STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014577	A. BUILDING: _____ B. WING _____	C 09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE HALLIE MEMORY CARE	4407 124TH STREET CHIPPEWA FALLS, WI 54729

(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 08/17/2026, Surveyor completed 4 complaint investigations at Lake Hallie Memory Care. Data was collected through 09/02/2026. Two of 4 complaints were substantiated. One deficiency was identified. One of 1 deficiency was a repeat violation; see Statement of Deficiency SGKV11, dated 11/13/2020. Census: 60	N 000		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health	N 431		

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

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N 431	Continued From page 1 status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure appropriate health monitoring for 1 of 1 sampled resident (Resident 1) by not following the 2-hour toileting schedule, not performing or documenting skin assessments, and not reporting significant changes in condition. This was a repeat deficiency; see Statement of Deficiency SGKV11, dated 11/13/2020. Findings include: The Department received multiple complaints related to resident care, treatment, and neglect. On 08/17/2026 at approximately 10:15 AM until 11:00 AM, Surveyor interviewed Administrator In Training (AIT) A. AIT A reported that Resident 1 recently passed away. AIT A stated that s/he had an incident where staff found him/her not coherent, soaked in thick dark honey-like urine, and with a pressure sore on his/her tailbone. EMS was called. AIT A explained that after some investigation, they were unaware of the last time someone gave Resident 1 water or charted a skin assessment. AIT A stated Resident 1 was on a 2-hour toileting schedule, which was not followed, resulting in the termination of an employee. At 11:40 AM, Surveyor reviewed Resident 1's toileting charting for 07/31/2026. The toileting checks showed that from 1:10 AM to 1:16 PM, every time Resident 1 was checked s/he was not incontinent. At 1:16 PM, it was noted Resident 1	N 431		

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N 431	Continued From page 2	N 431		

was incontinent. The last documented 2-hour toileting check performed on Resident 1 before s/he was sent out via EMS (Emergency Medical Services) was at 3:23 PM; Resident 1 was sent via EMS at 9:00 PM.

At 11:45 AM, Surveyor reviewed Resident 1's observation notes.

A note dated 07/22/2026 at 3:30 AM read, " ... Resident is rarely incontinent and would better benefit with four-hour toileting."

A note dated 07/22/2026 at 7:15 PM read, "Resident's intake has decreased drastically the past couple of days. Resident is not able to feed [him/herself] but then when staff attempt to feed [him/her] [s/he] states [s/he] is not hungry."

A note dated 07/27/2026 at 6:00 PM read, "Resident's intake has decreased. Resident constantly states [s/he] is full and often refuses to eat more than a couple of bites."

A note dated 07/31/2026 at 10:30 AM read, "Resident has been declining; it is really hard to get [him/her] up and ready for the day. [S/he] is super stiff and sore. When it comes to eating, [s/he] is not eating at all, seems like [s/he] has been losing a lot of weight. While doing my checks I am making sure the resident is as comfortable as possible. While sitting in [his/her] wheelchair [s/he] seems to be very uncomfortable."

A note dated 07/31/2026 at 9:00 PM read, "Staff arrived on shift today and [staff] reported to staff that resident was minimally responsive. Staff entered residents [sic] room and it smelled strongly. Staff noted resident [sic] was curled up

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N 431	Continued From page 3	N 431		

in [his/her] bed, grimacing [his/her] [sic] face with [his/her] mouth wide open. Residents mouth was very dry, the insides of [his/her] lips were peeling and skin [sic] flaking off. Staff attempted to verbally stimulate resident, but resident was lethargic and unresponsive. Staff sternal rubbed resident and resident began moaning and clenching [his/her] eyes. Staff noted resident was extremely saturated with urine. Residents [sic] urine was dark brown and had a honey like consistency. Resident was more alert after about 10 minutes so staff utilized the STS (sit-to-stand) per care plan to get resident off of [his/her] bottom due to [him/her] remaining in bed [sic] previous shift, and wanting to get pressure off of [his/her] bottom ...upon standing resident up, staff noted multiple large open sores on residents coccyx and right hip. Coccyx sore was open and a white substance was leaking out of the middle of the sore, and [sic] smelled very foul. Resident was wincing in pain when staff removed the depend ... residents [sic] appearance was pale and [his/her] face appeared to look sunken in ...911 and EMS arrived ...Upon investigation, no skin assessments in residents file show [sic] that its an ongoing issue ...this staff has personally made observation notes mentioning residents drastically decreased intake. Resident is not on intake monitoring".

