STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019881	A. BUILDING: _____ B. WING _____	C 04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE CEDARBURG	W56 N225 MCKINLEY BLVD CEDARBURG, WI 53012

(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 04/16/2025, Surveyor conducted one (1) complaint investigation at LakeHouse Cedarburg. Additional information was gathered through 04/21/2025. As a result of the survey 1 complaint was substantiated and 3 deficiencies were identified. Census: 25	N 000		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the person administering residents' medications or treatments initialed the medication administration record (MAR) after administration. Findings include: On 04/16/2025 at 9:30 AM, Surveyor interviewed Resident 1. Resident 1 confirmed staff bring him/her his/her medication. Surveyor observed a	N 415		

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

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N 415	Continued From page 1	N 415		

med cup with a number of pills on the table next to Resident 1. Resident 1 stated some staff observe him/her taking medications, but other staff bring medications in, set on table and leave. Resident 1 confirmed s/he had not taken the morning medications yet and pointed to the cup of medications sitting on the table next to him/her.

On 04/16/2025 at 9:48 AM, Surveyor interviewed Resident 2. Surveyor observed Resident 2's insulin and blood sugar kit sitting on the table in front of Resident 2. Resident 2 acknowledged staff do his/her insulin and keep the insulin in the med cart. Resident 2 stated s/he was unsure why the insulin and blood sugar kit was left in his/her room, but that her blood sugar was low this morning and s/he did not receive any insulin.

On 04/16/2025 at 10:10 AM, Surveyor interviewed Caregiver C. Caregiver C stated Resident 1 can take his/her own medications. Caregiver C confirmed s/he passed Resident 1's medications and left them on his/her table. Caregiver C stated s/he puts pills in the cup and signs them out as s/he knows Resident 1 will take the medications. Caregiver C acknowledged s/he forgot the insulin and blood sugar kit as it was still in Resident 2's room. Caregiver C confirmed the insulin and blood sugar kits are kept in the med cart and should not be left in resident rooms.

On 04/16/2025 at 10:30, Surveyor requested Resident 1 and Resident 2's MAR, individual service plan (ISP) and medication policy from RN B.

Resident 1

Resident 1 was admitted to the provider on

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02/12/2015 with diagnoses including hypertension, depression bipolar disorder and diabetes. Surveyor reviewed Resident 1's April 2025 MAR. Resident 1 received the following oral medications in the morning: Amphet/Dextr 30 MG Tab, Baclofen 10 MG Tab, Calcium / D 600 MG-400IU, Cetirizine 10 MG Tab, Dalfampridin 10 MG Tab, Diltiazem ER 180 MG Cap, Docusate SOD Cap 100 MG Cap, Elmiron 100 MG Cap, Escitalopram 20 MG Tab, Ferosul 325 MG Tab, Linzess 72 MMCG Cap, Metformin 500 MG ER Tab, Myrbetriq 50 MG Tab, Omeprazole 40 MG Cap, Oxycod/APAP 5-325 MG Tab, Vitamin D3 2000 Unit Cap, and Xarelto 10 MG Tab. The April MAR reflected Elmiron 100 MG Cap - Take 1 Capsule by mouth three times daily. The MAR reflected an exception for Elmiron for 04/01/2025, 04/02/2025, 04/03/2025, 04/04/2025, 04/05/2025, 04/06/2025, 04/07/2025, 04/08/2025, 04/09/2025, 04/10/2025, 04/11/2025, 04/12/2025, 04/13/2025, 04/14/2025, 04/15/2025 for the morning, midday and evening med time and morning med time on 04/16/2025.

Review of Resident 1's ISP reflected: Medication/Treatments - "Requires employees assist/administer medications up to 3x[sic] per day with more than 4 medications per pass." "Medication passers will administer medications and insulin to resident at scheduled times."

