STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017800	A. BUILDING: _____ B. WING _____	R-C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBERGE AT OAK VILLAGE A MEMORY CARE COMM	W128 N6900 NORTHFIELD DR MENOMONEE FALLS, WI 53051

(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 11/04/2025, the Bureau of Assisted Living, Southern Regional Office conducted a verification visit of statement of deficiency (SOD) 3GKY12 and a complaint investigation at Auberge At Oak Village A Memory Care Community, located at W128 N6900 Northfield Drive in Menomonee Falls, WI. Two repeat citations of noncompliance were issued. The complaint was unsubstantiated. Census: 40 Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 11, Resident 15, Resident 16, Resident 20, and Resident 21 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 11 and Resident 14 did not receive polyethylene glycol (prescribed for constipation), as prescribed.	{N 352}		

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

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{N 352}	Continued From page 1 Resident 16 did not receive lidocaine patch (prescribed for pain relief) administration, as prescribed. Resident 20 and Resident 21 did not receive multiple medications, as prescribed. This requirement is being cited for a third time. See Statement of Deficiency (SOD) 3GKY11, issued on 11/20/2024, and SOD 3GKY12, issued on 06/18/2025. The findings include: Example 1: Resident 11's polyethylene glycol (powdered bowel medication) On 11/04/2025 at 9:48 A.M., Surveyor observed Resident 11 seated in the television lounge/living room area of the facility. On 11/04/2025 at approximately 10:37 A.M., Surveyor observed Health Services Director (HSD) R remove one 30-daily dose container of polyethylene glycol labeled with Resident 11's name from one of 2 medication carts. The container's pharmacy label dated "06/05/25 [2025]" included the practitioner's prescription including, "Take 1 capful (17 grams) by mouth every day. Mix powder with water - for constipation - fill to the line inside the cap." The manufacturer's label included the container originally included "30 once-daily doses [equaling 510 grams]." The container included "Open 08/06/2025" handwritten in black marker. Surveyor observed approximately one eighth of the powdered medication remaining in the container.	{N 352}		

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{N 352}	Continued From page 2 HSD R said, "Not much [powdered medication] left in there [container]." Surveyor observed HSD R removed another 30-daily dose container of polyethylene glycol labeled with Resident 11's name from the same medication cart. The container's pharmacy label including Resident 11's name was partially removed so that the refill date was no longer available. Surveyor observed HSD R remove the cap to this container revealing an intact safety seal. HSD R told Surveyor these were the only 2 containers of polyethylene glycol currently available for Resident 11 at the facility. HSD R told Surveyor Resident 11 required caregiver administration of all prescribed medications. On 11/04/2025, Surveyor reviewed Resident 11's record, as received from Administrator A. Resident 11 was admitted to the facility on 04/22/2022 with diagnoses including "altered mental status" and multiple sclerosis. Resident 11's practitioner's orders included a prescription for polyethylene glycol with directions to "Give 17 GM (gram)/scoop powder by mouth. Mix 17 gm(s) in 8 ounces of water or other beverage and drink by mouth daily for constipation." Surveyor reviewed Resident 11's medication administration records (MARs) from 09/01/2025 through 11/04/2025. Resident 11's September 2025 MAR included documentation Resident 11 was administered 30 of 30 potential doses. Resident 11's October 2025 MAR included documentation Resident 11 was administered 31 of 31 potential doses. Resident 11's November 2025 MAR included documentation Resident 11 was administered 4 of 4 potential doses. In total, the documentation within Resident 11's MARs from 09/01/2025 through 11/04/2025 included a total of 65 administered doses.	{N 352}		

