scheduled Morphine. Surveyor noted R1's health continued to decline. R1's progress note dated [DATE] at 8:18 AM documents: resident is actively dying. Surveyor reviewed R1's Resident Controlled Substance records for Morphine Sulfate (Concentrate) Oral Solution. On [DATE], Licensed Practical Nurse (LPN)-M documented: Date: [DATE], Time: 1600, Amount Given: 0.25 . On [DATE], LPN-M documented: Date: [DATE], Time: 1800, Amount Given: 0.25 . On [DATE], LPN-M documented: Date: [DATE], Time: 2000, Amount Given: 0.25 . On [DATE], LPN-M documented: Date: [DATE], Time: 2200, Amount Given: 0.25 . Surveyor noted on [DATE], on the evening shift, that R1 did not receive the correct dosage of scheduled morphine for 4 consecutive doses. Surveyor noted R1 was given 0.25ml instead of 0.5ml of Morphine for these 4 doses. Facility staff administered half of the prescribed dosage. (Cross-reference F760). On [DATE] at 12:00 PM, Surveyor requested to speak with LPN-M to conduct an interview. Director of Nursing (DON)-B informed Surveyor that LPN-M was no longer employed at facility. R1's progress note dated [DATE] at 6:40 documents in part: [R1] passed away at approximately 6:30 AM . (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:32 PM, Surveyor interviewed RN-F who gave R1 compressions on [DATE]. RN-F stated that RN-F was alerted by a CNA that R1 was unresponsive. RN-F stated that when RN-F entered R1's room, RN-F noticed that R1 was in distress. RN-F stated that R1 had a pulse at that time. RN-F sent the CNA to retrieve oxygen. RN-F stated that RN-F did not have a phone or any other help, so RN-F had to determine if R1 was a DNR or not. RN-F stated in order to find that information, RN-F would need to leave the room and go to a computer. RN-F stated that R1 was experiencing a rapid decline and RN-F had to decide to follow protocol or stay with R1 and work with the information that RN-F had at hand. RN-F stated RN-F could not establish DNR status, so RN-F used RN-F's nursing judgement and decided to start CPR. RN-F stated that R1 was eased to the floor and R1 did not have a pulse. RN-F stated RN-F completed between 12 and 15 compressions with a good response. Surveyor asked if R1 was wearing a DNR bracelet. RN-F stated that RN-F did not notice a bracelet before administering compressions but was alerted to the bracelet after the fact. RN-F stated that it was unfortunate that RN-F did not see the bracelet prior to administering compressions. Surveyor asked if RN-F had received training on codes, CPR, or how to get help in determining code status. RN-F stated that RN-F is CPR certified but does not recall receiving training from the facility on codes. RN-F stated that there is not a process for calling a code. RN-F stated that there is not a portable phone that you can call other nurses. RN-F stated that the only way to determine code status is to leave the resident alone and RN-F did not feel comfortable leaving R1 since R1 was experiencing a rapid change of condition. Surveyor asked if R1 was in pain after the incident. RN-F stated that R1 complained of chest pain with movement after the compressions were given. On [DATE] at 1:14 PM, Surveyor interviewed CNA-I. CNA-I stated that CNA-I stated that CNA-I was doing rounds on [DATE] when CNA-I passed R1's room. CNA-I stated that CNA-I saw R1 on the floor and the nurse (RN-F) was assessing R1. CNA-I stated that RN-F told CNA-I to get a sling to help get R1 off the floor. CNA-I indicated that CNA-I did not see RN-F giving compressions to R1. CNA-I stated that R1 was responsive by the time CNA-I passed R1's room. Surveyor asked if R1 complained of any pain after the incident on [DATE]. CNA-I stated that R1 complained of chest pain. Surveyor asked how long the pain lasted. CNA-I stated that the pain lasted until R1 passed away. CNA-I stated that R1 would say that it hurts with any cares. On [DATE] at 1:25 PM, Surveyor interviewed Anonymous staff-G. Anonymous staff-G stated that Anonymous staff-G was working on a different unit the night of [DATE]. Anonymous staff-G stated that another staff member alerted Anonymous staff-G that a resident was unresponsive. Anonymous staff-G rushed to R1's room and noted that R1 was on the floor and RN-F was with R1. Anonymous staff-G stated that Anonymous staff-G saw R1's DNR bracelet on R1's wrist. Anonymous staff-G stated that Anonymous staff-G helped with whatever was needed and then returned to Anonymous staff-G's unit. Surveyor asked if R1 complained of pain. Anonymous staff-G stated that R1 was complaining of pain in R1's chest and back. Surveyor asked where a staff member would find code/DNR status. Anonymous staff-G stated that it is in the electronic medical record and R1 had it on R1's wrist. Anonymous staff stated R1 was only to have comfort measures in place and should not have received compressions. Anonymous staff-G stated, The whole thing was crazy. