STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	C 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, WI 53711

(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 03/21/2025, with information gathered through 05/07/2025, Surveyor conducted 6 complaint investigations at Courtyard at Fitchburg - Memory Care. Seventeen deficiencies were identified. Six of 6 complaints were substantiated. Census: 29	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on interview and record review, after receiving allegations of abuse for 1 of 1 resident, the provider did not take immediate steps to ensure the safety of residents, investigate and	N 158		

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

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N 158	Continued From page 1	N 158		

document the allegations to make a determination about the alleged caregiver misconduct.

The provider did not investigate after Caregiver F and Caregiver H observed and reported Med Technician L had been physically aggressive towards Resident 2 during med administration.

Findings include:

The provider is licensed for a community based residential facility (CBRF), Class CNA (nonambulatory), to serve up to 36 residents within the client groups advanced aged, irreversible dementia/Alzheimer's, terminally ill, and physically disabled.

Abuse, as defined in Wisconsin Statue 46.90(1)(f), is the failure of a caregiver to try to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care. Physical abuse" means the intentional or reckless infliction of bodily harm. Bodily harm" means physical pain or injury, illness, or any impairment of physical condition.

On 02/27/2025, the Department received a complaint alleging residents were physically forced to take their medications.

On 03/22/2025, at approximately 3:00 PM, Surveyor interviewed Caregiver H. Caregiver H stated s/he and Caregiver F were getting Resident 2 ready for bed and Med Technician L came in to Resident 2's room to give him/her his/her evening meds. Caregiver H stated Resident 2 was really worked up that evening when s/he arrived for his/her shift, and s/he did

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not want to take his/her medications. Caregiver H stated Med Technician L took the cup of pills and forced them against his/her mouth; did the same with the water. Water was spilling out. Caregiver H stated, "I told [Med Technician L] to stop. I cleaned [Resident 2] up. I told [previous Administrator I] and s/he had me write up a statement." Surveyor asked how Med Technician L responded when s/he asked him/her to stop. Caregiver H stated, "[Med Technician L] kept saying [Resident 2] has to take the medications. [S/he] wouldn't try to redirect or let us calm [him/her] down. [Resident 2] does have the right to refuse." Surveyor asked if staff had received training and/or redirection after this incident. Caregiver H stated, "Nothing happened. It was frustrating."

On 03/22/2025, at approximately 3:30 PM, Surveyor interviewed Regional Vice President of Operations (RVPO) A. Surveyor asked for a copy of the internal investigation into Caregiver F's and Caregiver H's observation regarding Med Technician L. RVPO A stated s/he would need to review previous Administrator I's and/or previous Nurse J's records to determine if this concern had been investigated.

On 03/22/2025, at approximately 4:50 PM, Surveyor interviewed Caregiver F. Caregiver F stated s/he was working with Caregiver H, and they were providing cares to Resident 2. Caregiver F stated, "It was around 10:15 PM to 10:30 PM and [Resident 2] hadn't had [his/her] evening meds yet, so we were waiting for [Med Technician L] to administer the meds before placing [him/her] in bed. [Med Technician L] came into the room and [Resident 2] wasn't too sure if [s/he] wanted to take the meds. [Med Technician L] grabbed [his/her] face and poured

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N 158	Continued From page 3	N 158		

the pills into [his/her] mouth, and then the water. Water was spilling everywhere. It wasn't good." Caregiver F stated Caregiver H informed previous Administrator I or Previous Nurse J. Surveyor asked if staff had received training and/or redirection after this incident. Caregiver F stated, "I do my best not to work with [Med Technician L]. [S/he] always has an attitude."

On 04/10/2025 at 3:20 PM, Surveyor received an email from RVPO A which contained a "Complaint/Grievance Form," dated 04/01/2025, that documented RVPO A had conducted an internal investigation into the concern due to Surveyor's expressed concern. The form stated, "Employee utilized inappropriate approach - cannot substantiate approach met definition of abuse."

On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO A and Executive Director B. RVPO A proceeded to look through some additional records held by previous Administrator I and was unable to locate any statements or internal investigations into Caregiver F's and Caregiver H's observations of Med Technician L aggressively administering medications to Resident 2.

On 04/26/2025, Surveyor reviewed the facility department file to determine if a written report had been filed regarding the allegation of physical aggression towards Resident 2. A written report was not on file.

On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor stated the provider was unable to show that Resident 2 or any other resident had been protected from

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N 158	Continued From page 4 inappropriate medication administration prior to Surveyor investigation. Surveyor did not receive a response.	N 158		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify 1 of 1 resident's representative when there was an allegation of abuse. Resident 2's Power of Attorney (POA) K was not informed when Caregiver F and Caregiver H observed Med Technician L being physically aggressive towards Resident 2 during med administration. Findings include: On 02/27/2025, the Department received a complaint alleging residents were physically forced to take their medications. On 03/22/2025, at approximately 3:00 PM, Surveyor interviewed Caregiver H. Caregiver H stated s/he had observed Med Technician L aggressively administer Resident 2's medications. Caregiver H stated s/he informed management, and they asked him/her to fill out a	N 170		

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N 170	Continued From page 5	N 170		

statement, which s/he did.

On 03/22/2025, at approximately 4:50 PM, Surveyor interviewed Caregiver F. Caregiver F stated s/he had observed Med Technician L aggressively administer Resident 2's medications when s/he was assisting Caregiver H.

On 03/24/2025 at 4:36 PM, RVPO A emailed Surveyor and stated, "I found the investigation notes regarding [Resident 2's] interactions with a staff member. This appears to have occurred in July of 2024. The individual indicated in this investigation no longer works here."

On 04/10/2025 at 3:20 PM, Surveyor received an email from RVPO A which contained a "Complaint/Grievance Form," dated 04/01/2025, that documented RVPO A conducted an internal investigation into the concern related to Med Technician L forcefully administering medications due to Surveyor's expressed concern. RVPO A documented, "Employee utilized inappropriate approach - cannot substantiate approach met definition of abuse."

On 04/11/2025, at approximately 10:15 AM, Surveyor interviewed Resident 2's POA K. Surveyor asked if s/he had been contacted when there was an incident involving Resident 2 not wanting to take his/her medication. POA K stated, "Staff have called me when [s/he] was refusing medications, sometimes I think s/he is just confused, there is frequent staff changes, and his/her cognition is declining. I was never informed of any incident regarding staff being forceful with him/her during med administration." Surveyor discussed the incident that had been explained by Caregiver F and Caregiver H. Surveyor had been informed that Resident 2 did

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N 170	Continued From page 6 not want to take his/her medication so Med Technician L forced him/her to take the medications. POA K was not contacted when the allegation was first expressed by Caregiver F and Caregiver H that they had observed Med Technician L be physically aggressive towards Resident 2 during med administration and RVPO A had not contacted POA K to notify him/her that a concern had been brought forward by the Surveyor. On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor stated that based on the information provided, there had been an allegation of forceful administration of medications to Resident 2 on two different occasions. POA K was not contacted regarding the allegations. Surveyor did not receive a response. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect Cross Reference: N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment	N 170		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure compliance was maintained with all laws governing the CBRF	N 196		

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N 196	Continued From page 7 (community-based residential facility). Findings include: The provider received a probationary license on 09/20/2023 and a regular license on 08/28/2024 as a class CNA (nonambulatory) CBRF able to serve up to 36 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled. On 03/22/2025, with information gathered through 05/05/2025, Surveyor conducted 6 complaint investigations at The Courtyard at Fitchburg - Memory Care. Seventeen deficiencies, including this one, were identified: N0158 83.12(2)(a) Caregiver: Investigating Abuse and Neglect N0170 83.12(5)(b) Notification: Abuse and Neglect Allegations N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0352 83.32(3)(h) Rights of Residents: Receive Medication N0364 83.33(3) Assistance with Grievance Procedure N0381 83.35(1)(a) Pre-Admission and Ongoing Assessments N0388 83.35(3)(c) Implement, Follow the Individual Service Plan N0389 83.35(3)(d) Service Plans Updated Annually or on Changes N0406 83.37(1)(g) Disposition of Medications N0410 83.37(1)(k) Medication Error or Adverse Reaction N0415 83.37(2)(d) Documentation of Medication Administration N0431 83.38(1)(g) Health Monitoring N0448 83.41(2)(a) Nutrition: Diet	N 196		

