STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525495	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living - Lakeshore at Siena	5643 Erie Street Racine, WI 53402

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not ensure a thorough investigation was completed for allegations of abuse/neglect for 1 (R7) of 2 Residents reviewed for alleged abuse. *The Facility did not ensure a thorough investigation was completed related to the allegation of neglect of R7 which was reported by Adult Protective Services on 6/24/25. Findings include: The Facility policy, titled, Abuse Investigation and Reporting, with a last revised date of 11/2023, documents: .Role of the Administrator or designee:A If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown sources reported, the Administrator or designee will assign the investigation to an appropriate individual. B. The administrator or designee will provide any supporting documents relative to the alleged incident to the person in charge of the investigation.C. The administrator or designee will keep the resident, and his/her representative informed of the progress of the investigation. Role of the Investigator:A. The individual conducting the investigation will, at a minimum:1. Review the completed documentation forms2. Review the Resident's medical record to determine events leading up to the incident3. Interview the person(s) reporting the incident4. Interview any witnesses to the incident5. Interview the Resident7. Interview associates members (on all shifts) who have had contact with the Resident during the period of the alleged incident9. Interview other Residents to who the accused employee provides care or services10. Review other Residents to whom the accused employee provides care or services B. The following guidelines will be used when conducting interviews: .3. Witness reports will be obtained in writing. Either the witness will his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. G. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator or designee. ReportingA. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported to the Administrator or designee and to the following other officials or agencies:1. The state licensing/certification agency responsible for surveying/licensing the community.2. Other officials in accordance with State Law, including adult Protective Services where state law provides for jurisdiction in long term care facilities;3. The Resident's Representative (Sponsor) of Record; .B. Alleged violations involving abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported:1. Abuse or Serious Bodily Harm-Immediately but not later than two hours. R7 was admitted to the facility on [DATE] with diagnoses of Pulmonary Hypertension (high blood pressure that affects arteries in the lungs and in the heart), Unspecified Protein-Calorie Malnutrition (deficiency of both protein and energy), Hypertensive Heart Disease (long term conditions developed from chronic high blood pressure), Hyperlipidemia (high levels of fat particles in the blood), Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limbs), Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). The facility does not have an activated Health Care Power of Attorney on file for R7. R7's admission Minimum Data Set (MDS) completed 4/4/25 documents R7's Brief Interview for Mental Status (BIMS) score to be 10, indicating R7 demonstrates moderately impaired skills for daily decision making. R7's MDS documents R7's Patient Health Questionnaire (PHQ-9) score to be 7 indicating R7 demonstrates mild depressive symptoms. R7 has no behavior concerns. R7 has range of motion impairment to both upper extremities. R7 required supervision for eating; required substantial/maximum assistance for showers, lower body dressing, mobility, and transfers; and requires partial/moderate assistance for upper body dressing. On 6/24/25, the facility submitted an Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report which documents Adult Protective Services (APS) arrived at the facility and reported a family member had reported an allegation of neglect on 6/22/25.On 7/2/25, at 2:33 PM, Surveyor requested and reviewed the facility's internal investigation of the allegation of neglect involving R7. Surveyor notes the file does not contain a Misconduct Incident Report. The file contained brief documentation with random notes in regard to R7's admission, 2 falls, and also contained an audit of call light wait times. The investigation contained in the facility documentation did have a summary of events, staff and resident interviews or a summary of findings. On 7/2/25, at 3:11 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regard to R7's facility reported incident (FRI) of the allegation of neglect. NHA-A confirmed NHA-A is responsible for submitting the facility incident reports. NHA-A stated the expectation is to report neglect concerns to the State Agency and the process is to interview the Resident, get details from family, interview staff to find evidence of what was alleged, look at a sample of Residents to interview to determine any other allegations. Surveyor shared with NHA-A that the facility investigation did