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{N 352}	Continued From page 3 On 11/04/2025 at 1:19 P.M., Surveyor conducted an interview with Resident 11's Pharmacy Representative W. Pharmacy Representative W told Surveyor one 510 gram container of polyethylene glycol was delivered to the facility on 07/11/2025 and another on 10/21/2025. On 11/04/2025 at approximately 1:40 P.M., Surveyor and HSD R discussed Surveyor's interview with Pharmacy Representative W. HSD R told Surveyor Resident 11's pharmacy delivered Resident 11's medications by mail to the facility and s/he had several unopened mailed packages in his/her office. Within HSD R's office, HSD R presented Surveyor with a sealed, unopened 510 gram container of polyethylene glycol labeled for Resident 11. The pharmacy label of this container included a refill date of "07/11/2025." HSD R said s/he did not know why this container had not been administered to Resident 11, as prescribed. HSD R told Surveyor the sealed, unopened polyethylene glycol remaining within the medication cart with only part of the pharmacy label remaining may have been refilled and delivered to the facility on 10/21/2025 but s/he had no way of knowing for sure. Based on Resident 11's polyethylene glycol prescription, Resident 11's supply of partially used container refilled on 06/05/2025 and 2 unopened polyethylene glycol containers, and the caregiver documentation of 65 doses administered between 09/01/2025 and 11/04/2025, Resident 11 did not receive polyethylene glycol administration as prescribed. Example 2: Resident 14's polyethylene glycol	{N 352}		

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{N 352}	Continued From page 4 (powdered bowel medication) On 11/04/2025 at approximately 10:43 A.M., Surveyor observed HSD R remove one 14-daily dose container of polyethylene glycol labeled with Resident 14's name from one of 2 medication carts. The container's pharmacy label dated "07/24/25 [2025]" included the practitioner's prescription including, "Take 17 GM(s) by mouth daily. Mix in 4 [to] 8 oz [ounces] of liquid." Surveyor observed approximately one quarter of the powdered medication remaining in the container. Surveyor observed HSD R remove another 14-daily dose container of polyethylene glycol labeled with Resident 14's name from the same medication cart. This container's pharmacy label dated "08/14/25 [2025]" and included the same practitioner's prescription. Surveyor observed approximately one quarter of the powdered medication remaining in the container. HSD R told Surveyor these were the only 2 containers of polyethylene glycol currently available for Resident 14 at the facility. HSD R told Surveyor Resident 14 required caregiver administration of all prescribed medications. On 11/04/2025, Surveyor reviewed Resident 14's record, as received from Administrator A. Resident 14 was admitted to the facility on 01/14/2025 with diagnoses including dementia. Resident 14's practitioner's orders included a prescription for polyethylene glycol with directions to "Give 17 G (gram)/dose powder by mouth one time per day, every day at 8:00 A.M. Take 17 GM(s) by mouth daily. Mix in 4 [to] 8 oz [ounces] of liquid." Surveyor reviewed Resident 14's MARs from 09/01/2025 through 11/04/2025. Resident 14's September 2025 MAR included documentation	{N 352}		

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{N 352}	Continued From page 5 Resident 14 was administered 30 of 30 potential doses. Resident 14's October 2025 MAR included documentation Resident 14 was administered 30 of 31 potential doses, with 1 dose documented as "refused" on 10/04/2025. Resident 14's November 2025 MAR included documentation Resident 14 was administered 4 of 4 potential doses. In total, the documentation within Resident 14's MARs from 09/01/2025 through 11/04/2025 included a total of 64 administered doses of polyethylene glycol. On 11/04/2025 at approximately 1:11 P.M., Surveyor conducted an interview with Resident 14's Pharmacy Representative X. Pharmacy Representative X told Surveyor one 14-day dose container of polyethylene glycol was delivered to the facility on 06/05/2025, 07/24/2025, and another on 08/14/2025. Pharmacy Representative X told Surveyor no other container's of polyethylene had been requested by the facility and/or delivered to the facility for Resident 11 since 08/14/2025. Based on Resident 14's polyethylene glycol prescription, Resident 14's supply of partially used containers refilled on 07/24/2025 and 08/14/2025, and the caregiver documentation of 64 doses administered between 09/01/2025 and 11/04/2025, Resident 14 did not receive polyethylene glycol administration as prescribed. Example 3: Resident 16's lidocaine 4 % patch (topical patch pain medication) On 11/04/2025 at 8:20 A.M., Surveyor observed Caregiver U and Caregiver V assist Resident 16 to transfer from Resident 16's bed to Resident 16's wheelchair utilizing a sit-to-stand type mechanical	{N 352}		

