STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009330	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NORTH	9329 S 48TH ST FRANKLIN, WI 53132

(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 12/14/2023, Surveyor completed 3 compliant investigations and 1 self-report review at Elizabeth Residence North. Four deficiencies were identified. One complaint was substantiated. Two complaints were unsubstantiated. There were no findings as a result of the self-report review. Census: 31	N 000		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training	N 247		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009330	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NORTH	9329 S 48TH ST FRANKLIN, WI 53132

(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 247	Continued From page 1 prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 employees obtained all task specific training. Caregiver D, who had responsibilities for providing assistance with activities of daily living, did not have training in the provision of personal care prior to assuming these duties. Findings include: On 12/05/2023, Surveyor conducted a review of 2 employees to verify compliance with task specific training requirements. Surveyor requested training records from Acting Administrator A for Caregiver D. The record for Caregiver D, hired 12/02/2022, did not contain evidence of training or evidence of meeting an exemption for personal care training. On 11/21/2023, at approximately 12:10 p.m.,	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009330	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NORTH	9329 S 48TH ST FRANKLIN, WI 53132

(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 247	Continued From page 2 Surveyor interviewed Registered Nurse (RN) E. RN E confirmed Caregiver D was responsible for providing personal cares and resident activities of daily living (ADLs). On 12/01/2023, at 4:10 p.m., Surveyor interviewed Caregiver D. Caregiver D confirmed s/he had provided personal cares to residents since his/her hire date. Caregiver D explained the other caregivers showed him/her how to do cares on the floor. The provider did not give him/her formal training on personal cares. "I just basically did floor training." On 12/06/2021, at approximately 3:18 p.m., Surveyor interviewed Acting Administrator A regarding the missing documentation. Acting Administrator A confirmed the provider did not have evidence Caregiver D completed or met an exemption for provision of personal care training prior to assuming these job duties. Acting Administrator A stated, "I was auditing the employee files. I knew the trainings were not up to date. We are looking into purchasing an electronic training system to help us better track all trainings."	N 247		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property.	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009330	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NORTH	9329 S 48TH ST FRANKLIN, WI 53132

(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 348	Continued From page 3	N 348		

This Rule is not met as evidenced by:
Based on record review, observation, and interview, the provider did not ensure 1 of 1 resident (Resident 1) was free from mistreatment. There was video evidence that Former Caregiver D verbally abused Resident 1.

Findings include:

On 09/11/2023, the Department received a complaint that a resident had been verbally abused by Caregiver D. There was a video camera previously placed in the resident's room due to suspicion of mistreatment.

On 08/22/2023, the facility submitted a Misconduct Incident Report (self-report) acknowledging Caregiver D had verbally abused Resident 1. Self-report indicated that there was video evidence the abuse had taken place on 08/11/2023 confirming the allegation.

On 11/17/2023, Surveyor observed video footage submitted by Healthcare Power of Attorney (HC POA) C. The incidents occurred on 08/11/2023. The following was observed in the video:

-Resident 1 appeared to be having difficulty breathing. Upon entering the room, Caregiver D did not provide Resident 1 with breathing treatment before s/he had him/her transfer into his/her wheelchair without assistance. Further observation identified Caregiver D was on his/her cell phone in Resident 1's room. Caregiver D stated, "S/he don't [sic] like to keep his/her oxygen on. I really think s/he trying to kill himself/herself because s/he knows s/he needs to keep his/her oxygen on all the time and then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009330	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NORTH	9329 S 48TH ST FRANKLIN, WI 53132

(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 348	Continued From page 4	N 348		

you come in his/her room and [expletive] be all on his/her floor ..." Caregiver D exited the room and left Resident 1 alone in the bathroom. The video had a timestamp at the bottom reading 08/11/2023 at 11:27 p.m.

-Resident 1 self-propelled himself/herself out of the bathroom with his/her feet. Resident 1 appeared to be having difficulty breathing. Surveyor observed Resident 1 wearing his/her compression stockings. Resident 1 called out for help for approximately 90 seconds before the video ended. The video had timestamp at the bottom reading 08/11/2023 at 11:31 p.m.

