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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 08/25/2026, Surveyor conducted a complaint investigation, verification visit, and self-report review at Lake Tomah Center. Data collection continued through 09/11/2026. Two of the 4 complaints were substantiated. Four deficiencies were identified. Two of the 4 deficiencies were repeat violations; see Statement of Deficiencies (SOD) 5MN311, dated 12/10/2024, 5MN312, dated 05/28/2026, and 5MN313, dated 04/23/2026. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 35	{N 000}		
{N 169}	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify Resident 1's physician when they had an incident or change in condition.	{N 169}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{N 169}	Continued From page 1	{N 169}		

Resident 1 reported to staff 1 unwitnessed fall and 1 unwitnessed seizure; the provider did not notify Resident 1's physician of these incidents.

This is a repeat deficiency. See Statement of Deficiency (SOD) 5MN313, dated 04/23/2026.

Findings include:

On 08/25/2026, Surveyor reviewed Resident 1's records.

Resident 1 was admitted to the facility on 01/02/2026. S/he did not have a legal representative.

Staff documented the following incident reports in August 2026 for Resident 1:

08/11/2026 - "Resident came to staff and reported that [s/he] went to go stand up from [his/her] chair in [his/her] room and went to reach for [his/her] walker and stood up a little bit and then said [s/he] fell back into [his/her] chair." The incident report indicated Resident 1's physician was not notified about the incident.

08/17/2026 - "Resident said [s/he] had been feeling funny all day and then came out and said [s/he] has had multiple seizures. Staff did not witness a seizure. [S/He] shared that [s/he] felt fine and did not want to go in, just wanted to tell staff. Staff took [his/her] blood pressure and it was 149/82." The incident report indicated Resident 1's physician was not notified about the incident.

On 08/25/2026 at 12:39 PM, Surveyor interviewed Resident 1. Resident 1 stated s/he

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{N 169}	Continued From page 2 recently had a fall and hit his/her head hard. Resident 1 stated s/he was unsure if staff notified his/her primary physician about the incident and commented s/he had to get a new physician this week. On 09/02/2026 at 9:00 AM, Surveyor interviewed Executive Director (ED) B and Director of Nursing (DON) C. ED B stated s/he did not see documentation in Resident 1's record to confirm his/her physician was notified of these incidents and would send any further documentation if found by the end of the day. DON C stated they were currently gathering physician fax numbers and providing staff with training for falls that included a new checklist. DON C stated with the new falls training, it was expected staff notify a resident's physician and care team keeping the fax confirmation in for the resident's record. The provider did not immediately notify Resident 1's physician when s/he self-reported a fall on 08/11/2026 and self-reported a seizure on 08/17/2026.	{N 169}		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their	N 389		

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N 389	Continued From page 3 involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not update individualized service plans (ISP) when there was a change in the residents needs and abilities as well as the program services, frequency and approaches. Findings include: On 08/25/2026, Surveyor reviewed Resident 1's and Resident 2's records. Resident 1 Resident 1 was admitted to the facility on 01/02/2026. S/he did not have a legal representative. Resident 1 had multiple diagnoses that included mild cognitive impairment, epilepsy, other abnormalities of gait and mobility, repeated falls, weakness, syncope and collapse, and fracture of unspecified part of neck of right femur. Staff documented the following incident reports in August 2026 for Resident 1: 08/11/2026 - "Resident came to staff and reported that [s/he] went to go stand up from [his/her] chair in [his/her] room and went to reach for [his/her] walker and stood up a little bit and then said [s/he] fell back into [his/her] chair." The incident report indicated Resident 1's physician was not notified about the incident. 08/17/2026 - "Resident said [s/he] had been feeling funny all day and then came out and said	N 389		

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[s/he] has had multiple seizures. Staff did not witness a seizure. [S/He] shared that [s/he] felt fine and did not want to go in, just wanted to tell staff. Staff took [his/her] blood pressure and it was 149/82." The incident report indicated Resident 1's physician was not notified about the incident.

