STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016400	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING CEDAR COTTAGE	12440 WARPATH LN MINOCQUA, WI 54548

(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 01/27/2026, Surveyor conducted a complaint (x6) investigation at Lake Shore Assisted Living Cedar Cottage. Data collection continued through 01/29/2026. Six of 6 complaints were substantiated. Three deficiencies were identified. One of 3 deficiencies was a repeat deficiency. See statement of deficiency (SOD) F80Q13, dated 09/14/2023, SOB311, dated 12/21/2023, and SOD SOB312, dated 07/18/2024. Census: 10	N 000		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on interview, observation and record review, the provider did not ensure employees in sufficient numbers on a 24-hour basis to meet the needs of Resident 1. Findings include: Between October 2025 and January 2026, the department received 6 complaints alleging concerns with staffing. The facility is licensed to serve up to 15 residents in the client groups developmentally disabled, irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, advanced	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016400	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING CEDAR COTTAGE	12440 WARPATH LN MINOCQUA, WI 54548

(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 396	Continued From page 1	N 396		

aged and physically disabled. The facility is connected to a residential care apartment complex (RCAC) and the RCAC is operated by the provider. Both facilities share caregivers during two 12-hour shifts (7 AM to 7 PM; 7 PM to 7 AM).

On 01/27/2026 at approximately 9:30 AM, Surveyor interviewed Executive Director (ED) A and Team Lead (TL) B. Surveyor asked about staffing. ED A and TL B confirmed the following: Caregivers worked 12-hour shifts (7 AM to 7 PM; 7 PM to 7 AM); 2 caregivers worked each shift and at least one caregiver per shift would be responsible to answer call lights and assist tenants in the RCAC next door. Both ED A and TL B confirmed that during a PM shift, if a caregiver was assisting a tenant next door, the facility would only have one caregiver available to assist the residents.

On 01/27/2026 at approximately 9:45 PM, Surveyor interviewed TL B. Surveyor asked about resident care. TL B reported that Resident 1 was a two-person transfer with a mechanical lift at all times for cares and transfers. TL B indicated that given the current schedule, if a caregiver was assisting tenants at night in the RCAC next door, the facility would be left with one caregiver. TL B indicated that the amount of time a caregiver would be assisting tenants in the RCAC "could vary throughout the shift."

On 01/27/2026 at approximately 10:46 AM, Surveyor interviewed Resident 1. Surveyor asked about staffing. Resident 1 indicated that "a lot of times" there was only one staff working on the floor later in the evenings (7 PM to 7 AM). Resident 1 indicated that s/he required the assistance of two caregivers and a mechanical lift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016400	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING CEDAR COTTAGE	12440 WARPATH LN MINOCQUA, WI 54548

(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 396	Continued From page 2 with cares and transfers. On 01/27/2026 at approximately 10:50 AM, Surveyor observed Caregiver E and Caregiver F provide cares to Resident 1. Both Caregiver E and Caregiver F confirmed that Resident 1 required the assistance of two people and a mechanical lift for all cares and transfers. On 01/28/2026, Surveyor Reviewed Resident 1's record. Resident 1 was admitted on 02/26/2021. Resident 1's diagnoses included: Obesity, Normal pressure hydrocephalus, Chronic back pain, Chronic heart failure. Resident 1's undated individual service plan (ISP) noted that Resident 1 required a mechanical lift and two people to assist with transfers. On 01/28/2026, Surveyor interviewed TL B via telephone. Surveyor asked about staffing and Resident 1's cares. TL B confirmed that Resident 1 required the assistance of two staff and a mechanical lift for cares and transfers for the past four months. TL B confirmed that two staff worked 7:00 PM to 7:00 AM and at least one staff during the shift would do rounds and would be required to assist tenants as needed in the RCAC next door. TL B indicated that the average daily census of the RCAC was 13. Surveyor asked TL B about how often/how much time a caregiver may spend at the RCAC during a 7:00 PM to 7:00 AM (leaving the facility with one caregiver). TL B commented, "It depends, right now a caregiver may make 10 to 12 trips over to the RCAC during a night shift." TL B indicated that each time a caregiver assisted a tenant, it could take 5 minutes or it could take one to two others. TL B reported that there was a tenant in the RCAC that required a lot of staff assistance at this time.	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016400	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING CEDAR COTTAGE	12440 WARPATH LN MINOCQUA, WI 54548

