STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017088	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMENSIONS LIVING PEWAUKEE WEST	N26W26511 COLLEGE AVE PEWAUKEE, WI 53072

(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 01/29/2026, with information gathered through 02/20/2026, the Bureau of Assisted Living, Southern Regional Office conducted two complaint investigations at Dimensions Living Pewaukee West located at N26W26511 College Aveune in Pewaukee, WI. Seven citations of noncompliance were issued, including 1 repeat violation of compliance. The complaints were substantiated. Census: 14	N 000		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer,	N 310		

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

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N 310	Continued From page 1 death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1's admission agreement was given in writing and explained to Resident 1's legal representative, as required. Resident 1's admission agreement was not signed by Resident 1's Legal Representative A, as required. The findings include: The department received complaint allegations including admission agreements were not being completed, as required. On 01/29/2026 at 11:40 A.M., Surveyor reviewed Resident 1's record, as provided by Administrator A. Resident 1's "Move In Record" included Resident 1 was admitted to the facility on 09/29/2025 with diagnoses including, "Alzheimer's disease with late onset." The document included Resident 1's "emergency contact #1" was Resident 1's Legal Representative L and Resident 1's "financial contact" was Resident 1's Spouse M.	N 310		

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N 310	Continued From page 2 Resident 1's "Medical Power of Attorney" document included Resident 1 executed this power of attorney on 04/17/2022. Resident 1's Legal Representative L was listed as Resident 1's "agent" and Resident 1's Alternate Legal Representative N was listed as "1st [first] Alt. [alternate] Agent." Resident 1's hospice agency's "communication notes" dated 09/29/2025 included, "Activated HCPOA [health care power of attorney; legal representative] is [his/her] [Resident 1's Legal Representative L]." Resident 1's "Lease Agreement & [and] Services Contract" included "Agreement start date 09/29/2029 [sic]" and listed Administrator A as "Executive Director of Community." Resident 1's Spouse M's signature was the sole signature included within this agreement and was documented under "responsible party" and dated 09/30/2025. Administrator A told Surveyor Resident 1's record did not include documentation of determination of incapacity, or activation of Resident 1's medical power of attorney. Administrator A told Surveyor s/he believed Resident 1's Spouse M was Resident 1's financial power of attorney, but Resident 1's record did not include documentation of financial power of attorney. Administrator A told Surveyor s/he discussed Resident 1's admission agreement with Resident 1's Spouse M on 09/30/2025, as signed, with Resident 1's Alternate Legal Representative N present at that time. Administrator A told Surveyor Resident 1's Legal Representative L told him/her Resident 1's Spouse M was Resident 1's financial power of attorney "at some point." On 02/09/2026 at 12:02 P.M., Surveyor conducted	N 310		

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an interview with Resident 1's Legal Representative L. Legal Representative L told Surveyor both Resident 1's health care, or medical, and financial powers of attorney were "activated" prior to Resident 1's admission to the facility.

On 02/09/2026 at 1:59 P.M., Surveyor received an email from Resident 1's Legal Representative L including Resident 1's durable financial power of attorney, Resident 1's determination of capacity (activation document), and Resident 1's admission agreement.
Resident 1's and Resident 1's Spouse M's "Durable Financial Power of Attorney" document included Resident 1 and Resident 1's Spouse M executed this power of attorney on 04/17/2022. Resident 1's Legal Representative L was listed as Resident 1's "agent" and Resident 1's Alternate Legal Representative N was listed as "2nd [second] Agent." This document was notarized on 04/17/2022.
Resident 1's "Determination of Incapacity For Activation of Health Care Power of Attorney" document was signed, as required, on 01/15/2021.
Resident 1's "Lease Agreement & [and] Services Contract" included "Agreement start date 09/29/2029 [sic]" and listed Administrator A as "Executive Director of Community." Resident 1's Spouse M's signature was the sole signature included within this agreement and was documented under "responsible party" and dated 09/30/2025. This document was the same as Surveyor reviewed onsite, 01/29/2026, as received from Administrator A.

On 02/10/2026 at 10:11 A.M., Surveyor conducted an interview with Resident 1's Legal Representative L. Resident 1's Legal Representative L told

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N 310	Continued From page 4 Surveyor s/he and Resident 1's Alternate Legal Representative N were in Resident 1's room on 09/30/2025 when Resident 1's Spouse M went to Administrator A's office to discuss some concerns. Resident 1's Legal Representative L said that was when Administrator A "had [Resident 1's Spouse M] sign [Resident 1's] service/admission agreement in [Administrator A's] office without [Resident 1's Legal Representative L and/or Resident 1's Alternate Legal Representative N] present." Resident 1's Legal Representative L said Resident 1 had moved in to the facility the day before, on 09/29/2025. Legal Representative L said s/he was not sure when s/he became aware of Administrator A asking Resident 1's Spouse to sign the agreement, and that it may have been later that same day. Legal Representative L said s/he did not see a copy of the signed document right away and did not believe s/he spoke to Administrator A about the document. Legal Representative L said it may not have dawned on him/her at that time to deal with Administrator A regarding the agreement because "there was a lot going on between Resident 1's move in, dealing with hospice, and etc." Legal Representative L said neither s/he nor Resident 1's Alternate Legal Representative N were ever approached by anyone at the facility, including Administrator A, to review and sign Resident 1's service/admission agreement. Legal Representative L said it "felt sneaky" Administrator A's had Resident 1's Spouse M sign the service/admission agreement. Resident 1's Legal Representative L said all of Resident 1's power of attorney documentation, including incapacitation/activation, were reviewed by and/or provided to Previous DOW O when s/he completed Resident 1's pre-admission assessment at the hospital before Resident 1	N 310		

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moved to the facility. Resident 1's Legal Representative L said the hospice agency that worked with Resident 1 at the facility also received all of Resident 1's power of attorney documentation, including incapacitation/activation. Resident 1's Legal Representative L told Surveyor Resident 1's power of attorney documents were "re-done" in April of 2022 to have Resident 1's Legal Representative L and Resident 1's Alternate Legal Representative N to become his/her agents instead of Resident 1's Spouse M. Resident 1's Legal Representative L said Resident 1's Spouse M was no longer able to make significant financial and health care decisions.

On 02/10/2026 at 10:39 A.M., Surveyor received an email from Resident 1's Legal Representative L including Resident 1's medical power of attorney. Resident 1's "Medical Power of Attorney" document included Resident 1 executed this power of attorney on 04/17/2022. Resident 1's Legal Representative L was listed as Resident 1's "agent" and Resident 1's Alternate Legal Representative N was listed as "1st [first] Alt. [alternate] Agent." This document was the same as Surveyor reviewed onsite, 01/29/2026, as received from Administrator A.

On 02/11/2026 at 4:28 P.M., Surveyor received an email from Administrator A.
The email included an email received by Administrator A on 09/19/2025 at 5:36 P.M. regarding a referral related to Resident 1. The document included Resident 1's Legal Representative L's name listed under "Family Information" with "POA [power of attorney]" hand-written next to his/her name.
The email included an attached copy of Resident

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1's progress notes from Resident 1's admission to the facility through Resident 1's death at the facility on 10/09/2025. A note dated 09/29/2025 at 5:51 P.M. by Previous DOW O included, "[Resident 1] was admitted at 1422 [2:22 P.M.] by ambulance from [hospital] accompanied by [Resident 1's Spouse M] and [Resident 1's Legal Representative L and Resident 1's Alternate Legal Representative N]." A note dated 09/30/2025 at 3:22 P.M. by Previous DOW O included, "The POA [Resident 1's Legal Representative L] met with this nurse and we discussed the reality of [Resident 1's] progression. [S/he] was very agreeable and stated that [Resident 1's Alternate Legal Representative N] and [Resident 1's Spouse M] were not as accepting of [Resident 1's] declining condition as [Resident 1's Legal Representative L] was."

On 02/16/2026 at 6:52 P.M., Surveyor received an email from Administrator A.
The email included, "[Resident 1] document for financial POA-HC [power of attorney - health care] and pre-admission assessment, I [Administrator A] am looking for, this was completed on paper by nurse but unable to locate both documents at this time."

On 02/17/2026 at 2:55 P.M., Surveyor conducted an exit interview with Administrator A and DOW C. Administrator A said s/he believed the facility had Resident 1's financial power of attorney and activation documentation as it was collected by the facility's Regional Director of Quality P at the time of Resident 1's admission to the facility on 09/29/2025, but Administrator A was unable to locate the documentation. Administrator A told Surveyor s/he had a hard time with Resident 1's

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N 310	Continued From page 7 Spouse M and Resident 1's Legal Representative L in terms of communication. Administrator A said Resident 1's Spouse M and Resident 1's Legal Representative L were Resident 1's legal representatives. Administrator A told Surveyor, "Ideally, have admission agreements signed the day before admission or the day of move-in." Surveyor informed Administrator A based on interview and record review Resident 1's legal representatives were Resident 1's Legal Representative L and Resident 1's Alternative Legal Representative N. Administrator A said the facility should have all power of attorney documentation including incapacitation/activation before the resident's admission agreement is signed.	N 310		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 4's right of self-determination was respected. The findings include: On 01/29/2026 at approximately 10:11 A.M., Surveyor observed Caregiver G and Caregiver H	N 355		

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transfer Resident 2 to the toilet utilizing a sit-to-stand mechanical lift. Surveyor observed Caregiver G and Caregiver H push Resident 2 in the sit-to-stand lift over the bathroom doorway threshold. Surveyor observed both Caregiver G and Caregiver H verbally warn Resident 2 s/he was about to "go over a big bump" when both caregivers pushed with effort to roll Resident 2 in the sit-to-stand lift over the threshold.

On 01/29/2026 at 12:28 P.M., Caregiver H told Surveyor the caregivers were to transfer Resident 4 with a "crank-type, non-electric [hydraulic] Hoyer mechanical lift" kept in the storage room across from Resident 4's room. Caregiver H said there was another, blue-grey colored mechanical lift stored in the same room but it was not being used because it did not work.

