STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019196	A. BUILDING: _____ B. WING _____	C 07/15/2025

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VITACARE LIVING CROSS PLAINS	2620 MILITARY RD CROSS PLAINS, WI 53528

(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 07/07/2025, with information gathered through 07/15/2025, Surveyor conducted a complaint investigation. Seven deficiencies were identified. Complaint was substantiated. Census: 17	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 4 of 4 residents. Resident 1's Trelegy Ellipta inhaler and Fluticasone nasal spray were not administered as prescribed. Resident 2's Fluticasone was not administered as prescribed. Resident 3's Cyanocobalamin (Vitamin B12) was not administered as prescribed. Resident 8's nebulizer treatments were not administered as prescribed. Findings Include: On 06/13/2025, a concern was filed with the department alleging residents did not receive	N 352		

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

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proper medication administration.

On 07/07/2025, at approximately 2:00 PM, Surveyor observed the medication cart with Med Passer B.

Example 1: Resident 1

Surveyor observed Resident 1's Trelegy Ellipta inhaler with a label that had a dispensed date of 04/11/2025 and a handwritten open date of 04/14/2025 and the inhaler had 0 of 30 doses remaining. Surveyor asked Med Passer B if Resident 1 had another Trelegy Ellipta inhaler. Med Passer B stated s/he administered the last dose that morning and would reorder the medication. Surveyor observed Resident 1's Fluticasone nasal spray with a dispensed date of 05/16/2025 and a handwritten open date of 05/16/2025. The bottle contained a minimal amount of a foamlike substance on the bottom. Med Passer B stated s/he would reorder the Fluticasone.

On 07/07/2025, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the facility 02/26/2025.

Resident 1's Medication Administration Records (MARs), dated 06/01/2025 to 07/07/2025, documented:
"Fluticasone 50 MCG (micrograms) Nasal Spray - Instill 2 sprays into each nostril once daily for allergies."
The MARs documented administration 36 out of 37 opportunities.
"Trelegy Ellipta 200 - Inhale 1 puff by mouth once daily for COPD (chronic obstructive pulmonary disease)."

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N 352	Continued From page 2 The MARs documented administration 36 of 37 opportunities. "Each bottle contains a net fill weight of 16 g (grams) and will provide 120 actuations. Each actuation delivers 50 mcg (micrograms) of fluticasone propionate in 100 mg (milligram) of formulation through the nasal adapter. The correct amount of medication in each spray cannot be assured after 120 sprays even though the bottle is not completely empty." (Source: National Institute of Health website, Fluticasone Propionate, 12/2022, https://dailymed.nlm.nih.gov/dailymed/fda (retrieval date - July 8, 2025).) Surveyor determined the Fluticasone bottle, marked as opened on 05/16/2025, would have a 30-day supply based on 120 actuations divided by 4 (2 sprays per nostril daily) and should have run out by approximately 06/15/2025. Surveyor determined the Trelegy Ellipta inhaler, marked as opened on 04/14/2025 had a 30-day supply and should have run out by approximately 05/13/2025. On 07/07/2025, at approximately 2:30 PM, Surveyor interviewed Administrator A. Surveyor requested Resident 1's May 2025 MAR to determine when his/her Fluticasone should have been reordered. Administrator A stated the provider had switched software programs and s/he did not have access to the previous program that housed the May MAR. Surveyor asked if Resident 1 had been out of the facility between 05/16/2025 and 06/01/2025. Administrator A stated s/he did not have any records stating that s/he had not been available for med administration. Surveyor explained his/her	N 352		

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observation of Resident 1's Trelegy Ellipta inhaler. Administrator A stated s/he would re-educate staff on proper administration as it was apparent residents were not receiving their medications, but staff were documenting the medication had been administered. Administrator A stated s/he would reach out to the provider to see if previous MARs could be submitted for review.

As of 07/11/2025 at 9:00 AM, Surveyor did not receive any additional documentation.