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N 196	Continued From page 8 N0449 83.41(2)(b) Nutrition: Meals N0450 83.41(2)(c) Nutrition: Menus Y3234 50.09(1)(e) Treatment Y3234 50.09(1)(L) Care Review of facility records documented a previous survey event identifying noncompliance, as follows: SOD KI2611 - dated 04/22/2024 On 04/22/2024, Surveyor conducted a standard license survey at Courtyard at Fitchburg - Memory Care. The survey identified five deficiencies. N0239 83.20(2)(a)-(d) Department-Approved Training Courses N0386 83.35(3)(a) Comprehensive Individualized Service Plan N0387 83.35(3)(b) Service Plan Development: Parties Involved N0408 83.37(1)(i) PRN Psychotropic Medication N0525 83.47(2)(d) Fire Drills On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO (Regional Vice President of Operations) A, Executive Director B and Regional Wellness Director C. RVPO A stated they were aware of the ongoing concerns.	N 196		
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	N 352		

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N 352	Continued From page 9 is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not administer medications in the intervals prescribed by a practitioner. Resident 1's prescribed methylphenidate (medication to treat attention deficit hyperactivity disorder [ADHD]), donepezil (treats symptoms of Alzheimer's disease), and turmeric were not administered as prescribed due to unavailability. Resident 9's prescribed Fluticasone Propionate (nasal spray) was not administered as prescribed. Resident 13's prescribed Estradiol was not administered as prescribed. Resident 19's 04/28/2025 8:00 AM medications were documented as received but they were in the med cart. Medications were found in resident rooms that were not prescribed to them or that were not administered. Findings Include: On 02/27/2025, 04/03/2025, and 04/23/2025, the Department received a complaint alleging residents were not receiving prescribed medications. Example 1: Resident 1 On 03/22/2025, Surveyor and Regional Vice President of Operations (RVPO) A reviewed Resident 1's record.	N 352		

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N 352	Continued From page 10 Resident 1 moved into the facility 07/18/2024 and discharged 02/27/2025. Resident 1's January and February 2025 MARs (Medication Administration Record) documented the following prescribed medication: "Methylphenidate HCL (hydrochloride) 20 MG (milligram) - Take 1 tablet by mouth in the morning. Scheduled at 8:00 AM. Start Date: 01/16/2025. Discontinued 02/12/2025." Documented as unavailable 01/21 to 02/12. "Donepezil HCL 5 MG - Take 1 tablet by mouth at bedtime. Scheduled at 8:00 PM. Start Date: 09/23/2024." Documented as unavailable 01/27 to 01/30. "Turmeric 500 MG - Take 2 capsules by mouth 2 times a day. Start Date: 09/30/2024. Scheduled at 8:00 AM and 8:00 PM." Documented as unavailable 01/27 to 01/30 for the 8:00 PM administration time. Resident 1's "Observations" documented: 01/24/2025 - [Pharmacy] have one more remaining refill of Methylphenidate HCL, reordered through [Pharmacy] portal. 01/29/2025 - Many of [Resident 1's] meds are not in cart. Call placed to [Pharmacy]. There is an insurance issue ... Writer will also call POA (power of attorney) for further direction. ... Spoke with [daughter/son]. Claiming to have not received any calls from [Pharmacy] ... 01/30/2025 - For now, family okay with paying out of pocket for 2 week supply of [Resident 1's] meds. 02/06/2025 - Reordered Methylphenidate through [Pharmacy] On 03/22/2025, at approximately 2:30 PM, Surveyor interviewed RVPO A. RVPO A stated	N 352		

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s/he reviewed the previous nurses' notes where it was documented there were concerns with Resident 1's insurance. Surveyor stated the observation notes documented that the insurance issue was not recognized until 01/29/2025 and on 01/30/2025, the family agreed to pay for the medications, but Resident 1 still did not receive the Methylphenidate. RVPO A stated s/he would need to determine if previous Nurse J had additional documentation.

Example 2: Resident 9

On 04/09/2025, at approximately 10:05 AM, Surveyor and Executive Director B observed Resident 9's medications in the med cart. Surveyor observed an opened bottle of Fluticasone Propionate, with a dispensed date of 12/02/2024, which appeared to be approximately 50% full.

On 04/13/2025, Surveyor reviewed Resident 9's record provided by RVPO A.

Resident 9 moved into the facility 12/04/2024.

Resident 9's MARs, dated 01/01/2025 to 04/11/2025, documented:
Fluticasone Propionate 50 MCG (micrograms) / actuation - Use 2 sprays in each nostril in the morning. Start Date: 12/04/2024.
The MARs documented administration for 99 out of 100 opportunities.

Resident 9's pharmacy packing lists documented the Fluticasone Propionate was only delivered on 12/02/2024.

"Each bottle contains a net fill weight of 16 g (grams) and will provide 120 actuations. Each

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actuation delivers 50 mcg (micrograms) of fluticasone propionate in 100 mg (milligram) of formulation through the nasal adapter. The correct amount of medication in each spray cannot be assured after 120 sprays even though the bottle is not completely empty." (Source: National Institute of Health website, Fluticasone Propionate, 12/2022, https://dailymed.nlm.nih.gov/dailymed/fda (retrieval date - July 24, 2024).)

Surveyor noted Resident 9's bottle of Fluticasone prescribed on 12/04/2024 would have run out approximately January 04, 2025 (2 sprays/actuations per nostril/day = 4 / day x 30 day = 120 sprays/actuations = 1 bottle / 30 days).

On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO A and Executive Director B. RVPO A stated a consultant had been hired to assist with auditing of medication administration and medication availability.

Example 3: Resident 13

On 05/02/2025, Surveyor reviewed Resident 13's record provided by Regional Wellness Coordinator C.

Resident 13 moved into the facility, 09/10/2024, with diagnoses including post-traumatic stress disorder (PTSD), neurocognitive disorder with Lewy bodies, and Parkinson's disease.

Resident 13's March and April MAR documented: Estradiol 0.1 MG/Gram - Apply 1 gram in the morning once a week on Tuesday. Start Date: 03/04/2025. End Date 04/02/2025.
The MARs documented the medication was not available on 04/02/2025.

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Estradiol 0.1 MG/Gram - Insert 0.5 gm (gram) at bedtime 2 times a week on Mondays and Thursdays. Start Date: 04/02/2025.
The MAR documented that the medication was not available on 04/14, 04/17, 04/21, 04/24, and 04/28.

On 04/29/2025, at approximately 5:15 PM, Surveyor interviewed Med Technician M and Med Technician N. Surveyor asked if there were concerns with residents not receiving their scheduled medications. Med Technician M and Med Technician N stated medications had been found on Resident 13's floor, meaning s/he did not receive them. Med Technician Q had been known to hand residents their pill cups and walk away, not ensuring residents had taken their medications. Med Technician N stated, "I have taken pictures of medications found in [Resident 13's] room, on the floor, [s/he] has Parkinson's, [s/he] is unsteady, you have to watch [him/her] take [his/her] medications."

Example 4: Resident 19

On 04/29/2025, at approximately 3:45 PM, Surveyor and Med Technician M observed Resident 19's medications in the med cart. Surveyor observed a medication pouch that stated 04/28/2025 8:00 AM - Amlodipine 10 MG (1), Losartan Potassium 100 MG (1), Pantoprazole 40 MG (1), Sertraline 100 MG (1), and Vitamin B-12 100 MCG (1). Med Technician M did not know why the medications had not been administered.

On 05/04/2025, Surveyor reviewed Resident 19's April 2025 MAR provided by Regional Wellness Coordinator C. The MAR documented that the medications from 04/28/2025 at 8:00 AM had

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N 352	Continued From page 14 been administered. Example 5: Medications On 04/17/2025, the Department received a concern alleging medication cups were being left in resident rooms. On 04/29/2025, at approximately 3:20 PM, Surveyor interviewed Med Technician M and Med Technician N. Med Technician M stated s/he was aware of medications being found in the wrong resident's room. Med Technician M stated Resident 5's Family Member (FM) O brought two pill cups of medications to him/her. Med Technician M stated, "I immediately knew they did not belong to [Resident 5]. One cup had 7 pills in it and the other had around 15 pills in it. FM O took a picture of them, and I gave the pills to Executive Director B." Med Technician M stated Med Technician P and Med Technician Q were working the previous shift before the medications had been discovered. Med Technician N explained that s/he had gone in to assist a resident and found medications on the floor, in their bed, or on them. Med Technician N stated, "I always take a picture so I can send it to [Wellness Coordinator R]." Med Technician N showed Surveyor some pictures which documented: "04/22/2025 5:40 AM - This is from pm shift and it was found on [Resident 17's] shirt." Wellness Coordinator R responded Thank you. "04/22/2025 11:25 PM - This was found in [Resident 18's] room on [his/her] bed from pm shift." On 04/23/2025 at 1:16 AM - Wellness Coordinator R responded, "I'll see about getting a crush order for [him/her] since [s/he] seems to be not swallowing that pill. Thank you."	N 352		