On 01/29/2026 at 12:39 P.M., Surveyor conducted an interview with Resident 4. Surveyor observed Resident 4 was seated in and independently utilized his/her electric wheelchair. Resident 4 told Surveyor s/he had lived at the facility since November 2024. Resident 4 told Surveyor s/he experienced a "stroke" in 2013 affecting the left side of his/her body requiring him/her to be dependent on caregiver assistance with most cares, including mobility and repositioning. Resident 4 told Surveyor s/he required full assistance with all transfers from caregivers utilizing a mechanical lift. Resident 4 said s/he had utilized a sit-to-stand mechanical lift for approximately a decade prior to and since moving to the facility in 2024. Resident 4 told Surveyor the use of the sit-to-stand lift worked well and it was the lift type s/he preferred for transfers. Resident 4 told Surveyor the use of the sit-to-stand

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allowed him/her to utilize his/her body as much as possible and maintain strength on his/her right side. Resident 4 said s/he also participated in regular physical therapy sessions until December 2025 to maintain strength. Resident 4 said the facility management told Resident 4 and the caregivers Resident 4 was to be transferred using a full body Hoyer-type mechanical lift instead of the sit-to-stand lift. Resident 4 told Surveyor s/he believed the change occurred around Thanksgiving 2025, but unsure of the exact date. Resident 4 said the facility management told him/her there was a concern regarding safety and a wheel on the sit-to-stand lift had broken when rolling over the bathroom doorway threshold. Resident 4 said s/he was upset, did not agree with the change in lift usage, and communicated his/her concerns with his/her public funding agency case management team. Resident 4 said a care planning meeting occurred at the facility on 12/04/2025 which was attended by Resident 4, two members of Resident 4's family, Administrator A, Director of Wellness [DOW] C, Resident 4's public funding agency Case Manager Q. Resident 4 told Surveyor s/he makes all decisions on his/her own behalf and liked to include his/her family in care planning meetings for support and additional advocacy. Resident 4 said the facility's concerns and recommended change in mechanical lift transfers were discussed during this meeting on 12/04/2025 including the facility recommending a physical therapy evaluation regarding use of the sit-to-stand lift. Resident 4 said Physical Therapist R evaluated him/her at the facility on 01/13/2026.

At 12:55 P.M., Surveyor received an email from Resident 4 including an attached email dated 01/13/2026 at 7:30 P.M. from Physical Therapist R

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to DOW C and carbon copied (cc'd) to Case Manager Q. The attached email included, "I [Physical Therapist R] was able to evaluate [Resident 4] today for a sit-to-stand transfer using the mechanical lift. [Resident 4] was able to stand on device without difficulty. The only time that the transfer concerned me [Physical Therapist R] was when we were getting [Resident 4] over the bathroom threshold. This was almost impossible (even without [him/her] on the sit-to-stand). I am imagining that this is the same for the Hoyer [full body] lift. My [Physical Therapist R's] first recommendation would be to change the threshold to allow the mechanical aids to over threshold more easily. The next would be for staff to put the sit-to-stand in the BR [bathroom] first and then have [Resident 4] come to the BR door and park at the doorway and then have staff use sit-to-stand from there. This eliminates multiple transfers and navigating the threshold. I was able to talk to [Assistant Administrator B] and [Maintenance Director D] about changing the threshold. [Maintenance Director D] said [s/he] could do it but would have to get the o.k. from [Administrator A]. To address difficulty repositioning [Resident 4] once in [his/her] w/c [wheelchair], I would recommend that 2 people stand on either side of the chair and scoot [him/her] back. Not all staff will be able to reach over [him/her] and scoot [him/her] back. I suggest having [him/her] sit on a chuck pad or towel to help with positioning. Please let me [Physical Therapist R] if you [DOW C] have any questions or concerns!" Resident 4 told Surveyor there had been no change made to his/her bathroom threshold as of this day, 01/29/2026. Resident 4 said caregivers had told him/her that DOW C had instructed the caregivers to continue to transfer Resident 4 with the full-body

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mechanical lift because DOW C was not part of the evaluation completed by Physical Therapist R and the caregivers had not been trained based on the evaluation. Resident 4 told Surveyor Physical Therapist R attempted to communicate with DOW C to set up a meeting, including 01/20/2026, to review his/her recommendations, but DOW C was not available at the facility.
At 12:58 P.M., Surveyor received an email from Resident 4 including an attached email dated 01/15/2026 at 3:14 P.M. from Physical Therapist R to DOW C and cc'd to Case Manager Q. The attached email included, "I [Physical Therapist R] set up a time to see [Resident 4] Tuesday the 20th [01/20/2026] in the afternoon. It'll [sic] be sometime after 145 [1:45 P.M.]. Will that work for you [DOW C] to discuss and go over transfers? Do you [DOW C] think we could have the threshold changed by then? My [Physical Therapist R's] schedule changed this afternoon so I was there an hour earlier than I intended so I have left for the day. If Tuesday afternoon does not work, please let me [Physical Therapist R] know what would work so we can get this figured out."
Resident 4 told Surveyor since November 2025, some caregivers continue to assist transferring Resident 4 with another sit-to-stand lift the caregivers were also using with a newer resident, Resident 2. Resident 4 told Surveyor s/he did not believe the facility repaired the wheel on the other sit-to-stand lift. Resident 4 said other caregivers used a crank-type (manual pump), full-body, hydraulic Hoyer mechanical lift to transfer Resident 4 because they have been told their employment would be terminated if they used the sit-to-stand lift to transfer Resident 4. Resident 4 said s/he did not want to get the caregivers in trouble.

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N 355	Continued From page 12 Resident 4 said the caregivers told him/her it was easier for the them to get the sit-to-stand lift over his/her bathroom threshold than it was with the manual pump Hoyer lift. Resident 4 told Surveyor when the caregivers used the manual pump Hoyer lift to toilet him/her during the day, s/he had to be transferred from his/her wheelchair to bed to pull his/her pants down and then lifted back up using the lift to wheel him/her to the bathroom if using a split sling or transfer him/her to a shower chair and then wheel him/her to the bathroom toilet and then reverse the process to transfer Resident 4 back to his/her wheelchair. Resident 4 said this process of using the Hoyer lift was harder on his/her body, especially when getting dressed and undressed, and did not allow him/her to use his/her body. Resident 4 said s/he used to have a bowel movement every morning when transferred to the toilet using the sit-to-stand during morning cares. Resident 4 said s/he now has a bowel movement three times per week because s/he did not want to go through the process of being transferred with the Hoyer lift to use the toilet. Resident 4 told Surveyor s/he had an urge to have a bowel movement this morning after s/he was "up" for the day and seated in his/her wheelchair. Resident 4 said s/he was waiting until this evening after supper to have a bowel movement with evening cares to avoid the hassle of being transferred with the Hoyer lift on this morning/early afternoon. Resident 4 told Surveyor s/he usually received caregiver assistance with evening cares and was transferred to bed right after dinner, at approximately 6:30 P.M. every evening. Resident 4 said s/he was concerned his/her body was getting weaker because s/he was not being transferred with the sit-to-stand lift regularly and	N 355		

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N 355	Continued From page 13 did not want to lose that strength s/he maintained with therapy and consistent sit-to-stand lift use.. On 01/29/2026 at approximately 1:44 P.M., Maintenance Director D and Surveyor observed two mechanical lifts stored within a room across from Resident 4's room. Maintenance Director D told Surveyor the white colored manual hydraulic Hoyer mechanical lift was being used by caregivers to transfer Resident 4 as directed by DOW C. Maintenance Director D told Surveyor the blue-grey colored automatic Hoyer mechanical lift had battery issues and was not functioning at this time. Maintenance Director D said Administrator A was aware of the battery issues. Photo #3. On 01/29/2026 at 2:45 P.M., Surveyor conducted an interview with Caregiver J. Caregiver J said s/he had worked at the facility since his/her hire in November of 2025 and primarily worked the afternoon/evening shift from 2:00 P.M. until 10:00 P.M. Caregiver J told Surveyor s/he usually assisted Resident 4 with evening cares between 5:30 P.M. and 6:30 P.M. per Resident 4's request. Caregiver J told Surveyor s/he transferred Resident 4 utilizing the sit-to-stand lift shared with Resident 2. Caregiver J said s/he heard from Resident 4 and other caregivers it was okay to use the sit-to-stand to transfer Resident 4. Caregiver J said s/he could look on the computer to see Resident 4's individual service plan (ISP) to check on which lift to use, but s/he had not done that for Resident 4 and was going by "word of mouth." Caregiver J said it was easier to get the sit-to-stand over Resident 4's bathroom threshold. Caregiver J said s/he and other caregivers "really have to push" the mechanical lifts over the	N 355		

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bathroom thresholds. Caregiver J said it "also happened with [Resident 2's] threshold."

On 01/29/2026 at approximately 2:55 P.M., Surveyor conducted an interview with Caregiver E. Caregiver E said s/he had worked at the facility since his/her hire in November of 2023 and primarily worked the afternoon/evening shift from 2:00 P.M. until 10:00 P.M. Caregiver E told Surveyor despite DOW C instructing caregivers to use the Hoyer-type lift to transfer Resident 4 because it was safer, s/he and other caregivers continued to use the sit-to-stand lift to transfer Resident 4 because it was never changed on Resident 4's care plan. Surveyor observed Resident 4's "Individual Service Plan/Service Plan" on Caregiver E's electronic tablet. The plan included, "Requires assistance of 2 staff for transferring with sit-to-stand lift." Photos #4 and #5 Caregiver E said using the Hoyer-type lift "takes away from being easier on him/her [Resident 4] and us [caregivers]." Caregiver E said s/he was unaware of any safety concerns or incidents when using the sit-to-stand lift with Resident 4.