Example 2: Resident 2

Surveyor observed Resident 2's bottle of Fluticasone, with a dispensed date of 02/19/2025 and a handwritten open date of 02/28/2025. The label on the Fluticasone stated, "Instill 2 sprays into each nostril once daily." Surveyor stated to Med Passer B that the bottle of Fluticasone had approximately 120 doses/actuations. Based on the prescription, the bottle would have supplied a 30-day period. Med Passer B stated this was the only bottle of Fluticasone for Resident 2 and s/he did not know why the medication had not been administered as prescribed.

On 07/10/2025, Surveyor reviewed Resident 2's record.

Resident 2 admitted to the facility 03/05/2020.

Resident 2's Medication Administration Records (MARs), dated 06/01/2025 to 07/07/2025, documented:
"Fluticasone 50 MCG (micrograms) Nasal Spray - Instill 2 sprays into each nostril once daily for allergies."
The MARs documented administration 37 of 37

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N 352	Continued From page 4	N 352		

opportunities.

On 07/07/2025, at approximately 2:30 PM, Surveyor interviewed Administrator A. Surveyor explained his/her observation of Resident 2's Fluticasone. Administrator A stated s/he would re-educate staff on proper administration as it was apparent residents were not receiving their medications, but staff were documenting the medication had been administered.

Example 3: Resident 3

Surveyor observed Resident 3's bottle of Cyanocobalamin, with a dispensed date of 03/15/2025. The label stated, inject 1 ML (milliliter) intramuscularly every 30 - 37 days. Surveyor asked Med Passer B if s/he administered the medication. Med Passer B stated s/he did not administer the medication and did not know who would administer it. Surveyor and Med Passer B reviewed the electronic MAR which did not document that the medication had been administered.

On 07/07/2025, at approximately 2:30 PM, Surveyor interviewed Administrator A. Surveyor asked for clarification as to who was responsible for administering the medication. Administrator A stated s/he would check with the provider and determine when it had been administered.

As of 07/11/2025 at 9:00 AM, Surveyor did not receive any additional documentation.

Example 4: Resident 8

On 07/07/2025, at approximately 1:40 PM, Surveyor interviewed Resident 8. Resident 8 stated that s/he did not receive his/her nebulizer

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N 352	Continued From page 5 treatment consistently. On 07/07/2025, at approximately 2:00 PM, Surveyor observed Resident 8's unopened box of Ipratropium/Albuterol solution, with a dispense date of 05/21/2025. On 07/07/2025, Surveyor reviewed Resident 8's record. Resident 8 admitted to the facility 05/22/2025 but was hospitalized 05/25/2025 to 06/05/2025. Resident 8's MARs, dated 06/06/2025 to 07/07/2025, documented: "Ipratropium/Albuterol Solution: Use 1 vial via nebulizer twice daily. Start Date: 06/05/2025 10:00 AM). The MARs documented administration on 06/09, 06/12, 06/16, 06/17, 06/19, 06/20, 06/21, 06/22, 06/24, 06/25, 06/26, 07/04, 07/05, 07/06, and 07/07. On 07/07/2025, at approximately 2:30 PM, Surveyor interviewed Administrator A. Surveyor asked for clarification as to who was responsible for administering the medication. Administrator A stated Resident 8 had just received his/her nebulizer. Administrator A and Surveyor walked into Resident 8's room and verified that the nebulizer had been set up. Surveyor found a bag of Ipratropium/Albuterol solution sitting on a table, underneath the nebulizer. The bag did not have a label on it, just Resident 8's last name handwritten on. The bag appeared to be unopened. Administrator A stated that solution should be placed in the med cart. Administrator A stated s/he would be discussing the concern with his/her staff as it was apparent the Ipratropium/Albuterol solution had not been	N 352		

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N 352	Continued From page 6 opened but staff documented they had administered nebulizer treatments.	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident's Individual Service Plan (ISP) was reviewed when s/he experienced a change of condition. Resident 1's ISP was not updated to include guidelines for staff to monitor his/her oxygen levels. Findings include: The provider is licensed for a community based residential facility (CBRF), Class CNA (nonambulatory), to serve up to 19 residents within the client groups advanced aged, physically	N 389		