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N 352	Continued From page 15 On 04/29/2025, at approximately 4:10 PM, Surveyor interviewed Executive Director B. Executive Director B stated s/he was given 2 pill cups full of medication. Executive Director B stated s/he immediately started an investigation and was unable to determine who the medications belonged to. Executive Director B stated, "It appeared that there was more than one resident's medications in a pill cup. I requested Med Technician P to report to me, but [s/he] quit after I asked him/her to report to me." On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor discussed the concerns with residents not receiving their prescribed medications. Surveyor did not receive a response. On 05/05/2025, at approximately 10:40 AM, Surveyor interviewed Resident 20's Power of Attorney (POA) X. POA X stated on 05/02/2025 a full vial of insulin was found in Resident 20's room. Resident 20, who is a diabetic, is not prescribed insulin. The vial was given to Associate Administrator F.	N 352		
N 364	83.33(3) Assistance with grievance procedures The CBRF shall assist residents with grievance procedures as required under this section. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were assisted with grievance procedures. Staff did not offer to assist Resident 8 to	N 364		

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complete a grievance form when s/he was dressed in another resident's clothing. Staff did not offer to assist Resident 17 to complete a grievance form when s/he reported missing personal items.

Findings include:

On 02/27/2025, the Department received a concern regarding the timeliness of laundry completion and laundry items not being returned to the proper resident.

The provider was licensed as a class CNA (nonambulatory) CBRF (Community-Based Residential Facility) able to serve up to 36 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled.

On 03/21/2025, at approximately 4:00 PM, Surveyor requested grievances and missing items reports for 2025 from Administrator I. Administrator I stated there were no grievances filed for laundry concerns. Administrator I stated, "When a resident or a family member brings a concern regarding laundry or a missing item, we make a note, try to resolve the concern the day it is brought to us, but there is no official grievance form filled out."

On 03/22/2025, at approximately 4:50 PM, Surveyor interviewed Caregiver F. Surveyor asked if residents or resident representatives had expressed concerns regarding laundry being misplaced. Caregiver F stated individuals had expressed frustration to him/her regarding a resident's laundry being misplaced. Caregiver F stated, "I don't know how the clothes can get misplaced. It should not happen. Everyone has

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a labeled laundry basket. We never mix residents clothes together to wash." Surveyor asked Caregiver F if s/he assisted residents with filling out a grievance form when they reported concerns of missing laundry. Caregiver F stated, "I have never filled out a grievance form, I just tell someone in management."

On 04/03/2025, at approximately 11:40 AM, Surveyor interviewed Med Technician P. Surveyor asked if s/he was aware of concerns regarding laundry being completed when scheduled and that laundry was misplaced. Med Technician P stated, "The laundry doesn't always get finished, so it doesn't get returned until the next day, which can be upsetting to the residents. There are times items don't get returned, and I don't understand how that happens. Laundry is to be done separately." Surveyor asked Med Technician P if s/he assisted residents with filling out a grievance form when they reported concerns of missing laundry. Med Technician P stated, "What is a grievance form, I don't think we have anything like that."

On 04/09/2025, at approximately 11:15 AM, Surveyor toured the laundry room. Surveyor observed cupboards in the room and opened the door to find 7 shelves worth of miscellaneous clothing and linens.

On 04/09/2025, at approximately 11:20 AM, Surveyor observed a sign hanging on the concierge's desk that stated, "[Resident 17] is missing purple hand towels which match [his/her] purple bath towels. [S/he's] also missing a hand towel with flowers."

On 04/11/2025, at approximately 5:15 PM, Surveyor interviewed Associate Administrator D.

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Surveyor explained his/her observations of the clothing/linens in the laundry room and the note regarding Resident 17's missing towels. Associate Administrator D stated the clothing were items that were misplaced and/or items that had been left behind when a resident discharged from the facility. Surveyor asked if there was a grievance process in place for residents that expressed concerns about missing laundry. Associate Administrator D stated s/he was not aware of any specific form.

On 05/05/2025 at 10:00 AM, Surveyor interviewed Regional Vice President of Operations (RVPO) A, Executive Director B and Regional Wellness Director C. RVPO A stated residents needed to make sure their laundry was labeled. RVPO A explained that laundry could be misplaced if the staff member who washed it, did not label the machine, and another staff member was going to finish the laundry process.

On 05/07/2025 at 7:06 PM, Surveyor received an email from Resident 8's Friend FF. Friend FF had emailed RVPO A on 05/07/2025 and stated, "I have repeatedly objected to [Resident 8] being dressed in someone else's clothes. Like this polo with a 5" tear in the neckline. (Picture was attached). Or clothes washed with a Depends. (Picture was attached). Plus all the clothes lost and never found. I have a list. I launder [Resident 8's] blouses and iron them, so [s/he] looks nice. Tonight I went through [his/her] laundry basket and found this (pictures of black slacks with a rubber band used to tighten the wasteband) First, these slacks are NOT [Resident 8's]. Second, a rubber band was placed on the waist band to cinch them up." Friend FF forwarded Surveyor an email that s/he had sent on 03/21/2025 to Assistant Administrator

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N 364	Continued From page 19 D, which stated: I have reported laundry problems to [RVPO A] on three occasions. Nothing has changed. o. I consistently find [Resident 8] dressed in someone else's clothes. When this is the case, I will ask that someone change [his/her] clothes immediately. o. I consistently find someone else's clothes in [Resident 8's] closet and laundry bin. o. Today [Resident 8's] bed had no mattress pad, no fitted sheet, just a cover sheet and a blanket. [Resident 8] has 2 mattress pads. There was a clean mattress pad and clean sheets in [his/her] closet. o. Yesterday I did part of [Resident 8's] laundry and found 3 pajama tops and no bottoms. o. [Resident 8] has plenty of clothes. [S/he] should be dressed in clothes that match/go together.	N 364		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by:	N 381		

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Based on observation, record review, and interview, the provider did not ensure an assessment for 1 of 1 resident's physical and mental condition was completed when there was a change in needs.

Resident 19 displayed difficulty maneuvering silverware and cups of hot liquid during mealtimes and was not reassessed to determine if s/he required sit-by assist.

Findings include:

The provider is licensed for a community based residential facility (CBRF), Class CNA (nonambulatory), to serve up to 36 residents within the client groups advanced aged, irreversible dementia/Alzheimer's, terminally ill, and physically disabled.

On 04/11/2025, at approximately 4:15 PM, Surveyor observed the evening meal. Resident 19's eating utensils and plated food was placed in front of him/her. Surveyor noted that Resident 19 unrolled his/her silverware and attempted to eat, unassisted, and displayed difficulty maneuvering his/her silverware to ensure food stayed on the eating utensil. Resident 19 spilled a lot of food onto the table. Staff did not assist him/her to ensure s/he received an adequate amount of food intake.

On 04/29/2025, at approximately 4:30 PM, Surveyor observed the evening meal. Associate Administrator D placed a cup of hot coffee on the table in front of Resident 19. Resident 19's dessert was placed on the table. Resident 19 attempted to maneuver his/her silverware to eat the dessert. Resident 19 displayed difficulty and most of the food landed on the table. When

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Resident 19 attempted to drink his/her coffee, s/he displayed shakiness and coffee was spilling. Med Technician M and Med Technician N observed this concern and called Resident 19's name several times as they walked over to the table. Med Technician M and Med Technician N stated a staff member would need to assist him/her as s/he would not be able to eat the soup and salad that was served. Associate Administrator D stated Resident 19 requested the coffee so s/he was given the coffee. Surveyor noted the coffee cup did not have a lid on it. Med Technician M and Med Technician N stated that Resident 19 needed to be assessed as a sit-by assist.

On 05/04/2025, Surveyor requested Resident 19's assessments and individual service plan from Regional Wellness Director (RWD) C.

On 05/05/2025, Surveyor reviewed Resident 19's documentation provided by Regional Wellness Director (RWD) C.

Resident 19 moved into the facility 01/09/2025.

Resident 19's "Care Plan," dated 02/06/2025, documented:
"Eating - Resident is independent with dining. Reminder to take all meals in dining room. Assistance cutting food. Requires assistance with set up of meal."

Assessments were not provided.