On 01/29/2026, Surveyor reviewed Resident 4's record, as provided by Administrator A. Resident 4's "Move In Record" included Resident 4 was admitted to the facility on 11/05/2024 with multiple diagnoses including, "Hemiplegia [paralysis] and hemiparesis [weakness] following other cerebrovascular disease affecting left, non-dominant side," diabetes," and "restless legs syndrome." Resident 4's "Move In Record" included Resident 4 was responsible for making decisions on his/her own behalf.
Resident 4's ISP dated 07/01/2025 included Resident 4's, Administrator A's, and Previous

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N 355	Continued From page 15 Director of Wellness [DOW] F's signature. Resident 4's ISP included the use of a sit-to-stand lift multiple times including, "Staff to assist with turning and positioning" and "Requires assistance [with] sit to stand lift for toileting, needs staff assistance for peri-care and to adjust clothing after toileting." Resident 4's ISP included, "Independent once transferred via sit to stand lift to wheelchair." Resident ISP included, "Independent with decisions about [his/her] care and environment, very particular about [his/her] routine and maintaining [his/her] routine. [Resident 4] is very set in [his/her] routine. [His/her] routine takes about an hour to complete. Staff to set aside enough time to complete [Resident 4's] routine to [his/her] satisfaction." Resident 4's ISP included, "[Resident 4] has set routine for [his/her] ADLs [activities of daily living] that is very specific and time consuming. Staff to allow for enough time to follow residents routine pwr [sic] [his/her] wishes." On 01/29/2026 at 5:15 P.M., Surveyor conducted an interview with DOW C. DOW C told Surveyor the last time Resident 4's ISP was reviewed was 07/01/2025, as Surveyor received from Administrator A, prior to DOW C's start of employment at the facility. DOW C said a care meeting with Resident 4's funding agency's case management team, Resident 4's family, Administrator A, and DOW C was held at the facility at the beginning of December 2025. DOW C said it was decided Resident 4 was to be evaluated by a physical therapist in regard to transfers. DOW C said Physical Therapist R assessed Resident 4 at the facility on 01/13/2026 but DOW C was not invited nor present at the assessment. DOW C provided a copy of the email s/he received from Physical	N 355		

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N 355	Continued From page 16 Therapist R dated 01/13/2026 at 7:30 P.M. from Physical Therapist R and carbon copied (cc'd) to Case Manager Q including the results of Physical Therapist R's evaluation of Resident 4 on 01/13/2026. This was same email Surveyor received from Resident 4 on 01/29/2026 at 12:55 P.M., as documented above. DOW C did not provide an email sent to him/her on from Physical Therapist R dated 01/15/2026 at 3:14 P.M. also cc'd to Case Manager Q including a request to meet to review the results of Physical Therapist R's evaluation of Resident 4. This email was provided to Surveyor from Resident 4 on 01/29/2026 at 12:58 P.M., as documented above. DOW C told Surveyor it had been his/her expectation for approximately the last month that all caregivers were to utilize a full-body Hoyer-type mechanical lift with all of Resident 4's transfers. DOW C said Resident 4 was only able to bear weight on one side of his/her body and only had the use of one arm. DOW C said caregivers had complained to DOW C they were having difficulty repositioning him/her back far enough in the wheelchair with the sit-to-stand lift. DOW C said caregivers had complained to DOW C that the sit-to-stand's battery died too quickly and DOW C believed the sit-to-stand's motor broke. DOW C said s/he was concerned with caregiver safety when it came to using the sit-to-stand lift with Resident 4. DOW C said s/he assisted a caregiver to transfer Resident 4 with the sit-to-stand, possibly around the end of December 2025, after the caregiver complained s/he was having difficulty with the sit-to-stand and DOW C became aware of the difficulty using the sit-to-stand with Resident 4's transfers. DOW C said s/he could not recall the caregiver's name and the caregiver was no longer employed at the	N 355		

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facility.
DOW C told Surveyor s/he "punted this situation to corporate" and was told to follow the corporation's policy regarding sit-to-stand lifts. DOW C said the policy included a resident must be able to use both handles of the sit-to-stand. DOW C provided Surveyor a copy of "HDG Health Dimensions Group" policy regarding sit-to-stand mechanical lift dated "2023." The policy included, "Mechanical lifts shall be used for resident transfers based on an individualized assessment of the resident's physical and cognitive abilities. Equipment must be used according to manufacturer guidelines, with properly trained staff, and in a manner that prioritizes resident safety, dignity, and functional ability." The documentation included, "A resident must be assessed and documented as appropriate for sit-to-stand device use prior to implementation. The resident must meet all of the following criteria: Cognitive status: Alert, cooperative, and able to follow directions. Weight-bearing ability: Able to bear partial weight through at least one leg. Upper body strength: Able to grasp and maintain hold of the device handles. Head and neck control: Adequate strength and stability. Tolerance: Able to safely tolerate the standing position."
DOW C said s/he spoke with Resident 4's funding agency case management on this morning and discussed the facility's policy. DOW C said Resident 4's funding agency case management told him/her the facility was being unfair to Resident 4.

On 01/29/2026 at 6:52 P.M., Surveyor conducted an interview with Administrator A and DOW C. DOW C said Resident 4 takes a great deal of caregiver's time, up to 1 or 2 hours, to provide

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cares because Resident 4 was very particular about personal cares. DOW C said there was a safety concern for Resident 4 and the caregivers regarding using the sit-to-stand lift to transfer Resident 4. Administrator A told Surveyor the wheel cracked on a sit-to-stand lift when it was used to transfer Resident 4 when it was rolled over the bathroom threshold. Administrator A said it was harder to get the sit-to-stand lift with Resident 4 in it over the bathroom threshold. Administrator A said Resident 4's body size and leaning to one side because of paralysis puts pressure on one side of lift. Administrator A said s/he was unable to recall when the sit-to-stand's wheel cracked when transferring Resident 4. Administrator A said staff training was provided regarding the use of the Hoyer lift. DOW C told Surveyor s/he assessed Resident 4's transfer with the sit-to-stand at the end of December 2025, possibly 12/30/2025, and determined a Hoyer mechanical lift would be used to transfer Resident 4. DOW C said s/he verbally instructed caregivers to use the Hoyer lift for all of Resident 4's transfers following this assessment. DOW C said s/he "just updated [Resident 4's] ISP tonight to Hoyer." Administrator A said s/he would send documentation of Resident 4's 12/04/2025 care meeting with case management, Resident 4's family, and facility management and Hoyer lift training provided to caregivers.

On 01/29/2026 at 7:00 P.M., Surveyor conducted a preliminary exit interview with Administrator A, DOW C, and Regional Nurse K, who joined via DOW C's phone, including a discussion about Resident 4's plan for transfers. DOW C said Physical Therapist R educated facility caregivers to use the sit-to-stand with Resident 4 when s/he was at the facility to evaluate Resident 4, despite

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N 355	Continued From page 19 Resident 4's need for a Hoyer lift. Regional Nurse K said Resident 4's funding case management team were pushing a resident rights perspective regarding Resident 4's lift. DOW C said s/he would be tracking how long it took caregivers to provide cares with Resident 4. DOW C said Resident 4 was a "complex [person]" and "should be [living] in a skilled nursing facility." On 01/29/2026 at 8:51 P.M., Surveyor received an email from Resident 4 including, "[Administrator A] and [DOW C] just came into my [Resident 4's] room to tell me [Resident 4] that their policy is that a person had to be able to use both arms to hold both handles to use the sit to stand [lift]. I [Resident 4] asked them for a copy of the policy and a copy of the care plan. I have both with me now." On 01/30/2026 at 10:32 A.M., Surveyor received an email from Administrator A including attachments. One attachment included an email from Administrator A to Case Manager Q dated 12/02/2025 including, "We [the facility] do have sit and stand Hoyer lift at the community. Concern I [Administrator A] am hearing from nursing is indicating [Resident 4] needs a Hoyer left [sic] as [s/he] is not safe with sit and stand. I do believe a care conference is necessary so everyone can be on the same page. [Resident 4] doesn't [sic] like the Hoyer, we have to use the safest option for resident transfer." One attachment included handwritten documentation including Administrator A's and DOW C's names at the end. The documentation included, "Care conference held on 12/04/2025. [Resident 4], [Resident 4's family members], and	N 355		

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[funding agency] case managers was [sic] present. Our meeting was in regard [sic] resident care at center and sit and stand transfer. Case managers and family was [sic] made aware [Resident 4] is not safe to use the sit and stand due to resident inability to fully stand or bear weigh [sic] as well as using both hands. Staff have and continued to report they are physically pulling on resident [sic] body to ensure [s/he] can safely sit in [his/her] electric wc [wheelchair] or toilet. Case manager, resident, and family was made aware that the ultimate goal is to ensure resident and staff remain safe. At this time, resident and staff are not safe due to the continue [sic] use of sit and stand. As a result of this safety concern, resident will be down graded to Hoyer lift which is the safest mean [sic] of resident transfer at this moment. To ensure resident continued improvement, nursing [facility] will obtain a therapy evaluation of resident using sit and stand lift."
One attachment included Resident 4's "progress notes" including a note documented by DOW C on 12/27/2025 at 8:00 P.M. The documentation included, "LATE ENTRY: RN [registered nurse] assessment completed at time to down grade resident to Hoyer lift versus sit-to-stand due to resident's ability to assist staff with repositioning [self] in to [his/her] wheelchair without requiring the use of a 2 person assist to physically lift [him/her] and move [him/her] towards the back of [his/her] wheelchair. ISP [individual service plan] has been updated, reviewed, and signed by [Resident 4] & [and] IDT [interdisciplinary team]."

02/05/2026 at 3:41 P.M., Surveyor conducted an interview with Resident 4's Case Manager Q. Case Manager Q told Surveyor Resident 4 was oriented and a reliable communicator. Case

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N 355	Continued From page 21 Manager Q said Resident 4 moved to the facility in November 2024 and had been using the sit-to-stand lift for all transfers without any concerns shared until November 2025 when 1 caregiver at the facility started to complain they were not able to push the sit-to-stand lift over Resident 4's bathroom threshold easily and it seemed Administrator A and DOW C "ran with" the complaint. Case Manager Q said Resident 4 called him/her on 11/07/2025 reporting s/he was told one of the sit-to-stand wheels cracked when used with him/her over the threshold and this was when things changed. Case Manager Q said s/he had asked Administrator A repeatedly about changing the threshold going in to Resident 4's bathroom without response from Administrator A. Case Manager Q told Surveyor there was a care plan meeting at the facility on 12/04/2025 with Resident 4, Resident 4's family members, Administrator A, and DOW C to discuss reports from the facility of Resident 4 having difficulty or was unable to hold onto both handles of the sit-to-stand during transfers. Case Manager Q said Administrator A and DOW C recommended Resident 4 have a physical therapy evaluation regarding sit-to-stand transfers. Case Manager Q said a member-centered plan was completed and signed on 12/04/2025 as part of the meeting and the sit-to-stand remained in use on the plan pending information from the physical therapy evaluation. Case Manager Q said the facility initiated the physical therapy evaluation after the care plan meeting to be completed by Physical Therapist R. Case Manager Q said the Physical Therapist R evaluated Resident 4 on 01/13/2026 and Case Manager Q was present. Case Manager Q said s/he was impressed by Physical Therapist R	N 355		

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describing him/her as efficient and thorough with his/her suggestions. Case Manager Q said Physical Therapist R offered to set up a training to provide instruction with transferring Resident 4 using the sit-to-stand with DOW C on 01/20/2026 but DOW C never responded, as far as Case Manager Q was aware.

