STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VICTORY VISION COMMUNITY LIVING EAST	968 E MADISON STREET WATERLOO, WI 53594

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{N 000}	Initial Comments On 12/02/2025, with information obtained through 12/12/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit and complaint investigation at Victory Vision Community Living East, a community-based residential facility (CBRF) located in Waterloo, WI. As a result of the survey, 4 deficiencies were identified. Three deficiencies are repeat deficiencies from Statement of Deficiency (SOD) N7X613, dated 11/08/2024, SOD N7X612, dated 05/16/2024, and SOD N7X611, dated 10/27/2023. The complaint was substantiated. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 5	{N 000}		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 7 different occasions of injuries sustained by Resident 10 throughout	N 161		

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

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his/her admission, which were either not observed and/or could not be adequately explained by him/her, were investigated.

Findings include:

On 12/02/2025, Surveyor conducted a complaint investigation into allegations of residents sustaining injuries of unclear origins.

At approximately 12:25 p.m., Surveyor interviewed Caregiver Coordinator C and Supervisor N about the needs of Resident 10, who had formerly resided with the provider. Caregiver Coordinator C reported that Resident 10 required staff assistance for all toileting and showering and sometimes feeding. Caregiver Coordinator C reported that Resident 10 was known to experience incontinence for which s/he required staff assistance to manage with brief changing. Caregiver Coordinator C reported that Resident 10 was non-verbal and generally non-communicative.

As part of the interview, Supervisor N reported that Resident 10 was known to be resistive to cares, including toileting, and would demonstrate aggressive behaviors towards staff. Supervisor N reported that Resident 10 was known to have self-injurious behaviors, which included hitting his/her own head with an open palm or closed fist, slapping his/her lower extremities with an open palm or heels of his/her hands, and hitting his/her elbows on the back of the toilet or the toilet bars. Supervisor N reported recalling occasions of there being marks on Resident 10's body and reported Resident 10 was known to bruise. Supervisor N reported that staff would update Resident 10's family when injuries/marks were observed, "but for awhile it seemed like

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every day." Supervisor N reported that the process for when an injury was observed or noted on residents was that staff were to make upper management aware and also fill out an incident report.

At approximately 12:50 p.m., Surveyor requested from Caregiver Coordinator C all injury documentation for Resident 10 throughout his/her admission as part of an overall request for his/her records.

At approximately 12:54 p.m., Surveyor interviewed Caregiver F regarding Resident 10. Caregiver F reported having seen "maybe a couple times" where Resident 10 hit him/herself on the sides of his/her head but reported that it was not hard. Caregiver F reported that Resident 10's balance "was off" and that s/he was known to run into things.

On 12/10/2025, at approximately 9:00 a.m., Surveyor interviewed Guardian R who was one of Resident 10's legal guardians. Guardian R reported that Resident 10 had autism and was both non-verbal and unable to communicate his/her needs. Guardian R confirmed Resident 10 required assistance from others for all his/her cares, including showering and toileting. Guardian R reported s/he was concerned about several injuries - mostly as bruises - that s/he observed Resident 10 to have sustained throughout his/her admission with the provider. Guardian R reported having concerns because there were occasions where either him/herself or Guardian S, Resident 10's other guardian, would discover these injuries on Resident 10 when they would visit him/her or pick him/her up for home visits, and they had received no communication about the injuries from the provider's staff. Guardian R reported that

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some of the injuries were visible just by looking at Resident 10, and some were made visible during the course of conducting toileting or bathing cares for him/her upon visits. Guardian R reported s/he photographed the injuries upon discovering them. Injuries of Resident 10 noted by Guardian R included the following:

1) Left eye bruising on 09/04/2025. Guardian R reported s/he had been informed by Manager G about the bruising approximately 1-2 days before having observed it for him/herself. Guardian R reported that Manager G reported that it wasn't clear how Resident 10 sustained the bruising but that from staff report it seemed s/he went to bed one night without it and woke up the next morning with it.

2) Right index finger metacarpophalangeal (MCP) joint redness/discoloration and left thumb MCP joint bruising on 09/20/2024. Guardian R reported s/he had asked Manager G about the injuries but never heard any follow up information about them.

3) Left ear discoloration on 03/31/2025. Guardian R reported s/he first noticed this when s/he picked up Resident 10 from the provider to take him/her to a medical provider appointment.

4) Right superior shoulder bruising, left chest bruising, and right ulnar forearm bruising on 04/07/2025. Guardian R reported s/he noticed these marks upon assisting Resident 10 with a bath when s/he was on a home visit that day.

5) Additional right shoulder bruising and redness and right knee superficial abrasions and bruising on 04/10/2025. Guardian R reported s/he also noticed these marks upon assisting Resident 10

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with a bath during a home visit (separate from the previous home visit).

6) Two superficial puncture mark-shaped abrasions on his/her left-sided forehead on 05/21/2025.

7) Right-sided torso area abrasion on 05/31/2025.

On 12/10/2025, Surveyor reviewed photographs of the above noted injuries, provided by Guardian R, with date and timestamp verification.

On 12/10/2025, Surveyor reviewed records provided by Licensee B and Manager G - which included Resident 10's record, records of texting communication between Manger G and Guardian R, and records of e-mail correspondence with various combinations of parties that included themselves, Resident 10's guardians, and Resident 10's case managers from his/her managed care organization. Surveyor also reviewed records of e-mail correspondence provided by Guardian R, which showed e-mails between various combinations of parties that included him/herself, Guardian S, the provider's management staff, and Resident 10's case managers.

Resident 10's record identified that s/he resided with the provider from 07/08/2024 to 06/25/2025. Resident 10 was identified as having legal co-guardians. Resident 10's facesheet only contained diagnoses of unspecified vitamin deficiency, generalized anxiety disorder, constipation, and diarrhea. Resident 10's record contained 2 individual service plans (ISPs) that had been created during his/her admission - one signed on 07/30/2024 and one signed on 04/14/2025. The only maladaptive behaviors

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identified on either plan, besides wandering, were identified under a heading of "Self-Abusive Behavior." The text within that heading documented, "Requires supervision and monitoring to help manage/redirect self-abusive behavior." The frequency was documented as, "As needed every day," and the desired goal was documented as, "Maintain low level of self-abusive behavior with supervision/intervention from staff." A "Behavioral Evaluation" in Resident 10's record was dated as completed on 05/08/2025 (approximately 1.5 months prior to Resident 10's discharge from the provider). The following assessment items were checked as being applicable to Resident 10:

- "Individual demonstrates attention seeking behavior daily which requires staff intervention" (no other clarifying documentation)

- "Individual shows signs of aggression toward others frequently and requires staff intervention" (no other clarifying documentation)

- "Individual frequently requires staff intervention to calm down, 3-4 times a week."