On 05/05/2025 at 10:00 AM, Surveyor interviewed Regional Vice President of Operations (RVPO) A, Executive Director B and RWD C. Surveyor discussed his/her observations of Resident 19 and asked when

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N 381	Continued From page 22 s/he would be reassessed to determine if /she needed sit-by assist with meals. RVPO A stated Resident 19 would need to display a permanent change in condition. RWD C stated, "This is a memory care unit, staff should always be monitoring the residents. I have not received a request by staff to have him/her reassessed."	N 381		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not follow the resident's Individual Service Plan (ISP) as written for 3 of 4 residents reviewed. Resident 4's bedroom did not receive identified housekeeping services. Resident 5's bedroom did not receive identified housekeeping services and s/he did not receive scheduled laundry services. Resident 15's laundry was not completed as scheduled. Findings include: The facility is licensed as a Class CNA (non-ambulatory) assisted living facility that can provide care and services to 36 residents within the client groups: terminally ill, irreversible dementia/Alzheimer's, advanced aged, and physically disabled. Findings include:	N 388		

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N 388	Continued From page 23 On 02/27/2025, the Department received a complaint alleging resident rooms were not provided housekeeping. Example 1: Resident 4 On 03/22/2025, at approximately 3:15 PM, Surveyor asked Med Technician L to tour Resident 4's bedroom. Surveyor stated there was a strong smell of urine as one entered Resident 4's bedroom. The smell could be detected from at least 10 feet from Resident 4's bedroom. Med Technician L stated, "I think the odor is in [his/her] carpet because [s/he] deals with incontinence and we find [him/her] on the floor." On 04/09/2025, at approximately 10:50 AM, Surveyor observed Resident 4's room and detected a urine like scent emanating throughout. On 04/18/2025 at 3:10 PM, Surveyor interviewed Regional Vice President of Operations (RVPO) B and Executive Director F. RVPO B stated that there had been a breakdown in shift responsibilities and who was responsible for what tasks. On 04/25/2025, Surveyor reviewed Resident 4's record provided by Regional Wellness Coordinator C. Resident 4 moved into the facility 10/22/2024. Resident 4's "Care Plan," dated 04/23/2025, documented: "Housekeeping Skills: Housekeeping staff will clean [Resident 4's] room 1x weekly and PRN (as needed)."	N 388		

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Example 2: Resident 5

On 03/22/2025, at approximately 2:30 PM, Surveyor detected a urine like scent emanating into the hallway from Resident 5's room. Surveyor entered Resident 5's room and determined his/her bed was a source of the odor.

On 03/22/2025, at approximately 4:50 PM, Surveyor interviewed Med Technician D. Med Technician D stated that soiled undergarments were left in garbage cans which would cause resident rooms to have an incontinence odor. Med Technician D stated Resident 5's room had a strong urine like scent odor, and s/he suspected it was due to his/her bed.

On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO B and Executive Director F. RVPO B stated that there had been a breakdown in shift responsibilities and who was responsible for what tasks.

On 04/28/2025, Surveyor reviewed Resident 5's record.

Resident 5 moved into the facility 09/16/2024.

Resident 5's "Care Plan," dated 02/20/2025, documented:
"Housekeeping Skills: [Resident 5] utilizes standard housekeeping services on Tuesdays and Thursdays. Staff will deep clean [Resident 5's] apartment weekly per the housekeeping schedule and assist in keeping [his/her] room clean and tidy through next review date."
"Laundry Services: [Resident 5] utilizes standard laundry services on Tuesday and Thursdays. Staff will wash, dry, fold and put away all of [Resident 5's] laundry and bed linens weekly per

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the laundry schedule and as needed through next review date."

On Tuesday, 04/29/2025, at approximately 3:40 PM, Surveyor observed Resident 5's room. Resident 5's laundry baskets were overflowing with soiled laundry. Surveyor observed a sign hanging on his/her bathroom door that stated, "Shower/Laundry Days - Mondays AM & Fridays AM." Surveyor noted the room had a urine like aroma and determined that Resident 5's blankets on his/her bed contained the aroma.

On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor discussed the observations of the rooms. Surveyor did not receive a response.

Example 3: Resident 15

On 02/27/2025, the Department received a concern regarding the timeliness of laundry completion and laundry items not being returned to the proper resident.

On 04/09/2025, at approximately 10:45 AM, Surveyor toured Resident 15's room. Resident 15's bathroom contained soiled black sweatpants hanging on a grab bar in the shower, 2 pairs of soiled sweatpants hanging on the grab bar next to the toilet, a pair of soiled black shorts lying on the floor next to the toilet, the laundry basket was full of soiled clothing.

On 04/25/2025, Surveyor reviewed Resident 15's "Service Plan," dated 11/20/2024, documented: "Resident will continue to utilize standard laundry services in order to have clean clothing and bed linens each day."

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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 4 of 6 resident's Individual Service Plans (ISPs) were updated when there was a change of condition in the resident's needs, abilities, or physical or mental condition. Resident 5's and 8's ISPs were not updated to provide guidance regarding his/her dietary requirements. Resident 14's and 15's ISPs were not updated to provide guidance for his/her showering behaviors. Resident 14's ISP was not updated to provide guidance regarding his/her refusal of medications. Findings include: Example 1: Resident 5	N 389		

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On 04/03/2025, the Department received a concern alleging residents did not receive assistance with eating.

On 03/22/2025, 04/09/2025, 04/11/2025, and 04/29/2025, Surveyor observed Resident 5 while Surveyor was onsite conducting complaint investigations. Resident 5 often walked up to Surveyor and engaged in small talk, that was unrelated to the current surroundings. Resident 5 and Surveyor would walk up and down the hallways together. Resident 5 was consistently walking. On 04/11/2025 and 04/29/2025, Surveyor also observed mealtimes and Resident 5 never sat down. Resident 5 would continue to walk around the facility and throughout the dining room. Resident 5 would occasionally grab a food item off the counter that s/he could eat while walking, for instance a bowl of dessert.

On 04/11/2025, at approximately 5:15 PM, Surveyor interviewed Associate Administrator D. Surveyor asked what Resident 5's normal routine was for mealtime. Associate Administrator D stated that Resident 5 was not going to sit down and eat a meal. Staff could encourage him/her to sit at the table and eat a meal, but s/he is not going to do it. Associate Administrator D stated Resident 5 does better with "finger foods" that s/he can easily eat while walking.

On 04/29/2025, at approximately 4:45 PM, Surveyor interviewed Med Technician N. Surveyor asked what Resident 5's normal routine was for mealtime. Med Technician N stated Resident 5 will not sit down and eat. Med Technician N stated, "As you saw, we got excited because [s/he] picked up a bowl of the dessert and started to eat it. [S/he] never eats. [His/Her] spouse will bring [him/her] food sometimes in the

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evening. I don't know if [s/he] has better luck. [S/he] is always on the move."

On 05/04/2025, Surveyor reviewed Resident 5's record provided by Regional Wellness Director C.

Resident 5 moved into the facility, 09/16/2024, with diagnosis including Alzheimer's.

Resident 5's ISP, dated 02/20/2025, documented:
"Eating: Requires verbal prompts to eat. Requires assistance with set up of meal. [S/he] needs reminders to stay at the table and that it is mealtime. [S/he] needs straws with [his/her] drinks."
"Orientation/Decision Making: High energy, highly active, and was accustomed to coming and going as often as [s/he] liked before moving here."
The ISP did not identify that Resident 5 will not sit down for meals or the need to provide finger foods.

On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor discussed the concerns that resident behaviors are not identified in their ISP to provide guidance to staff members on how to provide adequate cares. Surveyor did not receive a response.

Example 2: Resident 8

On 04/03/2025, the Department received an allegation that residents were not receiving prescribed diets.

On 04/11/2025, at approximately 12:10 PM, Surveyor observed Resident 8 during the noon meal. Resident 8 was provided a plate of food

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which consisted of baked fish, brussel sprouts, and rice pilaf. Resident 8 did not attempt to use his/her silverware but did pick a brussel sprout up with his/her fingers.

On 04/11/2025, at approximately 4:50 PM, Surveyor observed Resident 8 during the evening meal. Resident 8 was provided a plate of food which consisted of lasagna hot dish, steamed carrots, and a dinner roll. Resident 8 did not attempt to eat the food. At approximately 5:30 PM, a staff member proceeded to stand over Resident 8 and assist him/her with eating.

On 04/12/2025, Surveyor reviewed Resident 8's record provided by Regional Vice President of Operations (RVPO) A.

Resident 8 moved into the facility 10/10/2024.

Resident 8's ISP, dated 10/15/2024, documented: "Eating: Independent with dining and enjoys a variety of foods. Requires assistance with set up of meal, such as opening packets, buttering bread, cutting meals, etc."