-Caregiver D returned to Resident 1's room. Resident 1 appeared to be having difficulty breathing while still sitting in his/her wheelchair. Caregiver D stated, "Go to bed you don't need no help [sic]. You're fine. You need to keep this on your face. It's time for bed. We're not doing this tonight [Resident 1] ...All that yelling for help. You're fine. Go to bed. You need to keep this on your face (Referring to oxygen). Go to bed. Get into bed. It's 11:40 p.m." When Resident 1 explained to Caregiver D that s/he could not breathe, Caregiver D responded, "Well, keep that on your face and you can breathe." Caregiver D turned off the light and walked out of the room, leaving Resident 1 to transfer him/herself into bed independently. Surveyor observed Resident 1 on the side of the bed. S/He appeared to be having difficulty breathing. The video had a timestamp at the bottom reading 08/11/2023 at 11:33 p.m.

On 11/21/2023 at approximately 1:15 p.m., Surveyor reviewed Resident 1's record and identified the following:
-Resident 1 was admitted on 11/01/2020, with diagnosis of heart disease, chronic obstructive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009330	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NORTH	9329 S 48TH ST FRANKLIN, WI 53132

(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 348	Continued From page 5	N 348		

pulmonary disease (COPD), and spinal stenosis.
-Resident 1's assessment, dated 08/05/2023, indicated Resident 1 ambulated with assistance, required assistance with activities of daily living (ADLs), utilized continuous oxygen, was disoriented, and agitated. Resident 1's file did not contain any additional documentation pertaining to Resident 1 needing legs elevated or assistance applying and removing his/her compression stockings daily.
-Resident 1's Individual Service Plan (ISP), dated 05/12/2023, identified s/he "required oxygen at all times."

On 11/21/2023 at 11:50 a.m., Surveyor interviewed Acting Administrator A. Acting Administrator A confirmed there was video evidence of Caregiver D verbally abusing Resident 1. Acting Administrator A stated that s/he had seen the video and "that behavior was not okay." Registered Nurse (RN) E stated that Caregiver D told Resident 1, "We are not doing this tonight" and left him/her sitting on the side of the bed alone. When Caregiver D came back into the room, s/he said, "This (resident) is trying to kill himself /herself; s/he keeps taking his/her oxygen off." Registered Nurse E confirmed Former Caregiver D's comments to Resident 1 were "inappropriate." Acting Administrator A stated Caregiver D expressed remorse for behavior and offered to quit upon discipline. Acting Administrator A stated Caregiver D had been coached for their actions and transferred to a different location.

Acting Administrator A stated the provider had an all staff meeting to discuss and retrain staff on resident rights. The provider also added additional staff and a third shift lead-caregiver to ensure all duties were being completed during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009330	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NORTH	9329 S 48TH ST FRANKLIN, WI 53132

(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 348	Continued From page 6 shifts.	N 348		
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 update 1 of 1 resident's individual service plan (ISP) to identify needs or necessary services. Resident 1 received updated physician recommendations after an emergency room visit on 08/17/2023. Resident 1's ISP was not updated with changes. Findings include: On 09/11/2023, the Department received complaints alleging a resident did not receive required services. On 11/21/2023 at approximately 1:15 p.m., Surveyor reviewed Resident 1's record and identified the following:	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009330	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NORTH	9329 S 48TH ST FRANKLIN, WI 53132

(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 7 -Resident 1 was admitted on 11/01/2020, with diagnosis of heart disease, chronic obstructive pulmonary disease (COPD) and spinal stenosis. -Resident 1's assessment, dated 08/05/2023, indicated Resident 1 ambulated with assistance, required assistance with activities of daily living (ADLs), required continuous oxygen, was disoriented, and agitated. Resident 1's file did not contain any additional assessment documentation pertaining to Resident 1 needing legs elevated or assistance applying and removing his/her compression stockings daily. -Resident 1's ISP, dated 05/12/2023, identified s/he "required oxygen at all times." Resident 1's ISP did not contain information regarding the following: elevating legs above the level of heart for 30 minutes, three to four times a day; wearing compression stockings as recommended; not wearing clothing with tight elastic around groin, thighs, knees or ankles; or looking at feet and legs every day, checking for any sores or open areas. -Resident 1's After Visit Summary from emergency room, dated 08/17/2023, stated, "After you leave, you should follow the instructions below: Elevate your legs above the level of your heart for 30 minutes, three to four times a day; Wear compression stockings as recommended; Do not wear clothing with tight elastic around groin, thighs, knees or ankles; Look at feet and legs every day, checking for any sores or open areas." On 11/30/2023 at approximately 3:15 p.m., Surveyor reviewed Resident 1's electronic record and identified the following:	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009330	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NORTH	9329 S 48TH ST FRANKLIN, WI 53132