The BSP also documented the following within labeled headings related to Resident 10's behaviors:

- Patterns: "Behaviors tend to happen during personal cares. Bathing, toileting, dressing, shaving, brushing teeth. On occasion during eating as well."

- "Triggers/Stressors": "Being cleaned up after a bowel movement. Sitting on toilet to void or have a [bowel movement]. Asking/redirecting [him/her] to sit down when [s/he] does not want to."

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N 161	Continued From page 6 - Pain: "This is unknown as [s/he] is non-verbal. However, staff do ask a series of questions such as. [sic] Touching [his/her] arm, hand, face body [sic] asking if that hurts. Sometimes [s/he] will wince or pull away if it's uncomfortable. [S/he] has a high pain tolerance." - "Obsessive Behaviors": " ...[S/he] will also pinch [his/her] upper arms as well." - Supervision: " ...If agitated [s/he] will, [sic] swing [his/her] arms/hands and will make contact with [him/herself] or others around [him/her]." - Potential risks: "Could potentially harm [him/herself] or others due to agitation." - "Do any of the individual's behaviors place themselves or others in danger?" A box for "Yes" was checked with the following documented: "While staff transport [him/her] to and from programming if agitated [s/he] will hit the dashboard or staff when they drive." - "Do any behaviors interfere with providing care?" A box for "Yes" was checked with the following documented: "While toileting and bathing [s/he] can hit preventing staff from being able to complete the necessary cares." Between both the ISPs and the BSP for Resident 10, Surveyor did not observe anything regarding his/her predisposition to bruise or how staff would monitor Resident 10's skin given his/her documented propensity to hit, swing his/her arms, and pinch his/her arms (the specific behaviors identified in the BSP). Resident 10's record included observation notes	N 161		

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N 161	Continued From page 7 throughout his/her admission as well as incident reports. From all the records provided, Surveyor observed the following in reference to the above documented injuries: 1) Left eye bruising (09/04/2025): An observation note from 09/03/2024 documented, "Upon arrival this morning resident was up and given breakfast by [overnight (NOC)] shift staff. I noticed resident had a black eye. NOC staff reported that when [s/he] woke up it was already there, and it wasn't there before [s/he] went to bed last night. Management was notified ..." There was no other documentation about this injury. 2) Right index finger MCP joint redness/discoloration and left thumb MCP joint bruising (09/20/2024): The same photos as reviewed by Surveyor (documented above) were sent in a text message conversation from Guardian R to Manager G on 09/20/2024 at 4:36 p.m. Guardian R then texted Manager G, " ...Any idea what happened to [his/her] hands today?" At 7:59 p.m., Manager G replied, "I am not sure I was not there today. I will check in with staff and see." There was no other documentation about these injuries. 3) Left ear discoloration (03/31/2025): An observation note dated 03/31/2025 documented, "Resident was gone with family most of the day. Came back around 2pm. [Guardian R] said [s/he] noticed a bruise on [his/her] ear and it was swollen.I [sic] let management know." There was no other documentation about this. 4) Right superior shoulder bruising, left chest bruising, and right ulnar forearm bruising (04/07/2025): There was no documentation about these injuries.	N 161		

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N 161	Continued From page 8 5) Additional right shoulder bruising and redness and right knee superficial abrasions and bruising (04/10/2025): There was no documentation about these injuries. 6) Two superficial puncture mark-shaped abrasions on his/her left-sided forehead (05/21/2025): An e-mail from Manager B to Resident 10's guardians and case managers noted that during a toilet transfer Resident 10 "scratched [him/herself] in the face and [s/he] has a scratch above [his/her] left eyebrow about an inch long." Surveyor observed that a linear approximate 1" scratch from the note was not consistent with the 2 superficial puncture mark-shaped abrasions in the picture of his/her injury. 7) Right-sided torso area abrasion (05/31/2025): An e-mail from Guardian S to Manager G, Licensee B, and Resident 10's case managers documented, " ...[Resident 10] also has a larger abrasion on the right side of [his/her] back which we noted on the log." There was no other documentation about this injury. Surveyor noted that this generally correlated with the photograph of that same date showing an abrasion on Resident 10's right-sided torso. Of note, an e-mail from Case Manager T to Manager G and Licensee B, among others of Resident 10's case management team, sent on 04/11/2025 documented, " ...Family has notified me of additional injuries/bruises that could have occurred within the past couple of weeks. Unfortunately, I was not notified timely to follow up on this right away. Do you have any additional incident reports that could possibly explain these?" From the list Case Manager T typed out,	N 161		

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the following injuries were documented: "left ear bruise/swelling" and "bruises on [his/her] neck and shoulder." Case Manager T also documented, "Just wondering if [s/he] may have had a fall recently or again possibly bumped into something? I am curious if we need to start looking at self-injurious behaviors of this is occurring now? In all the years I have known [him/her] [s/he] has not displayed any [self-injurious behaviors (SIBs)] but this could be a new thing for [him/her] too so just trying to brainstorm on this. Any information would be helpful, thank you!" Surveyor did not observe any follow up communication responding to this or reports noting these injuries. Surveyor noted that the injuries identified by Case Manager T loosely correlated with part of the injuries identified on 04/07/2025 and 04/10/2025 (as documented above).

On 12/10/2025, at approximately 10:56 a.m., Surveyor interviewed Manager G. Manager G reported there was disagreement between the provider's staff and Resident 10's guardian regarding the nature of Resident 10's self-injurious behaviors. Manager G reported that Resident 10's guardians denied Resident 10 displayed self-injurious behaviors, but that staff had observed Resident 10 sometimes hit tables, walls, railings (including the grab bars surrounding the toilet), his/her chest, and his/her face. Manager G reported that sometimes Resident 10 pushed on his/her ears. Surveyor reviewed the above dates with Manager G and requested evidence of any additional communications, changes of skin condition noted, or injuries noted on/around each of the above dates, due by the end of the day.