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{N 352}	Continued From page 6	{N 352}		

lift. Surveyor observed Resident 16 make facial grimaces and audible groaning sounds during the transfer. At 8:45 A.M., Resident 16 told Surveyor s/he experienced chronic pain "all over" but primarily in his/her hips and lower back.

On 11/04/2025 at approximately 10:39 A.M., Surveyor observed HSD R remove a box containing 7 lidocaine 4 % transdermal patches from one of 2 medication carts. The box had an affixed pharmacy label including Resident 16's name, the medication name, the medication prescription with directions for application, the date the prescription was filled by the pharmacy, and the number of patches originally contained within the box. The label included, "Apply 1 patch topically daily. Apply in the morning. Remove at bedtime." The label included 30 patches were filled by the pharmacy on 08/13/2025. HSD R told Surveyor this box was the only box of lidocaine patches available for Resident 16 at the facility. HSD R told Surveyor Resident 16 required caregiver administration of all prescribed medications.

On 11/04/2025, Surveyor reviewed Resident 16's record as provided by HSD R. Resident 16 was admitted to the facility on 08/16/2024 with diagnoses including dementia and chronic pain. Resident 16's practitioner's orders included a prescription for lidocaine pain relief 4% patch including, "Apply 1 patch topically daily. Apply in the morning, remove at bedtime." Surveyor reviewed Resident 16's MARs from 09/01/2025 through 11/04/2025. Resident 16's September 2025 MAR included documentation Resident 16 was administered 29 of 30 potential doses/applications of lidocaine 4%, with 1 dose's documentation left blank on 09/02/2025. Resident

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{N 352}	Continued From page 7 16's October 2025 MAR included documentation Resident 16 was administered 30 of 31 potential doses/applications of lidocaine 4%, with 1 dose's documentation left blank on 10/02/2025. Resident 16's November 2025 MAR included documentation Resident 16 was administered 4 of 4 potential doses/applications of lidocaine 4%. In total, the documentation within Resident 16's MARs from 09/01/2025 through 11/04/2025 included a total of 63 administered doses/applications of lidocaine 4%. On 11/04/2025 at approximately 1:11 P.M., Surveyor conducted an interview with Resident 16's Pharmacy Representative X. Pharmacy Representative X told Surveyor one box of 30 lidocaine 4% patches was delivered to the facility on 08/14/2025. Pharmacy Representative X told Surveyor there have been no lidocaine 4% patches requested by the facility and/or delivered to the facility for Resident 16 since 08/14/2025. On 11/04/2025 at 1:34 P.M., Surveyor conducted an interview with Resident 16 and Resident 16's Legal Representative S within Resident 16's room. Surveyor observed Legal Representative S lift the back of Resident 16's shirt, revealing an intact medication patch dated "11/4 [11/04/2025]" affixed to Resident 16 lower back. Legal Representative S told Surveyor s/he visits Resident 16 almost every afternoon during the week and often adjusts Resident 16's shirt upon Resident 16's request. Legal Representative S said s/he had concerns Resident 16's lidocaine patch was not being administered as prescribed. Legal Representative S said s/he rarely observes a patch located on Resident 16's patch.	{N 352}		