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:04 PM, Surveyor interviewed NHA-A and DON-B. NHA-A stated that the facility identified the concerns that RN-F gave compressions to R1 against R1's wishes. NHA-A stated the facility has educated current staff members on checking for code status before starting CPR, the CPR policy, and the Change of Condition policy. The facility completed audits on all residents' code status to ensure the correct documents are in place, the orders are in the medical record, and the code status appears in the ribbon within the electronic medical record. In addition, NHA-A stated that the facility did a care plan audit that was completed today to assure that advanced directives were correct in all residents' care plans. The facility has been completing Code drills because of this incident. DON-B stated that they are completing one minute management, where management will interview random staff to assure, they are aware of the process and retaining the education that is being completed. NHA-A stated that RN-F was pulled from the floor and suspended after the incident. Before returning to work RN-F will receive further education. Surveyor asked if wearing a DNR bracelet is part of a facility policy. DON-B stated that they do not require residents to wear a DNR bracelet. DON-B stated that a resident can choose to wear a bracelet, and the facility will add an intervention to the resident's care plan. Surveyor asked if R1 was wearing a DNR bracelet. DON-B stated that DON-B saw the DNR bracelet on R1 on [DATE]. Surveyor asked if the bracelet was an intervention on R1's care plan. DON-B stated that DON-B would look to see if the DNR bracelet was in R1's care plan. On [DATE] at 2:55 PM, NHA-A returned to Surveyor with a past non-compliance folder. NHA-A indicated again that the facility identified the concern of CPR being completed on a resident who is a DNR. NHA-A stated that the facility recognized that no resident would want CPR if it were not following their wishes. The facility wanted to focus on the concern so that it does not happen again. On [DATE] at 9:45 AM, Surveyor interviewed NHA-A and DON-B. Surveyor asked if RN-F received training on the code process. NHA-A and DON-B stated that RN-F is CPR certified. NHA-A stated that the topic is covered in new hire orientation and is briefly gone over during nurse-to-nurse training in orientation. NHA-A stated that the Maintenance Director will take new employees on a facility tour to ensure that new staff know where the code carts and AEDs are located. NHA-A confirmed that RN-F did complete new hire orientation. Surveyor asked what the expectation is for staff who are alone, and a resident goes unresponsive. DON-B stated that staff should yell for help, if unable to get help, the staff member should go to computer to check for code status. DON-B stated that code status is also covered in nurse-to-nurse report at the beginning of the staff's shift. Surveyor asked if the DNR bracelet being worn by R1 was in R1's care plan. DON-B stated that it is not in the care plan. (Cross-reference F678). NHA-A provided a power point slide from the new hire orientation presentation. Surveyor reviewed the facility's new hire orientation slide titled, CPR. The slide contains the following bullet points: Licensed staff must maintain current CPR certification through CPR training that includes hands-on practice and in-person skills assessment . Center clinicians are certified in [Basic life support]-[CPR] through programs approved . Each center requires the placement and use of an [AED]. Discuss and show where AED is located. Center staff must participate in Code Drills throughout the year. Surveyor noted the specifics and step by step instructions of a code are not included on the CPR slide presented at new-hire orientation. Surveyor noted that where to find advanced directives/DNR status is not included on the CPR slide. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action Plan to prevent Recurrence: [Primary Care Physician], Hospice MD, and POA notified. Hospice in person visit. Skin eval. Pain eval. [Change of Condition] evaluation with [vital signs], Nursing evaluation. Morphine as needed ordered. Identification of other potentially affected residents and action: Current facility residents have the potential to be affected. Current residents will be reviewed for code status orders/documentation. Code status verified on PCC ribbon banner. CP plans are updated appropriately. Systemic measures to prevent reoccurrence: Reeducation to licensed nurses on need to verify code status prior to initiating CPR. If DNR-do not initiate CPR. If full code, initiate CPR and activate 911. Performance effectiveness and monitoring: DON/designee will conduct Code drills. Will be completed on each shift weekly for 4 weeks. Interviews of 5 nurses per week will be conducted x 4 weeks on various shift using case studies and what if scenarios to validate understanding and expectations required during a code situation. Scenarios will include situations where [resident] is a DNR, and others will be scenario where resident is a full code. Results of the above audits will be brought to the [Quality Assurance and Performance Improvement (QAPI)] . QAPI committee met on [DATE] to review above plan. Dated ,d+[DATE]-Ongoing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Lake Country Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 North Summit Village Way Oconomowoc, WI 53066	