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N 389	Continued From page 7 disabled, and irreversible dementia/Alzheimer's. On 07/07/2025, at approximately 12:45 PM, Surveyor interviewed Resident 1 in his/her bedroom. Surveyor observed an oxygen concentrator, which was not turned on, and oxygen tubing lying around the room. Resident 1 explained to Surveyor that s/he utilized oxygen often, especially while sleeping. Resident 1 stated his/her concentrator would be set at 4 liters of oxygen when utilized. On 07/11/2025, Surveyor reviewed Resident 1's record. Resident 1 admitted to the facility, 02/26/2025, with diagnosis including chronic obstructive pulmonary disease (COPD). Resident 1's individual service plan, dated 05/16/2025, documented: "Respiratory Equipment: Needs assistance with other respiratory equipment, specify: Resident is prescribed inhalers and staff assist with these." Resident 1's "Scheduled Services" report did not document that s/he utilized oxygen at all. On 07/12/2025 at 12:20 PM, Surveyor emailed Administrator A and requested Resident 1's physician order identifying his/her oxygen requirements. As of 07/15/2025 at 8:00 AM, Surveyor did not receive any documentation.	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication.	N 408		

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N 408	Continued From page 8 When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure that 1 of 1 resident (Resident 8) record included the rationale for use and description of behaviors requiring the as-needed (PRN) psychotropic medications (Quetiapine and Hydroxyzine). Findings include: On 06/13/2025, a concern was filed with the department alleging residents did not receive proper medication administration. On 07/07/2025, at approximately 2:50 PM, Surveyor observed Resident 8's blister card of PRN Quetiapine in the med cart, with a dispensed date of 05/21/2025; 22 of 30 tablets	N 408		

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remained in the blister card.

On 07/07/2025, Surveyor reviewed Resident 8's record.

Resident 8 admitted to the facility, 05/22/2025, with diagnoses including anxiety and depression.

Resident 8's MARs, dated 05/22/2025 to 07/07/2025, documented:
"Quetiapine Tab (tablet) 25 MG (milligram) - Take 1 tablet by mouth twice daily as needed for depression/anxiety. Start Date: 05/22/2025."
Administered:
05/24 - Anxiety - Not Effective
06/09 - Pain - Effective
06/11 - Anxiety - Effective
06/15 - Anxiety - Effective
06/26 - Anxious - Effective
The MARs documented 5 administrations when 8 tablets had been dispensed from the blister card.
"Hydroxyzine Tab 25 MG - Take 1 tablet by mouth 3 times daily as needed for anxiety. Start Date: 05/22/2025."
Administered:
05/24 - Anxiety - Not Effective
06/05 - Anxiety - Effective
06/06 - Anxiety - Effective
06/07 - Anxiety - Not Effective
06/08 - Very antsy about [his/her] medication and needing it desperately.
06/08 - Anxiety through the roof per resident request - a little effective
06/10 - Anxiety - Effective
06/10 - Sent out with resident to medical appt - effective
This continued for a total of 19 administrations.

Resident 8's individual service plan (ISP), dated 06/23/2025, documented:

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N 408	Continued From page 10 "Psychotropic Medication Review: PRN Psychotropic Medications in use: Quetiapine, Hydroxyzine" "Behavior: Will get agitated with staff if [s/he] does not receive medications at the time that [s/he] wants them. [S/he] will become very demanding towards the staff will be very disrespectful." "Mental Illness: Anxiety - Currently on medication regimen and is stable. Depression - Does not currently take medications but is set up to see a psychologist." The ISP did not document a rationale for the administration of the PRN Quetiapine and Hydroxyzine. On 07/07/2025, at approximately 3:00 PM, Surveyor interviewed Administrator A. Surveyor reviewed the documentation with Administrator A and requested clarification as to what behaviors does Resident 8 exhibit when s/he is requesting a PRN psychotropic and how do staff know which medication to administer. Administrator A could not give a clear explanation of Resident 8's behaviors but stated there were concerns that Resident 8 was a pill seeker. On 07/13/2025 at 8:15 AM, Surveyor emailed Administrator A and requested clarification on when staff were to administer Resident 8's PRN Hydroxyzine versus the PRN Quetiapine. As of 07/15/2025 at 8:00 AM, Surveyor did not receive a response.	N 408		
N 415	83.37(2)(d) Documentation of medication administration.	N 415		

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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 observation, record review, and interview, the provider did not ensure proper documentation on the Medication Administration Record (MAR) for 1 of 2 resident reviewed.