At 12:30 PM, Surveyor reviewed skin assessment documentation for Resident 1. The only documented skin assessment was the assessment entered on the date of the incident 07/31/2026, by the caregiver who found the wounds.

At 12:45 PM, Surveyor reviewed an Investigation Summary- Potential Neglect document. The report read, "On 07/31/2026, [Caregiver C]

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N 431	Continued From page 4 documented in the resident's care notes that providing morning care was difficult because [Resident 1] appeared 'stiff and sore'. The documentation also indicated that [Resident 1] demonstrated minimal interest in eating. Although a change in the resident's condition was documented, the caregiver did not directly report these concerns to facility leadership at this time ... [Resident 1] was admitted ... with diagnosis of altered/changed mental status. On the morning on 08/03/2026, the hospital social worker contacted [provider] and reported that based upon concerns communicated to the hospital by EMS, Adult Protective Services (APS) had been contacted regarding potential neglect. [Provider] immediately initiated an internal investigation ... Based upon the available documentation and staff interviews, the facility determined that there was a likelihood that [Caregiver C] did not consistently follow [Resident 1's] established two-hour toileting program on 07/31/2026. The investigation also determined that [Caregiver C] documented a change in [Resident 1's] condition but did not directly report the change to available facility leadership. Based upon the findings of the investigation, [Caregiver C's] employment was terminated ... Education was provided to staff regarding accurate and objective documentation and the importance of accurately communicating resident condition and skin integrity concerns to EMS and other medical providers ... Overall, the investigation identified concerns regarding adherence to the resident's toileting plan and failure to report a documented change in condition to leadership. The investigation did not substantiate that the resident had multiple open pressure wounds at the time of hospital admission, based upon the hospital documentation available to the facility."	N 431		

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N 431	Continued From page 5 At 1:10 PM, Surveyor interviewed Administrator B. Administrator B stated a staff observation note documented that Resident 1 had open wounds. Administrator B stated an investigation was completed and it was found that Resident 1's hospital admission was for change in mental status and it only noted on his/her after visit summary (AVS) that there was a healing old pressure sore. Administrator B stated they attempted to get detailed hospital records but were never successful. Administrator B stated that caregiver documentation had exaggerated the wounds on Resident 1's bottom. Administrator B stated calling EMS was appropriate and confirmed Resident 1 had a change in condition, but the provider did not believe Resident 1's skin condition was as bad as noted. On 09/02/2026 at 8:00 AM, Surveyor reviewed hospital documentation provided by [Hospital]. A hospital note dated 08/04/2026 at 12:03 PM, included a note under Details of Hospital Stay - Hospital Course. This note read in part, "[Resident 1] is a 68-year-old [fe/male] with dementia, psychosis, obstructive sleep apnea, and a history of agitation, who was admitted from a memory care facility with altered mental status, lethargy, and dehydration. On arrival, [s/he] was noted to be arousable but confused, with intermittent hypotension and hypoxia, and had perineal sores and poor oral intake ...The principal problem was toxic-metabolic encephalopathy attributed to polypharmacy in the setting of advanced dementia and dehydration ... [S/he] had a stage 2 decubitus ulcer on [his/her] coccyx and a reddened heel". On 09/02/2026 at 2:20 PM, Surveyor interviewed AIT A. AIT A stated that s/he would be performing chart audits every morning to ensure nothing was	N 431		

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N 431	Continued From page 6 getting missed moving forward. AIT A stated that s/he planned to provide education to all floor staff.	N 431		