Resident 2

Resident 2 was admitted to the provider on 01/30/2025 with diagnoses including hypertension, atrial fibrillation, chronic kidney disease and diabetes. Surveyor reviewed Resident 2's April 2025 MAR. Resident 2 had orders for "Insulin Lisp Inj 100/ML - Inject three times daily per sliding scale before meals: For BS

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N 415	Continued From page 3 100 - 150 = 8 units; 151-200 = 9 unties; 201 - 250 = 10 unites; 251 - 300 = 12 units; 301 - 350 14 units." Resident 2's blood sugar for 04/16/2025 morning was 72, MAR reflected no insulin administered. Resident 2 had orders for Lidocaine Pain Relief - 4% Ptch - Apply 1 patch topically every day for 12 hours then leave off for 12 hours for pain to back. Surveyor observed the MAR for April 2025 to reflect Resident 2 received the Lidocaine patch every morning, however on 04/01/2025, 04/03/2025, 04/08/2025, 04/10/2025, 04/12/2025, 04/13/2025 and 04/14/2025 Caregiver D signed the MAR "Med not available no patch." Review of Resident 2's ISP reflected: Medication/Treatments - "Requires employees assist/administer medications more than 3x[sic] per day with 4 or fewer medications per pass." "Resident will accept and take medications and insulin as ordered through next review." Documenting Medication Pass policy - "3. The MARs are signed/initialed at the time the medication is poured." "5. When assisting a resident with self-administration of medications, the Med Tech will: a. Check and compare the information on the medication label with the MAR. b. Check the six (6) rights - Right Resident, Right Medication, Right Time, Right Dosage, Right Route, and Right Documentation. c. Check the expiration dates on the medication to ensure it is not expired. d. Observe the resident to ensure all medications scheduled for the med pass are consumed by the resident. i. No medication can be left with the resident to self-administer at a later time."	N 415		

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N 415	Continued From page 4 On 04/16/2025 at approximately 11:45 AM, Surveyor interviewed Caregiver C. Caregiver C stated s/he was unsure why Resident 1's Elmiron was showing as an exception. Caregiver C stated s/he believes s/he gave Resident 1 the medication in the morning, however there has not been a mid day dose and that s/he believed Resident 1 was only receiving 2 times a day. On 04/16/2025 at 12:00 PM, Surveyor interviewed RN B. RN B stated s/he was unsure if the patch had fallen off of Resident 2 or if the patch was stuck to Resident 2's clothes. RN B stated s/he will look into the patch. RN B acknowledged caregiver should be passing medications and observing residents taking the medication and should not let medication in the cup in a resident's room. RN B confirmed staff are to take the insulin pens and blood sugar kits with them and keep them locked in the med cart. RN B stated s/he was aware of a problem with Resident 1's Elmiron, but s/he would need to look into that and get back to Surveyor. RN B acknowledged regarding medications, "Honestly they need to get better." RN B confirmed s/he has found medications left on the table, and stated staff should watch the residents take the medications. On 04/16/2025 at 4:01 PM, Surveyor received an email from Executive Director (ED) A. Attached to the email was information provided by RN B. RN B stated, "Care Manager spoke with [Caregiver D] about why the removal of the patch was marked as 'not given.' [Caregiver D] stated that if [s/he] didn't see the patch, [s/he] would mark it as an exception as not removed. [Caregiver D] stated that [s/he] 'didn't really pay attention to it' [sic] To resolve the issue, the staff	N 415		

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N 415	Continued From page 5 member [Caregiver D] was counseled on the proper procedure to follow for documentation of removal of a pain patch." RN B stated s/he will audit the medication record for compliance. RN B stated, "[S/he] spoke with the pharmacist and the medication Elmiron required a PA for pharmacy to fill the script. After numerous attempts on their end to have [Doctor E] sign the PA, [s/he] did not and the pharmacy admitted they had stopped requesting the PA." RN B stated s/he will talk with doctor about discontinuing the medication.	N 415		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not ensure 25 of 25 residents' medications were securely stored. Findings include: The facility is licensed to provide services for up to 65 residents who may be advanced aged, physically disabled and/or irreversible dementia/Alzheimer's. The census at time of survey was 25. On 04/16/2025, Surveyor entered the facility at approximately 8:30 AM. Surveyor observed 2 medication carts sitting near the entrance/exit of the dining room. Surveyor observed 1 medication cart unlocked, and the 2nd medication cart unlocked with the keys in the lock. Surveyor did not observe any staff near the medication carts;	N 419		