Case Manager Q said s/he never received anything in writing from the facility regarding the use of a Hoyer lift to transfer Resident 4. Case Manager Q said s/he and Resident 4's case management team would expect to be notified of any change to Resident 4's ISP. Case Manager Q said nothing had been received in regard to DOW C's documentation on 12/27/2025 at 8:00 P.M. within Resident 4's progress notes including, "LATE ENTRY: RN [registered nurse] assessment completed at time to down grade resident to Hoyer lift versus sit-to-stand..."

Case Manager Q said s/he spoke with DOW C on 01/29/2026 and DOW C said per the facility's policy, Resident 4 would have to use both handles of the sit-to-stand and that s/he was referring this concern to Regional Nurse K. Case Manager Q said s/he attempted to contact Regional Nurse K without success. Case Manager Q said DOW C said the main issue with Resident 4's use if the sit-to-stand was that caregivers had to use 2 caregivers to position Resident 4 in the wheelchair. Case Manager Q said s/he asked DOW C to refer to Physical Therapist R's recommendations from 01/13/2026 regarding repositioning Resident 4 but DOW C did not provide a response. Case Manager Q said s/he received no response to his/her questions to Administrator A about replacing Resident 4's bathroom threshold since this was one of the facility's previous "main issues" with Resident 4's use of the sit-to-stand.

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N 355	Continued From page 23 Case Manager Q said none of this was fair to Resident 4, the facility had changed the target issue regarding the sit-to-stand several times. Case Manager Q said Resident 4 needed to continue to use the sit-to-stand, as evaluated by Physical Therapist R, to maintain his/her physical strength and it is the least restrictive option for him/her. Case Manager Q said Resident 4 has had no changes in his/her physical ability since s/he moved in to the facility in November 2024 and no change in his/her cognitive ability that would impact the use of the sit-to-stand lift. Case Manager Q said the facility had never communicated with Resident 4's case management team that Resident 4 required too much or more services than the facility could provide, or that Resident 4 required more time to provide cares than documented within Resident 4's ISP dated 07/01/2025. Case Manager Q said Resident 4's level of care at the facility had not changed since his/her admission to the facility except perhaps improvements s/he experienced with physical therapy late in 2025. On 02/11/2026, Surveyor received records from Resident 4's public funding agency case management team. A care plan dated 07/01/2025 through 12/31/2025 included, "...[Resident 4] had made significant progress with outside therapy, and [s/he] will ask [his/her] doctor to sign orders to restart therapy." The plan included, "[Resident 4's] physical ability is limited on one side following CVA [stroke]" and "[Resident 4's] health and long term care status is stable. No new member risks are identified and current strategies to reduce existing risks are effective." A case note dated 11/07/2025 included	N 355		

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communication from Resident 4, "...that the sit-to-stand transfer device broke a wheel while member was being transferred." The note included, "They [Previous Caregiver S] offered to use a Hoyer to transfer [him/her] back to bed, but [s/he] refuses to use the Hoyer device." The note included, "...an extra sit-to-stand device was being brought in to the facility. [Case Manager Q] spoke with mgr [manager], [Administrator A], and confirmed that by contract the CBRF [facility] is required to provide transfer device for member. [Administrator A] verbalized understanding. [Case Manager Q] encouraged [Administrator A] to call with questions."

A case note dated 11/10/2025 included, "[Resident 4] reported there were no other concerns over the weekend and that the sit-to-stand device is being repaired" and "[Resident 4] has not had a change of condition."

A case note dated 11/12/2025 included, "[Resident 4] called to report that there continues to be issues with the transfer DME [durable medical equipment]. [Case Manager Q] placed call to CBRF and spoke at length to [Caregiver S]. Left message for [Administrator A] and requested return call."

A "Rehab [rehabilitation] Specialist Care Management" note by Rehabilitation Specialist T dated 11/13/2025 included, "Consult related to [Resident 4] use of sit-to-stand versus Hoyer lift at CBRF. [Resident 4] prefers to use the sit-to-stand lift..." Rehabilitation Specialist T's documentation included, "It sounds like [Resident 4] is safe to use the sit-to-stand, but not while [Resident 4] is being pushed over threshold. Recommendation: [Resident 4] to continue to use sit-to-stand, unless feeling weaker and then Hoyer should be used. [Resident 4] to be transferred into [sic] rolling

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shower chair in [his/her] bedroom and then rolled over threshold, while safely seated in chair."
A case note dated 12/01/2025 included, "Message from [Resident 4] that the sit-to-stand DME was not working over the weekend. Call returned to [Resident 4]. Call initiated to [Administrator A] regarding equipment. Left message and requested return call."
A case note dated 12/02/2025 included, "Further follow up attempted with [Administrator A] to confirm progress toward needed DME for [Resident 4]" and "Additional follow up attempted with [Administrator A] both by phone and email communication."
A case note dated 12/04/2025 included, "Visit later held with [Administrator A], [DOW C]...[Resident 4]...[Resident 4's funding agency registered nurse (RN) Case Manager U], [Rehabilitation Specialist T] by phone, as well as this CM [Case Manager Q]. Overall, [Resident 4's] care plan and functioning has not changed other than CBRF preference for Hoyer device. They [the facility] are borrowing another resident's Hoyer at this time. Discussion that appropriate equipment for transfers need [sic] to be provided, and if a Hoyer is determined to be most appropriate, plans must be developed for continued bathing and toileting which does not result in [Resident 4] being unable to be transferred at appropriate times. [Administrator A] acknowledged this issue. [Administrator A] will follow up with rental of equipment and sling. [Administrator A] will request an order for PT [physical therapist] to review safety with transferring with a sit-to-stand and will inform team when evaluation is scheduled."
A "Rehab Specialist Care Management" note by Rehabilitation Specialist T dated 12/04/2025

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included, "Attended care conference with [Administrator A] and [DOW C] from the facility, [Resident 4] and [his/her] family, [RN Case Manager U], and [Case Manager Q] to assist in determining safety of use of a sit-to-stand versus a Hoyer lift. [Resident 4] has expressed [his/her] desire to continue to use the sit-to-stand."
Rehabilitation Specialist T's documentation included, "Advised from clinical experience, that [Resident 4] needed to be able to bear at least 50 % of [his/her] weight through lower extremities and have at least one arm to assist with pulling up to stand." Rehabilitation Specialist T's documentation included, "Caregivers expressed concern with moving [Resident 4] in sit-to-stand over thresholds. Advised that [Resident 4] be transferred to rolling shower chair (that was ordered with larger casters) prior to going over thresholds. Agreed [Resident 4] would be re-evaluated by therapy to recommend appropriate lift: sit-to-stand versus Hoyer lift."
A case note dated 12/16/2025 included, "[Resident 4] informed [case management] team that assessment is ordered through on site therapy company with new battery and charger provided for sit-to-stand DME. No date for assessment is scheduled per [Resident 4's] report."
A case note dated 12/18/2025 included, "Call to [Resident 4]. [Case Manager Q] confirmed that staff are currently using a sit-to-stand for all [his/her] transfers and it is functioning correctly. No assessment is scheduled yet."
A case note dated 01/05/2026 included, "[Case Manager Q] followed up with [Resident 4] regarding therapy evaluation for use of sit-to-stand for transfers. No date has been set yet for therapy evaluation. [Case Manager Q] contacted [Administrator A] and requested update."

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N 355	Continued From page 27 A case note dated 01/13/2026 included, "Visit at CBRF with [Resident 4] and [Resident 4's] family for PT safety assessment with Physical Therapist R. Demonstration by staff, [Caregiver V], of transfer with sit-to-stand device. PT offered suggestions for improved safety with use of sit-to-stand device related to environmental issue of transition piece at threshold of the bathroom door." The documentation included, "[Physical Therapist R] will work with [DOW C] to resolve concerns but feels that the sit-to-stand device is appropriate for member use." The documentation included, "[Resident 4] has not had a change of condition." A case note dated 01/22/2026 included, "Follow up with [Physical Therapist R] following sessions with [DOW C] to demonstrate safety with sit-to-stand device. Therapy is recommending removal of threshold to bathroom. [Case Manager Q] requested update from [DOW C] and [Administrator A] regarding this issue." A case note dated 01/26/2026 included, "[Resident 4] reported to [Case Manager Q] that the scheduled visit with [Physical Therapist R] and [DOW C] was not held because [DOW C] left the building prior to scheduled meeting without notifying [Resident 4] or [Physical Therapist R]. [Case Manager Q] placed call to [Administrator A] and left a message inquiring about transfer status and safety with [Resident 4's] transfers due to high threshold in the bathroom." A "Rehab Specialist Care Management" note by Rehabilitation Specialist T dated 01/27/2026 included, "[Resident 4] had been using the sit-to-stand consistently, but due to staff concerns [s/he] has been transferred with a Hoyer." The documentation included, "It would be the responsibility of the CBRF to provide an	N 355		