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{N 352}	Continued From page 8 On 11/04/2025 at approximately 1:40 P.M., HSD R told Surveyor s/he applied Resident 16's lidocaine 4% patch to Resident 16's back this morning. HSD R told Surveyor it was clear to him/her Resident 16 was not being administered the lidocaine 4% patch daily as prescribed. Based on Resident 16's lidocaine 4% patch prescription, Resident 16's supply of a remaining lidocaine 4% patches refilled on 08/14/2025, and the caregiver documentation of 63 doses administered between 09/01/2025 and 11/04/2025, Resident 16 did not receive lidocaine 4% patch administration as prescribed. On 11/04/2025 at approximately 10:45 A.M., HSD R and Surveyor discussed Resident 11's and Resident 14's polyethylene and Resident 16's lidocaine 4% patch administration concerns and the facility's previous noncompliance with medication administration as prescribed. HSD R told Surveyor medication training had been provided to caregivers responsible for medication administration following issuance of the last SOD 3GKY12. HSD R told Surveyor Former Resident Care Coordinator (RCC) B was supposed to be conducting audits of the medication cart to ensure administration of resident medications was being completed as required. HSD R told Surveyor cart audits had not been completed by anyone since Former RCC B terminated full-time employment "a month or so ago." Example 4: Resident 20 On 11/04/2025, Surveyors reviewed Resident 20's records which documented:	{N 352}		

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{N 352}	Continued From page 9 Resident 20 was admitted to the facility on 08/12/2022. Resident 20's diagnosis included epilepsy and dementia. Surveyors reviewed Resident 20's MAR from 09/01/2025-11/04/2025 and noted the following medications not documented as administered (left blank/not charted) on several days: Tylenol 500 mg- Take 2 tablets three times daily. Not documented on: 09/08/2025 at 5:00 PM 09/11/2025 at 5:00 PM 09/12/2025 at 12:00 PM 10/07/2025 at 12:00 PM Divalproex 125 mg- Take 1 capsule twice daily. No documented on: 09/07/2025 at 5:00 PM 09/08/2025 at 5:00 PM 09/11/2025 at 8:00 AM 09/11/2025 at 5:00 PM Donepezil 10 mg- Take 1 tablet every evening. Not documented on: 09/08/2025 at 5:00 PM 09/11/2025 at 5:00 PM Escitalopram 10 mg- Take 1 tablet daily. Not documented on: 09/03/2025 at 8:00 PM Memantine 10 mg- Take 1 tablet twice daily. Not documented on: 09/08/2025 at 5:00 PM 09/11/2025 at 5:00 PM 09/23/2025 at 5:00 PM 09/27/2025 at 5:00 PM	{N 352}		

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{N 352}	Continued From page 10 Mirtazapine 7.5 mg- Take 1 tablet every evening. Not documented on: 09/08/2025 at 5:00 PM 09/11/2025 at 5:00 PM Phenytoin 30 mg- Take 6 capsules at bedtime. Not documented on: 09/08/2025 at 5:00 PM 09/11/2025 at 5:00 PM Quetiapine 25 mg- Take 1 tablet every evening. Not documented on: 09/08/2025 at 5:00 PM 09/11/2025 at 5:00 PM Vitamin D3 25 mcg- Take 1 tablet every evening. Not documented on: 09/08/2025 at 5:00 PM 09/11/2025 at 5:00 PM On 11/04/2025, Surveyors reviewed the facility staff schedule, specifically looking at 09/05/2025 AM shift, 09/08/2025 PM shift, 09/11/2025 PM shift, 09/17/2025 AM shift, 09/22/2025 AM shift, and 10/07/2025 AM shift, when most of the omissions occurred. Surveyors discussed the schedule with Administrator A and with HSD R, who stated the "red" on the schedule represents a call in. Surveyors were informed an "AM shift" is from 6:30 AM - 2:45 PM, and a "PM shift" is from 2:30 PM - 10:45 PM. Based on the staffing schedule, on 09/05/2025 there were 2 med techs on AM shift scheduled with no call ins. On 09/08/2025 there were 2 med techs on PM shift scheduled with no call ins. On 09/11/2025 there were 3 med techs scheduled with 2 call ins, so only 1 med tech was reflected on the	{N 352}		