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however Surveyor observed several residents sitting in the dining room eating breakfast. Surveyor observed Caregiver F walked down the hall toward the dining room. Caregiver F greeted Surveyor and observed the medication carts unlocked. Surveyor observed Caregiver F locking the 1st cart, removing the keys and locking the 2nd cart. Surveyor questioned Caregiver F on locking the medication carts and Caregiver F responded s/he was not the med passer. Caregiver F acknowledged s/he saw the med carts unlocked, so s/he locked them and removed the keys to give to the med passer. At approximately 8:40 AM, Executive Director (ED) A and RN B walked toward Surveyor. Surveyor shared his/her observations with ED A and RN B. RN B went into the dining room and found Caregiver G. RN B took the med keys away from Caregiver G and gave the keys to Caregiver C. RN B stated staff have been doing better locking the carts up and that staff know the carts are to be locked prior to walking away from the cart and to keep the keys on their person.

On 04/16/2025 at 10:10 AM, Surveyor interviewed Caregiver C. Caregiver C stated Caregiver G left after RN B questioned him/her on the med cart. Caregiver C stated s/he was on cart 1 and that s/he had stepped away from cart to administer a medication to a resident. Caregiver C acknowledged s/he normally locks the med cart and stated, "I know the cart should be locked when walking away from cart." Caregiver C acknowledged Caregiver G was on the other cart and had left the keys in the cart.

On 04/16/2025 at approximately 12:00 PM, Surveyor interviewed RN B. RN B confirmed Caregiver G had left as s/he was upset RN B took med keys away from him/her. RN B stated s/he

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N 419	Continued From page 7 will work with staff to ensure the medication carts are locked. The provider did not ensure residents' medications were locked/securely stored.	N 419		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure adequate and appropriate care was provided within the capacity of the facility for 4 out of 4 residents reviewed (Resident 1, Resident 2, Resident 3 and Resident 4). Findings include: The provider is licensed as a class CNA	Y3244		

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Y3244	Continued From page 8	Y3244		

(non-ambulatory) to provide care for up to 65 residents in the following client groups: advanced age, irreversible dementia/Alzheimer's, and physically disabled.

On 04/09/2025, the department received a complaint alleging residents experienced long wait times to receive assistance with care and not receiving showers.

RESIDENT 1

On 04/16/2025 at 9:37 AM, Surveyor interviewed Resident 1 regarding pendant response times. Resident 1 acknowledged s/he uses his/her pendant and reported staff sometimes respond right away and sometimes take a couple of hours. Resident 1 stated s/he feels like staff should respond in 5 - 10 minutes.

On 04/16/2025 at 10:45 AM, Surveyor reviewed Resident 1's face sheet and noted Resident 1 was admitted to the provider on 02/12/2015 with diagnoses including hypertension, depression bipolar disorder and diabetes. Resident 1's individual support plan (ISP) dated 02/26/2025, noted s/he needs assistance of 1 care staff with bilateral lower extremity and some assistance may be needed with top; assist with showering twice a week; resident will call for assistance if needed with managing incontinence care; resident has had more than 1 fall in last 3 months, resident will call for assistance with ambulation when s/he is feeling weak; med passers will administer medications and insulin to resident. At 11:00 AM, Surveyor reviewed the Alarm Response Report for Resident 1's pendant usage from 03/02/2025 through 04/15/2025. Surveyor noted several instances when Resident 1 waited over 20 minutes for a response from