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appropriate lift, whether larger wheels were needed on the lift, or the threshold needed to be adjusted."
A case note dated 01/27/2026 included, "Call from [Resident 4] stating the staff are still instructed to use the Hoyer, and there has been no communication from [Administrator A] regarding the training with [Physical Therapist R] for use of the sit-to-stand or the removal of the threshold to the bathroom. Discussed next steps. [Case Manager Q] contacted [Physical Therapist R] who confirmed s/he has reached out multiple times to [DOW C] regarding training with no result. [Case Manager Q] attempted to call [Administrator A] and left message with request to return call with update."
A case note dated 01/29/2026 at 7:43 A.M. included, "Call [sic] and communication with [Administrator A] and [DOW C] were initiated to follow up regarding [Resident 4's] transfer status. [DOW C] attempted return voicemail and stated transfer policy was being reviewed by corporate RN. [DOW C] stated that they have a policy that [Resident 4] needs to be able to hold both sides of the sit-to-stand. [DOW C] also stated that the issue they [the facility] are having with [Resident 4] related to positioning [him/her] in [his/her] chair after transfer. [DOW C] stated that [Administrator A] is responsible for the decision to change the threshold in the facility because it is environmental. [DOW C] provided the contact information for [Regional Nurse K]. [Case Manager Q] attempted to call [Regional Nurse K] and left message."
A case note dated 02/05/2026 included, "Call from [Dialysis Social Worker W] regarding recent concerns reported by [Resident 4] at CBRF. Discussed [Resident 4's] concern for use of Hoyer instead of sit-to-stand. [Dialysis Social Worker

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N 355	Continued From page 29 W] stated that [s/he] is concerned that [Resident 4] will lose strength and functioning with lack of weight bearing during transfers with sit-to-stand. [Case Manager Q] in agreement." On 02/09/2026 at 8:05 A.M., Surveyor conducted an interview with Physical Therapist R. Physical Therapist R told Surveyor his/her first encounter with Resident 4 was on 01/13/2026 when Physical Therapist R conducted an evaluation of Resident 4's transfers. Physical Therapist R said s/he and one facility caregiver provided assistance with a transfer with Resident 4 using a sit-to-stand lift in Resident 4's room. Physical Therapist R told Surveyor s/he sent an email to DOW C and Case Manager Q of his/her evaluation summary of Resident 4's transfer with the sit-to-stand lift. Physical Therapist R said the email also included Physical Therapist R's recommendations for use of the sit-to-stand. Physical Therapist R said Resident 4 utilized his/her right arm, was able to bear weight on his/her right side, and was stable during the sit-to-stand transfer. Physical Therapist R said the only concern s/he observed during the evaluation was the height of threshold going into Resident 4's bathroom. Physical Therapist R said s/he and the caregiver assisting had difficulty getting/rolling the sit-to-stand lift over the high threshold while Resident 4 remained stable in the sit-to-stand. Physical Therapist R said s/he did discuss the transfer with the caregiver. Physical Therapist R said s/he did not provide training to facility caregivers. Physical Therapist R said s/he did volunteer to provide staff training regarding his/her recommendations but received no response from the facility's management. Physical Therapist R said s/he recommended the facility change Resident 4's bathroom threshold to	N 355		

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eliminate difficulty rolling the lift over the threshold. Physical Therapist R said there was no facility management present during the evaluation on 01/13/2026. Physical Therapist R said s/he saw Assistant Administrator B and Maintenance Director D at the facility following the evaluation and discussed Physical Therapist R's concern with Resident 4's bathroom threshold. Physical Therapist R said s/he included this information within the email s/he sent to DOW C and Case Manager Q on 01/13/2026. This was the same email Surveyor received from Resident 4 on 01/29/2026 at 12:55 P.M., as documented above. Physical Therapist R said s/he was at the facility on 01/15/2026 to visit another resident but there was no management at the facility, including DOW C, to discuss his/her evaluation of Resident 4. Physical Therapist R said s/he sent an email to DOW C on 01/15/2026 and asked if s/he would be available on the afternoon of 01/20/2026 to discuss his/her evaluation of Resident 4's transfer, but did not receive a response from DOW C. This email was provided to Surveyor from Resident 4 on 01/29/2026 at 12:58 P.M., as documented above. Physical Therapist R said s/he always observed to see if a resident was stable with the use of a sit-to-stand during an evaluation, and Resident 4 remained stable throughout the entire transfer evaluation. Physical Therapist R said s/he did not see anything "glaring of concern" that Resident 4 would not be able to safely use the sit-to-stand lift to transfer, except for his/her main concern with the height of the bathroom threshold. Physical Therapist R said a change of that threshold seemed like a simple fix. Physical Therapist R said facility caregivers have mentioned "in general" they had difficulty pushing/rolling lifts over the bathroom thresholds and assumed they had the

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same difficulty with the Hoyer lifts.
Physical Therapist R said s/he had not received any further communication from the facility regarding Resident 4 after his/her evaluation of Resident 4 on 01/13/2026.

On 02/17/2026 at 2:55 P.M., Surveyor conducted an exit interview with Administrator A and DOW C. Administrator A, DOW C, and Surveyor discussed the facility's policy regarding use of sit-to-stand lifts. DOW C said there had been no changes to the "HDG Health Dimensions Group" policy used by the facility regarding sit-to-stand mechanical lifts dated "2023." DOW C said "corporate" felt the use of the sit-to-stand to transfer Resident 4 was a risk despite Physical Therapist R's evaluation on 01/13/2026. DOW C said s/he did not know what Resident 4's previous ability was using the sit-to-stand before DOW C started working at the facility and the caregivers employed at the facility now probably were not here then or aware of Resident 4's ability then. DOW C said s/he did not know if "corporate" was aware Resident 4 could only use 1 handle on the sit-to-stand before this issue arose.
Administrator A, DOW C, and Surveyor discussed Administrator A's and DOW C's hand-written documentation of the case conference held at the facility on 12/04/2025 regarding Resident 4, as received by Surveyor on 01/30/2026.
Administrator A said a previous caregiver that had worked at the facility in November 2025 determined the use of a sit-to-stand for Resident 4's transfers was unsafe. Administrator A said s/he was unable to recall that caregiver's name.
DOW C said current caregivers continued to have concerns with the use of a sit-to-stand to transfer Resident 4. Administrator A said the facility had

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recently purchased a new Hoyer lift and described the lift was blue-gray in color with no issues going over Resident 4's bathroom threshold.
Administrator A said the new Hoyer lift was stored in the room across from Resident 4's room during Surveyor's onsite visit and was being used by caregivers for Resident 4 transfers. Surveyor discussed Caregiver H and Maintenance Director D stating the blue-gray colored Hoyer lift was not working during Surveyor's onsite visit, Maintenance Director D stating the lift had battery issues.
Administrator A said s/he was not aware of that lift having battery issues since purchase.
Administrator A and DOW C said they both believed all caregivers had been using the new Hoyer lift and not the manual, hydraulic lift, since the new Hoyer lift was purchased.
Administrator A said there was a delay in obtaining the therapy evaluation related to a payee issue and Resident 4 was refusing to use the Hoyer lift for transfers during that time between December 2025 and January 2026. Administrator A said the facility's goal was to ensure caregivers and residents were safe.
Administrator A told Surveyor there have been discussions with Maintenance Director D about changing the bathroom thresholds in resident rooms. Administrator A said Maintenance Director D had been working to find a material to match and lower the thresholds. Administrator A said s/he would check with Maintenance Director D to find out why it was taking time to change the thresholds.
Administrator A, DOW C, and Surveyor discussed DOW C's documented late entry progress note in Resident 4's record dated 12/27/2025 including DOW C's "...assessment completed at time to down grade [Resident 4] to Hoyer lift...," as

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received by Surveyor on 01/30/2026. DOW C told Surveyor his/her documented assessment occurred on 12/27/2025 and s/he added the last sentence including "ISP has been updated, reviewed, and signed by [Resident 4] & IDT" on 01/29/2026 after Surveyor's onsite visit, despite this date not being included within the documentation. DOW C said s/he could see the date 01/29/2026 of the progress note on "the screen" but was unable to print a copy with that date. DOW C said s/he provided Resident 4 a copy of the updated ISP and a copy of the sit-to-stand policy to Resident 4 after Surveyor left the facility on the evening of 01/29/2026. DOW C said s/he would forward a copy of Resident 4's ISP revised on 01/29/2026 "right away" to Surveyor.

On 02/17/2026 at 4:07 P.M., Surveyor received an email from DOW C including an attachment of Resident 4's ISP. The attached ISP was the same ISP Surveyor received while at the facility on 01/29/2026. In response, Surveyor sent an email to DOW C and Administrator A on 02/18/2026 at 6:10 A.M. including, "The ISP you forwarded to me [Surveyor] yesterday afternoon is the same ISP you provided to me onsite, dated 07/01/2025."

On 02/18/2026 at 7:59 A.M., Surveyor received an email from Administrator A including, "Previous ISP was sent [sic] error. See attached for new ISP." The attached ISP included highlighted revisions dated "01/29/2026" including, "Requires assistance of Hoyer to transfer on and off the commode" in both "Bladder" and "Bowels" sections of the ISP. The ISP included a highlighted revision dated "01/29/2026" including, "Requires assistance of 2 staff to use Hoyer lift for toileting" in the "Toileting" section of the ISP. The

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N 355	Continued From page 34 ISP included a highlighted revision dated "01/29/2026" including, "Requires assistance of 2 staff for transferring with Hoyer lift" in the "Transferring" section of the ISP. The last page, "Page 11," was 1 of 3 pages of the ISP numbered "11" and included the signatures dated "01/29/2026" of Administrator A, DOW C, and Resident 4. On 02/18/2026 at 12:45 P.M., Surveyor conducted an interview with Resident 4 to discuss the ISP dated 01/29/2026. Resident 4 told Surveyor Administrator A and DOW C entered his/her room on 01/29/2026 at approximately 8:00 P.M. after Surveyor had left the facility. Resident 4 said s/he was in bed for the night and watching television. Resident 4 said Administrator A and DOW C said "this is enough, you [Resident 4] have to stop this and in order to stay here [at facility] [Resident 4] would have to use the Hoyer lift based on the facility's policy and procedure." Resident 4 said s/he thought they meant s/he needed to stop telling people s/he did not want to use the Hoyer for his/her transfers. Resident 4 said s/he thought this because Surveyor had just left the building and s/he had also discussed his/her concerns with his/her funding agency's case management team. Resident 4 told Surveyor s/he asked for a copy of the facility's policy for sit-to-stand transfers and it was provided to him/her. Resident 4 said s/he asked Administrator A where in the policy it said both hands were required to use the sit-to-stand lift. Resident 4 said Administrator A and DOW C told him/her the policy included, "handles, plural" needed to be held to use the sit-to-stand lift. Resident 4 said this was the first time s/he had seen or received a copy of this policy. Resident 4 said s/he also asked for a copy of his/her ISP.	N 355		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMENSIONS LIVING PEWAUKEE WEST	N26W26511 COLLEGE AVE PEWAUKEE, WI 53072