From the records provided, there was no further

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N 161	Continued From page 10 information regarding the above injuries. On 12/11/2025, at approximately 10:00 a.m., Surveyor interviewed Licensee B and Manager G. When asked about the self-injurious behaviors as identified in Resident 10's ISP, Manager G reported that Resident 10's self-injurious behaviors were not the traditional behaviors they were used to because it didn't seem that Resident 10 was intentionally hurting himself. Manager G reported that Resident 10 would spend time in his/her room and would sometimes come out with the injuries as unwitnessed by staff. Manager G and Licensee B reported that there were some marks on Resident 10's body that they were not made aware of because his/her family only communicated about them to Resident 10's case managers. When asked to confirm that Resident 10's skin would have been visible during the course of daily cares that staff assisted with, including toileting and showering, both acknowledged understanding Surveyor's concern. Surveyor reviewed the above dates with Licensee B and Manager G. Licensee B reported that s/he believed they discussed each of the injuries but confirmed not having other follow up documentation to provide.	N 161		
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 record review and interview, the provider did not ensure that the individual service plan (ISP) for Resident 10, which directed for food and fluid intake tracking, was implemented	N 388		

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N 388	Continued From page 11 and followed as written. This is a repeat deficiency. See Statement of Deficiency (SOD) N7X611, dated 10/27/2023, and SOD N7X613, dated 11/08/2024. Findings include: On 12/02/2025, at approximately 12:25 p.m., Surveyor interviewed Caregiver Coordinator C and Supervisor N about Resident 10's needs. Caregiver Coordinator C reported that Resident 10 was non-verbal and generally non-communicative. Caregiver Coordinator C reported recalling that there were some concerns about weight loss experienced by Resident 10 during his/her admission but that s/he was known to eat a lot between 3 daily meals consisting of double portions and snacks throughout the day. Both Caregiver Coordinator C and Supervisor N reported not being sure if Resident 10's food or fluid intakes were monitored or documented during his/her admission. At approximately 12:54 p.m., Surveyor interviewed Caregiver F. Supervisor N was present during the interview as well. Caregiver F denied that food or fluid intake monitoring or documentation was required for Resident 10. Supervisor N reported that for a period Resident 10's guardian requested staff to document Resident 10's caloric intake, which staff documented as entries in his/her task administration record (TAR). Supervisor N reported that after some time this stopped because it was determined that Resident 10 was eating/drinking enough and there weren't any more concerns about his/her intake. At approximately 12:50 p.m., Surveyor requested	N 388		

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from Caregiver Coordinator C all TARs throughout Resident 10's admission as well as any existing records of all routine monitoring cares done for Resident 10 throughout his/her admission, including intake.

On 12/10/2025, Surveyor reviewed Resident 1's record. Resident 10's resided with the provider from 07/08/2024 to 06/25/2025. Resident 10 was identified as having legal co-guardians. Resident 10's diagnoses included autism and an unspecified vitamin deficiency. Resident 10's record contained 2 individual service plans (ISPs) that had been created during his/her admission - one signed on 07/30/2024 and one signed on 04/14/2025. Within his/her first ISP, the following was documented under the "Eating" heading:

- Resident's needs: "Assistance required in eating meals. Staff to document consumption monitoring per meal." Goal: "To maintain proper food eating habits."

- Resident's needs: "Monitoring and documentation of food intake outside of their scheduled meal times." Goal: "To maintain an appropriate amount of intake per day outside of meal times."

The second ISP, from 04/14/2025, identified the same meal and snack consumption monitoring and documentation needs with the addition of, "And Fluids [sic] as well."

In reviewing TARs for Resident 10, Surveyor observed a heading for "Eating" with separate entries for breakfast, lunch, and dinner, with the directive that staff were to, "Monitor percentage consumed." Another heading for "Snack Monitor" contained the directive, "Monitor and document

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N 388	Continued From page 13 food intake outside of scheduled meal times as it occurs." Timed snack entries were listed as 10:00 a.m., 2:00 p.m., and 7:00 p.m. From 05/05/2025 through 06/25/2025, Surveyor observed the following 31 missing entries across 28 days: - 05/05/2025 through 05/07/2025: Lunch - 05/08/2025: Dinner - 05/09/2025: Lunch - 05/10/2025: Breakfast, lunch, and dinner - 05/13/2025 through 05/15/2025: Lunch - 05/20/2025: Lunch - 05/21/2025: Dinner - 05/24/2025: Dinner - 05/27/2025 through 05/29/2025: Lunch - 06/02/2025: Lunch - 06/05/2025: Lunch - 06/06/2025: Lunch - 06/10/2025: Lunch - 06/12/2025: Lunch - 06/14/2025: Dinner - 06/16/2025: Dinner - 06/18/2025: Breakfast and lunch - 06/20/2025: Lunch - 06/21/2025: Dinner - 06/22/2025: Dinner - 06/23/2025: Lunch - 06/24/2025: Lunch The TARs also contained several scheduled daily entries for staff to track Resident 10's fluid intake with the directive, "Indicate how much fluids each resident receives per fluid oz. as follows: Breakfast Snack Lunch Dinner Snack." The corresponding times for the daily entries were 8:00 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m., and 6:00 p.m. From 05/05/2025 through 06/25/2025, Surveyor observed the following 55 missing entries across 30 days:	N 388		