Resident 8's 'as needed' (PRN) Oxycodone (pain) was prescribed to be administered when pain levels were between 4 and 10. The MARs did not document pain levels.
Resident 8's prescribed Olopatadine (eye drops) was not available due to needing a new prescription and staff documented that the medication had been administered when it was not available for administration.

Findings include:

On 06/13/2025, a concern was filed with the department alleging residents did not receive proper medication administration.

On 07/07/2025, at approximately 2:30 PM, Surveyor observed Resident 8's blister card of PRN Oxycodone, which was dispensed on

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06/26/2025, and had 73 of 84 tablets remaining.

On 07/07/2025, Surveyor reviewed Resident 8's record.

Resident 8 admitted to the facility 05/22/2025.

Resident 8's MAR, dated 07/01/2025 to 07/07/2025, documented:
"Oxycodone Tab (tablet) 20 MG (milligram) - Take 1 tablet by mouth every 4 hours as needed for moderate to severe pain scale 4-10. Start Date: 06/05/2025)."
Administered:
07/03 - 1 administration
07/04 - 4 administrations
07/05 - 3 administrations
07/06 - 3 administrations

The MAR did not document pain levels.

Resident 8's MAR, dated 06/01/2025 to 07/07/2025, documented:
"Olopatadine 0.2% Ophthalmic solution - Instill 1 drop in both eyes once a day. Scheduled at 9:00 AM"
06/15/2025 - Not in Cart
06/16/2025 - Medication was reordered and not delivered yet
06/18/2025 - Not in Cart
06/23/2025 - Not in Cart
Medication was documented as administered 06/17, 06/19, 06/20, 06/21, 06/22, 06/24 to 06/30, 07/06
Medication was documented as "H" (hospital) 07/01 to 07/03
The MAR was blank regarding administration on 07/04 and 07/05

On 07/07/2025, at approximately 3:00 PM,

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N 415	Continued From page 13 Surveyor interviewed Administrator A. Administrator A stated that there were concerns that Resident 8 was an opioid seeker and staff should have been asking him/her about pain levels when the medication was being administered. Administrator A called the pharmacy while Surveyor waited and was informed the prescription for Resident 8's Olopatadine had not been renewed. Administrator A stated staff would be re-educated on the proper way to document medication administration.	N 415		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 resident received assistance with personal cares.	N 425		

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N 425	Continued From page 14	N 425		

Resident 6's bed was not stripped down when the bed displayed signs of incontinence.

Findings include:

On 06/13/2025, a concern was filed with the department alleging resident rooms were not provided adequate housekeeping.

On 07/07/2025, at approximately 12:30 PM, Surveyor observed Resident 6 in his/her bedroom, watching television. Surveyor observed what appeared to be feces like stains on Resident 6's comforter which was on the made bed. Surveyor commented to Resident 6 that it appeared his/her bedding needed to be replaced with clean linens. Resident 6 stated, "Yeah probably, depends on who is working."

On 07/10/2025, Surveyor reviewed Resident 6's record.

Resident 6 admitted to the facility 07/20/2021.

Resident 6's individual service plan (ISP), dated 05/22/2025, documented:
"Laundry: Staff to provide weekly laundry services. Staff will wash, dry and fold [Resident 6's] laundry and put away weekly and as needed."
"Toileting Needs: [Resident 6] is on a two hour toileting schedule. Staff assist [Resident 6] with [his/her] toileting needs and assist [him/her] with changing depends."