08/25/2026 - "Resident fell trying to set [his/her] plate down. Lost balance and fell on [his/her] side onto [his/her] ribs into a chair onto the floor. [S/He] said [s/he] did not want to go in and [s/he] feels fine. At about 9pm [sic], [Resident 1] had a hard time moving due to pain and [his/her] face was starting to swell on the left side. [Resident 1] stated the side of [his/her] head hit when [s/he] fell. A transporter took [him/her] to ER (emergency room) ...[Resident 1] is back from the ER and the diagnosis was Accidental [sic] fall initial encounter, and Closed [sic] injury initial encounter."

Resident 1's ISP, last updated on 07/10/2026, read in part under physical disabilities, "Resident's Needs/Preferences:
It is suspected that resident has seizures and is epileptic so [s/he] requires 24/7 awake staff. At the previous placement, [s/he] has gotten up in the night to use the bathroom and had a seizure on the toilet.
Resident's desired Goals & Outcomes:
Service Provider Responsibilities:
Document and report to IDT (interdisciplinary team) and PCP (primary care physician) when resident has a seizure." The ISP did not list Resident 1's desired Goals & Outcomes related to seizures and was not updated after Resident 1's self-reported seizure on 08/17/2026.

The ISP read in part under fall risk,

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"Resident's Needs/Preferences:
Resident has been identified as a fall risk.
Resident's desired Goals & Outcomes:
To be free from falls.
Service Provider Responsibilities:
Keep room free of trip hazards, remind resident to use walker as needed. Report any changes to IDT and PCP." The ISP was not updated after Resident 1's self-reported fall on 08/11/2026.

On 08/25/2026 at 12:39 PM, Surveyor interviewed Resident 1. Resident 1 stated s/he had a seizure approximately 2 weeks ago that lasted all day. Resident 1 stated it was a stronger seizure that scared him/her, so s/he told staff about it. Resident 1 stated s/he had seizures often and they caused him/her to stare at people. Resident 1 stated s/he recently had a fall and hit his/her head hard due to losing his/her balance while putting clothes away. Resident 1 stated s/he did not want to be medically evaluated.

On 08/25/2026 at approximately 2:30 PM, Surveyor interviewed Administrator A and Executive Director (ED) B. Administrator A stated staff had not witnessed Resident 1 having a seizure and his/her previous facility did not know what they looked like. Administrator A stated staff had also not witnessed Resident 1's falls. Administrator A indicated staff's responsibilities if a resident was having a seizure where making sure the resident was safe, help lowering them to the ground, and give an emergency medication is ordered. Administrator A stated this would be individualized for each resident depending upon the type of seizures they had.

On 08/25/2026 at 4:25 PM, Surveyor interviewed Caregiver F. Caregiver F confirmed Resident 1 self-reported an unwitnessed seizure last week.

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N 389	Continued From page 6 Caregiver F stated if a resident were to have a seizure s/he would contact his/her manager, take the resident's vital signs, let the resident's guardian know, and fill out an incident report. On 09/02/2026 at 9:00AM, Surveyor interviewed ED B and Director of Nursing (DON) C. DON C stated s/he was in the process of updating all resident ISPs in the facility and had not gotten to Resident 1's yet. DON C stated if Resident 1 reported a seizure, staff were to take his/her vital signs, ask if s/he wanted to be assessed, and assure safety. DON C stated they had no formal policy and procedure for resident seizures. ED B and DON C agreed Resident 1's ISP should have more specific interventions and guidance related to Resident 1's seizures. Resident 2 Resident 2 was admitted to the facility on 07/19/2022. S/he did not have a legal representative. Resident 2 had multiple diagnoses that included Parkinson's disease, drug induced subacute dyskinesia, and periodic limb movement disorder. Staff documented incident reports from 03/20/2026 to 07/16/2026 that Resident 2 had approximately 11 falls and multiple near falls. Staff documented multiple injuries with 4 falls resulting in emergency room (ER) visits. An incident report on 06/03/2026, read in part, "The resident was at the dinner table when [s/he] tried to move [his/her] wheelchair but, instead of going in reverse, [s/he] went forward at full speed into the table. This caused the resident sitting across from [him/her] to be pinned under the table. [S/He] continued moving forward after being asked to stop. [Resident 2] then shifted into	N 389		