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Y3244	Continued From page 9 caregivers. The dates and times are as follows: 03/02/2025: Initiated at 10:07 AM Wait Time 1 hour 43 minutes 03/03/2025: Initiated at 5:08 PM Wait Time 1 hour 3 minutes 03/05/2025: Initiated at 10:58 AM Wait Time 33 minutes 03/05/2025: Initiated at 4:21 PM Wait Time 2 hour 13 minutes 03/09/2025: Initiated at 2:23 PM Wait Time 50 minutes 03/09/2025: Initiated at 8:12 PM Wait Time 30 minutes 03/14/2025: Initiated at 2:21 PM Wait Time 24 minutes 03/16/2025: Initiated at 9:10 AM Wait Time 34 minutes 03/17/2025: Initiated at 8:05 PM Wait Time 32 minutes 03/20/2024: Initiated at 7:32 PM Wait Time 21 minutes 03/21/2025: Initiated at 11:04 AM Wait Time 45 minutes 03/22/2025: Initiated at 4:42 PM Wait Time 26 minutes 03/23/2025: Initiated at 7:32 PM Wait Time 32 minutes 03/24/2025: Initiated at 2:07 PM Wait Time 39 minutes 03/25/2025: Initiated at 5:41 PM Wait Time 38 minutes 04/02/2025: Initiated at 1:57 PM Wait Time 1 hour 15 minutes 04/04/2025: Initiated at 8:34 PM Wait Time 1 hour 12 minutes 04/06/2025: Initiated at 10:08 AM Wait Time 22 minutes 04/06/2025: Initiated at 8:19 PM Wait Time 41 minutes	Y3244		

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Y3244	Continued From page 10 04/07/2025: Initiated at 8:24 AM Wait Time 2 hours 39 minutes 04/07/2025: Initiated at 1:34 PM Wait Time 1 hour 19 minutes 04/07/2025: Initiated at 8:26 PM Wait Time 25 minutes 04/08/2025: Initiated at 8:55 PM Wait Time 1 hour 33 minutes 04/08/2025: Initiated at 8:10 PM Wait Time 32 minutes 04/09/2025: Initiated at 11:59 AM Wait Time 1 hour 4 minutes 04/11/2025: Initiated at 3:13 PM Wait Time 52 minutes 04/15/2025: Initiated at 10:54 AM Wait Time 1 hour 11 minutes 04/15/2025: Initiated at 3:55 PM Wait Time 2 hours 38 minutes RESIDENT 2 On 04/16/2025, at 9:48 AM, Surveyor interviewed Resident 2 regarding pendant response times. Resident 2 acknowledged s/he uses his/her pendant and reported response depends on who is working. Resident 2 stated s/he feels like staff should respond in 10 minutes, and sometimes they do respond within 10 minutes, but there are times s/he has to wait longer for assistance. Resident 2 stated s/he does not receive showers 2 times a week. On 04/16/2025, at 10:45 AM, Surveyor reviewed Resident 2's face sheet and noted Resident 2 was admitted to the provider on 01/30/2025 with diagnoses including hypertension, atrial fibrillation, chronic kidney disease and diabetes. Resident 2's ISP dated 02/27/2025, noted s/he needs minimal assist for bilateral upper extremity and maximum assist for bilateral lower extremity;	Y3244		

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Y3244	Continued From page 11 assist with showering twice a week; minimal supervision for toileting; and requires employees to escort or push wheelchair because of a physical limitation. At 11:00 AM, Surveyor reviewed the Alarm Response Report for Resident 2's pendant usage from 03/04/2025 through 04/15/2025. Surveyor noted several instances when Resident 2 waited over 20 minutes for a response from caregivers. The dates and times are as follows: 03/04/2025: Initiated at 4:54 PM Wait Time 44 minutes 03/06/2025: Initiated at 8:38 AM Wait Time 58 minutes 03/07/2025: Initiated at 12:39 AM Wait Time 46 minutes 03/07/2025: Initiated at 5:13 PM Wait Time 1 hour 14 minutes 03/07/2025: Initiated at 6:30 PM Wait Time 2 hours 10 minutes 03/08/2025: Initiated at 12:05 AM Wait Time 1 hour 10 minutes 03/09/2025: Initiated at 4:44 PM Wait Time 58 minutes 03/10/2025: Initiated at 1:12 PM Wait Time 53 minutes 03/10/2025: Initiated at 6:09 PM Wait Time 45 minutes 03/12/2025: Initiated at 3:12 PM Wait Time 22 minutes 03/16/2025: Initiated at 2:04 PM Wait Time 21 minutes 03/18/2025: Initiated at 3:15 PM Wait Time 29 minutes 03/18/2025: Initiated at 6:10 PM Wait Time 48 minutes 03/19/2025: Initiated at 2:26 PM Wait Time 28 minutes 03/20/2025: Initiated at 10:14 AM Wait Time 1	Y3244		