(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 355	Continued From page 35 Resident 4 said Administrator A and DOW C provided him/her with a copy of an ISP but did not review the ISP with him//her at that time and did not discuss any changes, including the use of a Hoyer lift, made to the ISP with him/her. Resident 4 said it was late and they asked me to sign a piece of paper with lines on it and Resident 4 believed it was to confirm receipt of the copy of the policy and the ISP, as stated by DOW C. Resident 4 said s/he did not realize s/he had signed the last page of an ISP including a change in use of sit-to-stand to Hoyer lift for transfers until the next morning when s/he was up, out of bed, awake, and had a chance to read all of the documentation. Resident 4 repeated to Surveyor Administrator A and DOW C did not review this ISP with him/her or tell him/her it contained the documented change to Hoyer lift use. Resident 4 said Administrator A and DOW C did not tell him/her s/he was signing the ISP in agreement with that change. Resident 4 said s/he felt "very uncomfortable and worried and could not even think after [s/he] realized the changes to [his/her] ISP the next morning." Resident 4 said "[s/he] was so upset" and "was still upset." Resident 4 told Surveyor previous reviews of his/her ISP had always been scheduled in advance and conducted in a meeting with Resident 4, his/her family, and his/her funding agency case management team, not by coming in to his/her room at night asking Resident 4 to sign documents. Surveyor asked Resident 4 if s/he had spoken to Administrator A and DOW C about this situation after the evening of 01/29/2026. Resident 4 said s/he had not because Administrator A and DOW C were not in the facility much after Surveyor's visit, and s/he was out of the facility 3 days per week.	N 355		

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Resident 4 said s/he had reached out to Case Manager Q and another advocate.
Resident 4 said the caregivers have been using a Hoyer lift for all of Resident 4's transfers since 01/29/2026 and s/he remains "unhappy" with the use of the Hoyer lift. Resident 4 said s/he really wanted to continue to use the sit-to-stand as s/he had been and based on the results of Physical Therapist R's evaluation on 01/13/2026.
Resident 4 said s/he would not have signed that signature page on the evening of 01/29/2026 if s/he had known it was an agreement of ISP change to Hoyer transfers.

On 02/19/2026 at 10:55 A.M., Surveyor received a cc'd email from Resident 4 to Administrator A, DOW C, and included another cc to Case Manager Q. The email included, "I [Resident 4] am writing to formally document and clarify the events that occurred on January 29 at approximately 8:00 P.M. On that evening, [Administrator A] and [DOW C] came to my [Resident 4's] room to discuss changing my care plan from sit-to-stand to Hoyer lift. During this conversation, I was given an ultimatum and told that I would have to leave the facility if I did not comply with the change, as it was required by company policy. This statement was made despite the physical therapist evaluation requested by [the facility], which recommended continued use of the sit-to-stand and indicated that the issue involves the threshold at the bathroom doorway. I requested copies of both the updated care plan and the company policy. [DOW C] then presented me [Resident 4] a paper to sign. I asked what the document was for, and [DOW C] stated that it was only to acknowledge receipt of the copies - not to approve the change itself. I want to make

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N 355	Continued From page 37 absolutely clear that I NEVER approved this change. If a review of my care plan is necessary, I am willing to meet during normal business hours in the office or conference room, with my family and the social worker present at the time of the meeting. It is not appropriate to conduct such discussions at night, in my room, while I am in bed. Please consider this correspondence a formal record of my position regarding this matter. Sincerely, [Resident 4]." On 02/20/2026 at 11:47 A.M., Surveyor received a cc'd email from Administrator A to Resident 4 and DOW C, and included another cc to Case Manager Q. The email included, "I [Administrator A] want to ensure understanding; [Resident 4] was never given an ultimatum by me [Administrator A] or [DOW C]. We discussed [his/her] new service plan and changes that were made. [Resident 4] requested a copy of the of [sic] facility policy for mechanical lifts, [DOW C] provided a copy of the policy to [Resident 4]. We did not discuss anything about [Resident 4] needing to leave the community if [s/he] doesn't [sic] comply. Our conversation was 100 % focus [sic] on the changes to resident services plan [sic]. [Resident 4] read, understood, and sign [sic] [his/her] new services plan; [Administrator A] provided [him/her] a copy. No discussion was held with [Resident 4] disagreement with new service plan until now."	N 355		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when	N 381		

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N 381	Continued From page 38 there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure the existence and/or use of a side rail on Resident 3's bed had been assessed prior to existence or use. The findings include: On 01/29/2026 at approximately 10:20 A.M., Surveyor observed Resident 3 seated in a chair in his/her bedroom visiting with Resident 3's Legal Representative I. Surveyor observed a transfer device located on the left side/open side of Resident 3's bed. The other side of Resident 3's bed was flush with full height wall. Resident 3's Legal Representative I told Surveyor s/he attached the transfer device to Resident 3's bed when Resident 3 moved to the facility in May of 2025 to assist Resident 3 when getting in and out of bed. Resident 3's Legal Representative I said s/he believed the facility management was aware of the transfer device since it had not been discussed nor removed since Resident 3's admission to the facility. Resident 3 told Surveyor s/he utilized the transfer device to help steady his/her balance when getting in and out of bed and	N 381		

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to reposition self once in bed, especially when not assisted by caregivers. Both Resident 3 and Resident 3's Legal Representative I told Surveyor Resident 3 was to have the assistance of a caregiver with transferring and ambulation.

On 01/29/2026 at approximately 2:55 P.M., Surveyor conducted an interview with Caregiver E. Caregiver E said s/he had worked at the facility since his/her hire in November of 2023 and primarily worked the afternoon/evening shift from 2:00 P.M. until 10:00 P.M. Caregiver E told Surveyor Resident 3 required caregiver assistance with transfers, including in and out of bed, and ambulation, including to and from Resident 3's bathroom.

On 01/29/2026, Surveyor reviewed Resident 3's record, as provided by Administrator A. Resident 3 was admitted to the facility on 05/02/2025 with diagnoses including, "...abnormalities of gait and mobility," "dizziness and giddiness," "age-related osteoporosis..." and "need for assistance with personal care."
Resident 3's most recent individual service plan (ISP) dated 07/01/2025 and signed by Administrator A and Previous Director of Wellness [DOW] F included, "Requires reminders: Has mild to moderate disorientation. Displays deficits in judgement." Resident 3's ISP included, "Is at risk for falls due to extremity weakness." Resident 3's ISP included, "Requires set up for: Walker, wheelchair" and "Will be able to move about the community with assistance." Resident 3's ISP included, "Requires stand-by-assistance for getting in and out of bed, chair. Requires use of railings or devices (initiated 05/05/2025)."
Resident 3's ISP did not include the specific

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existence/use of a transfer device on Resident 3's bed.

On 01/29/2026 at approximately 5:53 P.M., Administrator A, DOW C, and Surveyor discussed the existence of Resident 3's transfer device. Both Administrator A and DOW C told Surveyor they were not aware of Resident 3's transfer device, of whom or when the transfer device was placed on Resident 3's bed, nor of an assessment for the use of a transfer device on Resident 3's bed. Surveyor asked Administrator A and/or DOW C to forward a copy, if located, of any documented assessment related to the existence/use of Resident 3's transfer device to Surveyor by noon on 01/30/2026. Surveyor verbally reiterated this request on 01/29/2026 at approximately 7:00 P.M., at the end of a preliminary exit meeting with Administrator A, DOW C, and Regional Nurse K.

On 01/30/2026 at 11:38 A.M., Surveyor sent an email to Administrator A including, "[Administrator A], [Surveyor] noticed [Administrator A] did not include documentation of an assessment related to [Resident 3's] transfer device on [his/her] bed. Please forward documentation of assessment, as requested yesterday at the end of the preliminary exit meeting, or let [Surveyor] know an assessment was not done. Thank you,..." Surveyor did not receive documentation of the requested assessment as of 02/17/2026.

On 02/17/2026 at 2:55 P.M., Surveyor conducted a final exit interview with Administrator A and DOW C. Administrator A told Surveyor the installation/use of a transfer device on Resident 3's bed was "probably not assessed and added to [Resident 3's] ISP" because Resident 3's family

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N 381	Continued From page 41 put it on Resident 3's bed after s/he was admitted to the facility. Administrator A said Resident 3 was admitted to the facility before Administrator A started employment at the facility in June 2025. Cross Reference N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan	N 381		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1's temporary service plan addressed Resident 1's mobility needs and dietary needs. The findings include: The department received complaint allegations including resident needs and services were not being provided, as required. On 01/29/2026 at 11:40 A.M., Surveyor reviewed Resident 1's record, as provided by Administrator A. Resident 1's "Move In Record" included Resident 1 was admitted to the facility on 09/29/2025 with diagnoses including, "Alzheimer's disease with late onset." Resident 1 was receiving hospice services during his/her entire stay at the	N 385		

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facility and died at the facility on 10/09/2025. Resident 1's hospice agency "skilled nursing visit note" dated 09/29/2025 included, "Prescribed diet, mechanical soft. Other: 1:1 supervision." Resident 1's hospice agency "patient care order" dated 10/03/2025 included, "Other; Diet: Puree diet with thin liquids...start date: 10/03/2025" and "Other; Discontinue mechanical soft diet...start date 10/03/2025." Resident 1's hospice agency "skilled nursing visit note" dated 10/03/2025 included, "Dentures are too big for [Resident 1's] mouth as [s/he] has lost a significant amount of weight. Puree diet now in place for [Resident 1's] safety."
Resident 1's individual service plan (ISP) dated 09/29/2025 included, "Will be able to meet eating/meals needs with assistance." Resident 1's ISP did not address Resident 1's initial order for a mechanical soft diet, 1:1 supervision, and Resident 1's change in diet to pureed with thin liquids as ordered on 10/03/2025.