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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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on observations, interview and record review, the facility failed to have a policy and procedure in place to ensure the code status of residents, as indicated in their advanced directives, was followed. This affected 1 (R1) of 1 residents reviewed for Cardiopulmonary Resuscitation. The facility's phone paging system, which is used to alert all staff of a code blue, was observed not working during survey. The facility's portable phones, which can also be used to alert all staff of a code blue, were not functional on all the units within the facility. The facility's overhead speaker system has not been functional for years. This deficient practice has the potential to effect 27 out of 82 residents who have designated to have full code status (designated to receive cardiopulmonary resuscitation [CPR]) in the facility. *The facility does not have a Code Blue policy and procedure. *R1 has a signed State DNR form, and an active MD order documenting DNR. On [DATE], R1 became unresponsive and was pulseless. Facility staff did not check R1's advanced directives prior to starting Cardiopulmonary Resuscitation (CPR) compressions on R1. R1 received compressions against R1's wishes. *The facility has a phone paging system which is used to call a code blue. Surveyor observed the phone paging system not working while on Survey. *The facility has portable phones that are to be always carried by nursing staff on each of the 4 units at the facility. These phones can also be used to call a code blue if the nurse is in a resident's room alone. While on survey, 2 units (100-unit and 300-unit) had a functional portable phone that could be used to alert and send a code blue page. The 400-unit's phone was just replaced and charging at the time of survey. The 200-unit's phone was missing. Staff expressed concern that reception for the portable phones is poor and unreliable. *The facility's overhead paging system has not been functional for years. Findings include: *On [DATE] at 7:20 AM, Director of Nursing (DON)-B informed Surveyor that the facility does not have a code blue policy. DON-B provided Surveyor with the facility CPR policy and CPR Drill document that is used to direct staff on code procedure. Surveyor was also provided a document used to help aid staff during a CPR drill. This document is titled, Code Blue response and responsibilities. Facility Policy & Procedure: (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled, Cardiopulmonary Resuscitation (CPR) with a review date of [DATE], documents, in part: It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation (CPR) . The facility will follow current American Heart Association (AHA) guidelines regarding CPR. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and: a. In accordance with the resident's advance directives, or b. In the absence of advance directives or a Do Not Resuscitate order; and c. If the resident does not show obvious signs of clinical death . CPR certified staff will be available at all times. The undated facility document titled, CPR DRILL documents, in part: Initial Responder: Non-nurse: check for responsiveness. Call for help, or I need a nurse STAT. Nurse: Verify that the scene is safe . Check responsiveness. Check for breathing/pulse for 10 seconds . Check airway . Was the chart checked for code status . Did the first responder call a code blue with location or delegate this task? (This should be an overhead page, may use phone in room if applicable.) Was the emergency response system activated immediately/911 called? . (If alone-discussion [regarding]: how to call 911 (use room phone, cell phone, provide initial 2 rounds of CPR then run to call for help, etc). Was the crash cart and [Automated External Defibrillator (AED)] brought to the scene . Was CPR initiated per code status? (Did the chart read full code or DNR) . The undated facility document titled, Code Blue Response and Responsibilities documents, in part: You are the staff member that enters the room and finds a resident unresponsive: What do you do? -As a CNA or non-nursing staff . Call for help and alert nurse immediately. -As the nurse . 1. Check safety of the scene. 2. Check resident responsiveness, pulse, breathing for 10 seconds. 