(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 396	Continued From page 3 On 01/28/2026 at approximately 4:15 PM, Surveyor interviewed Caregiver C via telephone. Surveyor asked about staffing. Caregiver C reported that s/he worked the PM/NOC (overnight) (7:00 PM to 7:00 AM) shift with another caregiver. Caregiver C reported that during the 7:00 PM to 7:00 AM shift, one caregiver assisted tenants in the RCAC next door throughout the shift, leaving the facility with one caregiver at times. According to Caregiver C, a caregiver could be called to assist tenants in the RCAC every hour to every 2 hours, it just depended on the evening. Caregiver C confirmed that Resident 1 required a mechanical lift and two staff to assist with cares and transfers. Caregiver C confirmed that there were times over the past few months when there was only one staff present in the facility between 7:00 PM and 7:00 AM due to the other staff needing to assist tenants in the RCAC next door. The provider did not ensure employees in sufficient numbers on a 24-hour basis to meet the needs of Resident 1.	N 396		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016400	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING CEDAR COTTAGE	12440 WARPATH LN MINOCQUA, WI 54548

(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 397	Continued From page 4	N 397		

basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure at least one qualified resident care staff was present in the facility during multiple overnight shifts between November 2025 and January 2026.

Wis. Admin. Code § DHS 83.02(42) states: "Qualified resident care staff" means an employee who has successfully completed all of the applicable training and orientation under subch. IV."

The deficiency is cited for the fourth time. See statement of deficiency (SOD) F80Q13, dated 09/14/2023, SOB311, dated 12/21/2023, and SOD SOB312, dated 07/18/2024.

Findings include:

Between October 2025 and January 2026, the department received 6 complaints alleging concerns with staffing and medications.

The facility is licensed to serve up to 15 residents in the client groups developmentally disabled, irreversible dementia/Alzheimer's disease,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016400	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING CEDAR COTTAGE	12440 WARPATH LN MINOCQUA, WI 54548

(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 397	Continued From page 5 emotionally disturbed/mental illness, advanced aged and physically disabled. On 01/27/2026 at approximately 9:30 AM, Surveyor interviewed Executive Director (ED) A and Team Lead (TL) B. Surveyor asked about staffing and medication training. ED A and TL B confirmed the following: Caregivers worked 12-hour shifts (7 AM to 7 PM; 7 PM to 7 AM); 2 caregivers worked each shift; at least one caregiver per shift would be responsible to answer call lights and assist residents in the provider's licensed residential care apartment complex (RCAC) next door. ED A reported that there was a trained medication passer during the 7:00 AM to 7:00 PM shift. Both ED A and TL B indicated that there was not always a trained medication passer during the 7:00 PM to 7:00 AM shift. TL B reported that Caregiver C and Caregiver D worked the 7:00 PM to 7:00 AM shift together. TL B confirmed that Caregiver C and Caregiver D were not trained to pass medications. On 01/28/2026, Surveyor reviewed the schedule (November 2025 to January 2026). The schedule noted the following: Caregiver C and Caregiver D worked together 14 days in November 2025, Caregiver C and Caregiver D worked together 17 days in December 2025 and Caregiver C and Caregiver D worked together 15 days in January 2026. On 01/28/2026, Surveyor reviewed Caregiver C's and Caregiver D's records. Caregiver C was hired on 07/25/2025. Caregiver C's record did not contain evidence of medication training. Caregiver D was hired on 08/22/2025. Caregiver D's record did not contain evidence of medication training.	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016400	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING CEDAR COTTAGE	12440 WARPATH LN MINOCQUA, WI 54548

