STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410133	A. BUILDING: _____ B. WING _____	R-C 10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN PARK HOUSE	109 W LAKE ST WAUPACA, WI 54981

(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 10/08/2025, Surveyors conducted a verification visit and investigated one complaint at Garden Park House. Additional information was gathered through 10/09/2025. Two (2) of 3 deficiencies from SOD CBLW13 were corrected The complaint was substantiated. Six (6) new deficiencies were identified Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed. Census: 11	{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.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, after receiving allegations of neglect, the provider did not take immediate steps to ensure the safety of residents or thoroughly investigate and document allegations. Manager B and Licensee A received allegations on 08/25/2025 and 09/17/2025 that Caregiver H was sleeping during 3rd shift and on 09/24/2025 and 09/25/2025 Manager B found Resident 9 completely soaked with urine. Resident 9 needed toileting assistance during the overnight hours and Manager B was concerned the 3rd shift staff did not provide the assistance. As of 10/08/2025, the provider had not completed an investigation into the incidents and Caregiver H continued to work alone during third shift. On 10/08/2025, Licensee A received an allegation Resident 9 was locked out of the facility all night long the preceding night and Caregiver H did not know Resident 9 was missing. After receiving the allegation, Licensee A allowed Caregiver H to work unsupervised during the night shift on 10/08/2025 and planned on allowing Caregiver H to work night shift on10/09/2025, when s/he had not yet completed an investigation into the allegations. Findings include: Surveyor interviewed Manager B on 10/08/2025 at 11:02 AM and 1:14 PM. S/he described incidents when Caregiver H did not provide necessary care to Resident 9 during third shift. Manager B said Resident 9 was emergently admitted on 09/22/2025 due to his/her ability to care for him/herself independently. Manager B	N 158		

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N 158	Continued From page 2 said a county caseworker facilitated the move, in part because Resident 9 did not have electricity or running water in his/her apartment. Manager B also said Resident 9 is heavily incontinent during the overnight hours, is at risk for falls and needs staff assistance with toileting at 1:00 AM and 5:00 AM. Example 1 - 10/08/2025: Manager B explained the morning of Surveyors' visit, Resident 9 told him/her s/he was locked out of the home overnight, did not have his/her cell phone and was scared. Resident 9 said s/he returned to his/her old apartment to sleep because s/he didn't know what else to do. Manager B said Caregiver H worked third shift and should have offered toileting twice, however when Manager B asked Caregiver H how Resident 9 could have been locked out of the building, Caregiver H had no idea Resident 9 was gone. Example 2 - 09/24 and 09/25/2025: Manager B also informed Surveyor of concerns dating back to 09/24 and 09/25/2025. Manager B showed Surveyor text correspondence and described feeling concerned Caregiver H was not providing resident care during 3rd shift. The text messages read: --09/24 at 10:11 AM Manager B texted Caregiver H and reminded him/her to walk with Resident 9 to the bathroom at 1am and 4am. S/he wrote, "[His/her] bed was soaked this morning. [S/he] is a fall risk." --09/25 at 9:02 AM Manager B texted Caregiver H and asked if s/he woke Resident 9 for toileting. Caregiver H replied, "I knocked on [his/her] door at 1am and [s/he] kinda mumbled [s/he] is alright..." Manager B replied, "[S/he] needs to have you assist [him/her] to the bathroom...	N 158		

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N 158	Continued From page 3 [his/her] whole bed us [sic] soaked." Caregiver H responded, "yeah I offered." Example 3 - 08/25/2025 and 09/17/2025: Finally, Manager B said there was another concern with Caregiver H reported by Resident 4 and Resident 7 in August 2025. Manager B explained misconduct investigations are Licensee A's responsibility, but to his/her knowledge investigations did not occur. Surveyors interviewed Manager B and Licensee A on 10/09/2025 at 2:40 PM and asked about the concerns during August. Licensee A acknowledged receiving a report on or about 08/24/2025 from Manager B, that residents reported Caregiver H was sleeping on the couch in the basement office and Resident 7 said s/he had evidence because s/he took a photo. Licensee A said s/he received a similar report from Resident 4. Licensee A told Surveyor s/he talked to Caregiver H and said, "You can't do that." S/he also provided Surveyor documentation of the only written response to the allegations, which was an employee warning notice dated 08/25/2025. The notice read, "[Resident 7] came down at 2 or 3am looking for some albaterol [sic] - I believe I left a note...(dated) 8-21...that we needed to check on [Resident 7] as [his/her] 02 has been lower at night...you are required to be available for the residents..." The form prompted for additional information to include the warning decision, manager signature and a signature from the caregiver acknowledging they have read and received a copy of the warning. All those sections were left blank.	N 158		