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N 388	Continued From page 14 - 05/05/2025 through 05/07/2025: 10:00 a.m. and 12:00 p.m. - 05/08/2025: 6:00 p.m. - 05/09/2025: 10:00 a.m. and 12:00 p.m. - 05/10/2025: 12:00 p.m., 2:00 p.m., and 6:00 p.m. - 05/13/2025: 10:00 a.m. and 12:00 p.m. - 05/14/2025: 12:00 p.m. and 2:00 p.m. - 05/15/2025: 10:00 a.m. and 12:00 p.m. - 05/19/2025: 2:00 p.m. and 6:00 p.m. - 05/20/2025: 10:00 a.m., 12:00 p.m., and 2:00 p.m. - 05/23/2025: 6:00 p.m. - 05/24/2025: 6:00 p.m. - 05/27/2025: 12:00 p.m. - 05/28/2025: 12:00 p.m. and 2:00 p.m. - 05/29/2025: 10:00 a.m. and 12:00 p.m. - 05/31/2025: 2:00 p.m. - 06/02/2025: 12:00 p.m. and 2:00 p.m. - 06/05/2025: 10:00 a.m. and 12:00 p.m. - 06/06/2025: 12:00 p.m. and 2:00 p.m. - 06/10/2025: 10:00 a.m. and 12:00 p.m. - 06/12/2025: 10:00 a.m., 12:00 p.m., and 2:00 p.m. - 06/14/2025: 6:00 p.m. - 06/16/2025: 6:00 p.m. - 06/17/2025: 2:00 p.m. - 06/18/2025: 8:00 a.m., 10:00 a.m., and 12:00 p.m. - 06/20/2025: 10:00 a.m. and 12:00 p.m. - 06/21/2025: 6:00 p.m. - 06/23/2025: 10:00 a.m., 12:00 p.m., and 2:00 p.m. - 06/24/2025: 12:00 p.m. On 12/10/2025, at approximately 9:00 a.m., Surveyor interviewed Guardian R who was one of Resident 10's legal guardians. Guardian R reported a concern that Resident 10 had experienced weight loss during his/her admission	N 388		

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N 388	Continued From page 15 with the provider. Guardian R reported that him/herself and other family noticed the weight loss and that Resident 10 had looked visibly thinner, particularly around the holidays. Guardian R reported that as part of this concern, there were discussions between him/herself, Guardian S (Resident 10's other legal guardian), Resident 10's case managers, and Manager G about food intake monitoring. Guardian R reported that Resident 10's medical provider had ordered for a food diary to be recorded by the provider's staff. Guardian R reported that Manager G told him/her that staff would only commit to documenting food intake percentages for Resident 10. On 12/10/2025, at approximately 10:56 a.m., Surveyor interviewed Manager G. Manager G reported that the expectation was for staff to document what foods Resident 10 consumed along with what % of each meal and snack s/he consumed. Surveyor discussed the concern that there were several blank entries within the TARs for Resident 10, specifically in May and June. Manager G reported s/he would look at the TARs and other notes in Resident 10's record to attempt to account for the missing entries. On 12/11/2025, at approximately 10:00 a.m., Surveyor interviewed Licensee B and Manager G and discussed the concern that staff were not always documenting Resident 10's food and fluid intake in accordance with his/her ISP. Manager G reported s/he went back and looked at the records but wasn't able to account for the missing entries.	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes	N 389		

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N 389	Continued From page 16 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 that Resident 10's individual service plan (ISP) was updated to reflect his/her changing needs and physical condition when s/he experienced an onset of physical aggression towards others until approximately 9 months after the behaviors started. His/her ISP was not updated to reflect his/her changing needs when s/he began utilizing an electronic fitness monitoring device in the context of his/her unintended weight loss concerns. This is a repeat deficiency. See Statement of Deficiency (SOD) N7X611, dated 10/27/2023, and SOD N7X612, dated 05/16/2024. Findings include: On 12/02/2025, at approximately 12:25 p.m., Surveyor interviewed Caregiver Coordinator C and Supervisor N about the needs of Resident 10, who had formerly resided with the provider.	N 389		

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N 389	Continued From page 17 Supervisor N reported that Resident 10 was known to be resistive to toileting and would hit staff "a lot." Supervisor N reported that Resident 10 would sometimes hit staff on the head as s/he walked by them. Caregiver Coordinator C reported that Resident 10 was known to be "sometimes" aggressive as evidenced by hitting, pulling, pinching behaviors which were mostly directed towards staff. Caregiver Coordinator C reported that Resident 10 was known to walk a lot and did not prefer to sit. Caregiver Coordinator C reported that Resident 10 would walk on and off throughout the day. Supervisor N reported that Resident 10 did not like to sit. Both Caregiver Coordinator C and Supervisor N reported there were some weight loss concerns for Resident 10 and as part of this Resident 10 wore an electronic fitness monitoring device. Supervisor N reported that use of the device specifically had been initiated due to concerns of the calories Resident 10 was burning and to monitor his/her daily steps due to all his/her walking. Both reported that Resident 10's family wanted him/her to wear the device all the time but that the device could be taken off at night. At approximately 12:54 p.m., Surveyor interviewed Caregiver F regarding Resident 10. Caregiver F reported that Resident 10 sometimes hit at staff but that it didn't hurt. On 12/10/2025, Surveyor reviewed Resident 1's record. Resident 10's resided with the provider from 07/08/2024 to 06/25/2025. Resident 10 was identified as having legal co-guardians. Resident 10's diagnoses included autism. Resident 10's record contained 2 individual service plans (ISPs) that had been created during his/her admission - one signed on 07/30/2024 and one signed on 04/14/2025. Regarding Resident 10's behaviors,	N 389		

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N 389	Continued From page 18 the following was documented under both ISPs: - Under the "Wandering Risk" heading: "Requires supervision and redirection from staff to help prevent wandering episodes. Not exit-seeking/no previous occurrences of elopement." Goal: "To have proper supervision and redirection techniques in place to prevent wandering." - Under the "Self-Abusive Behavior" heading: "Requires supervision and monitoring to help manage/redirect self-abusive behavior." Goal: "Maintain low level of self-abusive behavior with supervision/intervention from staff." - Under the "Destructive/Abusive" heading: "Not applicable" A "Behavioral Evaluation" documented, dated 05/08/2025, documented the following: - "Individual demonstrates attention seeking behavior daily which requires staff intervention" (no other clarifying documentation) - "Individual shows signs of aggression toward others frequently and requires staff intervention" (no other clarifying documentation) - "Individual frequently requires staff intervention to calm down, 3-4 times a week." The BSP also documented the following within labeled headings related to Resident 10's behaviors: - Patterns: "Behaviors tend to happen during personal cares. Bathing, toileting, dressing, shaving, brushing teeth. On occasion during eating as well."	N 389		