(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 397	Continued From page 6 On 01/28/2026 at approximately 4:15 PM, Surveyor interviewed Caregiver C via telephone. Surveyor asked about staffing and medication training. Caregiver C reported that s/he worked 12-hour shifts (7 PM to 7 AM) with Caregiver D. Caregiver C confirmed that Caregiver C and Caregiver D were not trained to pass medications. Caregiver C indicated that s/he could recall a time a few months ago, when a resident asked for a Tylenol while Caregiver C and Caregiver D were working and neither Caregiver C nor Caregiver D could give the resident the Tylenol. The provider did not ensure at least one qualified resident care staff was present in the facility during multiple PM/NOC (overnight) shifts between November 2025 and January 2026.	N 397		
N 435	83.38(1)(k) Transportation. 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: Transportation. The CBRF shall provide or arrange for transportation when needed for medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest. CBRFs that transport residents shall develop and implement written policies addressing the safe and secure transportation of residents.	N 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016400	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING CEDAR COTTAGE	12440 WARPATH LN MINOCQUA, WI 54548

(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 435	Continued From page 7	N 435		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not arrange transportation services adequate to meet Resident 2's needs.

Resident 2 missed behavioral health and medical appointments due to not having transportation available.

Findings include:

Between October 2025 and January 2026, the department received 6 complaints alleging concerns with staffing and transportation.

The facility is licensed to serve up to 15 residents in the client groups developmentally disabled, irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, advanced aged and physically disabled.

On 01/27/2026 at approximately 9:45 AM, Surveyor interviewed Team Lead (TL) B. Surveyor asked about transportation. TL B reported that the van was not working and had not been started for the past 4 to 5 months. TL B indicated the van needed tires and multiple repairs (including fixing seat belts and breaks). TL B reported that there had been times where shopping trips and medical and mental health appointments had to be canceled due to not having transportation available. TL B indicated, "We do the best we can and try to use a transport company, door dash/Uber and sometimes I have used my personal vehicle to drive residents."

On 01/27/2026 at approximately 2:08 PM, Surveyor interviewed Executive Director (ED) A.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016400	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING CEDAR COTTAGE	12440 WARPATH LN MINOCQUA, WI 54548

(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 435	Continued From page 8 Surveyor asked about transportation. ED A stated, "Transportation is an issue." On 01/28/2026 at approximately 12:44 PM, ED A noted the following via e-mail, "In regarding to the Van [sic], Yes residents have missed appointments due to not having transportation. The Van [sic] needs significant repairs of new tires, brakes, wheel bearings, tie rods, seat belts, muffler, exhaust leak, Door [sic] hatch fixed. And if you drive the Van [sic] over 55 MPH(,) (it shakes) violently." On 01/28/2026 at approximately 2:29 PM, ED A verified the following via e-mail: Resident 2 missed a behavioral health appointment in November 2025 and on December 26, 2025; Resident 2 missed a urology appointment (ultrasound and labs) on 12/09/2025; and the van has not been running for the past 4 months. On 01/28/2026 at approximately 4:15 PM, Surveyor interviewed Caregiver C via telephone. Surveyor asked about transportation. Caregiver C reported, "There has been an issue with transportation" and that staff have used their personal vehicles before to pick up residents from the hospital. Caregiver C commented that transportation was not available to take residents shopping and at times a medical transport service assisted with transportation, but the service was not always available. On 01/29/2026 at approximately 1:00 PM, Surveyor interviewed ED A and TL B via telephone. ED A and TL B reiterated that transportation services had been an issue for several months. ED A and TL B indicated the issues with transportation range from not having staff available to drive, not having a functioning	N 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016400	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE ASSISTED LIVING CEDAR COTTAGE	12440 WARPATH LN MINOCQUA, WI 54548

(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 435	Continued From page 9 transport van to having limited transportation services available in the area. ED A indicated that s/he would talk to the owners about ensuring transportation services are provided to the residents as needed and as identified in their service agreements. The provider did not arrange transportation services adequate to meet Resident 2's needs.	N 435		