(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 8 -08/21/2022: Registered Nurse (RN) E wrote, "Elevate legs above the level of heart for 30 minutes, three to four times a day [sic] Wear compression stockings. Do not wear clothing with tight elastic around groin, thighs, knees or ankles [sic] Look at feet legs and ankles every day, checking for sores or open areas [sic]" -08/23/2022: RN E wrote, "Please put his tubigrips [sic] on in the morning and off at night." -08/28/2022: RN E wrote, "Legs are looking good. Encourage him/her to lay down in bed and elevate his/her feet a few times a day and remember to apply his/her tubi grips [sic] in the morning and off at night. [Family member] is big on 2 hour [sic] checks during the day and during the night for toileting..." On 11/22/2023 at approximately 2:30 p.m., Surveyor interviewed RN E and reviewed Resident 1's assessment history. RN E stated, "Because s/he was at baseline when we assessed on 08/05/2023, we never did a change in condition or update to his/her ISP." On 12/06/2023 at approximately 3:45 p.m., Surveyor interviewed Acting Administrator A and RN E. RN E confirmed the ISP was not updated after emergency room visit to include August 2023 emergency room recommendations.	N 389		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009330	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NORTH	9329 S 48TH ST FRANKLIN, WI 53132

(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 416	Continued From page 9	N 416		

rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3).

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure the administration of injectable medications by unlicensed caregivers was delegated by a Registered Nurse (RN) pursuant to the Nurse Practice Act [s. N 6.03(3)] and in accordance with accepted standards of practice. The provider did not make any provisions for an RN to delegate and monitor the administration of nebulizer medication to residents by unlicensed caregivers for 2 of 2 caregivers reviewed (Caregiver D and Caregiver H).

Findings include:

According to N 6.03(3), Supervision and Direction of Delegated Acts, "In the supervision and direction of delegated acts an RN shall do all of the following:

(a) Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.
(b) Provide direction and assistance to those supervised.
(c) Observe and monitor the activities of those supervised.
(d) Evaluate the effectiveness of acts performed under supervision."

On 12/06/2021 at 11:00 a.m., Surveyor reviewed employee records. The following was identified:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009330	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH RESIDENCE NORTH	9329 S 48TH ST FRANKLIN, WI 53132

(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 416	Continued From page 10	N 416		

The record for Caregiver D, hired 12/02/2022, did not include any evidence of delegation for nebulizer medication administration by an RN for Caregiver D.

The record for Caregiver H, hired 04/17/2014, did not include any evidence of delegation for nebulizer medication administration by an RN for Caregiver H.

On 12/06/2021, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/01/2020. Resident 1's physician's order, dated 07/03/2023, included albuterol (0.083%) with instructions to inhale 3 milliliters via nebulizer twice a day.

Resident 1's MAR from 07/03/2023-08/10/2023 identified Caregiver D administered albuterol nebulizer treatments 4 times. Caregiver H administered albuterol nebulizer treatments 29 times.

On 12/06/2023, at approximately 4:05 p.m., Surveyor interviewed Registered Nurse (RN) E. Surveyor requested RN delegation documentation for Caregivers D and H. RN E replied, "I check the staff usually. I didn't see that [Caregiver D] was delegated. A former RN may have done it." Surveyor gave RN E until 12/07/2023 at 6:00 p.m. to provide any remaining documentation. As of 12/08/2023 at 8:00 a.m. no further information was provided.