3. Open airway if necessary. If no pulse or respirations: Initiate emergency response system: Yell for help from staff, may pull call light, call out CODE BLUE loudly. When other staff respond, start to delegate. You are in charge of the code. Delegate to confirm code status, bring crash cart and AED immediately, activate emergency response 911 immediately, overhead page CODE BLUE (if phone in room may use phone to page and call 911). (If no response from staff/alone, may leave resident and call 911, check code status, call code, retrieve AED) . Surveyor noted the CPR Drill document, and the Code Blue Response and Responsibilities document indicates that code status should be checked before compressions are started. Surveyor noted the documents state that an overhead page should be used to call a code blue. Surveyor noted that in the CPR Drill document, if a staff member is alone, the staff member should call 911 from the room phone/cell phone, provide initial 2 rounds of CPR then run to call for help. Surveyor noted that in the Code Blue Response and Responsibilities document, if a staff member is alone, the staff member may leave the resident and call 911, check code status, call code and retrieve AED. Surveyor noted a discrepancy in the facility documents as to what staff should do if they are alone when a resident is unresponsive. On [DATE] at 1:38 PM, NHA-A wanted to provide clarity to the Surveyor regarding the facility document titled, Code Blue Response and Responsibilities. NHA-A indicated that education was recently completed regarding codes and code status. The facility CPR policy and Change of Condition Policy were used as the official education. The Code Blue Response and Responsibilities document was not used to educate staff, it was an education piece. NHA-A stated that the document is used as a guideline and helps to ask the probing questions. NHA-A confirmed that the facility does not have a policy regarding code blue. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1 example: *R1 was admitted to the facility on [DATE] with diagnosis that include Cerebrovascular disease, Dementia, Hypertension, Atrial Fibrillation, Pacemaker, and Type 2 Diabetes. R1's Significant change Minimum Data Set (MDS) assessment dated [DATE] documents that R1 severely cognitively impaired and requires partial to moderate assist for toileting, mobility and transfer. R1's has an activated Power of Attorney (POA). Surveyor located multiple signed State DNR forms in R1's electronic medical record. The most recent State DNR form, signed by R1's POA is dated [DATE]. R1's active MD order dated [DATE] documents: DNR. R1's Advanced Directive Care plan initiated [DATE] documents: Resident's advanced directive is: DNR. Goal: Resident's wishes will be honored. Pertinent Interventions include: Follow advanced directive per MD orders. Refer to Md orders for code status. Follow facility protocol for identification of code status . Surveyor noted R1 was started on hospice services on [DATE] with the goal of comfort measures. R1's Hospice Care plan dated [DATE], documents the following intervention: Honor advanced directives. R1's progress note entered by Registered Nurse (RN)- F, dated [DATE] at 6:45 PM documents, in part: : Nurse called to resident's room by CNA who stated, Resident is not responding. CNA reports that [R1] was providing [bedtime] care when the resident became unresponsive. Upon entering the room and assessment, resident is slumped and limp in the wheelchair; unresponsive to verbal stimulation. Skin noted as cold and pale. Lips are blue-tinged and labored mouth breathing is noted. A weak pulse of 40 is noted to the internal carotid artery. Breathing is labored at 8 per minute. Vigorous sternal chest rub applied; ineffective. Jaw-chin [lift] applied; ineffective. CNA sent to get oxygen line and tank. Resident's condition declining quickly. Chest rise and fall is absent. Intermittent shallow breaths noted. Resident assessed for pulse to radial and the carotid artery - pulse is absent. This nurse is unable to ascertain the resident's code status at this time and situation. Resident lowered to the floor. Upon assessment, pulse is still absent - CPR initiated. CPR effective. Oxygen at 2 [liters per minute] provided for support. [Vital signs] [temperature] 97.3, [pulse] 79, [blood pressure] ,d+[DATE], [respiratory rate] 20, [Oxygen saturation] 98%, [Blood sugar] 331. Surveyor noted, RN-F initiated CPR without checking for R1's code status. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:32 PM, Surveyor interviewed RN-F who gave R1 compressions on [DATE]. RN-F stated that RN-F was alerted by a CNA that R1 was unresponsive. RN-F stated that when RN-F entered R1's room, RN-F noticed that R1 was in distress. RN-F stated that R1 had a pulse at that time. RN-F sent the CNA to retrieve oxygen. RN-F stated that RN-F did not have a phone or any other help, so RN-F had to determine if R1 was a DNR or not. RN-F stated in order to find that information, RN-F would need to leave the room and go to a computer. RN-F stated that R1 was experiencing a rapid decline and RN-F had to decide to follow protocol or stay with R1 and work with the information that RN-F had at hand. RN-F stated RN-F could not establish DNR status, so RN-F used RN-F's nursing judgement and decided to start CPR. RN-F stated that R1 was eased to the floor and R1 did not have a pulse. RN-F stated RN-F completed between 12 and 15 compressions with a good response. Surveyor asked if R1 was wearing a DNR bracelet. RN-F stated that RN-F did not notice a bracelet before administering compressions but was alerted to the bracelet after