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N 158	Continued From page 4 Licensee A acknowledged s/he did not follow up with Caregiver H to ensure s/he signed the warning notice and the form was the extent of his/her investigation and documentation of the incident. Licensee A said s/he talked briefly with Resident 7 and Resident 4, but s/he did not document the talks and did not interview other residents or other staff to determine the scope of the potential problem. In addition, Licensee A did not provide evidence that the concerns documented in Manager B's texts from 09/24 and 09/25 were investigated. In a follow up interview with Licensee A on 10/09/2025 at 3:15 PM, s/he verified third shift caregivers are expected to be awake and in addition to Resident 9's needs during overnight hours, Resident 12 has dementia. On 10/10/2025, Surveyor interviewed Resident 7. S/he clarified there were 2 incidents when s/he believed Caregiver H was sleeping while working alone on 3rd shift. The first was 08/24/2025 when Resident 7 was short of breath had had an oxygen saturation level in the 80's (s/he checks him/herself). The second was on 09/17/2025 which was when s/he took the photo and shared with management. Licensee A follow up: During the exit conference on 10/08/2025 at approximately 4:00 PM, Surveyor shared concerns with Licensee A that allegations dating back to 08/25/2025 were not investigated and Caregiver H continued to work alone during third shift. Subsequently, Resident 9 was locked out of the facility, had to spend the night at an unsafe location and Caregiver H did not know Resident 9 was missing. Surveyor explained in addition to	N 158		

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N 158	Continued From page 5 investigating the August and September incidents, there should be an investigation into the concerns from the previous night. Surveyor reviewed the regulatory requirement to conduct and document a thorough investigation and to ensure the immediate protection of all residents while the matter was pending. On 10/09/2025 at 3:15 PM, Surveyor conducted a follow up interview with Licensee A. S/he said Caregiver H worked alone the previous night and was scheduled to work alone tonight. Licensee A said s/he had many other things to do today and the only investigative step s/he had taken to this point was to interview Caregiver H who denied the allegations.	N 158		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not submit a self-report to the Department after Resident 3 experienced falls resulting in injuries and emergency room treatment. Findings include: Prior to conducting the onsite visit, Surveyor reviewed Department records. The last	N 165		

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N 165	Continued From page 6 self-reported incident submitted by the provider was in 2018. Surveyor reviewed Resident 3's record on 10/08/2025 at 1:43 PM, which included two after visit summaries after s/he received emergency department (ED) treatment for injuries sustained during falls: --06/25/2025: ED visit due to fall resulting in contusion of scalp, strained neck muscle and laceration of left hand. Testing included CT of head and cervical spine and left hand Xray. The ED disposition information included information about the "Fragility Fracture Liaison" to "help you recover as quickly as possible from this fracture ..." --09/26/2025: ED visit due to fall resulting in injury of the head, abrasion of the forearm and scalp laceration. Staples were applied to the scalp laceration. During an interview with Manager B and Licensee A on 10/08/2025 beginning at 2:40 PM, they confirmed Resident 3 sustained the 2 aforementioned falls resulting in ED treatment. Both managers said they did not submit self-reports to the Department because they were unaware of the requirement. Cross Reference: N0287 DHS 83.27(2)(a) Admissions Compatible With The License Class N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Change	N 165		
N 287	83.27(2)(a) Admissions compatible with the license class	N 287		

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N 287	Continued From page 7 A CBRF may not admit or retain any of the following persons: A person who has an ambulatory or cognitive status that is not compatible with the license classification under s. DHS 83.04(2). This Rule is not met as evidenced by: Based on interview and record review, the provider admitted and retained residents whose ambulatory status was not compatible with their licensure classification. Effective 05/27/2025, the provider's licensure classification changed from semi-ambulatory to ambulatory. As of 10/07/2025, the provider retained Resident 3 who walked with difficulty and experienced falls while ambulating. According to interviews and Resident 3's ISP, s/he needed a walker for ambulation. On 09/22/2025, the provider admitted Resident 9 who had a recent diagnoses of persistent weakness and history of falls. Resident 9 received physical therapy and the therapist recommended the use of a walker. Findings include: Prior to conducting the onsite visit, Surveyor reviewed Department records. During a survey ending on 12/23/2024, a deficiency was issued because the facility did not have at least 2 grade level or ramped exits to grade for semi-ambulatory residents. In response to the deficiency on 05/27/2025, the provider changed their licensure classification from semi-ambulatory to ambulatory.	N 287		