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Y3244	Continued From page 12 hour 22 minutes 03/20/2025: Initiated at 6:53 PM Wait Time 1 hour 10 minutes 03/21/2025: Initiated at 4:43 PM Wait Time 31 minutes 03/23/2025: Initiated at 3:38 PM Wait Time 33 minutes 03/24/2025: Initiated at 10:07 AM Wait Time 28 minutes 03/26/2025: Initiated at 3:57 PM Wait Time 1 hour 40 minutes 03/26/2025: Initiated at 9:41 PM Wait Time 43 minutes 03/27/2025: Initiated at 3:19 PM Wait Time 26 minutes 03/31/2025: Initiated at 1:20 AM Wait Time 38 minutes 04/02/2025: Initiated at 12:08 PM Wait Time 24 minutes 04/04/2025: Initiated at 10:06 PM Wait Time 55 minutes 04/05/2025: Initiated at 5:51 PM Wait Time 35 minutes 04/08/2025: Initiated at 2:20 PM Wait Time 40 minutes 04/12/2025: Initiated at 12:58 AM Wait Time 29 minutes 04/13/2025: Initiated at 12:10 AM Wait Time 29 minutes 04/13/2025: Initiated at 4:58 PM Wait Time 2 hours 35 minutes 04/15/2025: Initiated at 4:43 PM Wait Time 41 minutes On 4/16/2025 at 11:00 AM, Surveyor reviewed Resident 3 and Resident 4's Alarm Response Report from 04/01/2025 - 04/15/2025. Surveyor noted several instances when Resident 3 and Resident 4 waited over 20 minutes for a response from caregivers. The dates and times are as:	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019881	A. BUILDING: _____ B. WING _____	C 04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Y3244	Continued From page 13 Resident 3 04/01/2025: Initiated at 6:06 AM Wait Time 50 minutes 04/01/2025: Initiated at 7:06 AM Wait Time 1 hour 5 minutes 04/01/2025: Initiated at 8:51 AM Wait Time 23 minutes 04/01/2025: Initiated at 12:16 PM Wait Time 1 hour 04/01/2025: Initiated at 3:49 PM Wait Time 50 minutes 04/01/2025: Initiated at 6:54 PM Wait Time 1 hour 22 minutes 04/02/2025: Initiated at 9:21 AM Wait Time 37 minutes 04/02/2025: Initiated at 7:51 PM Wait Time 1 hour 14 minutes 04/03/2025: Initiated at 8:33 AM Wait Time 47 minutes 04/03/2025: Initiated at 12:14 PM Wait Time 34 minutes 04/03/2025: Initiated at 5:16 PM Wait Time 1 hour 12 minutes 04/04/2025: Initiated at 6:59 PM Wait Time 23 minutes 04/04/2025: Initiated at 10:33 PM Wait Time 42 minutes 04/05/2025: Initiated at 7:13 AM Wait Time 1 hour 6 minutes 04/05/2025: Initiated at 1:10 PM Wait Time 52 minutes 04/05/2025: Initiated at 3:10 PM Wait Time 1 hour 3 minutes 04/05/2025: Initiated at 9:34 PM Wait Time 1 hour 24 minutes 04/06/2025: Initiated at 12:00 PM Wait Time 2 hours 14 minutes 04/06/2025: Initiated at 8:29 PM Wait Time 52	Y3244		