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N 389	Continued From page 7 reverse and left the dining area." An incident report indicated on 07/17/2026, Resident 2 had an unwitnessed fall in his/her bathroom. Resident 2 had put his/her call light on at 12:44 AM and staff found him/her laying on the bathroom floor. Resident 2 was not medically evaluated. An incident reported indicated on 07/17/2026 at 10:37 AM, Resident 2 was sent in to be medically evaluated for confusion and being unable to bear weight on his/her lower extremities. Resident 2's ISP was last reviewed by Resident 2 and his/her care team on 07/18/2025. Under chronic illnesses, the ISP did not indicate Resident 2's diagnosis Parkinson's disease or the service provider's responsibilities. The ISP indicated Resident 2 required full assistance from staff for ambulation and that s/he always used a powered wheelchair to get around the facility. Under mobility status, the ISP did not indicate the service provider's responsibilities. The ISP indicated Resident 2 was very unsteady and would benefit from having staff near when s/he transferred. Under transferring assistance, The ISP did not indicate the service provider's responsibilities. The ISP indicated Resident 2 was a fall risk but did not indicate the service provider's responsibilities or any interventions to prevent falls. Surveyor was given an updated ISP for Resident 2 dated 07/17/2026 with a note that read, "ISP was updated & then [s/he] did not return, so no signatures on it." On 08/25/2026 at 11:09 AM, Surveyor interviewed Administrator A. Administrator A stated Resident	N 389		

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N 389	Continued From page 8 2 was independently ambulatory when s/he was first admitted and by his/her discharge s/he required 2 staff assistance. On 08/25/2026 at 11:48 AM, Surveyor interviewed Caregiver D and Caregiver E. Caregiver E stated Resident 2 was having a lot of falls prior to his/her discharge and had been refusing staff assistance. Caregiver E stated Resident 2 had safety concerns with his/her powered wheelchair after an incident where s/he lost control and pushed a table into another resident. Caregiver E stated Resident 2 was unable to use the powered wheelchair until occupational therapy (OT) did an evaluation. On 09/02/2026 at 9:00AM, Surveyor interviewed ED B and DON C. DON C stated s/he was in the process of updating all resident ISPs in the facility. DON C stated Resident 2 was refusing help from staff with ambulation and transfers and prior to his/her discharge they had just implemented staff to use a gait belt. DON C agreed Resident 2's ISP was not comprehensive to his/her care needs and should have been updated after each fall.	N 389		
{N 432}	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs.	{N 432}		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not provide medication administration appropriate to the resident's needs for Resident 3 and Resident 4.

This deficiency is being cited for the third time. See Statement of Deficiency (SOD) 5MN311, dated 12/10/2024, SOD 5MN312, dated 05/28/2025, SOD 5MN313, dated 04/23/2026.

Findings include:

On 05/15/2026 and 06/15/2026, the Department received complaints regarding medication concerns.

On 08/25/2026, Surveyor reviewed Resident 3's and Resident 4's records.

Resident 3
Resident 3 was admitted on 05/21/2026 and was his/her own decision maker. The Individual Service Plan (ISP) dated 06/19/2026, indicated staff managed and administered Resident 3's medications.

Surveyor reviewed Resident 3's May and June 2026 Medication Administration Records (MARs) and found the following:

For Xifaxan 550 mg, staff had notations indicating the medication was not available on 05/22/2026, 05/24/2026, 05/25/2026, and 05/26/2026. On 05/27/2026, the MAR indicated this medication