On 02/09/2026 at 12:02 P.M., Surveyor conducted an interview with Resident 1's Legal Representative L. Resident 1's Legal Representative L said s/he never saw Resident 1 served a pureed meal or food after the hospice agency ordered a pureed diet for Resident 1. Resident 1's Legal Representative L described an example of observing caregivers provide Resident 1 with ground food during his/her visit with Resident 1 on 10/04/2025. Resident 1's Legal Representative L said the caregivers told him/her the facility did not have a blender available to puree Resident 1's food. Resident 1's Legal Representative L said Administrator A told him/her the facility would need to purchase a blender to puree Resident 1's food.

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N 385	Continued From page 43 On 02/17/2026 at 2:55 P.M., Surveyor conducted an exit interview with Administrator A and Director of Wellness (DOW) C. Administrator A told Surveyor Resident 1 was admitted to the facility on a regular diet which changed to a pureed diet following admission. Administrator A said Resident 1 was the first resident at the facility to have a pureed diet. Administrator A told Surveyor Resident 1 was sporadic with his/her ability to feed self before and after the pureed diet was ordered for Resident 1. Administrator A told Surveyor s/he did not know why Resident 1's temporary ISP did not reflect Resident 1's mechanical diet order upon admission, 1:1 assistance with eating, and the change to a pureed diet order. Administrator A told Surveyor s/he recalled purchasing a blender to puree Resident 1's food and would forward a copy of the receipt to Surveyor. Administrator A told Surveyor s/he would have taken the blender to the facility after purchase, but was not sure of the date. On 02/17/2026 at 5:36 P.M., Surveyor received an email from Administrator A including, "See attached for blender purchase in October 2025 and receipt." The attached receipt identified a "blender/food processor" was purchased on 10/03/2025 at 6:47 P.M.	N 385		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for	N 386		

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each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not ensure Resident 2's comprehensive individual service plan (ISP) addressed Resident 2's needs, including assistance with transfers.

The findings include:

On 01/29/2026 at approximately 10:04 A.M., Surveyor conducted an interview with Resident 2. Resident 2 told Surveyor s/he had required full assistance with personal cares, including showers, and transfers utilizing a sit-to-stand mechanical lift since before his/her admission to the facility at the beginning of January 2026. Resident 2 told Surveyor s/he was no longer ambulatory and was dependent on the use of wheelchair.

On 01/29/2026 at approximately 10:11 A.M., Surveyor observed Caregiver G and Caregiver H transfer Resident 2 to the toilet utilizing a sit-to-stand mechanical lift. Following this observation, Caregiver H told Surveyor Resident 2

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required the assistance of 2 caregivers utilizing the sit-to-stand mechanical lift with all transfers and required assistance with showers twice weekly on Monday and Thursday during the "PM shift [2:00 P.M. to 10:00 P.M.]."

On 01/29/2026, Surveyor reviewed Resident 2's record, as provided by Administrator A. Resident 2's "Move In Record" included Resident 2 was admitted to the facility on 01/02/2026 with diagnoses including, "multiple fractures of ribs, bilateral...," "multiple fracture[s] of T5-T6 [thoracic spine]...," and "unspecified fall, subsequent encounter." Resident 2's "Move In Record" included Resident 2 was responsible for making decisions on his/her own behalf.
Resident 2's ISP dated 01/05/2026 included Resident 2's, Administrator A's, and Director of Wellness [DOW] C's signature. Resident 2's ISP included Resident 2 was "independent with decisions about [Resident 2's] care and environment" and was "Independent: No apparent memory lost [sic] and oriented, able to recall or retain information (i.e. recent events, directions, time, place of situation). Makes safe judgements and functions appropriately in social situations." Resident 2's ISP included, "Vitals monitoring, will maintain independence for monitoring vitals." Resident 2's ISP included Resident 2 required assistance with "use of toilet," with bathing, including "transferring in/out," and with mobility, including "requires assistance for: (specify needs, stairs, escorts or devices)." Resident 2's ISP included Resident 2 "required assistance for: (specify: assistive device, wheelchair, scooter, cane, walker." Resident 2's ISP included, "requires assistance for (specify: toileting activity, to and from toilet, peri-care; adaptive device i.e.

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grab bars, raised toilet, commode at night or bed pan; negotiate clothing after toileting)." Resident 2's ISP included, "requires assistance for: (specify: getting in and out of bed, chair, care. Requires use of railings or devices." Resident 2's ISP did not include Resident 2's need for the use of a mechanical lift, including a sit-to-stand mechanical lift, with all transfers.

On 01/29/2026 at 5:41 P.M., Surveyor conducted an interview with DOW C. DOW C told Surveyor Resident 2 required the use of a sit-to-stand mechanical lift with all transfers. DOW C said the use of the sit-to-stand was not included within Resident 2's ISP because s/he believed Resident 2's use of the sit-to-stand changed after Resident 2 was admitted to the facility and his/her ISP was not updated with this change. DOW C said s/he conducted Resident 2's pre-admission assessment and there was no use of a sit-to-stand within Resident 2's pre-admission documentation. DOW C said s/he did not recall when Resident 2 began requiring the use of the sit-to-stand following admission to the facility and that s/he had not assessed Resident 2 for the use of the sit-to-stand mechanical lift.

On 02/11/2026 at 4:28 P.M., Surveyor received an email from Administrator A, as requested. The email included Resident 2's "Pre-Move In" assessment conducted by DOW C on 12/29/2025 including information obtained from, "admit/pre-admit paperwork, interview(s) self, interview(s) family, interview(s) significant other, observations(s), and record review." The assessment included Resident 2 was independent with monitoring vitals. The assessment included Resident 2 required the use of a manual

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 386	Continued From page 47 wheelchair and the use of a "mechanical lift - sit to stand" for transferring. On 02/17/2026 at 2:55 P.M., Surveyor conducted an exit interview with Administrator A and DOW C. DOW C told Surveyor Resident 2 was not independent with monitoring his/her own vital signs and would need to correct that within Resident 2's ISP. DOW C said s/he recalled Resident 2 required the use of the sit-to-stand mechanical lift when s/he conducted Resident 2's pre-admission assessment and has needed it since Resident 2's admission to the facility. DOW C told Surveyor s/he did not know why Resident 2's sit-to-stand was not included within Resident 2's ISP and it was "possibly changed by someone else" in the electronic documentation system utilized by the facility. DOW C said s/he would make a correction within Resident 2's ISP. Cross Reference: N0425 DHS 83.38(1)(a) Personal Care	N 386		
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 observation, interview, and record review, the provider did not ensure Resident 3's individual service plans (ISPs) was implemented and followed, as written. This requirement is being cited for the second time. See Statement of Deficiency (SOD)	N 388		

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N 388	Continued From page 48 DSWG11, issued 09/20/2023. The findings include: The department received complaint allegations including resident needs and services were not being provided, as required. On 01/29/2026 at approximately 10:20 A.M., Surveyor observed Resident 3 seated in a chair in his/her bedroom visiting with Resident 3's Legal Representative I. Surveyor observed a transfer device located on the left side/open side of Resident 3's bed. Resident 3 told Surveyor s/he utilized the transfer device to help steady his/her balance when getting in and out of bed and to reposition self once in bed, especially when not assisted by caregivers. Both Resident 3 and Resident 3's Legal Representative I told Surveyor Resident 3 was to have the assistance of a caregiver with transferring and ambulation. Resident 3 told Surveyor s/he was to call for caregiver assistance by pushing his/her call pendant, but s/he did not currently have possession of a call pendant. Resident 3 told Surveyor s/he gave his/her call pendant to a caregiver to have it fixed because it was not working. Resident 3 said s/he did not know the name of the caregiver. Resident 3 said s/he was told by a caregiver more than a week ago the facility was in the process of getting a new pendant for Resident 3, and did not know the name of the caregiver. Resident 3's Legal Representative I told Surveyor this was the first s/he was hearing of this and was not made aware Resident 3 did not have a functioning call pendant. Both Resident 3 and Resident 3's Legal Representative I told Surveyor Resident 3 needs a	N 388		

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functioning call pendant to call for assistance to be safe with transfers, ambulation, and any emergency needs. Resident 3 told Surveyor s/he had been transferring and ambulating, including to and from the bathroom, without the supervision and/or assistance of a caregiver since s/he did not have a call pendant. Resident 3's Legal Representative I told Surveyor s/he was very concerned about Resident 3's risk for falls and not having a call pendant available to call for caregiver assistance with mobility.
Surveyor observed a pull-type call cord installed within Resident 3's bathroom wall next to toilet.

On 01/29/2026 at 11:20 A.M., Caregiver G told Surveyor Resident 3's call pendant was put on the medication cart to be replaced a few days ago, and said s/he was unsure of that date. Caregiver G said Maintenance Director D was made aware of Resident 3's call pendant not working, and said s/he did not know who reported it to Maintenance Director D.

On 01/29/2026 at 11:48 A.M., Maintenance Director D told Surveyor s/he was not aware of any resident call pendants not working currently. Maintenance Director D told Surveyor s/he just became aware of Resident 3 not having a call pendant available and immediately provided a new, functioning call pendant to Resident 3.
Maintenance Director D said Caregiver G just informed him/her after Surveyor spoke with Caregiver G and asked Caregiver G about Resident 3's pendant.
Maintenance Director D said the caregivers were to fill out a work order for or verbally inform him/her of anything not working or needing repair, including call pendants. Maintenance Director D said blank

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work order forms were available on the wall right outside his/her office, as observed by Surveyor. Maintenance Director D said the caregivers should fill them out and slide them under his/her office door when s/he was not readily available to discuss concerns. Maintenance Director D told Surveyor caregivers were reminded at every caregiver meeting about this process, and more frequently "actually." Maintenance Director D said this process was not always completed by the caregivers, despite being reminded on a regular basis.