On 07/07/2025, at approximately 3:00 PM, Surveyor interviewed Administrator A. Surveyor discussed his/her observations of Resident 6's room. Administrator A stated Resident 6's bed should not have been made with what appeared to be soiled bedding and would discuss this

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N 425	Continued From page 15 concern with staff. Cross Reference: M0481 83.43(1) Environment Safe, Clean and Comfortable	N 425		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that is safe, clean, comfortable, and homelike. Findings include: On 06/13/2025, a concern was filed with the department alleging resident rooms were not provided adequate housekeeping. On 07/07/2025, at approximately 11:30 AM, Surveyor and Caregiver C toured Resident 7's room and detected a urine-like scent that emanated throughout the room. Caregiver C stated this was a concern with Resident 7's room due to his/her incontinence. Surveyor asked Caregiver C if there was dedicated housekeeping staff to complete these tasks. Caregiver C stated, "The caregivers are responsible for everything. Housekeeping. Kitchen. Meds. Cares." Surveyor asked if the caregivers were able to maintain the rooms as identified in their	N 481		

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ISPs. Caregiver C stated s/he was not able to speak for the other staff members, but s/he knew the rooms did not always get cleaned, based on the condition of them when s/he had been off for several days in a row.

On 07/07/2025, at approximately 11:35 AM, Surveyor toured Resident 4's room and observed:
-Flooring throughout the room was covered in a dirt-like substance.
-Toilet bowl had a brown colored stain in the drainage area and a brown streaking pattern around the interior bowl
-Room had a urine like scent
-Garbage cans contained soiled disposable undergarments

On 07/07/2025, at approximately 11:40 AM, Surveyor toured Resident 1's room and observed:
-The walls displayed missing sections of drywall, likely caused by Resident 1's ambulation in his/her wheelchair
-The bathroom floor was covered in a dirt-like substance and soiled toilet paper. The kitchen floor area appeared to have liquid food like spillage stains.
-Toilet bowl had a brown colored stain in the drainage area and a brown streaking pattern around the interior bowl
-Oxygen concentrator had a layer of a dust-like substance on the base where the hosing connects
-Kitchenette counter displayed circular liquid beverage rings that looked similar to coffee cup spills

On 07/07/2025, at approximately 12:30 PM, Surveyor toured Resident 6's room and detected a strong urine like scent emanating throughout the room. Surveyor observed a soiled chuck pad

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N 481	Continued From page 17 in the laundry basket. The bathroom flooring appeared to not have been mopped recently due to the appearance of brown smudge patterns on the floor. On 07/07/2025, at approximately 1:00 PM, Surveyor toured Resident 2's room and observed: -Toilet riser seat had what appeared to be dried on feces like substance, along with toilet paper, on the sides, along with the interior of the toilet bowl -Room had a urine like scent -Garbage cans contained soiled disposable undergarments -The bathroom and kitchen floor were covered in a dirt-like substance. On 07/07/2025, at approximately 1:20 PM, Surveyor toured Resident 5's room and observed: -Flooring throughout the room was covered in a dirt-like substance. -Shower drain had a thick white substance covering approximately 75% of the drain On 07/07/2025, at approximately 3:15 PM, Surveyor interviewed Administrator A. Surveyor reviewed his/her observations with Administrator A and stated s/he would discuss the concern with the provider to determine if additional staffing was required.	N 481		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to:	Y3234		

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Y3234	Continued From page 18 (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were treated with courtesy, respect and full recognition of the resident's dignity and individuality. Resident 1 was not provided transfer assist when tired due to being assessed as being independent. Resident 3 and Resident 6 were awoken during sleep hours to be toileted. Findings include: On 06/13/2025, a concern was filed with the department alleging staff interaction with residents was inappropriate. Example 1: Resident 1 On 07/07/2025, at approximately 12:45 PM, Surveyor interviewed Resident 1. Surveyor noted that Resident 1 was seated in an electric wheelchair. Surveyor asked Resident 1 if there were concerns s/he would like me to discuss with Administrator A. Resident 1 stated, "There are	Y3234		

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times I feel weak, and I would like assistance to transfer from my chair to my bed. Staff will tell me I am not on the list, or I can do it myself. I use a urinal when I am in bed because it can be difficult to get out of bed, and staff are to empty it, that doesn't always happen."

On 07/07/2025, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the facility, 02/26/2025, with diagnoses including bilateral lower extremity edema (body tissue swelling), chronic pain, chronic obstructive pulmonary disease (lung disease) and hypertension (high blood pressure).