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N 389	Continued From page 19 - "Triggers/Stressors": "Being cleaned up after a bowel movement. Sitting on toilet to void or have a [bowel movement]. Asking/redirecting [him/her] to sit down when [s/he] does not want to." - "Activities ...Does the individual participate in any purposeful activities that help with behaviors?": "Watching [his/her] movies from [his/her] list. Walking to get out some of [his/her] frustration. Sensory tiles. Quite [sic] time if over stimulated in [his/her] room with [his/her] sound machine on." - "Environmental Factors": Boxes for "Over stimulation" and "Loud or specific sounds" were checked. - "Obsessive Behaviors": " ...[S/he] will also pinch [his/her] upper arms as well." - Supervision: " ...If agitated [s/he] will, [sic] swing [his/her] arms/hands and will make contact with [him/herself] or others around [him/her]." - Potential risks: "Could potentially harm [him/herself] or others due to agitation." - "Do any of the individual's behaviors place themselves or others in danger?" A box for "Yes" was checked with the following documented: "While staff transport [him/her] to and from programming if agitated [s/he] will hit the dashboard or staff when they drive." - "Do any behaviors interfere with providing care?" A box for "Yes" was checked with the following documented: "While toileting and bathing [s/he] can hit preventing staff from being able to complete the necessary cares."	N 389		

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N 389	Continued From page 20 A series of interventions, including cuing Resident 10 to go to his/her room, using a sound machine, giving a water bottle or snack, offering "favorite figures", offering a walk, or assisting with putting on a favorite movie or television program, were documented for staff to utilize in trying to manage Resident 10's behaviors. Between both the ISPs and the "Behavior Evaluation" document for Resident 10, Surveyor did not observe anything regarding use of an electronic fitness monitoring device. Surveyor reviewed observation notes for Resident 10 throughout his/her admission and observed several documented occurrences of Resident 10 demonstrating aggression towards staff and/or peers, even prior to the development of his/her "Behavioral Evaluation" document on 05/08/2025, which included the following: - 08/03/2024 (7:15 p.m.): " ...Hitting at staff and pushing them out of [his/her] way." - 09/23/2024 (6:15 p.m.): " ...did hit at staff a few times ..." - 10/07/2024 (11:30 a.m.): "Hit staff in left eye during toileting and cleaning [him/her] up." - 10/22/2024 (2:15 p.m.): "[Resident 10] has been pretty aggressive the last 2 days with us, [s/he]s hit staff in the face and back with closed fists. [S/he] squeezed staffs had [sic] causing it the [sic] swell and [s/he] been very vocal. [S/he] been hitting walls and has been wanting to walk instead of sitting." - 11/04/2024 (12:30 p.m.): "[Resident 10] has	N 389		

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N 389	Continued From page 21 been super aggressive towards staff today [s/he]s been hitting full closed fist and [s/he]s been yelling out super loud, very agritated [sic] today." - 11/14/2024 (3:00 p.m.): " ...a few different times tabbed/hit staff ..." - 11/27/2024 (12:45 p.m.): " ...During cares slapping staff ..." - 12/02/2024 (3:00 p.m.): " ...During toileting pinching staff arms when [s/he] went to sit ...GOt [sic] [his/her] 2pm snack (two cookies) and held onto it for over and [sic] hour and finally took a bit [sic] and then smashed it onto staffs [sic] head/face." - 12/04/2024 (1:15 p.m.): " ...Snacks offered [s/he] would hit at staff's arms, back and face ..." - 12/05/2024 (1:19 p.m.): " ...staff offered fluids, snacks and toileting and would go to sit [him/her] back down and [s/he] would hit the staff ...During lunch didn't want to stay sitting and kept hitting staff in head and arms ..." - 12/06/2024 (9:51 a.m.): " ...When [s/he] finally sat at table keep [sic] hitting at staff ..." - 12/06/2024 (9:00 p.m.): " ...Seem agitated still, was hitting staff on and off throughout the shift at meals and toileting ..." - 12/11/2024 (8:15 a.m.): " ...resident had behaviors all morning, hitting staff and other residents ..." - 12/12/2024 (2:45 p.m.): " ...hitting staff, smacked staff in head/face."	N 389		

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N 389	Continued From page 22 - 12/13/2024 (1:35 p.m.): " ...[s/he] was hitting staff when they would try to assist [him/her] in taking a bite ..." - 12/13/2024 (6:15 p.m.): " ...Hitting at walls, windows/blinds, staff, food etc ..." - 12/18/2024 (8:15 a.m.): " ...when staff started getting resident dressed, started hitting staff and not listening ..." - 12/19/2024 (1:30 p.m.): " ...Would try to hit peers and staff but was easily redirected with no thank you ..." - 12/20/2024 (1:00 p.m.): " ...When staff would try to assist to have [him/her] sit, [s/he] would say no and try to hit staff ..." - 12/27/2024 (8:00 p.m.): " ...Saying no a lot and hitting staff ..." - 12/30/2024 (3:15 p.m.): " ...hitting at staff ...when staff would try to have [him/her] sit [s/he] would push at staff and say no ...threw about an oz of [his/her] boost at staff. Over all [sic] agitated today ..." - 01/06/2025 (1:45 p.m.): " ...hitting at staff with cares and at meals ...Hitting at peers when pacing, easily redirected, but yelled no and stupid ..." - 01/13/2025 (3:00 p.m.): "[S/he] hit at staff a few times but was easily redirected." - 01/20/2025 (2:45 p.m.): " ...[S/he] was hitting at staff was toileting [him/her]. [S/he] hit staff on the head and in the chest ..."	N 389		

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N 389	Continued From page 23 - 01/26/2025 (7:45 p.m.): " ...Resident was hitting at staff and also tried to hit [his/her] housemates." - 02/25/2025 (6:00 p.m.): "Hitting at staff with cares and meals ..." - 03/09/2025 (6:30 p.m.): " ...during meal and cares hitting at staff. During meal did try to hit housemates, they were moved out of arms [sic] reach." - 03/17/2025 (5:30 a.m.): "Resident didn't have a not so good evening; at dinner time [s/he] was hitting staff and residents ..." - 03/22/2025 (10:45 a.m.): "Was aggressive towards me and hit me on multiple occasions." - 03/23/2025 (5:30 a.m.): " ...at dinner time [s/he] was hitting staff and residents ..." - 03/23/2025 (6:15 p.m.): " ...I was toileting the resident and changing [his/her] diaper in which the resident punch me very hard on my back." - 04/05/2025 (10:45 p.m.): " ...During dinner time resident was hitting staff and did not want to sit down and eat ..." - 04/14/2025 (7:45 p.m.): " ...Was combative towards staff, hitting furniture/chairs ..." - 04/15/2025 (10:45 p.m.): " ...combative towards staff all shift. Hit staff closed fist on head, shoulders, back, pinched staff arms with cares/toileting ..." - 04/17/2025 (3:00 p.m.): "Seems over all [sic] agitated today, hitting at staff with cares, meals, snacks, in passing. When redirected [his/her]	N 389		

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tone raises and says No and brings up [his/her] fist. Hit staff in arms, pinched staffs [sic] arms, punched staffs [sic] back, head."