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Y3244	Continued From page 14 minutes 04/07/2025: Initiated at 12:48 AM Wait Time 22 minutes 04/07/2025: Initiated at 8:03 AM Wait Time 26 minutes 04/07/2025: Initiated at 10:21 AM Wait Time 37 minutes 04/07/2025: Initiated at 1:23 PM Wait Time 36 minutes 04/08/2025: Initiated at 7:01 AM Wait Time 35 minutes 04/08/2025: Initiated at 8:00 AM Wait Time 2 hours 48 minutes 04/08/2025: Initiated at 12:04 PM Wait Time 1 hour 28 minutes 04/08/2025: Initiated at 5:57 PM Wait Time 40 minutes 04/08/2025: Initiated at 7:19 PM Wait Time 1 hour 39 minutes 04/09/2025: Initiated at 9:16 PM Wait Time 39 minutes 04/09/2025: Initiated at 10:07 PM Wait Time 27 minutes 04/10/2025: Initiated at 7:23 AM Wait Time 52 minutes 04/11/2025: Initiated at 7:45 PM Wait Time 27 minutes 04/11/2025: Initiated at 9:38 PM Wait Time 25 minutes 04/12/2025: Initiated at 8:07 PM Wait Time 26 minutes 04/13/2025: Initiated at 4:43 PM Wait Time 5 hours 8 minutes Resident 4 04/01/2025: Initiated at 4:57 AM Wait Time 55 minutes 04/01/2025: Initiated at 8:50 AM Wait Time 21 minutes	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y3244	Continued From page 15 04/01/2025: Initiated at 11:57 AM Wait Time 47 minutes 04/01/2025: Initiated at 6:00 PM Wait Time 33 minutes 04/02/2025: Initiated at 8:47 AM Wait Time 28 minutes 04/02/2025: Initiated at 6:21 PM Wait Time 29 minutes 04/03/2025: Initiated at 6:00 PM Wait Time 27 minutes 04/04/2025: Initiated at 11:57 AM Wait Time 1 hour 9 minutes 04/04/2025: Initiated at 5:59 PM Wait Time 1 hour 41 minutes 04/05/2025: Initiated at 11:37 AM Wait Time 21 minutes 04/05/2025: Initiated at 6:36 PM Wait Time 39 minutes 04/06/2025: Initiated at 5:59 PM Wait Time 56 minutes 04/06/2025: Initiated at 7:59 PM Wait Time 29 minutes 04/08/2025: Initiated at 7:58 AM Wait Time 59 minutes 04/09/2025: Initiated at 5:59 PM Wait Time 37 minutes 04/12/2025: Initiated at 4:56 AM Wait Time 36 minutes 04/12/2025: Initiated at 12:11 PM Wait Time 24 minutes 04/14/2025: Initiated at 5:59 PM Wait Time 27 minutes 04/15/2025: Initiated at 5:58 PM Wait Time 24 minutes 04/16/2025: Initiated at 4:57 AM Wait Time 30 minutes On 04/16/2025 at approximately 11:22 AM, Surveyors interviewed RN B. RN B stated Resident 3 has a wrist call button and accidentally	Y3244		

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Y3244	Continued From page 16 bumps it. Surveyor shared findings with RN B and RN B acknowledge the wait times were long, and s/he would review the call response times. RN B stated residents receive 2 showers a week and staff complete a shower sheet. Surveyor requested the shower schedule and weekly shower sheets from RN B. RN B provided the shower schedule and Surveyor observed Resident 1 on Tuesday and Friday, and Resident 2 on Wednesday and Saturday. RN B provided Surveyor with a shower sheet for Resident 1 on 03/14/2025, 03/25/2025, 04/11/2025 and 04/15/2025; and Resident 2 on 04/16/2025. RN B stated s/he had additional shower sheets and would need to find them and would send the shower sheets to Surveyor by end of the day. On 04/16/2025 at 4:01 PM, Surveyor received an email from Executive Director (ED) A. Attached to the email was information provided by RN B. RN B stated, "I have not been able to locate any further shower documentation. To resolve this issue, it will be threefold. 1. I will be leaving a note for all staff in the breakroom to remind them that shower sheets must be completed for every single resident that is assisted with showering, even if they refuse. When completed, the sheets will be placed into my mailbox outside my office. 2. I will add to the shower list a note concerning the shower sheets and the need for them to be filled out with every shower given and even if the resident refuses. 3. I will be auditing the compliance with this task and I will be having [Caregiver C] initiate [his/her] task sheets for staff which will also help cue staff into remembering to fill out a shower sheet and turn it in." The provider did not ensure adequate and appropriate care was provided within the capacity of the facility.	Y3244		

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