Surveyor noted the ISP did not outline that Resident 8 was a sit-by assist with eating.

On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor discussed the concerns that resident behaviors are not identified in their ISP to provide guidance to staff members on how to provide adequate cares. Surveyor did not receive a response.

Example 3: Resident 14

On 02/27/2025, the Department received a

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concern alleging residents do not receive medications as prescribed.
On 04/03/2025, the Department received a concern alleging residents did not receive scheduled showers.
On 04/23/2025, the Department received a concern alleging medications are not given on time.

On 03/22/2025, at approximately 3:25 PM, Surveyor interviewed Caregiver E. Surveyor asked if there were any residents who would refuse showers. Caregiver E stated, "[Resident 14] was difficult to shower. [S/he] refused to get in the shower. We would have to lay towels onto the bathroom floor and convince [him/her] to stand on the towels while we use the shower head and wash [him/her] while standing there. It is difficult and [s/he] probably hasn't always gotten [his/her] shower due to that."

On 04/18/2025, at approximately 3:10 PM, Surveyor interviewed RVPO A and Executive Director B. Surveyor asked for documentation showing when a resident received or refused a shower. RVPO A stated staff charted by exception.

On 04/28/2025, Surveyor reviewed Resident 14's record provided by Regional Wellness Coordinator C.

Resident 14 moved into the facility 05/02/2024.

Resident 14's "Observations," documented:
"01/27/2025 - Resident have been refusing meds and cares on second shift more than s/he used to ..."
"01/29/2025 - Resident will not get up and come down for lunch will not take meds ..."

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"02/08/2025 - Resident refused all of his/her pills today."
"02/09/2025 - Resident refused morning and noon pills."
"03/01/2025 - Resident got upset with writer for giving resident their 4 PM pills and almost hit the writer."
04/20/2025 - Continues to not take his/her medication as prescribed.

Resident 14's ISP, dated 04/15/2025, documented:
"Bathing: Requires physical assist for showering. Once every Monday, Wednesday and as needed."
"Physical Disabilities - Falls: To receive assistance from staff with managing/administering medications per physician's orders. [Resident 14] uses Scheduled psychotropics."

On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor discussed the concerns that resident behaviors are not identified in their ISP to provide guidance to staff members on how to provide adequate cares. Regional Wellness Director C stated that a refusal is not a behavior, "It is their right to refuse."

Example 4: Resident 15

On 04/03/2025, the Department received a concern alleging residents did not receive scheduled showers.

On 04/09/2025, at approximately 10:45 AM, Surveyor observed Resident 15 in his/her room. Resident 15 was dressed in several layers of

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clothes along with winter boots.

On 04/15/2025, Surveyor reviewed Resident 15's record provided by RVPO A.

Resident 15 moved into the facility 04/30/2024.

Resident 15's "Observations," dated 01/01/2025 to 04/09/2025, documented:
"02/25/2025 - Staff noticed resident had a bm (bowel movement) accident. Multiple staff approached. Several staff members, including this writer have attempted to approach [Resident 15] regarding changing [his/her] pants due to incontinence and resident is refusing to allow staff to assist in cares."
03/27/2025 - This staff had a conversation with the residents [son/daughter] about hygiene concerns. Resident refuses to shower. I learned that resident is scared of water and the shower. [S/he] does okay in a tub if [s/he] trust you enough. [S/he] has refused wearing incontinent undergarments as well. I tried to have a conversation with [him/her] but [s/he] refuses to wear them. We reapproach but have been unsuccessful. I talked to the [son/daughter] on March 25, 2025 at 3:45 PM. [His/her] room needs to be checked on shifts for incontinence in [his/her] bed."

Resident 15's ISP, dated 05/29/2024, documented:
"Bathing: Resident will maintain current level of independence, with set up assist from staff. Staff to set up bathing supplies."
"Bathroom Assistance: Resident is continent of bowel and bladder and manages independently. [Resident 15] can take care of [his/her] toileting needs independently."

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N 389	Continued From page 33 On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor discussed the concerns that resident behaviors are not identified in their ISP to provide guidance to staff members on how to provide adequate cares. Regional Wellness Director C stated that a refusal is not a behavior, "It is their right to refuse." Cross Reference: Y3234 50.09(1)(e) Treatment	N 389		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.	N 406		

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N 406	Continued From page 34 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications that had been changed, discontinued, or expired were removed from the medication cart and disposed of within 30 days. Findings include: On 04/03/2025, the Department received a concern alleging residents were receiving the wrong medications and the med cart was not organized. On 04/09/2025, at approximately 9:55 AM, Surveyor and Executive Director B observed the medication cart and observed: Resident 2's container of Nitroglycerin, with a dispensed date of 11/03/2023, and a discard date of 11/2024. Resident 6's bottle of Systane Original eye drops, with a dispensed date of 02/09/2024, and a discard date of 02/20/2025. Resident 7's bottle of Carbamide Peroxide (eye drops), with a dispensed date of 10/30/2024, and a discontinued date of 11/10/2024. Resident 7's bottle of Carbamide Peroxide, with a discontinued date of 10/16/2024. Resident 11's bottle of Fluticasone Propionate, with a dispensed date of 01/29/2025, and a discontinued date of 02/08/2025. Resident 12's container of Nitroglycerin, with a dispensed date of 02/22/2024, and a discard date of 02/2025. Resident 12's container of Nitroglycerin, with a dispensed date of 01/26/2025, and a discard date of 01/2025. Executive Director B stated s/he had just asked the nurse to review the medication cart for	N 406		

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N 406	Continued From page 35 expired medications and s/he would have to discuss his/her process to ensure accuracy. On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor discussed the concern with expired medications stored with current medications. Surveyor did not receive a response.	N 406		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify 2 of 2 resident's prescribing practitioner, nurse, or pharmacist when s/he did not receive his/her prescribed medication for 2 or more consecutive days. Resident 10 did not receive his/her scheduled Metamucil as prescribed due to refusals.	N 410		

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Resident 13 did not receive his/her scheduled Rivastigmine (cognition-enhancing medication) as prescribed due to refusals.

Findings include:

On 02/27/2025 and 04/03/2025, the Department received complaints alleging residents were not receiving prescribed medications.

Example 1: Resident 10

On 04/12/2025, Surveyor reviewed Resident 10's record provided by Regional Vice President of Operations (RVPO) A.

Resident 10 moved into the facility, 03/13/2024, with diagnoses including benign neoplasm of colon, chronic kidney disease, irritable bowel syndrome, and dementia.

Resident 10's March and April Medication Administration Records (MARs), dated 03/01/2025 to 04/09/2025, documented:
-Metamucil Smooth - Orange - Mix 12.2G (grams) in 8 oz (ounces) of liquid and take by mouth in the morning.
The MARs documented Resident 10 refused the medication 39 out of 41 opportunities.

Resident 10's 2025 Observations documented:
04/09/2025 - was informed today that [Resident 10] is refusing to take [his/her] Metamucil and has been for several days. Advised the med tech to contact the doctor via fax.

The MARs documented this concern had been occurring since the beginning of March.

On 04/18/2025 at 3:10 PM, Surveyor interviewed

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RVPO A and Executive Director B. Surveyor discussed that when residents are not taking/refusing medications for 2 or more days, the provider needs to show that the prescribing practitioner, nurse, or pharmacist had been contacted. RVPO A stated s/he would discuss this concern with the nurse.

Example 2: Resident 13

On 04/25/2025, Surveyor reviewed Resident 13's record provided by Regional Wellness Director C.

Resident 13 moved into the facility, 09/10/2024, with diagnoses including post-traumatic stress disorder (PTSD), neurocognitive disorder with Lewy bodies, and Parkinson's disease.

Resident 13's March and April MARs, dated 03/01/2025 to 04/22/2025, documented:
-Rivastigmine 9.5 MG / 24 Hour - Apply 1 patch topically at bedtime (dementia). Scheduled at 8:00 PM. Start Date: 02/11/2025.
The MARs documented Resident 13 refused the medication 25 out of 53 opportunities.
Documented refusals greater than 2 days:
03/08/2025 to 03/14/2025

On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO A and Executive Director B. Surveyor discussed that when residents are not taking/refusing medications for 2 or more days, the provider needs to show that the prescribing practitioner, nurse, or pharmacist had been contacted. RVPO A stated s/he would discuss this concern with the nurse.