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{N 352}	Continued From page 11 schedule. On 09/17/2025 there were 2 med techs scheduled for AM shift with no call ins. On 09/22/2025 there were 2 med techs scheduled for AM shift with 1 call in, so only 1 med tech was reflected on the schedule. On 10/07/2025 there were 2 med techs scheduled for AM shift with 1 call in, so only 1 med tech was reflected on the schedule. HSD R stated the facility may run with only 1 med tech at times, during the noon or pm medication pass, but that the morning or bedtime medication passes are too heavy, so there are always at least 2 med techs for those passes. HSD R stated if other coverage isn't found, s/he would assist as the 2nd med passer. On 11/04/2025 at approximately 12:30 PM, Surveyors interviewed HSD R who confirmed the medication passes above were not documented. S/he stated s/he would like to think the missing documentation is because staff forgot to chart, but that s/he could not confirm the medication was administered and they were considered "legal" omissions without being charted. Example 5: Resident 21 On 11/04/2025, Surveyors reviewed Resident 21's records which documented: Resident 21 was admitted to the facility on 02/25/2025. Resident 21's diagnosis included muscle weakness, dysphagia, other toxic encephalopathy, and hypokalemia. Surveyors reviewed Resident 21's MAR from 09/01/2025-11/04/2025 and noted the following medications not documented as administered (left	{N 352}		

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AUBERGE AT OAK VILLAGE A MEMORY CARE COMM	W128 N6900 NORTHFIELD DR MENOMONEE FALLS, WI 53051

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{N 352}	Continued From page 12 blank/not charted) on several days: Carboxymethylcellulose Sodium- Instill 1 drop into both eyes three times daily. Not documented on: 09/05/2025 at 8:00 AM 09/17/2025 at 12:00 PM 09/22/2025 at 12:00 PM 10/07/2025 at 8:00 AM 10/07/2025 at 12:00 PM Albuterol nebulizer- Inhale 3 MLs via nebulizer three times daily. Not documented on: 09/17/2025 at 12:00 PM 09/18/2025 at 8:00 AM 09/18/2025 at 12:00 PM 09/21/2025 at 8:00 PM 09/22/2025 at 12:00 PM 10/02/2025 at 8:00 AM 10/07/2025 at 8:00 AM 10/07/2025 at 12:00 PM Guaifenesin 100 MG/5 ML- Take 20 MLs three times daily. Not documented on: 09/17/2025 at 12:00 PM 09/22/2025 at 8:00 AM 09/22/2025 at 12:00 PM 10/07/2025 at 8:00 AM 10/07/2025 at 12:00 PM Valproic Acid 250 MG/5 ML- Take 5 MLs three times per day every day. Not documented on: 09/05/2025 at 8:00 AM 09/17/2025 at 12:00 PM 09/22/2025 at 12:00 PM	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017800	A. BUILDING: _____ B. WING _____	R-C 11/04/2025

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{N 352}	Continued From page 13 10/07/2025 at 8:00 AM 10/07/2025 at 12:00 PM Lidocaine 4% patch- Apply to lower back daily and remove at bedtime. Not documented on: 10/07/2025 at 8:00 AM On 11/04/2025, Surveyors reviewed the facility staff schedule, specifically looking at 09/05/2025 AM shift, 09/08/2025 PM shift, 09/11/2025 PM shift, 09/17/2025 AM shift, 09/22/2025 AM shift, and 10/07/2025 AM shift, when most of the omissions occurred. Surveyors discussed the schedule with Administrator A and with HSD R, who stated the "red" on the schedule represents a call in. Surveyors were informed an "AM shift" is from 6:30 AM - 2:45 PM, and a "PM shift" is from 2:30 PM - 10:45 PM. Based on the staffing schedule, on 09/05/2025 there were 2 med techs on AM shift scheduled with no call ins. On 09/08/2025 there were 2 med techs on PM shift scheduled with no call ins. On 09/11/2025 there were 3 med techs scheduled with 2 call ins, so only 1 med tech was reflected on the schedule. On 09/17/2025 there were 2 med techs scheduled for AM shift with no call ins. On 09/22/2025 there were 2 med techs scheduled for AM shift with 1 call in, so only 1 med tech was reflected on the schedule. On 10/07/2025 there were 2 med techs scheduled for AM shift with 1 call in, so only 1 med tech was reflected on the schedule. HSD R stated the facility may run with only 1 med tech at times, during the noon or pm medication pass, but that the morning or bedtime medication passes are too heavy, so there are always at least 2 med techs for those passes.	{N 352}		