the fact. RN-F stated that it was unfortunate that RN-F did not see the bracelet prior to administering compressions. Surveyor asked if RN-F had received training on codes, CPR or how to get help in determining code status. RN-F stated that RN-F is CPR certified but does not recall receiving training from the facility on codes. RN-F stated that there is not a process for calling a code. RN-F stated that there is not a portable phone that you can call other nurses. RN-F stated that the only way to determine code status is to leave the resident alone and RN-F did not feel comfortable leaving R1 since R1 was experiencing a rapid change of condition. Surveyor asked if R1 was in pain after the incident. RN-F stated that R1 complained of chest pain with movement after the compressions were given. On [DATE] at 11:40 AM, Surveyor interviewed LPN-E. LPN-E stated that LPN-E knew R1 very well. Surveyor asked what R1's advanced directive status was. LPN-E stated that R1 was a DNR. LPN-E stated that LPN-E knew all her resident's code status. LPN-E stated that R1 wore a DNR bracelet on R1's left wrist all the time. Surveyor asked where a staff member would look for advanced directives/code status. LPN-E stated that LPN-E would look in the electronic medical record. LPN-E stated that code status is seen when you open a resident's chart. On [DATE] at 2:04 PM, Surveyor interviewed NHA-A and DON-B. NHA-A stated that the facility identified the concerns that RN-F gave compressions to R1 against R1's wishes. NHA-A stated the facility has educated current staff members on checking for code status before starting CPR, the CPR policy and the Change of condition policy. The facility completed audits on all resident's code status to ensure the correct documents are in place, the orders are in the medical record and the code status appears in the ribbon within the electronic medical record. In addition, NHA-A stated that the facility did a care plan audit that was completed today to assure that advanced directives were correct in all resident's care plans. The facility has been completing Code drills because of this incident. DON-B stated that they are completing one minute management, where management will interview random staff to assure, they are aware of the process and retain the education that is being completed. Surveyor asked if wearing a DNR bracelet is part of a facility policy. DON-B stated that they do not require residents to wear a DNR bracelet. DON-B stated that a resident can choose to wear a bracelet, and the facility will add an intervention to the resident's care plan. Surveyor asked if R1 was wearing a DNR bracelet. DON-B stated that DON-B saw the DNR bracelet on R1 on [DATE]. Surveyor asked if the bracelet was an intervention on R1's care plan. DON-B stated that DON-B would look to see if the DNR bracelet was in R1's care plan. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:45 AM, Surveyor interviewed NHA-A and DON-B. Surveyor asked if RN-F received training on the code process. NHA-A and DON-B stated that RN-F is CPR certified. NHA-A stated that the topic is covered in new hire orientation and is briefly gone over during nurse-to-nurse training in orientation. NHA-A stated that the Maintenance Director will take new employees on a facility tour to ensure that new staff know where the code carts and AEDs are located. NHA-A confirmed that RN-F did complete new hire orientation. Surveyor asked what the expectation is for staff who are alone, and a resident goes unresponsive. DON-B stated that staff should yell for help, if unable to get help, the staff member should go to a computer to check for code status. DON-B stated that code status is also covered in nurse-to-nurse report at the beginning of the staff's shift. Surveyor asked if the DNR bracelet being worn by R1 was in R1's care plan. DON-B stated that it is not in the care plan. *PHONE PAGING system and PORTABLE PHONE interviews and observations: On [DATE] at 9:45 AM, Surveyor interviewed NHA-A and DON-B. Surveyor asked how the phone paging system works. NHA-a and DON-B indicated that a staff member can go to phone at the nurse's station or on a portable phone, dial 5000 and say CODE BLUE. The page will be transmitted to all 4 of the nurse's station phones within the facility. NHA-A stated that this is not an overhead page, that this page only goes to the nurse's station phones. NHA-A and DON-B stated that the page can be heard by any staff on the unit. NHA-A stated that the portable phones available on each unit and are kept on the nurse's medication cart. NHA-A stated that the phones are available for staff to carry, and they should be carrying them. NHA-A stated that it is expected that nurses carry the portable phones especially on the weekends. Surveyor asked if there was a reason that the portable phones are not mentioned on any of the documents provided (CPR policy, CODE Drill document and the Code blue response and responsibilities). NHA-A stated it is not on the Code blue response and responsibilities, but staff should be aware of the expectation to carry the portable