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N 287	Continued From page 8 DHS 83.02(6)(6) "Ambulatory" means the ability to walk without difficulty or help. DHS 83.02(51)(51) "Semi-ambulatory" means a person is able to walk with difficulty or only with the assistance of an aid such as crutches, cane or a walker. RESIDENT 3: On 10/07/2025 at 10:21 AM, Surveyor interviewed Manager B. Manager B described Resident 3 as being a high risk for falls and said, "Physical therapy recommended a walker or cane, but since we had to switch to ambulatory I told [him/her] we can't have that in the building." Surveyor asked Manager B if s/he agreed Resident 3 needed to use a walker and s/he replied, "Oh my God, yes." On 10/07/2025 at 10:28 AM, Surveyors interviewed Resident 3 and asked about his/her use of a walker. Resident 3 replied, "We are not allowed to have them in here... Sometimes my legs get sore and tired at night... I had a fall on the back stairs. I missed 3 stairs and cracked my head open. You can see I still have bruising... I had 5 staples in the back of my head." Surveyors observed Resident 3 had a bruise on his/her forehead that was approximately 4 inches long by 1 inch wide and a dark bruise on his/her left cheek bone approximately 1.5 inches in diameter. On 10/07/2025 at 11:02 AM, Surveyors interviewed Housekeeper J. S/he said since the licensure change to ambulatory, it was common knowledge that assistive devices are not allowed in the home, even if residents need them. Housekeeper J said, "I think [Resident 3] should definitely have something, s/he just got staples in	N 287		

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N 287	Continued From page 9	N 287		

[his/her] head." Housekeeper J said s/he was one of the staff who responded to the fall. S/he recalled it happened when Resident 3 was walking up the concrete stairs from the dining room in the basement level and s/he fell backwards. Housekeeper J said Resident 3 bled profusely and was sent to the emergency department.

Surveyors reviewed Resident 3's complete facility record on 10/08/2025 at 1:43 PM. Resident 3 was admitted on 10/04/2024. The individual service plan category titled "Physical Disabilities" read, "Uses walker." This need remained the same during an ISP update on 05/02/2025. However, on 10/01/2025 the ISP was updated to read, "GPH (Garden Park House) Ambulatory only - no walkers or cane in building."

--The record contained evidence of at least 7 falls since June 2025, including the aforementioned fall on 09/26/2025 a 2:15 PM. The fall report read, "...was walking up the stairs from basement to first floor (outside)...tripped on one stair & hit [his/her] head on concrete step. Blood from back of head & nose...called 911..."

--The record did not contain evidence of a provider initiated discharge.

Progress notes documented the following:

--08/10/2025: The managed care organization (MCO) set up a tour of a different facility and Resident 3 was interested in moving.
--08/15/2025: accepted to the new facility but was "torn" about moving due to friends s/he has at GPH.
--09/02/2025: Resident 3 was "upset" and changed his/her mind about the move.

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N 287	Continued From page 10 --09/18/2025: "keeps talking about moving again. I told [him/her] I will not have any part of helping facilitate a move. [S/he] keeps changing [his/her] mind and upsetting all that are involved..." Author: Manager B --Undated note: "...still talks about going to another place to live, [s/he] cannot make up [his/her] mind. I told [him/her] I am out of it, [s/he] will need to talk to [MCO] about this." Author: Manager B --09/25/2025: "[MCO] says [Resident 3] is un-safe [sic] at GPH. Falls frequents [sic] GPH has new license for ambulatory only - [Resident 3] unable to use walker or cane inside." Surveyors interviewed Manager B and Licensee A on 10/08/2025 at 2:40 PM and they verified Surveyor's review of the record. They both described Resident 3 as having difficulty with walking and being at high risk for falls. Manager B said the MCO care manager first identified the need for Resident 3 to move in the spring of 2025, when the licensure classification changed and the provider said s/he could not use his/her walker. Manager B confirmed s/he was frustrated with Resident 3 changing his/her mind about moving in August 2025 and was no longer involved in any efforts to facilitate a move. Manager B and Licensee A verified they did not initiate a 30 day written discharge notice for Resident 3 and they have not been allowing him/her to use any sort of assistive device for ambulating in the home. They explained they prohibited the use of any assistive device because it was their interpretation of the requirement when the licensure class changed. Administrator A said s/he would proceed with discharge and take the necessary steps to ensure Resident 3 was safe until an appropriate placement could be secured.	N 287		