- 04/19/2025 (5:45 p.m.): "Resident keeps hitting staff in head when staff tries to feed, clean , [sic] change and or toileting the resident."

- 04/21/2025 (8:15 p.m.): " ...combative towards staff with any of [his/her] cares ..."

- 04/30/2025 (2:15 p.m.): " ...[S/he] tried to hit house staff in face ..."

- 05/07/2025 (1:30 p.m.): "Today before leaving for day programming [s/he] did hit me in the side of the face with a closed fist. My ear was red and swollen ..."

- 05/07/2025 (2:30 p.m.): " ...staff went to buckle [him/her] up to get hit in the face/forehead closed fist, hitting dash of vehicle. Kept hitting staff arms while driving. Once inside hit at staff but walked to [his/her] room ..."

Surveyor reviewed records of e-mail correspondence with various combinations of parties that included the provider's staff, Resident 10's guardians, and Resident 10's case managers from his/her managed care organization. Surveyor noted the following:

- E-mail from Manager G to Resident 10's case managers on 05/07/2025 (1:34 p.m.): " ...Also I want to make you aware of [his/her] agitation last week. [S/he] did hit a staff member in the eye. [S/he] did have a bruised eye and [s/he] had just taken off [his/her] glasses as [s/he] had been hitting during toileting and transfers to and from the vehicles. [S/he] also during toileting twisted a

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staff [sic] wrist and caused some swelling and pain ...Today before programming [s/he] did hit me in the side of the face with a closed fist. My ear was red adn [sic] swollen but not bruised at this time..."

- Additional correspondence on 05/07/2025 discussed the willingness of the above participants to collaborate on the development of a behavioral support plan (BSP) for Resident 10.

- E-mail from Licensee B to Resident 10's guardians and case managers on 05/14/2025 (3:51 p.m.) and subsequent e-mails that day from the case managers indicated that Resident 10's BSP was provided to all parties that day.

From the above observation notes and e-mail correspondence, Surveyor noted that Resident 10's "Behavior Evaluation" wasn't completed until approximately 9 months after the onset of his/her physical aggressive behaviors towards others.

Regarding Resident 10's use of an electronic fitness monitoring device, Surveyor observed the following:

- E-mail from Guardian R to Manager G on 12/26/2024 (7:24 a.m.): " ...We actually purchased the fitbit wrist monitor that [Resident 10's medical provider] suggested that will measure all sorts of information that [s/he] thought will be useful. The battery will last 10 days and it will not need to be removed for showering or anything like that. [S/he] will be coming back with this today ..."

- E-mail from Manager G to both of Resident 10's guardians on 04/03/2025 (10:01 a.m.): " ...I am following up on an email that was sent this

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morning to [Supervisor N] in regards to [Resident 10] fitness tracker. [Guardian R] you stated you wanted staff to keep [his/her] Fitbit tracker on at all times. But it was established when [Guardian S] came to do training at programming that we would take [his/her] watch off at night when [s/he] sleeps to give [his/her] skin a break. As it is causing skin breakdown. We are trying to avoid any skin concerns ..."

- Observation note entry from 03/09/2025 (6:30 p.m.): " ...[His/her] fitness watch/tracker isn't staying on [his/her] wrist."

At approximately 9:00 a.m., Surveyor interviewed Guardian R regarding the use of Resident 10's electronic fitness monitoring device. Guardian R reported that Resident 10's device was supposed to never be removed and that s/he could tell from the corresponding smartphone application paired with the device that staff had been removing it during Resident 10's admission. Guardian R reported that Resident 10 would not have been able to don or doff the device by him/herself.

On 12/10/2025, Surveyor reviewed records of e-mail correspondence provided by Guardian R, which included the following in reference to his/her electronic fitness monitoring device:

- E-mail from Guardian R to Manager G on 12/26/2024 (5:49 p.m.): " ...[Resident 10] is wearing [his/her] new Fitbit on [his/her] wrist. It's completely waterproof, so it does not need to be removed for showering or charging or anything like that ..."

At approximately 10:56 a.m., Surveyor interviewed Manager G regarding the use of Resident 10's electronic fitness monitoring device

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and his/her physical aggression towards others. Manager G reported that Guardian R and Guardian S wanted Resident 10 to wear the device 24 hours per day but that s/he voiced concerns about skin breakdown. Manager G reported s/he had noticed some occasions of redness at Resident 10's wrist so staff took it off after Resident 10's showers to let the device and his/her wrist dry. Manager G confirmed that Resident 10 was known to hit staff and sometimes other residents. Manager G reported that Resident 10 sometimes pinched fellow residents and so during these occasions [s/he] had to be sat more than an arm's length away from them.

On 12/11/2025, at approximately 10:00 a.m., Surveyor interviewed Licensee B and Manager G. Both acknowledged Surveyor's concerns regarding the lack of Resident 10's electronic fitness monitoring device use and wear schedule in his/her ISP. Manager G confirmed that there had been some confusion between Resident 10's guardians and him/her regarding the wear schedule of Resident 10's electronic fitness monitoring device. Both acknowledged Surveyor's concern that Resident 10's needs related to management of his/her aggressive behaviors towards others was not included in his/her ISP until approximately 9 months after onset.