phone. DON-B stated that education had recently been completed to direct staff to clarify the expectations that staff should make sure that the portable phones are always carried. On [DATE] at 10:15 AM, Surveyor interviewed LPN-E. Surveyor asked LPN-E if each unit has a portable phone for nursing staff usage. LPN-E responded that they are aware of a portable phone on the 300 unit but that they do not utilize the portable phone. LPN-E elaborated that the portable phone on the 300 unit doesn't work well and that the portable phone reception is poor and unreliable. LPN-E told Surveyor that they rely on the telephone at the 300-nursing station desk to communicate with staff, doctors or resident family members. LPN-E added that they keep their medication cart close to the 300-nursing station desk so that they can hear the phone and readily access it. On [DATE] at 12:25 PM, Surveyor asked NHA-A and DON-B if they were aware of staff stating that reception is poor and unreliable. NHA-A and DON-B stated that they had never heard that. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:30 PM, Surveyor asked for a demonstration of the phone paging system. DON-B walked Surveyor to the 400 unit. DON-B walked down the hallway to the 300-unit nurse's station to test the paging system. Surveyor did not hear a page come through the phone system on the 400-unit. DON-B returned to Surveyor at 12:32 PM. Surveyor informed DON-B that a page was not heard. DON-B stated that DON-B did not think that DON-B was doing it right. DON-B walked back down the hallway to the 300-unit nurse's station. Surveyor did not hear a page come through on the 400-unit. DON-B returned to the 400-unit at 12:34 PM. Surveyor informed DON-B a page was not heard. DON-B stated that everyone could hear throughout the 3 other units and DON-B did not know why the page was not coming through to the 400-unit. DON-B adjusted the volume on the 400-unit phone and turned the volume up. DON-B walked back down the hallway to the 300-unit at 12:35 PM. Surveyor did not hear a page come through on the 400-unit. At, 12:36 PM, DON-B returned to the 400-unit. DON-B asked if the page was effective. Surveyor informed DON-B that a page was not heard. DON-B informed Surveyor that DON-B was going to send a page through the 400-unit phone. DON-B picked up the 400-unit phone, dialed 5000 and stated, test ., test ., test . DON-B and Surveyor walked down the hallway to the 300-unit. Surveyor noted 2 staff members sitting at the nurse's station. At 12:37 PM, DON-B asked the two staff members at the desk if the page that was just sent was heard. Both staff members stated, No. At 12:38 PM, DON-B stated that the staff member at the front desk was going to send a test page to all unit phones. Surveyor did not hear a page come through the 300-unit. NHA-A walked toward the 300-unit and asked if a page was heard. DON-B stated No. DON-B spoke to the front desk staff by telephone and asked if a page was sent. Surveyor heard that a page was sent from the front desk staff. DON-B stated that a code drill was conducted yesterday, and the phone paging system was working fine. DON-B indicated that DON-B was confident that this would be easy to demonstrate. DON-B mentioned that there could be a do not disturb function on the phone and could contribute to not hearing the testing page. DON-B examined the 300-unit nurse's station phone to see if the do not disturb function was on. At 12:42, Maintenance director (MD)-L arrived on the 300-unit to help trouble shoot. DON-B restarted the 300-unit phone. DON-B stated that DON-B was going to go to a different unit to see if the page is going through. Surveyor stayed in the 300-unit waiting for a test page to come through. At 12:53 PM, Surveyor heard the test page come through the 300-unit phone. Surveyor noted that the observation of the phone paging system was started at 12:30 PM and the first page that Surveyor heard was at 12:53 PM, 23 minutes later. Surveyor noted that volume was adjusted on phones. Surveyor noted that a phone was restarted. Surveyor noted that DON-B mentioned a do not disturb function on the phones. Surveyor noted that multiple things could play a part in a page going through or not going through the phone system. On [DATE] at 12:55 PM, Surveyor asked that DON-B demonstrate how a portable phone page will come through to the nurse's unit phones. DON-B borrowed LPN-E's portable phone and sent a test page. Surveyor heard test ., test ., test Come through the unit phone on the 300-unit. Surveyor asked that DON-B go to the end of the hallway and send a page. At 12:56 PM, DON-B went to the end of the hallway. Surveyor heard DON-B's voice stating test ., test ., test but did not hear the page come through to the unit phone. Assistant Director of Nursing (ADON)-K was standing at the 300-unit nurse's station and stated, check the signal. DON-B returned to Surveyor and stated I think I did it wrong. DON-B then went back down the hallway and sent another test page which was heard by Surveyor. Surveyor noted that either there was a signal problem or DON-B did not send the page the same way DON-B had sent a page to be heard at the 300-unit nurse's station a minute prior. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:50 PM, ADON-B provided the portable phone education that was completed with staff. ADON-B stated that education was completed on [DATE] through [DATE] and covered that portable phones are to be carried by the nurses. Surveyor asked if every unit had a portable phone. ADON-B stated that the 100-unit and the 300-unit have phones. The 400-unit just got a portable phone today and it is being charged. ADON-B stated the 200-unit does not have a portable phone. ADON-B indicated that the 100-unit and 200-unit were sharing a phone at this time. Surveyor noted that if a code were to take place on the 200 or 400 unit at this moment, the nurse would not have the option of a portable phone to call a code. Surveyor reviewed the education provided about portable phones. The training log/In-service sheet is titled, lunch and learn dated [DATE]. The education documents, in part: . Phone use: Portable phones are 100 and 300 unit. Nurses, please carry the phone and respond to calls to ensure we are responding to [Nurse Practitioner/Primary Care Physician] and family calls. No personal phones are to be used . Surveyor noted that the education does not mention that these portable phones could be used to call a code. On [DATE] at 1:38 PM, Surveyor interviewed NHA-A. NHA-A informed Surveyor that the facility completed a factory reset on the phone system and it is up and running now. Surveyor asked about the portable phones not being available on all units. NHA-A stated the facility now has 3 phones that are working. NHA-A stated that the 200-unit had a phone once upon a time. NHA-A stated that they are looking for the 200-unit phone. NHA-A indicated that the 200-unit is a short hallway and is close enough to the 100-unit in the case of an emergency. *OVERHEAD paging system interviews: On [DATE] at 12:42 PM, Surveyor was informed by MD-L that the facility's main overhead paging system is not working. On [DATE] at 1:00 PM, Surveyor interviewed MD-L. Surveyor asked how long the overhead paging system has not worked. MD-L stated, I don't know. Surveyor asked if it had been down days, weeks, months, or years. MD-L stated months. MD-L stated that a while ago MD-L was conducting a fire drill and that is when MD-L noted that the overhead paging system no longer worked. MD-L stated that MD-L arranged for someone to come look at the overhead paging system on Friday of this week. On [DATE] at 1:38 PM, NHA-A informed Surveyor that the old system for overhead paging has not worked for a long time. NHA-A stated it was an intercom system, but it is not functional and is not part of the process for calling a code. NHA-A indicated that the phone system is to be used for calling a code. NHA-A stated that the overhead intercom system is not part of the code blue process outlined by the facility. On [DATE] at 2:36 PM, NHA-A stated that the overhead paging system has not worked for years. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor noted that the facility has an additional method of an overhead page that could be heard from all areas of the building, but the overhead intercom paging system does not currently work. Surveyor noted that an overhead intercom paging system would not require volume adjustments and would not have a do not disturb function like the phone paging system. On [DATE] at 2:36 PM, NHA-A, DON-B, Regional Nurse Consultant-C and [NAME] President of Success-D were informed of the following concerns: The facility does not have a Code Blue policy to direct staff step-by-step in the case of a resident going unresponsive. R1 was given CPR compressions against R1's wishes. The phone paging system, which is used to call a code, was observed to not be working properly. Surveyor started observation at 12:30 PM and the first test page was not heard until 12:53 PM. The portable phones, which can also be used to call a code, were not available on all 4 units of the facility. Staff member reported the portable phone reception is poor and unreliable. The overhead paging system is not functional and has not been functional for years.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on interview and record review the Facility did not ensure 1 (R1) of 4 residents were free from significant medication errors. *On [DATE], R1 was prescribed scheduled morphine due to severe chest and back pain. On [DATE], R1 was not administered the full dosage of their scheduled morphine for four consecutive opportunities. Findings include: R1 was admitted to the facility on [DATE] with diagnoses that include Cerebrovascular disease, Dementia, Hypertension, Atrial Fibrillation, Pacemaker, and Type 2 Diabetes. R1's Significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documents that R1 is severely cognitively impaired and requires partial to moderate assist for toileting, mobility and transfer. Surveyor reviewed R1's closed medical record including progress notes, Electronic Medication Administration Record (EMAR), physicians orders and