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N 287	Continued From page 11 RESIDENT 9: During the aforementioned interview with Housekeeper J s/he volunteered s/he is also "nervous" because Resident 9 doesn't use any assistive device and is unsteady with walking. Surveyor interviewed Manager B at 1:40 PM about Resident 9's fall risk. Manager B confirmed Resident 9 has experienced falls, including one on 09/26/2025. Manager B said it was not documented in the record, but showed Surveyor a text from Licensee A on 09/26/2025 at 7:15 PM which read, "[Resident 9] fell outside in the smoking area. [S/he] got [him/herself] up with a little help from a stool and me holding chair secure. (winking emoji)" Surveyor reviewed Resident 9's record 10/08/2025 at 1:17 PM. Resident 9 was admitted on 09/22/2025. The record contained: --preadmission transition of care/physician visit summary dated 09/18/2025. The report noted Resident 9 was recently hospitalized (09/10-09/15/2025) for infection, persistent weakness and falls. --09/25 fall report: "slid off [his/her] bed and couldn't get up by [him/herself]...called paramedics to lift [him/her]." --physical therapy visit note dated 10/06/2025 which read, "...Still is at risk for falls due to unsteadiness and impulsiveness." The note documented the need for supervision and stand by assistance for mobility and recommended "rollator (walker) for amb (ambulation) outside of the facility." Author: Physical Therapist (PT) G Surveyor interviewed Physical Therapist G on 10/09/2025 at 8:22 AM. PT G said Resident 9 is	N 287		

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N 287	Continued From page 12 "not real safe walking." Surveyor asked about the wording of the 10/06/2026 visit note and use of the walker outside. PT G said, "I definitely feel they would be better off using the walker indoors" and Resident 9 would be "safer," however s/he didn't write it that way because staff said they are not allowed to have assistive devices in the facility. Cross Reference: N0165 DHS 83.12(4)(c) Reporting Incidents with Serious Injury N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Change	N 287		
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 record review and interview, the provider did not ensure all individual services plans (ISPs) were updated based on assessment. Between 06/25/2025 and	N 389		

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(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 389	Continued From page 13 10/07/2025, Resident 3 experienced 7 falls and the ISP was not updated based on assessment to identify his/her needs and interventions for fall prevention. Findings include: On 10/08/2025 at 1:43 PM, Surveyor reviewed Resident 3's record. The record did not contain fall assessments. Incident reports documented a history of falls, including the following: --06/25/2025: while walking down the hall tripped "on own feet" and fell on his/her right side hitting his/her head and sustaining 2 abrasions on the left hand. Staff called 911 and s/he was sent to the emergency department. --07/09/2025: tripped and tried to break his/her fall with both hands. Sustained skin tears on the left arm. It was noted s/he "shuffles over [his/her] own feet." --07/11/2025: found on the floor in his/her room. Said s/he tried to pick something up and "fell on [his/her] own feet." Skin tear on right elbow. --07/22/2025: found on the floor at the top of the stairs. Walked him/her back to his/her room. Resident 3 said s/he was feeling weak. --08/05/2025: another resident informed staff Resident 3 fell and that resident "picked [him/her] up...bumped [his/her] head, had a goose egg, didn't want anything. Is walking fine." --09/26/2025: as s/he was walking up the stairs, fell backwards and his/her head on the concrete. Sent to the ED where s/he received 5 staples to close the wound on his/her head. --10/01/2025: unwitnessed fall in the bathroom	N 389		

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	410133	A. BUILDING: _____ B. WING _____	R-C 10/09/2025

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N 389	Continued From page 14	N 389		

Resident 3's ISP was last updated 10/01/2025:
--Supervision - "fall risk - staff to assist [Resident 3] with walking when [s/he] is weak."
--Physical Disabilities - identified the need for a walker during previous ISP reviews, however intervention was removed during the ISP update on 10/01/2025.

The ISP was silent to the pattern of falls since June 2025 and did not identify new or modified interventions for fall prevention.

Surveyors interviewed Licensee A and Manager B on 10/07/2025 at 2:40 PM.

The managers confirmed Resident 3 was experiencing frequent falls and the ISP was not updated based on assessment to identify new interventions. Manager B said s/he is responsible for ISPs and wouldn't know what to do to mitigate Resident 3's fall risk. S/he said, "[Resident 3] shuffles when [s/he] walks and falls. No matter how many times you remind [him/her] to slow down and pick up your feet. Someone is not going to be with [him/her] all the time."