On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor

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N 410	Continued From page 38 discussed the concern of resident refusal of medications not being reported to the prescribing practitioner, nurses or pharmacist. Surveyor did not receive a response.	N 410		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure proper documentation on the Medication Administration Record (MAR) for 2 of 2 residents reviewed. Resident 1's MARs documented medication administration when the medication was not available. Resident 13's MARs contained blanks where medication administration should have been documented and documented medication administration and/or refusal when the medication was not available. Findings include:	N 415		

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N 415	Continued From page 39 Example 1: Resident 1 On 03/22/2025, Surveyor and Regional Vice President of Operations (RVPO) A reviewed Resident 1's record. Resident 1 moved into the facility 07/18/2024 and discharged 02/27/2025. Resident 1's January 2025 MAR documented the following: Acetaminophen 500 MG (milligram) - Take 2 tablets by mouth 3 times a day. Start Date: 09/05/2024 Amlodipine Besylate 10 MG - Take 1 tablet by mouth in the morning. Start Date: 07/29/2024 Atorvastatin Calcium 20 MG - Take 1 tablet by mouth in the morning. Start Date: 07/29/2024 Clopidogrel 75 MG - Take 1 tablet by mouth in the morning. Start Date: 07/29/2024 Duloxetine HCL 30 MG - Take 1 capsule by mouth in the morning. Start Date: 09/24/2024 Fluticasone Propionate 50 MCG (micrograms) / actuation - Use 1 spray in each nostril in the morning. Start Date: 11/26/2024 The MAR documented that the medications were not available on 01/27, 01/29 and 01/30 but documented as administered on 01/28/2025. On 03/22/2025, at approximately 2:30 PM, Surveyor interviewed Regional Vice President of Operations (RVPO) A. RVPO A stated s/he would re-educate staff on proper medication administration documentation. Example 2: Resident 13 On 04/28/2025, Surveyor reviewed Resident 13's	N 415		

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record provided by Regional Wellness Coordinator C.

Resident 13 moved into the facility, 09/10/2024, with diagnoses including post-traumatic stress disorder (PTSD), neurocognitive disorder with Lewy bodies, and Parkinson's disease.

Resident 13's March 2025 MAR documented:
-Diclofenac Sodium 1% - Apply 4 grams to affected area 3 times a day (pain). Start Date: 09/24/2024. Scheduled at 8:00 AM, 12:00 PM, and 8:00 PM.
The MAR documented that the 8:00 PM medication was not available 03/03, 03/05, 03/06, 03/12, 03/13, 03/16, 03/18, 03/19, 03/21
The MAR documented that the 8:00 PM medication was refused on 03/08, 03/09, 03/10, 03/14, 03/17, 03/20
The MAR documented administration of the 8:00 PM medication on 03/04, 03/07, 03/11
The MAR did not document medication administration for Resident 13's 8:00 AM medications on 03/15/2025: DHEA (dehydroepiandrosterone - a steroid hormone), Vitamin B12, Vitamin C, Cranberry, D-Mannose (supplement), Escitalopram Oxalate (antidepressant), Folbee (supplement), Senior Tabs, Vitamin D3, Fluticasone Propionate (nasal spray), Methenamine Hippurate (antibiotic), Omega-3 Fish Oil, Senna-Docusate (laxative)
The MAR did not document medication administration for the 6:00 AM Carbidopa-Levodopa (Parkinson's medication) on 03/15/2025.
The MAR did not document medication administration for the 9:00 AM Carbidopa-Levodopa on 03/15/2025, 03/19/2025.
The MAR did not document medication administration for the 6:00 PM

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N 415	Continued From page 41 Carbidopa-Levodopa on 03/22/2025. The MAR did not document medication administration for the 10:00 AM Levothyroxine Sodium on 03/01, 03/10, 03/11, 03/15, 03/18, 03/19, 03/20, 03/25, 03/30 On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor discussed the concerns with proper documentation of medication administration. Surveyor did not receive a response.	N 415		
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	N 431		

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N 431	Continued From page 42 changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 2 residents reviewed received appropriate health monitoring to meet his/her needs. Resident 8 had a physician order for weekly weight monitoring which was not completed. Resident 20's blood sugar (BS) levels were not monitored. Findings Include: Example 1: Resident 8 On 04/03/2025, the Department received an allegation that residents were not receiving prescribed diets resulting in weight loss. On 04/11/2025, at approximately 12:10 PM, Surveyor observed Resident 8 during the noon meal. Resident 8 was provided a plate of food. Resident 8 did not attempt to use his/her silverware but did pick a brussel sprout up with his/her fingers and attempt to take a bite. Resident 8 proceeded to get up and walk away from the table without eating. On 04/11/2025, at approximately 4:50 PM, Surveyor observed Resident 8 during the evening meal. Resident 8 was provided a plate of food which consisted of lasagna hot dish, steamed carrots, and a dinner roll. Resident 8 did not attempt to eat the food. At approximately 5:30 PM, a staff member proceeded to stand over	N 431		

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Resident 8 and assist him/her with eating.

On 04/25/2025, Surveyor reviewed Resident 8's record provided by Regional Wellness Director C.

Resident 8 moved into the facility 10/10/2024.

Resident 8's medical document, dated 03/21/2025, documented:
"Unintentional Weight Loss - Weekly weights (monitor weight loss)."

Resident 8's March and April Medication Administration Records (MARs), dated 03/01/2025 to 04/25/2025, documented:
"Weekly Weights - Notify the Wellness Director and PCP (primary care physician) if weight Increase OR Decrease of 3 lbs (pounds) or more. Start Date: 02/13/2025."
The MARs did not document any weights.

On 05/05/2025 at 10:00 AM, Surveyor interviewed Regional Vice President of Operations (RVPO) A, Executive Director B and Regional Wellness Director C. Surveyor stated the MARs had not documented any weights for March and April. Regional Wellness Director C stated the weights are not documented on the MARs, they are documented under vitals. Surveyor stated vitals section appeared on the MARs. Regional Wellness Director C stated s/he would send Resident 8's weights.

As of 05/06/2025 at 1:00 PM, Surveyor did not receive any additional documentation.

Example 2: Resident 20

On 02/27/2025, 04/03/2025, and 04/23/2025, the Department received a complaint alleging

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N 431	Continued From page 44 residents were not receiving blood sugar monitoring. On 04/25/2025, Surveyor reviewed Resident 20's record. Resident 20 moved into the facility 08/30/2024 with diagnosis including diabetes. Resident 20's March and April MAR, dated 03/01/2025 to 04/23/2025, documented: "Freestyle Freedom Lite - Check Blood Sugar in the morning. Scheduled at 8:00 AM. Start Date: 09/03/2024." "Freestyle Lite Test - Check Blood Sugar daily. Scheduled at 8:00 AM. Start Date: 09/15/2024." The MARs documented: 03/02 BS 172, 03/22 BS 126, 04/06 BS 100 and 11 refusals. On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor stated that Resident 20's BS levels were not monitored daily. Wellness Director C stated that the BS levels were documented in the notes section of the MARs, not the vitals section. On 05/06/2025, Surveyor reviewed the MARs again and determined the notes section matched the vitals section and Resident 20's BS levels were not monitored as prescribed.	N 431		
N 448	83.41(2)(a) Nutrition: diet. Diets. 1. The CBRF shall provide each resident with palatable food that meets the recommended dietary allowance based on current dietary guidelines for Americans and any special dietary	N 448		

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needs of each resident. 2. The CBRF shall provide a therapeutic diet as ordered by a resident ' s physician.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure residents received a diet specific to their diagnosis.

Resident 8 was prescribed a mechanical soft diet which s/he did not receive.

Findings include:

On 04/03/2025, the Department received an allegation that residents were not receiving prescribed diets.

On 04/03/2025, at approximately 11:00 AM, Surveyor interviewed Caregiver W. Surveyor asked if s/he was aware that residents were on dietary restrictions. Caregiver W stated there were residents who required pureed meals or mechanical soft meals, and they did not receive them. Caregiver W stated, "The cooks plate the food."

On 04/11/2025, at approximately 12:09 PM, Surveyor observed Resident 8 attempting to eat a brussel sprout that was plated for his/her noon meal.

On 04/11/2025, at approximately 4:44 PM, Surveyor observed Resident 8's evening meal which contained a hard dinner roll.

"Vegetables - Avoid - Broccoli, cabbage, Brussels

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sprouts, asparagus, or other fibrous, nontender, or rubbery cooked vegetables. ... Breads - Recommend - o Soft pancakes, well moistened with syrup or sauce. o Pureed bread mixes, pregelled or slurried breads that are gelled through entire thickness. - Avoid - all Others." (Source: Swallowing Disorder Foundation, National Dysphagia Level 2: Mechanically Altered Nutrition Therapy, undated, https://swallowingdisorderfoundation.com/wp-content/uploads/2011/06/mech-altered-breakdown.pdf (retrieval date - April 26, 2025).)