comprehensive care plans. Surveyor noted R1 was started on hospice services on [DATE] with the goal of comfort measures due to multiple non-responsive episodes and overall decline. R1's Advanced Directive Care plan initiated [DATE] documents: Resident's advanced directive is: DNR. Goal: Resident's wishes will be honored. Pertinent Interventions include: Follow advanced directive per MD orders. Refer to Md orders for code status. Follow facility protocol for identification of code status . R1's Hospice Care plan dated [DATE], documented: Honor advanced directives. R1's progress note entered by Registered Nurse (RN)- F, dated [DATE] at 6:45 PM documents: .Nurse called to resident's room by CNA who stated, Resident is not responding. CNA reports that [R1] was providing [bedtime] care when the resident became unresponsive. Upon entering the room and assessment, resident is slumped and limp in the wheelchair; unresponsive to verbal stimulation. Skin noted as cold and pale. Lips are blue-tinged and labored mouth breathing is noted. A weak pulse of 40 is noted to the internal carotid artery. Breathing is labored at 8 per minute. Vigorous sternal chest rub applied; ineffective. Jaw-chin [lift] applied; ineffective. CNA sent to get oxygen line and tank. Resident's condition declining quickly. Chest rise and fall is absent. Intermittent shallow breaths noted. Resident assessed for pulse to radial and the carotid artery - pulse is absent. This nurse is unable to ascertain the resident's code status at this time and situation. Resident lowered to the floor. Upon assessment, pulse is still absent - CPR (cardiopulmonary resuscitation) initiated. CPR effective. Oxygen at 2 [liters per minute] provided for support. [Vital signs] [temperature] 97.3, [pulse] 79, [blood pressure] ,d+[DATE], [respiratory rate] 20, [Oxygen saturation] 98%, [Blood sugar] 331. Surveyor noted, RN-F initiated CPR without checking for R1's code status. R1 was not to receive any life saving measures due to DNR status and wish for no hospitalization s. (Cross-reference F578). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Lake Country Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 North Summit Village Way Oconomowoc, WI 53066	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R1's Pain level scale scorings from [DATE]-[DATE]. On [DATE] Evening shift, Surveyor noted R1's Pain level score to be ,d+[DATE]. On [DATE] Night shift, Surveyor noted R1's Pain level score to be ,d+[DATE]. On [DATE] Evening shift, Surveyor noted R1's Pain level score to be ,d+[DATE]. On [DATE] Night shift, Surveyor noted R1's Pain level score to be ,d+[DATE]. On [DATE] day shift, Surveyor noted R1's Pain level score to be ,d+[DATE]. On [DATE] Evening shift, Surveyor noted R1's Pain level score to be , d+[DATE]. On [DATE] Night shift, Surveyor noted R1's Pain level score to be ,d+[DATE]. On [DATE] day shift, Surveyor noted R1's Pain level score to be ,d+[DATE]. On [DATE] Night shift, Surveyor noted R1's Pain level score to be ,d+[DATE]. Surveyor reviewed R1's Physician orders. On [DATE] an order was obtained for Morphine Sulfate (Concentrate) Oral Solution, 100 mg/5 mL (mililiters), give 0.25 mL by mouth every 2 hours as needed for Pain: Pain-moderate: Pain-severe, Shortness of Breath. On [DATE] an order was obtained for Morphine Sulfate (Concentrate) Oral Solution, 100 mg/5 mL (mililiters), give 0.5 mL by mouth every 2 hours for Pain. Surveyor reviewed R1's Resident Controlled Substance records for Morphine Sulfate (Concentrate) Oral Solution. On [DATE] Licensed Practical Nurse (LPN)-M documented: Date: [DATE], Time: 1600, Amount Given: 0.25 . On [DATE] LPN-M documented: Date: [DATE], Time: 1800, Amount Given: 0.25 . On [DATE] LPN-M documented: Date: [DATE], Time: 2000, Amount Given: 0.25 . On [DATE] LPN-M documented: Date: [DATE], Time: 2200, Amount Given: 0.25 . On [DATE] at 12:00 PM, Surveyor requested to speak with LPN-M to conduct an interview. Director of Nursing (DON)-B informed Surveyor that LPN-M was no longer employed at facility. On [DATE] at 1:45 PM, Surveyor Conducted interview with DON-B. DON-B provided Surveyor with a Summary regarding a medication variance for R1 on [DATE]. DON-B told Surveyor that on [DATE] they had looked at R1's Morphine Sulfate orders, Resident Controlled Substance records, and assessed the opened Morphine Sulfate bottle. DON-B told Surveyor that it was discovered on [DATE] Evening shift that LPN-M had administered Morphine Sulfate 0.25 mL four times on [DATE]. DON-B told Surveyor that this was an medication variance due to R1 not receiving the correct dosage of scheduled Morphine Sulfate 0.5 mL every 2 hours as scheduled. On [DATE] at 2:30 PM, Surveyor met with Nursing Home Administrator (NHA), DON-B, Regional Nurse Consultant-C and VP of Success-D. Surveyor shared concerns related to LPN-M not providing the correct dosage of R1's scheduled Morphine Sulfate to R1 for 4 consecutive doses on [DATE] in which LPN-M administered only half of the prescribed dosage for each administration. The facility did not provide any additional information to Surveyor at this time.