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{N 352}	Continued From page 14 HSD R stated if other coverage isn't found, s/he would assist as the 2nd med passer. On 11/04/2025 at approximately 12:30 PM, Surveyors interviewed HSD R who confirmed the medication passes above were not documented. S/he stated s/he would like to think the missing documentation is because staff forgot to chart, but that s/he could not confirm the medication was administered and they were considered "legal" omissions without being charted.	{N 352}		
{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 involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 20's individual service plan (ISP) was updated when there were changes in his/her condition or needs.	{N 389}		

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{N 389}	Continued From page 15 This requirement is being cited for a third time. See Statement of Deficiency (SOD) 3GKY11, issued on 11/20/2024, and SOD 3GKY12, issued on 06/18/2025. Findings include: On 11/04/2025 at approximately 8:30 AM, Surveyors observed Resident 20 in the dining room. Resident 20 was utilizing a broda chair for mobility, and Surveyors noted a hoyer sling underneath Resident 20. Surveyors observed Resident 20's breakfast being served and noted Resident 20 received thickened liquids and pureed food. Surveyors toured the facility and entered Resident 20's room. Surveyors noted Resident 20 had a high-low hospital bed and a large fall mat (mattress) propped against the closet door. On 11/04/2025 at approximately 8:30 AM, Surveyors interviewed Caregiver Y. Caregiver Y stated Resident 20 utilizes a hoyer with assistance from 2 staff members for transfers, and the broda chair for mobility. Caregiver Y stated Resident 20 received thickened liquids, a pureed diet, and required total assistance with eating. Caregiver Y proceeded to assist Resident 20 with eating breakfast. On 11/04/2025 at approximately 11:30 AM, Surveyors interviewed Resident 20's Legal Representative Z. Resident 20's Legal Representative Z stated Resident 20 has been experiencing a progressive decline and a decrease in liquid intake and food consumption. Resident 20's Legal Representative Z stated Resident 20 is considered a "frequent faller", utilizes a hoyer lift for transfers, and a broda chair for mobility. Legal	{N 389}		

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{N 389}	Continued From page 16 Representative Z stated Resident 20 has been on hospice services and stated s/he has an open area on his/her coccyx. On 11/04/2025 Surveyors reviewed Resident 20's records and identified the following: Resident 20 was admitted to the facility on 08/12/2022. Resident 20's diagnosis included epilepsy and dementia. Surveyors reviewed Resident 20's ISP, signed and dated 09/09/2025. Resident 20's ISP did not include the following: -Use of a broda chair for mobility -Use of a hoyer lift with assistance from 2 staff for transfers -Fall risk status or precautions in place (hospital bed and fall mat) -Diet order or level of assistance with eating -Condition of skin or required care to maintain skin integrity On 11/04/2025 at approximately 2:40 PM, Surveyor reviewed the concern of missing information from Resident 20's ISP, with HSD R and Administrator A. Both were surprised and unaware of Resident 20's ISP missing so much information. HSD R indicated to Administrator A, that a previous employee was supposed to have updated Resident 20's ISP. HSD R showed Surveyors his/her "to do list" which did include an update to Resident 20's ISP, but did not go into detail of what would be updated. Administrator A and HSD R stated they would get it updated to reflect Resident 20's current needs.	{N 389}		