Licensee A stated they did not have a policy for responding to falls and were recently just discussing how they could use education in this area.

Surveyor note: The Department issued a publication for providers in February 2022 titled "FALLS IN ASSISTED LIVING FACILITIES" which read in part:

"Falls resulting in serious injury or death continue to occur in assisted living settings. For this reason, the Division of Quality Assurance (DQA) is reminding assisted living providers of the need

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N 389	Continued From page 15 to identify residents at risk for falls and to implement strategies for falls prevention. Falls prevention begins with identifying those residents who are at risk for falls. A thorough assessment should take place prior to admission and whenever there is a change in the resident's condition. The following factors may predict an individual's likelihood of falling: Incontinence or need for toileting assistance; Impaired gait or balance, including the use of assistive devices; A history of falls within the past three months; Medications/Medical conditions. Once risks are identified, the resident's individual service plan (ISP) should contain approaches to prevent falls from occurring. The following are some examples of interventions: Occupational therapy (OT)/physical therapy (PT) recommendations; Teaching correct use of assistive devices; Environmental modifications; Anticipation of needs; Physical assistance with daily living activities; Supervision; Proper footwear; Exercise programs to improve balance and gait. Every fall should result in a post-fall assessment to determine the cause of the fall and the need for additional or modified interventions. Comprehensive reporting information will identify date, time, location, a description of what the individual was doing, assistive devices in use and their condition, environmental status, and physical or mental condition of the person prior to the fall. Review of those assessments can also reveal a pattern associated with time, place, and staff present." Cross Reference: N0165 DHS 83.12(4)(c) Reporting Incidents with Serious Injury N0287 DHS 83.27(2)(a) Admissions Compatible With The License Class	N 389		

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N 481	Continued From page 16	N 481		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all areas of the home were safe, clean and well maintained. This is a repeat deficiency being cited for the third time. See Statement of Deficiency CBLW11, dated 04/05/2024 and Statement of Deficiency CBLW12, dated 12/23/2024. Findings include: RESIDENT 8'S ROOM: Surveyor interviewed Resident 8 in his/her room on 10/08/2025 at 10:15 AM. Surveyor observed Resident 8 was elderly and there was a quad cane positioned at his/her door. Resident 8 said s/he normally does not need the cane, but s/he prefers to use it to navigate the stairs and at other times. Surveyor also observed there was no transition strip from the hallway flooring into Resident 8's room. This presented a tripping hazard because tile flooring in the room was approximately 1 inch higher than the hallway flooring. As Surveyor exited the room at 10:20 AM, Manager B was in the hallway. S/he confirmed	N 481		

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N 481	Continued From page 17 Surveyor's observation and said the floor had been like that for a long time. RESIDENT 10'S ROOM: Surveyors observed Resident 10's room at on 10/08/2025 at 10:48 AM. The carpet was light gray and there was an area approximately 10 inches in diameter that was stained. Resident 10 told Surveyors s/he sometimes drops his/her soda. Surveyors interviewed Housekeeper J at 10:52 AM. S/he confirmed Surveyors' observation of the carpet and said s/he has identified the concern to Licensee A because s/he has been unable to remove the stains; however Licensee A has not addressed the concern.	N 481		
{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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{Y3234}	Continued From page 18 This Rule is not met as evidenced by: Based on interview and record review, Licensee A and Caregiver I did not treat Resident 3 and Resident 7 with dignity, courtesy, respect and with full recognition of their individuality. Resident 3 and Resident 7 complained about the meals and Caregiver I and Licensee A reacted by yelling and speaking to the residents disrespectfully. In addition, the provider did not adjust the meal offerings to ensure the residents' individual preferences were considered. This is a repeat deficiency. See Statement of Deficiency CLBW13, dated 06/04/2025. Findings include: RESIDENT 3: Surveyors interviewed Resident 3 on 10/08/2025 at 10:28 AM. S/he volunteered, "I want out of here. [Licensee A] barged in my room without knocking and yelled at me...It was about a letter...about the vegetarian food. I didn't even write it, I just signed it...S/he was angry. Oh I never saw [him/her] so mad." Resident 3 said the interaction ended when Licensee A "walked out and slammed the door." Resident 3 said the incident occurred approximately 1 week ago and since then no changes had been made related to the concerns with the food. Resident 3 went on to say Caregiver I and one other resident are vegetarian, so Caregiver I often has "vegetarian nights." Resident 3 said, "Like tomorrow we are having baked potato bar. I am not a vegetarian I like meat and beef." Surveyor asked if alternatives are offered and Resident 3 said the only alternative is a peanut butter and jelly (PB&J) sandwich. Resident 3 said one time	{Y3234}		

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{Y3234}	Continued From page 19	{Y3234}		

s/he told Caregiver I s/he would just make his/her own meal and Caregiver I said, "You can't change the menu...make yourself a PB & J."