On 04/25/2025, Surveyor reviewed Resident 8's record provided by Regional Wellness Director C.

Resident 8 moved into the facility 10/10/2024.

Resident 8's medical document, dated 03/21/2025, documented:
"Unintentional Weight Loss - Mechanical Soft Diet."

"A mechanical soft diet is a texture-modified diet that restricts foods that are difficult to chew or swallow. It's considered Level 2 of the National Dysphagia Diet in the United States. Foods can be pureed, finely chopped, blended, or ground to make them smaller, softer, and easier to chew. It differs from a pureed diet, which includes foods that require no chewing." (Source: Healthline website, What is a mechanical soft diet?, October 07, 2021, https://www.healthline.com/nutrition/mechanical-soft-diet#bottom-line (retrieval date - April 26, 2025).)

On 04/29/2025, at approximately 4:30 PM, Surveyor observed Cook S plating the resident evening meal.

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N 448	Continued From page 47 On 04/29/2025, at approximately 4:45 PM, Surveyor observed Resident 8 at the evening meal. Resident 8 was served a bowl of cream soup with chunks of vegetables and a green leafy salad. On 04/29/2025, at approximately 4:55 PM, Surveyor interviewed Med Technician M, who was assisting Resident 8 with eating. Surveyor asked who was responsible to ensure residents were plated their prescribed dietary meals. Med Technician M stated, "Tonight, it would have been [Cook S]." Surveyor asked if Med Technician M knew that Resident 8 was prescribed a mechanical soft diet. Med Technician M stated s/he knew that and would not attempt to feed Resident 8 the salad. On 04/29/2025, at approximately 5:20 PM, Surveyor toured the kitchen and observed a sign that stated, "[Resident 8] mechanical soft foods." On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and Regional Wellness Director C. Surveyor stated based on his/her observations, Resident 8 was not served a mechanical soft diet. Surveyor did not receive a response. Cross Reference: DHS N0389 83.35(3)(d) Service Plans Updated Annually or on Changes	N 448		
N 449	83.41(2)(b) Nutrition: meals Meals. 1. The CBRF shall provide meals that are routinely served family or restaurant style, unless contraindicated in a resident ' s individual service plan or for short-term medical needs. 2. The	N 449		

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N 449	Continued From page 48 CBRF shall provide at least 3 meals a day, unless otherwise arranged according to the program statement or the resident ' s individual service plan. A nutritious snack shall be offered in the evening or more often as consistent with the resident ' s dietary needs. 3. If a resident is away from the CBRF during the time a meal is served, the CBRF shall offer food to the resident on the resident ' s return. This Rule is not met as evidenced by: The provider did not ensure a nutritious snack was offered during evening hours or more consistent with the resident's dietary needs for 29 of 29 residents. Findings include: On 04/03/2025, the Department received a concern alleging residents to not receive snacks in the evening. On 04/03/2025, at approximately 11:40 AM, Surveyor interviewed Med Technician P. Surveyor asked if evening snacks were provided to the residents. Med Technician P stated s/he was not aware of any snacks being passed in the evening. On 04/09/2025, at approximately 11:00 AM, Surveyor toured the facility and observed the daily menu times which documented: "Breakfast - 8:00 AM, Lunch - 12:00 PM, Dinner - 4:30 PM" On 04/09/2025, at approximately 11:30 AM, Surveyor interviewed Concierge DD. Surveyor	N 449		

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N 449	Continued From page 49 discussed the concern regarding the early dinner time and if residents needed a snack later in the evening. Concierge DD stated the provider was trying to implement snacks. On 04/14/2025, at approximately 11:20 AM, Surveyor interviewed Cook BB and Cook CC. Surveyor asked if they prepared evening snacks for the residents. Cook CC stated that snacks were purchased but were not passed out to the residents on a regular basis. Cook BB and Cook CC stated that if a resident specifically asked for a snack, a snack could be given. On 04/14/2025, at approximately 12:10 PM, Surveyor interviewed Cook AA. Surveyor asked if they prepared evening snacks for the residents. Cook AA stated this was an area that could be improved upon. On 04/18/2025 at 3:10 PM, Surveyor interviewed Regional Vice President of Operations (RVPO) A and Executive Director B. RVPO A and Executive Director B continued to take notes.	N 449		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: The provider did not make reasonable	N 450		

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adjustments to the menu for 1 of 1 resident's food likes, habits, customs, conditions and appetites.

Resident 13 requested a cheeseburger prior to the evening meal being prepared, and s/he was not provided it.

Findings include:

On 04/29/2025, at approximately 4:30 PM, Surveyor observed the evening meal. Surveyor heard Resident 13 ask where his/her cheeseburger was. Cook S had plated him/her the scheduled evening meal which consisted of corn chowder and a mini chef salad. At 5:10 PM, Surveyor observed Cook S exit the building. Surveyor asked Med Technician N if Cook S was returning to the building to provide Resident 13 with his/her requested meal. Med Technician N explained, "[Cook S] had probably already put all the food away and left for the evening and I know [Resident 13] did not get [his/her] cheeseburger and [Cook S] knew that she was supposed to be served that for dinner." Med Technician N showed Surveyor a sign in the kitchen that documented: "Substitutions for [Resident 13] - week of April 27th: Tuesday dinner (cheeseburger - no summer corn chowder), Wednesday lunch (chicken - no country fried pork tenderloin), Wednesday dinner (cheese pizza with extra cheese, bacon lettuce tomato pizza), Thursday dinner (chicken - no root beer, bbq [barbeque] pork sandwich), Saturday dinner (cheeseburger, no baked chicken drumstick)." Med Technician N stated Resident 13 was very particular about what foods s/he ate, so there was always an amended menu for him/her.

On 05/05/2025 at 10:00 AM, Surveyor interviewed RVPO A, Executive Director B and

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N 450	Continued From page 51 Regional Wellness Director C. Regional Wellness Director C stated there were specific foods identified on the alternative menu. Surveyor asked if accommodations had been being made for Resident 13 since there was a sign in the kitchen for the week of April 27th with Resident 13's identified food requests. Surveyor did not receive an additional response. On 05/07/2025, at approximately 4:35 PM, Surveyor interviewed Resident 20's Family Member (FM) GG. FM GG stated, "My [mom/dad] rarely will come out to the dining room, due to an incident that happened when [s/he] first moved in, so [s/he] eats in [his/her] room. I usually put in [his/her] menu requests the day before, because [s/he] usually doesn't like what is on the menu. [S/he] is a very picky eater. When it is delivered to [his/her] room, you hope that it is warm and it is what was actually ordered."	N 450		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact.	Y3234		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure residents were treated with courtesy, respect and full recognition of the resident's dignity and individuality.

Findings include:

Caregiver G acted disrespectfully towards Resident 13.
Resident 4 and Resident 8 did not receive assistance with his/her meals.

Example 1:

On 04/03/2025, the Department received a concern alleging staff acted disrespectfully towards residents.
On 04/23/2025, the Department received a concern alleging residents are verbally abused.

On 03/22/2025, at approximately 3:25 PM, Surveyor interviewed Caregiver E and Concierge Y. Surveyor asked if they had ever witnessed a staff member act inappropriately towards a resident. Caregiver E stated, "I don't want to get into trouble, but it is upsetting to me. I watch [Caregiver G] yell at [Resident 13]. You know, [s/he] has behaviors, and [s/he] will place [him/herself] on the floor. [Caregiver G] will start yelling at [him/her] 'Get your fat [explicative words] off the floor, I don't have time for this.' [Caregiver G] is like that with everyone, residents and staff. [S/he] doesn't care who hears [her/him]." Caregiver E stated, "There are times

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when family members will ask [Caregiver G] what time the resident will receive their meds, like Resident 20's [son/daughter] asked and [s/he] rudely responds, '[S/he'll] get them when [s/he] gets them.' I just don't think we should be talking to residents or family members like that."

On 03/22/2025, at approximately 4:50 PM, Surveyor interviewed Caregiver F. Surveyor asked if they had ever witnessed a staff member act inappropriately towards a resident. Caregiver F stated there were concerns regarding Resident 13's behaviors. Caregiver F stated, "[S/he] will place [him/herself] on the floor, it is a behavior, and if you are rude to [him/her], [s/he] will remember it. [S/he] is smart." Caregiver F stated, "Staff do not care what they say towards each other and how it may affect the residents. There are always staff yelling at each other, swearing. It is so unprofessional."