not include interviews with staff and other residents. NHA-A informed Surveyor that NHA-A didn't anticipate Surveyors to come into the facility. NHA-A stated NHA-A took documentation of the investigation, placed in NHA-A's bag, and removed the documentation from the facility. NHA-A stated NHA-A didn't have time to assemble the paperwork yet. Surveyor shared the concern the facility did not complete a thorough investigation as there are no staff or resident statements to assist in determining if neglect occurred or not. NHA-A expressed understanding of the concern that a thorough investigation was not completed for R7's allegation of neglect. On 7/2/25, at 3:54 PM, NHA-A informed Surveyor that NHA-A would be providing additional information on the investigation. At the time of the survey exit no additional information had been provided. On 7/3/25, at 11:04 AM, Surveyor was provided staff statements and Resident interviews dated 6/24/25. However, the staff interview questions are not specific in addressing R7's allegation of neglect which included multiple issues. There are 2 questions:1. Have you seen/heard/witnessed any employee or staff ignoring or neglecting facility Residents when they needed care in this facility?2. Have you ignored or neglected a Resident who needed care in this facility.The staff member was to circle yes or no.Surveyor noted there is no signature of the staff member who completed each questionnaire.The Resident interview questionnaires are dated 6/24/25 but were not available as part of the investigation of R7's allegations of neglect during the survey process. Surveyor notes there is no signature of whom interviewed the resident.Surveyor has concerns that a thorough investigation was not completed. Surveyor was unable to obtain schedules of employees working during the time of R7's allegation of neglect to identify if the staff interviewed worked during the time in questions and would have knowledge of the situation.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility did not ensure residents received adequate fluid intake for 1 (R1) of 1 Residents reviewed for nutrition. R1was transferred from the facility to the hospital on [DATE] due to weakness, encephalopathy (a disturbance of brain function causing confusion, and abnormal lab values). The facility did not ensure R1 received adequate fluid intake to maintain acceptable parameters of hydration as evidenced by failing to total and assess daily fluid intake, accurately assess and complete on-going assessments for signs and symptoms of dehydration when R1 was assessed to be at risk for dehydration and had a history of poor oral intakes. Findings include:R1 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease, Dementia, Delirium and Acute Kidney failure. R1's admission MDS (Minimum Data Set) with an ARD (Assessment Reference) of 11/11/24 documents R1 has a BIMS (Brief Interview for Mental Status) score of 07, indicating R1 was severely cognitively impaired at the time of assessment and has both short- and long-term memory impairments. R1 required assistance of 1 staff for transfers and personal cares at the time of assessment. Surveyor reviewed R1's hospital referral information dated 11/4/24, which documents a speech therapy evaluation was recommended and completed. A video swallow study was declined by the patient. The patient needs assist for feeding and can feed self. Volitional swallow (The act of swallowing that is initiated intentionally by the individual, as opposed to a reflexive swallow which occurs automatically. It's the conscious decision to swallow, often associated with eating or drinking.) present and weak. multiple swallows noted. Slightly slow mastication, however functional to consume, complete mastication with complete oral clearance. Occasional double swallow.Recommendations: Diet: Regular, thin. Feeding guidelines: feeds self a tolerated, slow rate of intake, sit up straight in bed/chair, stay upright after meals, small bites, small single sips, limit talking while eating, limit distractions when eating, stop feeding if coughing and periodic liquid wash.Surveyor notes the hospital identified eating guidelines were not included in R1's care plan. Eating guidelines would be important for staff to be aware of due to R1's diagnosis of Parkinson's Disease, Dementia and history of and risk for dehydration. R1 was discharged from the facility on 11/21/24 due to a change of condition and abnormal lab values. Surveyor reviewed R1's hospitalization records from 11/21/24, which documented the following, .Patient presents with abnormal labs .Today labs were done which showed that he had a Potassium of 6.8, Blood Urea Nitrogen (BUN) of 127 and Creatinine of 14.27 .Patient presents here with gradual decline in mental status over the past couple weeks, abnormal labs at nursing home, mucous membranes are dry .dry and encephalopathic .profoundly high creatinine of 15.6, BUN elevated to 133, Potassium of 6.7 .gave him an IV (intravenous) fluid bolus .nephrologist recommends bicarbonate drip (an intravenous medication for treatment of acute and chronic kidney disease). Surveyor notes the reference ranges for Potassium to be 3.5-5.1 millimoles