On 12/12/2025, at approximately 9:39 a.m., Surveyor interviewed Case Manager Supervisor U, who reported having been involved in Resident 10's care management. Case Manager Supervisor U confirmed that Resident 10 had an electronic fitness monitoring device that was initiated due to concerns of him/her having experienced unintended weight loss. Case Manager Supervisor U reported that Resident

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N 389	Continued From page 28 10's guardians wanted him/her to wear the device all the time. Case Manager Supervisor U reported that the expectation was that staff would help Resident 10 don it for daytime wear but s/he wasn't sure if it was to be used throughout the night. Case Manager Supervisor U reported recalling that there were questions from Resident 10's guardians about his/her device wear schedule but wasn't sure about the specific details. Regarding Resident 10's behaviors, Case Manager Supervisor U confirmed that Resident 10 was known to demonstrate aggressive behaviors towards others with specifically striking them.	N 389		
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	N 431		

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N 431	Continued From page 29 communication with the resident ' s physician and other health care providers, and shall record any 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 record review and interview, the provider did not ensure that Resident 10's health was monitored when s/he experienced an unintended weight loss during his/her admission. This is a repeat deficiency. See Statement of Deficiency (SOD) N7X611, dated 10/27/2023. Findings include: On 12/02/2025, Surveyor conducted a complaint investigation into allegations of residents experiencing unintended weight loss. At approximately 12:25 p.m., Surveyor interviewed Caregiver Coordinator C and Supervisor N about the needs of Resident 10, who had formerly resided with the provider. Caregiver Coordinator C reported that Resident 10 loved walking and was known to walk near constantly from the time s/he was awake until the time s/he was asleep because s/he did not like to sit. Supervisor N reported that there were some concerns about Resident 10's weight due to his/her activity level but that Resident 3 was known to eat a lot, including 3 daily meals that were double portioned and snacks. Supervisor N reported s/he was unsure if Resident 10 had specifically experienced weight loss during his/her admission. At approximately 12:54 p.m., Surveyor	N 431		

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interviewed Caregiver F regarding Resident 10. Caregiver F reported that Resident 10 walked a lot. Caregiver F confirmed that Resident 10 received double-portions for each meal.

On 12/10/2025, Surveyor reviewed Resident 1's record. Resident 10's resided with the provider from 07/08/2024 to 06/25/2025. Resident 10 was identified as having legal guardians. Resident 10's diagnoses included autism. Resident 10's record contained 2 individual service plans (ISPs) that had been created during his/her admission - one signed on 07/30/2024 and one signed on 04/14/2025. Both ISPs identified that staff assistance was required for eating and that staff were to document intake for each meal and snack. The ISP from 04/14/2025 added that fluid intake monitoring was to be documented as well. Both ISPs documented that Resident 10 was a "wandering risk" and required staff supervision and redirection "to help prevent wandering episodes" six times daily "and as needed." Neither ISP contained information regarding to weight management needs (including weight tracking) or concerns of weight loss. Neither ISP contained information about the double-portions Resident 10 had reportedly received with meals.

A "Vitals History" document identified that the provider recorded weight on an approximate monthly basis for Resident 10 throughout his/her admission except for March 2025, where weights were taken weekly. The following weights were recorded:

- 07/10/2024: 132.9 lbs
- 08/12/2024: 131.4 lbs
- 09/09/2024: 136.3 lbs
- (No weight for October 2024)
- 11/04/2024: 134.1 lbs

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N 431	Continued From page 31 - 11/22/2024: 132.9 lbs - (No weight for December 2024) - 01/13/2025: 132.3 lbs - 02/24/2025: 132.9 lbs - 03/10/2025: 121 lbs - 03/17/2025: 125.5 lbs - 03/24/2025: 125.5 lbs - 03/31/2025: 128.2 lbs From the above, Surveyor noted a loss of 11.9 lbs in the 2-week period between 02/24/2025 - 03/10/2025. Surveyor reviewed Resident 10's observation notes throughout his/her admission. There was no evidence of further follow up documentation about the weight loss recorded on 03/10/2025 and no other entries about any weight loss concerns in general. At approximately 9:00 a.m., Surveyor interviewed Guardian R regarding Resident 10's weight management needs. Guardian R reported that Resident 10 was non-verbal and non-communicative. Guardian R reported that Resident 10 was known to pace when his/her needs weren't met, which indicated that s/he was usually either hungry, thirsty, had to use the bathroom, or did not like what was on television. Guardian R reported that Resident 10 began pacing a lot in the period after s/he was admitted to the provider and that his/her electronic fitness monitoring device, use of which was initiated during his/her admission, was recording between 20,000 - 28,000 steps per day that Resident 10 was walking. Guardian R reported that after some time with the provider Resident 10's family, including him/herself, noticed that Resident 10 was losing weight. Guardian R reported that Resident 10 looked thinner and s/he could see	N 431		

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Resident 10's ribs where s/he hadn't been able to before. Guardian R reported that Resident 10's most significant weight loss was around the holidays where s/he was weighed to be around 119 lbs. Guardian R reported that Resident 10's baseline weight was around 130 lbs and s/he had no unintended weight loss concerns prior to his/her admission to the provider. Guardian R reported that Resident 10's weight loss was not intentional and that s/he as well as other members of Resident 10's family were concerned for him/her.

Surveyor reviewed After Visit Summaries from visits Resident 10 had with his/her medical provider, provided by Guardian R. The first summary, dated 12/18/2024, documented that Resident 10's appointment had addressed weight loss concerns and recorded Resident 10's weight as 122 lbs and 3.2 oz. The second summary, dated 03/25/21025, documented that Resident 10's appointment had addressed concerns with his/her low weight, weight loss, and inability to gain weight, and recorded Resident 10's weight as 121 lbs.