Resident 1's individual service plan, dated 05/16/2025, documented:
"Mobility - Ambulation: Unable to ambulate"
"Mobility - Bed: Independent - no assistance needed with bed mobility"
"Mobility - Transfer: Independent - no assistance needed with transferring"
"Mobility - Wheelchair: Independent - no assistance needed with wheelchair"

On 07/07/2025, at approximately 3:15 PM, Surveyor interviewed Administrator A. Surveyor asked for clarification as to when Resident 1 should be provided assistance with transfers. Administrator A stated that Resident 1 is very independent, but if there are times s/he feels s/he needs assistance for safety, staff should always provide it. Administrator A stated Resident 1 had expressed concerns regarding receiving assistance from staff.

Example 2: Resident 3

On 07/07/2025, at approximately 12:30 PM,

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Y3234	Continued From page 20 Surveyor interviewed Resident 3, who was sitting in his/her wheelchair in his/her bedroom. Caregiver C observed Surveyor speaking with Resident 3. Surveyor asked Resident 3 if there were concerns s/he would like me to discuss with Administrator A. Resident 3 stated, "I do not like getting up at 6:00 AM, sometimes I want to sleep. I do not like being woke up to toilet." On 07/07/2025, Surveyor reviewed Resident 3's record. Resident 3 admitted to the facility 03/19/2024. Resident 3's ISP, dated 05/15/2025, documented: "Mobility - Transfer: Needs assistance with transferring" "Toileting Needs: Staff assistance of one needed for toileting. Two hour toileting schedule." "Sleep Patterns: [Resident 3] typically awakes between 5:30 - 6:00 AM. [S/he] will cat nap during the day in [his/her] recliner. Preferred bedtime is between 10 - 11 PM." Resident 3's "Care Plan" documented: Toileting: 12:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM. Start Date: 07/17/2024. On 07/07/2025, at approximately 3:15 PM, Surveyor interviewed Administrator A. Surveyor asked for clarification on when residents are awoken during sleep hours. Administrator A stated when the ISP identified they were on a two-hour toileting schedule. Administrator A stated residents should be allowed to awaken when they are ready. Surveyor asked for clarification on whether a resident should be awakened to toilet. Administrator A stated the concern would be reviewed.	Y3234		

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Example 3: Resident 6

On 07/07/2025, at approximately 12:40 PM, Surveyor interviewed Resident 6. Surveyor asked Resident 6 if there were concerns s/he would like me to discuss with Administrator A. Resident 6 stated, "I hate being woke up to go to the bathroom."

On 07/07/2025, Surveyor reviewed Resident 6's record.

Resident 6's ISP, dated 05/22/2025, documented:
"Mobility - Transfer: Needs assistance with transferring. Staff assistance of two to assist with transferring to and from the bathroom, recliner, and bed."
"Toileting Needs: [Resident 6] wears Depends and needs staff assistance with changing them. Two hour toileting schedule."
"Sleep Patterns: [Resident 6] prefers to rise anytime between 7:30 AM - 10:00 AM. [Preferred bedtime is 10:00 PM."

Resident 6's "Care Plan" documented:
Toileting: 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM. Start Date: 07/03/2024.

Additional Interviews:

On 07/07/2025, at approximately 12:15 PM, Surveyor interviewed Caregiver C. Surveyor asked if residents had confided in him/her regarding concerns with their cares. Caregiver C stated residents had commented that call light response times could be long. Caregiver C stated, "I have been off for a couple of days and when I came in, you could tell that scheduled

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Y3234	Continued From page 22 cares had not been completed." Caregiver C stated that there had been continuous staff turnover, so agency staff had been utilized, while new staff were hired and trained. On 07/07/2025, at approximately 1:05 PM, Surveyor interviewed Resident 2. Surveyor asked Resident 2 if there were concerns s/he would like me to discuss with Administrator A. Resident 2 stated, "The main thing is there is a lot of agency staff that come through here and they do not know the residents or how to take care of them. Call light response times can be long."	Y3234		