Surveyor observed a dry erase board in the dining room with the weekly menu. Lunch on 10/09 was a baked potato bar and dinner on 10/11 was grilled cheese and tomato soup.

Surveyor reviewed Resident 3's record on 10/08/2025 at 1:43 PM. The record contained a "RESIDENT SATISFACTION EVALUATION" completed by Resident 3 and dated 10/01/2025. The form included prompts and then responses of; yes, somewhat, no or don't know. Surveyor noted Resident 3's responses to prompts about references and respect:

--The facility meets my treatment preferences. - No
--The facility meets my preferences for services.- No
--I am treated respectfully at all times. - Somewhat
--I feel that my rights are being protected. - Somewhat
--People respect my privacy. - Somewhat

Resident 3 also wrote, "I don't like the owner of the house - barges in my room and yells at me."

RESIDENT 7:
Surveyor interviewed Resident 7 on 10/08/2025 at 10:52 AM. S/he said, "I filed a petition about the meals...when Caregiver I works [s/he] makes a lot of vegetarian stuff...some meals with no meat, some with a little meat like quiche..." Resident 7 said s/he addressed the petition to Caregiver I, but "[Licensee A] came in to my room and yelled and screamed me. [S/he] was so mad,

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{Y3234}	Continued From page 20	{Y3234}		

[s/he] was spitting nails." Resident 7 recalled Licensee A asked him/her how the food here compared to what s/he was eating at the "bug place." Resident 7 explained Licensee A was referring to his/her living situation before s/he moved into the facility and said it felt like Licensee A was giving an "ultimatum" that s/he would make him/her move if s/he kept complaining. Resident 7 said there has been no changes to the meals since that time and the alternative is a PB&J sandwich. Resident 7 said just the day before s/he asked his/her care manager to find a different place to live because of how s/he is treated by Licensee A and Caregiver I.

At 12:35 PM, Manager B provided Surveyor with the document written by Resident 7. It read, "We the undersigned respectfully request that vegetarian meals be served once a month rather than twice a week. The majority of us living here are not vegetarian. Just because 1 resident & 1 staff member are vegetarian don't [sic] mean the rest of us have to be forced into eating vegetarian meals. I believe an alternative choice of meals should be offered to the non vegetarian [sic] residents when the 1 vegetarian staff member is working." The letter was signed by Resident 7 and six other residents.

Surveyor interviewed Housekeeper J at 11:02 AM. S/he said, "I've heard [Caregiver I] yell at [Resident 7] a few times and at [Resident 3] and [Resident 4] about the food...One time [Resident 7]...said, 'I don't really want quiche again' and [Resident 3] said, 'Me either.' Caregiver I came out of the kitchen and yelled, 'Then you don't have to eat it. You can have a PB & J!'" Housekeeper J said Caregiver I was "loud and very rude, very condescending about it and then

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{Y3234}	Continued From page 21 just didn't explain anything further...[S/he] always has this attitude...like it's my way or no way, you don't get a choice and [Licensee A] will side with [him/her]." LICENSEE A INTERVIEW: Surveyors interviewed Licensee A on 10/08/2025 at 2:40 PM. S/he said the document written by Resident 7 was given to Caregiver I on 10/02/2025 and Caregiver I was "very upset, [s/he] was going to walk out" because s/he felt disrespected by the residents. Caregiver I told Licensee A, "You need to have my back on this." Licensee A said s/he also was very frustrated with Resident 7 because s/he felt like the letter was not true and s/he was involving the other residents. Licensee A explained "food is very important to me" and described how s/he makes sure residents are eating well even when they might not want to. Licensee A denied frequent meals were being served without meat and provided Surveyor a different version of the menu. Licensee A also said s/he felt like s/he needed to defend Caregiver I because Resident 3 and 7 "just don't like [him/her]." Licensee A acknowledged s/he was upset when s/he talked to Resident 3 and Resident 7 and it was possible s/he could have raised his/her voice when addressing them.	{Y3234}		