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{N 432}	Continued From page 10 was put on hold. For the M-Natal Plus tablet, staff had notations indicating the medication was not available on 05/22/2026, 05/23/2026, 05/24/2026, 05/25/2026, 05/27/2026, 05/29/2026, 05/30/2026, and 05/31/2026. The June 2026 MAR indicated Resident 3 received his/her first dose of M-Natal Plus on 06/02/2026. For Baclofen 10 mg tablet, staff had notations indicating the medication was not available on 05/30/2026, 05/31/20260, and 6/01/2026. The June 2026 MAR indicated Resident 3 received his/her first dose of Baclofen on 06/02/2026. For Vitamin D3 soft gel pill, staff had notations indicating the medication was not available on most of the days from 05/31/2026 through 06/25/2026, when it was put on hold. Staff charting indicated on 06/14/2026, 06/19/2026, and 06/20/2026 indicated the medication was given on those days. On 06/10/2026 staff charted the medication as refused by Resident 3 and on 06/15/2026 and 06/22/2026 staff charted "WF", which per the charting code meant Resident 3 was with family. For Lactulose 10 gm/10 ml solution, staff had notations indicating the medication was not available on 06/16/2026 for the 4:00 PM dose and on 06/17/2026 and 06/18/2026 for the 8:00 AM dose. On 08/25/2026 at approximately 2:30 PM, Surveyor interviewed Administrator A and Executive Director (ED) B. Administrator A explained managed care organizations (MCOs) no longer covered resident vitamins upon admission. Administrator A stated residents were	{N 432}		

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expected to pay the pharmacy bill for their vitamins. Administrator A stated they had been having continuous trouble trying to get Resident 3's Xifaxan. Administrator A stated it was their policy and procedure to not admit a resident until they had their medications in the facility from the pharmacy. Administrator A stated s/he did Resident 3's admission and the previous provider sent Resident 3's medication bubble packs with him/her. Administrator A stated the bubble packs were sent to their pharmacy to repackage and not all the medications that they received matched what Resident 3 had ordered upon admission.

On 08/25/2026 at 4:28 PM, Surveyor attempted to interview Resident 3, but there was no answer at his/her door.

On 09/02/2026 at 9:00AM, Surveyor interviewed ED B and Director of Nursing (DON) C. DON C indicated Resident 3 was an emergency admission. DON C indicated Resident 3's Xifaxan was a self-pay medication from Canada and was not available since admission. DON C and ED B reviewed Resident 3's MAR and were not sure why multiple medications for Resident 3 were not available upon admission.

On 09/02/2026 at 2:37 PM, Surveyor received an email from Care Manager (CM) G. CM G's email read in part, "One medication of concern was Rifaximin (Xifaxan), which was not covered by the member's insurance. The member had been privately paying for the medication through a supplier in Canada, and an R&B waiver was approved to assist with providing member enough funds to cover it. It has since been reported that the supplier is no longer able to provide the medication. As a result, the member was advised to contact her GI provider to discuss alternative

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{N 432}	Continued From page 12 options and resources to get the medication. As the medication is no longer being purchased, the R&B waiver was requested to be discontinued." Resident 4 Resident 4 was admitted on 01/15/2024 and was his/her own decision maker. Resident 4 had diagnoses that included neoplasm (abnormal growth of tissue) of uncertain behavior of the skin, follicular cysts of the skin and subcutaneous tissue, history of other malignant neoplasm of skin, and edema. The Individual Service Plan (ISP) dated 08/21/2026, indicated staff managed and administered Resident 4's medications. The ISP indicated Resident 4 may request medications at times or in ways that were not consistent with the current medication orders. Surveyor reviewed Resident 4's August 2026 MAR and found the following: For Doxycycline 100 mg tablet, staff had a notation on 08/06/2026 that read, "don't have". For Mepilex 4x4 to be applied to wound daily, staff had a notation on 08/21/2026 that read, "ordered and they are sending them 28." The staff reason for not passing this treatment read, "Out of Building". There was no charting to indicate this treatment was administered to Resident 4 by staff for 7 days from 08/01/2026 to 08/25/2026. For Chlorhexidine 4% solution, there was no charting to indicate this medication was administered to Resident 4 by staff once weekly on 08/10/2026, 08/17/2026, and 08/24/2026.	{N 432}		