Surveyor continued reviewing Resident 10's record. Within his/her observation notes, several entries noted Resident 10's pacing, walking, and/or wandering - including on 07/08/2024, 08/03/2024, 08/04/2024, 08/18/2024, 08/19/2024, 08/20/2024, 08/26/2024, 08/31/2024 (x2), 09/01/2024, 09/02/2024 (x2), 09/09/2024, 09/10/2024, 09/13/2024, 09/14/2024 (x2), 09/16/2024, 09/17/2024, 09/23/2024, 09/24/2024, 09/27/2024, 09/30/2024, 10/08/2024 (x2), 10/14/2024, 10/22/2024, 10/26/2024, 10/27/2024, 10/28/2024, 10/29/2024, 10/30/2024, 11/04/2024, 11/05/2024, 11/06/2024, 11/07/2024, 11/08/2024, 11/10/2024, 11/11/2024, 11/14/2024, 11/17/2024,

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N 431	Continued From page 34 when [s/he] chooses too [sic]." Of note, there was no evidence of follow up communication and/or assessment into the reported 10-lb weight loss on 10/30/2024 within Resident 10's record based on the weight loss Manager G was informed of. From Resident 10's Vitals History document, no weight was taken in October and the next weight after the above text message conversation was recorded on 11/04/2024 (5 days after the conversation took place). On 12/10/2025, Surveyor reviewed records of e-mail correspondence from Licensee B and Manager B showing communication with various combinations of parties that included themselves, Resident 10's guardians, and Resident 10's case managers from his/her managed care organization. Surveyor also reviewed records of e-mail correspondence provided by Guardian R, which showed e-mails between various combinations of parties that included him/herself, Guardian S, the provider's management staff, and Resident 10's case managers. From the e-mails, Surveyor observed the following: - E-mail from Guardian S to Manager G dated 01/30/2025 (11:38 a.m.): " ...I want to make sure everyone knows that, as of yesterday, [Resident 10]'s weight is dowen [sic] to 121. This is very concerning. Bathing [him/her] and seeing [his/her] body, [s/he] is looking like a bag of bones. I am asking for a continuous push of food. When [s/he] is comfortable in [his/her] new chair watching programs of interest, [s/he] is very capable of feeding [him/herself] while seated and drinking water for [him/herself] while in reach ..." Manager G replied on the same day, "We will continue to push fluids and food, we will also continue with	N 431		

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the watch on as well. [S/he] has snacks with [him/her] while sitting in [his/her] chair or beanbag with [him/her] most times. [S/he] will feed [him/herself] when [s/he] wants to eat or drink. But staff does encourage [him/her] to also snack more. Thank you for this information and we will continue to monitor him."

- E-mail from Manager G to Resident 10's guardians and case managers dated 02/04/2025 (2:23 p.m.): "The snacks will be written in as they provide them." Attached to this e-mail was a document named "Calories." The document itself, upon being opened, was titled, "VICTORY VISION [RESIDENT 10] MENU 2025." Seven days were listed out - 02/03/2025 through 02/09/2025 - and various foods were listed under headings for breakfast, lunch, and dinner. Another heading was identified for snacks, which only had snacks for 02/03/2024 listed. For 02/03/2025, the number of calories consumed were recorded for each of Resident 10's meals and snacks. No other calories were recorded - consistent with 02/03/2025 having been the only date that fully passed prior to this-email being sent.

(Of note, from the e-mails reviewed and Resident 10's record, the only other evidence of calorie intake tracking in Resident 10's record were located in his/her task administration records (TARs), which began showing a prompt for staff to track intake calories on 01/31/2025, consistent with the timing of the weight loss concerns from the previous e-mail discussion. However, from 01/31/2025 - 03/31/2025 (when Resident 10 began nearing his/her baseline weight according to the provider's weight tracking), there were 64 blank meal entries. Of the snack entries for the same date range, calories were not recorded or

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N 431	Continued From page 36 tracked for any snacks consumed.) - E-mail from Guardian S to Manager G dated 03/18/2025 (6:06 p.m.): " ...[Resident 10]'s [electronic fitness monitoring device] band was laying on the table. The data is showing that [s/he] is going to bed Thursday night and not sleeping until 5:00 AM on Friday. Then on Friday morning getting up at 8:00AM, then taking a nap from 10:30-12:30PM. Steps: [S/he] was out of bed on Thursday night at 11:00PM till 8:00PM Friday [s/he] had 16,000 steps. Please let me know your thoughts here. I will weigh [him/her] before I drop [him/her] off tomorrow morning and let you know. I definitely have some concerns. With all of these steps its is [sic] no wonder [s/he] is not able to keep [his/her] weight that [s/he] is gaining." - E-mail from Guardian S to Manager G dated 03/26/2025 (6:28 p.m.): " ...I wanted to let you know that [Resident 10]'s weight is down two pounds. I know this doesn't sound like much, but if [s/he] were to get sick, I know [s/he] doesn't have much to lose without being in trouble. I really want to pack some weight on [him/her]. We are going to give [him/her] a protein shake tonight before [s/he] goes to bed and one as usual in the morning in addition to [his/her] normal meals.Lets [sic] see what that does ..." Surveyor did not observe any follow-up information regarding the above concerns raised. At approximately 10:56 a.m., Surveyor interviewed Manager G regarding Resident 10's weight loss. When asked what was done when the approximate 12-lb weight loss was recorded in March 2025, Manager G reported that there were meetings and conversations with Guardian	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018368	A. BUILDING: _____ B. WING _____	R-C 12/12/2025

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N 431	Continued From page 37	N 431		

R and Guardian S about Resident 10's pacing. Manager G reported that Resident 10 seemed more active. Manager G reported that s/he was the one who had asked Resident 10's guardians about initiating use of an electronic fitness monitoring device to assess how many calories Resident 10 was burning. Manager G reported s/he believed Guardian R had been working with Resident 10's medical provider to assess for any underlying causes to explain his/her weight loss. Manager G reported that staff began to encourage Resident 10 to have higher caloric intake to help offset the calories s/he burned from pacing. When asked to clarify what "higher caloric intake" meant, Manager G clarified that staff started giving Resident more protein-based foods, 2-3 servings of fruit per meal, double portions of meals, and more snacks throughout the day.

Of note, despite Manager G having reported initiation of Resident 10's electronic fitness monitoring in response to Surveyor's question regarding the March 2025 weight loss, e-mail records reviewed showed use of the device began in December 2024 (see N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes). There was no evidence of the dietary interventions Manager G reported initiation of within either of Resident 10's ISPs throughout his/her admission.

On 12/11/2025, at approximately 10:00 a.m., Surveyor interviewed Licensee B and Manager G. When discussing the approximate 12-lb weight loss in March 2025, Manager G reported that s/he believed the jump in Resident 10's weight could have been related to his/her bowel movement regimen or a couple of days of having decreased intake. Manager G confirmed that the weight loss

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N 431	Continued From page 38 felt significant but reported that s/he thought there was a "bigger picture" as to what was going on. Manager G reported that upon Resident 10 moving into the provider's home s/he began developing new patterns related to pacing and feeding.	N 431		