On 04/03/2025, at approximately 11:00 AM, Surveyor interviewed Caregiver W. Surveyor asked if they had ever witnessed a staff member act inappropriately towards a resident. Caregiver W stated, "I don't understand it, especially on second shift, staff just act like they don't realize this is not a hang out place, this is the home of the residents. They are yelling, talking 'smack.' I wonder if the residents understand what is going on, cause it isn't right."

On 04/22/2025 at 3:18 PM, Social Worker (SW) T contacted the Department with concerns regarding Resident 13's comments at a recent medical appointment. Resident 13 had expressed concerns that when s/he had fallen onto the floor, staff would make fun of him/her.

On 04/30/2025, at approximately 10:50 AM,

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Surveyor interviewed Caregiver U and Caregiver V. Surveyor asked if they had ever witnessed a staff member act inappropriately towards a resident. Caregiver U and Caregiver V explained that med technicians will yell at the caregivers in front of the residents. Caregiver U stated, "[Med Technician N] was yelling down the hallway, swearing, wanting to know where I was. I was in a resident room, stripping down the bed. I walk out into the hallway and ask [him/her] what [s/he] needs. [S/he] just swears at you. If you say anything to management, you will be blamed." Caregiver V stated, "I do not understand why some staff are allowed to speak that way in a residents home."

On 05/05/2025 at 10:00 AM, Surveyor interviewed Regional Vice President of Operations (RVPO) A, Executive Director B and Regional Wellness Director C. Surveyor discussed the concern that staff act disrespectful in front of residents. RVPO A stated they were aware of the staffing concerns.

On 05/07/2025, at approximately 4:35 PM, Surveyor interviewed Resident 20's Family Member (FM) GG. FM GG explained that s/he had witnessed caregivers speak to each other "very unprofessional like." FM GG stated it was concerning, since it was done in front of residents.

Example 2:

On 04/03/2025, the Department received a concern alleging residents did not receive assistance with eating.

On 04/03/2025, at approximately 11:00 AM, Surveyor interviewed Caregiver W. Surveyor

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asked if s/he was required to assist residents with eating. Caregiver W stated, "Yes, I have, and it can be difficult, because you are trying to feed 3 people at once. There are not enough caregivers available during the meals to assist the residents. What is sad, those residents that need assistance, sit there, and wait and watch other residents eat until someone can finally help them."

On 04/11/2025, at approximately 12:00 PM, Surveyor observed the noon meal:
12:07 PM - Drinks passed to Resident 4 and Resident 8; tablemates are eating.
12:09 PM - Med Technician P cut up Resident 4's and Resident 8's fish and walked away
12:11 PM - Resident 8 is eating with his/her fingers and Resident 4 is staring at his/her food.
At approximately 12:20 PM, Med Technician P sat down to assist Resident 4 and Resident 8. Resident 8 left the table and the majority of his/her food remained on his/her plate.

On 04/11/2025, at approximately 4:15 PM, Surveyor observed the evening meal:
4:27 PM - Resident 8's food was plated and placed on table. His/her table mates are eating. Resident 8 was not at the table.
4:31 PM - To go meals packaged
4:41 PM - Cook EE assisting Resident 8 to the table
4:44 PM - AA D feeding Resident 23 and Med Technician M feeding another resident
4:48 PM - Resident 8 sitting at table and Resident 4 attempting to eat his/her food with his/her hands
4:52 PM - Resident 8 has gotten up and walked away from food
4:54 PM - AA D approached Resident 8 and asked if s/he needed assistance

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4:55 PM - To go food was being delivered
4:58 PM - AA D is feeding another resident

On 04/11/2025, at approximately 5:10 PM, Surveyor walked over to AA D, who was assisting Resident 23, and commented that Resident 4 and Resident 8 had not been provided sit-by assistance with their meals. Resident 4 had received his/her plate prior to Resident 8, who received his/her plate at approximately 4:27 PM. AA D stated s/he had been observing the concern and then requested Med Technician M to assist Resident 4 and Resident 8. Med Technician M sat down and assisted Resident 4 and Resident 8. Resident 8 did not remain at the table and did not eat the majority of his/her food.

On 04/18/2025 at 3:10 PM, Surveyor interviewed RVPO A and Executive Director B. Surveyor discussed the concern that residents who required assistance with eating, were being provided his/her food but not receiving assistance, resulting in his/her food possibly becoming cold after waiting 45 minutes to receive assistance, and s/he is watching others eating. RVPO A and Executive Director B took notes.

On 04/29/2025, at approximately 4:30 PM, Surveyor observed the evening meal:
4:30 PM - Desserts are sitting out on the tables
4:40 PM - Resident 4 and Resident 8 are sitting at the table, with their tablemates, who have received their hot meal. Resident 4 is watching the residents eat. Resident 8 is attempting to eat the dessert with his/her fingers.
4:45 PM - Resident 4's family shows up and states to him/her they will help him/her with his/her meal. Resident 4 and Resident 8 receive their hot food, which is a bowl of soup.
4:48 PM - Med Technician M sat down to assist

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Y3234	Continued From page 57 Resident 8. Cross Reference: N0389 83.35(3)(d) Service Plans Updated Annually or on Changes Cross Reference: N0448 83.41(2)(a) Nutrition: Diet	Y3234		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observations, record review and interview, the provider did not ensure residents received adequate and appropriate cares. Resident 14 did not receive scheduled showers. Findings include:	Y3244		

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On 02/27/2025, the Department received a concern alleging residents are not allowed to choose a time when they prefer their showers. On 04/03/2025, the Department received a concern alleging residents are not receiving scheduled showers.

Example 1: Resident 14

On 03/22/2025, at approximately 3:25 PM, Surveyor interviewed Caregiver E. Surveyor asked if residents were receiving their scheduled showers. Caregiver E explained that Resident 14 is very difficult to shower. Caregiver E stated, "[S/he] will not get into the shower, so [his/her] showers are missed. [S/he] requires a lot of time and sometimes 2 caregivers, because we have to basically put towels on the floor and shower [him/her] in the middle of the bathroom. If we are understaffed, which is often, we do not have the time to do [his/her] shower." Surveyor asked if staff were to document that a resident received a shower. Caregiver E stated, "We are to inform the incoming shift."

On 04/03/2025, at approximately 11:00 AM, Surveyor interviewed Caregiver W. Surveyor asked if there were concerns with staff completing scheduled showers for residents. Caregiver W stated there was a breakdown in communication among staff, so staff would not know who needed showers or what showers had been completed. Caregiver W stated, "There are also problems where certain staff members will not shower certain residents or if a resident says no, the staff just walk away. They do not try to redirect or reapproach. [Resident 14] is a prime example. Staff know [s/he] is difficult so they will skip [his/her] showers." Surveyor asked if staff were to document that a resident received a

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shower. Caregiver W stated, "We are supposed to be updated by staff but it doesn't happen."

On 04/03/2025, at approximately 11:40 AM, Surveyor interviewed Med Technician P. Surveyor asked if there were concerns with staff completing scheduled showers for residents. Med Technician P explained that showers are not completed when scheduled. Med Technician P explained this was due to staffing shortages or staff not knowing which residents need to be showered.

On 04/25/2025, Surveyor reviewed Resident 14's record.

Resident 14 moved into the facility 05/02/2024.

Resident 14's "Care Plan," dated 04/15/2025, documented:
"Assist with Showers on Monday and Wednesday mornings. Once every Monday, Wednesday and As Needed." [Resident 14] will have physical assistance with showering one to two times weekly until next assessment."

On 04/18/2025 at 3:10 PM, Surveyor interviewed Regional Vice President of Operations (RVPO) A and Executive Director B. RVPO A stated there had been a breakdown in communication between staff as to who was responsible for providing the resident showers. Executive Director B explained that new shower schedules had been developed to ensure all staff knew when a resident was scheduled for a shower and staff were to document when a shower has been completed. Surveyor asked if RVPO A and Executive Director B were aware that staff had reported that Resident 14's scheduled showers had been skipped due to his/her behaviors.

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Y3244	Continued From page 60 RVPO A and Executive Director B did not have a response. On 04/29/2025, at approximately 5:15 PM, Surveyor interviewed Med Technician M and Med Technician N. Surveyor asked if there were concerns regarding residents receiving showers. Med Technician M and Med Technician N stated residents do not receive their scheduled showers. Med Technician N stated, "I will come on to shift and find out a resident's scheduled shower was not given."	Y3244		