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LAKE TOMAH CENTER	321 BUTTS AVENUE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 432}	Continued From page 13 For Mupirocin 2% ointment to be administered 2 times per day for the first 5 days of the month, there was no charting to indicate this medication was administered by staff for 6 doses from 08/01/2026 to 08/05/2026. For antibacterial strong strips to apply 5 to 10 strips to skin sores daily, there was no charting to indicate this treatment was administered to Resident 4 by staff for 13 days from 08/01/2026 to 08/25/2026. For Vanecream applied to skin daily, there was no charting to indicate this treatment was administered to Resident 4 by staff for 13 days from 08/01/2026 to 08/25/2026. On 09/02/2026 at 9:00AM, Surveyor interviewed ED B and DON C. DON C stated they reached out to Resident 4's providers and got his/her medications reviewed as s/he was seeing multiple providers. DON C stated to help with Resident 4 requesting creams to be applied not as ordered, they created a sheet for staff and Resident 4 to reference frequency and where to apply his/her multiple creams. DON C stated Resident 4 was now receiving in-home nursing care services for his/her wound care. DON C stated the expectation was for Administrator A to review resident MARs at the end of each shift and felt the lack of staff charting for some of the medications was a documentation issue. The provider did not ensure Resident 3 and Resident 4 received medication administration appropriate to meet their needs.	{N 432}		
N 639	83.59(2)(a) One-hand, one-motion door operation	N 639		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 639	Continued From page 14 All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all exits had one-hand, one-motion hardware. Findings include: On 08/25/2026 at 12:17 PM, Surveyor observed Resident 5's room. Surveyor observed the door to have a deadbolt lock and separate push door latch. Surveyor engaged the lock and was unable to open the door using one-hand, one-motion. On 09/10/2026 at 10:40 AM, Surveyor reached out to Executive Director (ED) B and Director of Nursing (DON) C inquiring about Resident 5's door lock. On 09/10/2026 at 2:36 PM, ED B replied via email, "To answer your question, Yes and no. DHS 83.59(2)(a) All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without using a key or special tool. This configuration only exists in Phase 2. We asked the department for clarification on this when they approved the plans. At the time, the department maintained that the configuration in the pictures met the specifications outlined in the code above. We configured the doors this way because	N 639		

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N 639	Continued From page 15	N 639		

residents were unintentionally locking themselves out of their rooms, with the keys inside, ona [sic] a daily nbasis [sic] in phase 1. When we had the plans approved for Phase 2, we adopted this configuration which the department inspected and licensed."

On 09/11/2026 at 8:54 AM, Surveyor received an email from ED B after requesting further information about the door lock mechanism that read,
"A little background on this concern is probably in order.

First I will answer your question directly.
-The push/pull levered handle and latching mechanisms installed on all resident bedroom doors in Phase 2 comply in all respects with DHS 83.59(2)(a)
-The deadbolt lock installed on all resident bedroom doors in Phase 2, which is a separate and independent piece of hardware from the levered handle and latching mechanism discussed above, complies in all respects with DHS 83.59(2)(c)

Now for some background information. The former hospital installed the push/pull levered handles and latching mechanisms throughout the building. When we transitioned the space in Phase 1 from hospital rooms to CBRF resident rooms we removed the push/pull levered handles and installed the standard lever handle locksets which we use everywhere else.

Once the facility was licensed and operating we observed that residents frequently struggled with the standard locksets. They often accidentally locked themselves out of their rooms or struggled to open the doors because they didn't fully rotate

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N 639	Continued From page 16	N 639		

the lever lock. Accordingly, we started looking for an alternative configuration which was easier for the residents for Phase 2.

The resident room door configuration depicted in the photo we're discussing for Phase 2 is the solution we developed, which the department approved during the licensure process. Regarding [Surveyor's] request for documentation of this, we feel that the fact the facility, in its present configuration, was inspected and licensed by a surveyor, and has had multiple subsequent completed surveys that did not identify this as a deficiency meets the documentation requirement for department approval of this configuration."

On 09/11/2026 at 10:09 AM, Surveyor received an email response from ED B when Surveyor again asked for evidence that the door could be opened with one-hand, one motion when both mechanisms were engaged that read in part, "If you feel that the current Phase 2 resident room door configuration does not meet DHS 83 requirements, we don't have a problem replacing the current hardware with a standard lever lockset. I will order the replacement hardware and install it. It's not a significant issue for us either way."

As of 5:00 PM on 09/11/2026, Surveyor did not receive any further documentation from the provider to demonstrate Resident 5's door was one hand, one motion.