per Liter (mmol/L), BUN 7-26 milligrams per deciliter (mg/dL) and Creatinine 0.60-1.30 mg/dL.On 7/2/25, at 11:08 AM, Surveyor conducted an interview with Certified Nursing Assistant (CNA)-C. CNA-C told Surveyor they remembered taking care of R1 frequently as they would often work double shifts and were assigned to R1 often. CNA-C recalled R1 was at the facility for not very long but midway through their stay they started acting different. Surveyor asked CNA-C to elaborate on what different meant CNA-C responded R1 had good days and bad days and that a couple of weeks before R1's discharge from the facility, she remembered R1 becoming more confused and that they didn't want to eat or drink with help and would become agitated. Surveyor asked CNA-C if they had reported their concerns about R1's medical condition to a nurse or a unit manager. CNA-C responded I know I told more than 1 nurse for sure . [R1] wasn't doing well, and I remember filling out a note about it to the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurses so [R1] could get looked at closer .I'm not sure why [R1] didn't go out to the hospital sooner .R1 was more and more confused, and I wondered if [R1] had an infection or was dehydrated or something [R1] wasn't acting right. Surveyor asked CNA-C what made them question if R1 was dehydrated. CNA-C responded that R1's lips and mouth were often dry and sticky and they could only get R1 to drink soda. Surveyor asked CNA-C if they recalled ever documenting R1's fluid intake. CNA-C told Surveyor they remember recording meal intakes but not specifically R1's fluid intake amounts. On 7/2/25, at 1:01 PM, Surveyor conducted interview with Registered Nurse (RN)-F. Surveyor notes RN-F is a unit manager at the facility on the unit where R1 resided. RN-F told Surveyor they recalled R1 had Dementia and Parkinson's Disease. RN-F also remembered R1 was a fall risk and very impulsive at times and suffered from generalized weakness. Surveyor asked RN-F if they recalled R1 experiencing a change of condition at any time throughout their stay at the facility. RN-F told Surveyor they remembered hearing R1 went to the hospital but R1 never came back to the facility after that. RN-F could not recall any details of why R1 went to the hospital. Surveyor asked RN-F if a resident is assessed to be at risk for dehydration what the facility protocol would be for monitoring a resident's risk. RN-F responded they would expect a resident who is at risk for dehydration to be monitored by checking for signs and symptoms of dehydration such as dry mucous membranes and tenting of the skin. Surveyor asked if a resident at risk for dehydration should have their intake and output monitored. RN-F responded, I would think for sure they should be on I&O (Intake and Output) to make sure they don't become dehydrated. Surveyor asked RN-F who would be responsible for monitoring a resident's I&O. RN-F responded it would be a collaboration between CNAs and Nurses to monitor for resident I&O. RN-F added if a resident is at risk for dehydration, it should definitely be care planned for the resident in the medical record. Surveyor reviewed R1's comprehensive care plan. R1's Nutrition care plan with an initiation date of 11/5/24 documents the following: R1 is at nutritional risk due to poor appetite and triggering for malnutrition. Documented interventions dated 11/8/24 include: .R1's meal intake is monitored daily .R1 is offered a minimum of 480 milliliters (mL) at each meal. R1's Dehydration risk care plan with an initiation date of 11/13/24 documents the following: R1 has a potential for fluid volume deficit related to inadequate oral intakes. R1 will be free from signs and symptoms of dehydration and will be well hydrated as evidenced by physical condition. Documented interventions dated 11/13/24 include: .Assess for signs/symptoms of dehydration (dizziness, confusion, decreased urine output, poor skin turgor, fever, constipation), assess skin turgor and mucus membranes for signs of dehydration every shift. Surveyor reviewed R1's Electronic Health Records. Surveyor was unable to identify any documentation of R1's fluid intake at meals, intake and output records or assessments of R1's hydration status. On 7/2/2025, at 4:00 PM, Surveyor conducted an interview with Director of Nursing (DON)-B. Surveyor asked DON-B if they could show Surveyor documentation of R1's fluid intake and hydration status monitoring. DON-B told Surveyor they would need to follow up on R1's record and would let Surveyor know if they could find additional information. On 7/2/25, at 5:05 PM, DON-B made Surveyor aware they could not find any additional information pertaining to monitoring of R1's hydration status. Surveyor shared concerns with DON-B and Director of Quality-E there is no documentation the facility was monitoring R1's fluid intake or hydration status when R1 was assessed to be at risk for dehydration. Surveyor shared concern R1's hospital records indicate R1 was exhibiting signs of dehydration upon arrival at the emergency room on [DATE] and had to receive intravenous fluids due to clinical signs of dehydration. No additional information was provided by the facility at this time.