On 01/29/2026 at 1:49 P.M., Maintenance Director D provided Surveyor with a documented print out of any evidence of call pendant availability and/or use for Resident 3 during January 2026, as requested. The document included "When: January 1, 2026 - [through] January 30, 2026." The document included one occurrence dated 01/29/2026 at 11:37 A.M. of call pendant usage during the entire month of January 2026. Maintenance Director D told Surveyor the occurrence at 11:37 A.M. was Maintenance Director D resetting the system after providing Resident 3 with a new, functioning call pendant. Maintenance Director D said s/he did not find evidence of any pendant calls from Resident 3 in January 2026 until it was reset on this day at 11:37 A.M.

On 01/29/2026 at 2:45 P.M., Surveyor conducted an interview with Caregiver J. Caregiver J said s/he had worked at the facility since his/her hire in November of 2025 and primarily worked the afternoon/evening shift from 2:00 P.M. until 10:00 P.M. Caregiver J said s/he recalled Administrator A informing caregivers near the beginning of January 2026 every resident received a new call

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pendant in December 2025. Caregiver J said Resident 3 required stand-by assistance with ambulation and transfers because Resident 3 was "somewhat" unsteady. Caregiver J said s/he was not aware Resident 3 did not have a functioning call pendant prior to receiving a new one on this day, 01/29/2026.

On 01/29/2026 at approximately 2:55 P.M., Surveyor conducted an interview with Caregiver E. Caregiver E said s/he had worked at the facility since his/her hire in November of 2023 and primarily worked the afternoon/evening shift from 2:00 P.M. until 10:00 P.M. Caregiver E told Surveyor Resident 3 required caregiver assistance with transfers, including in and out of bed, and ambulation, including to and from Resident 3's bathroom. Caregiver E said Resident 3 had and used a call pendant in recent past. Caregiver E said s/he was unaware Resident 3 did not have a functioning call pendant until Resident 3 told him/her last evening, on 01/28/2026, his/her call pendant was not working and s/he no longer had a call pendant. Caregiver E said Resident 3 told him/her Resident 3 gave the call pendant to someone and it needed to be fixed.

On 01/29/2026, Surveyor reviewed Resident 3's record, as provided by Administrator A. Resident 3 was admitted to the facility on 05/02/2025 with diagnoses including, "...abnormalities of gait and mobility," "dizziness and giddiness," "age-related osteoporosis..." and "need for assistance with personal care."
Resident 3's most recent individual service plan (ISP) dated 07/01/2025 and signed by Administrator A and Previous Director of Wellness [DOW] F included, "Requires reminders: Has mild

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to moderate disorientation. Displays deficits in judgement." Resident 3's ISP included, "Requires set up for: Walker, wheelchair" and "Will be able to move about the community with assistance." Resident 3's ISP included, "Requires stand-by-assistance for getting in and out of bed, chair." Resident 3's ISP included Resident 3 required assistance with use of toilet related to bladder and bowel incontinence. Resident 3's ISP included, "Will be encouraged to call for assistance when needed" related to "[Resident 3] is at risk for falls due to extremity weakness." Resident 3's ISP included, "Fall interventions...personal items and call device pendant, (and) pull cord, call light within reach." Resident 3's "Point of Care Audit Report" from 01/01/2026 through 01/29/2026 at 4:14 P.M., included caregiver task documentation. An example of tasks related to "Toileting: Requires Assistance" and "Mobility: Requires Assistance" documented by caregivers within a 24-hour period on 01/01/2026 was as follows:
"Scheduled time: 5:59 A.M.; Effective time: 2:08 A.M.; Documented time: 2:08 A.M."
"Scheduled time; 1:59 P.M.; Effective time: 1:23 P.M.; Documented time: 1:24 P.M."
"Scheduled time; 9:59 P.M.; Effective time: 9:15 P.M.; Documented time: 9:16 P.M."
Between 01/01/2026 and 01/29/2026, most 24-hour periods included 3 separate times tasks were scheduled, effective, and documented, or once per shift. Some 24-hour periods between 01/01/2026 and 01/29/2026 included 2 separate times tasks were scheduled, effective, and documented, but not more than 3 times per any 24-hour period.
On 01/29/2026 at approximately 5:41 P.M., DOW C told Surveyor the daily tasks listed on each

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N 388	Continued From page 53 resident's "Point of Care Audit Report" were pulled from each resident's ISP. DOW C said the caregivers usually document at the end of their shift the tasks/cares provided during their entire shift, not necessarily every time an individual task was provided throughout the shift. DOW C said if a resident was provided with a task more than once per shift, that task was to be documented each time within the "Point of Care Audit Report" but that was not how caregivers were documenting tasks. On 01/29/2026 at 5:53 P.M., Administrator A told Surveyor s/he was not aware Resident 3 did not have a pendant available or that his/her pendant was not working. Administrator A said caregivers were to report to management any fixes/repairs needed and any issues with resident call pendants. On 02/17/2026 at 2:55 P.M., Surveyor conducted a final interview with Administrator A and DOW C. Administrator A verbally confirmed the only location of a pull-type call cord in each resident's apartment/room was in the wall next to each resident's bathroom toilet. Cross Reference N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 388		
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	N 425		

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N 425	Continued From page 54 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, interview, and record review, the provider did not ensure Resident 2 and Resident 4 were provided with services adequate to meet Resident 2's and Resident 4's personal care needs. The findings include: The department received complaint allegations including resident personal care needs were not being provided, as required. Example 1: Resident 2's Toileting/Call Pendant On 01/29/2026 at approximately 10:04 A.M., Surveyor conducted an interview with Resident 2. Resident 2 told Surveyor s/he had required full assistance with personal cares, including showers, and transfers utilizing a sit-to-stand mechanical lift since before his/her admission to the facility at the beginning of January 2026. Resident 2 told Surveyor s/he was no longer	N 425		

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ambulatory and was dependent on the use of wheelchair.
Resident 2 told Surveyor s/he was to call for caregiver assistance from the caregivers by pushing his/her call pendant. Resident 2 said s/he wore the pendant as a necklace and had it with him/her at all times. Resident 2 said his/her calls for assistance were not always answered in a timely fashion. Surveyor asked Resident 2 to provide an example. Resident 2 told Surveyor s/he waited for at least 2 hours to be transferred off of the toilet yesterday, 01/28/2026, after being transferred to the toilet by caregivers. Resident 2 said s/he pressed his/her pendant to call for assistance and pulled the bathroom call cord next to the toilet when s/he thought the caregivers had forgotten about him/her. Resident 2 told Surveyor s/he believed the caregivers told him/her they were helping another resident which caused the delay in response to his/her call for assistance off of the toilet.
Resident 2 told Surveyor s/he needed to use the toilet during this interview and pressed the button on his/her pendant. Surveyor observed a red light blinking on Resident 2's pendant after s/he pressed it.

On 01/29/2026 at approximately 10:11 A.M., Surveyor observed Caregiver G and Caregiver H transfer Resident 2 to the toilet utilizing a sit-to-stand mechanical lift. Following this observation, Caregiver H told Surveyor Resident 2 required the assistance of 2 caregivers utilizing the sit-to-stand mechanical lift with all transfers.

On 01/29/2026 at 11:48 A.M., Surveyor conducted an interview with Maintenance Director D. Maintenance Director D explained the call pendant

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process including a resident pushes the button on their pendant to call for assistance and a red light blinks on the pendant and the pendant vibrates quietly until it is cleared. Maintenance Director D said the call then communicated with 2 electronic tablets the caregivers were to have within hearing distance while they were on duty. Maintenance Director D said the caregivers were to use a magnet held against the resident's call pendant to clear and reset the pendant, preferably, when they respond to the resident. Maintenance Director D said the activated call pendant button could also be held down until a blue light flashes to clear and reset the pendant. Maintenance Director D said s/he ran a test to check average call pendant response times once a week and physically checked a random resident's call pendant once weekly to ensure it was functioning. Maintenance Director D said s/he had observed the electronic tablets kept on at the charging station on the dining room counter "a lot." Maintenance Director D said the caregivers either need to be close to a tablet to hear it announce an activated call pendant, or check the tablet often. Maintenance Director D said s/he was aware of long pendant wait times and have discussed this with Administrator A.

On 01/29/2026 at 1:23 P.M., Surveyor observed two pink-colored electronic tablets located on a countertop in the facility's dining room. One of the 2 tablets was plugged into a charger. Caregiver H told Surveyor 1 tablet was charging because the night shift did not charge it and it was at "zero" battery life this morning. Caregiver H said the tablet made a "computer [notification] sound" a "ding" when a resident pushes their pendant. Caregiver H said the sound can be heard within

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close range of the tablet and the tablet continued to sound until it was "acknowledged" on the tablet or the actual pendant was physically cleared. Caregiver H said s/he utilized a small magnet to physically clear resident pendants until a light blue flashes indicating the call was cleared.

On 01/29/2026 at 1:49 P.M., Maintenance Director D provided Surveyor with a documented print out of any evidence of call pendant use for Resident 2 during from 01/15/2026 through 01/29/2026, as requested. Maintenance Director D explained Resident 2 pushed his/her pendant button yesterday as documented on "January 28, 2026 [at] 3:14 P.M." Maintenance Director D explained Resident 2's pendant was acknowledged at the tablet and known by a caregiver at "2:14 hrs [hours]" after Resident 2 pushed the pendant. Maintenance Director D explained Resident 2's pendant was not cleared as documented for "14:40 hrs". Maintenance Director D said Resident 2 waited for 2 hours and 14 minutes after calling for assistance and it appeared as though the caregiver did not appropriately clear the call and it was reset after 14 hours and 40 minutes. Additional documented examples of extended times between Resident 2's call pendant activation and it being acknowledged included the following:
01/15/2026 at 9:47 A.M., "49:07 mins [minutes],"
01/15/2026 at 1:17 P.M., "59:01 mins,"
01/20/2026 at 1:25 P.M., "47:02 mins,"
01/21/2026 at 2:35 P.M., "40:29 mins,"
01/23/2026 at 12:55 P.M., "1:44 mins,"
01/24/2026 at 2:03 A.M., "1:07 hrs [hours]," and
01/25/2026 at 1:23 P.M., "1:48 hr [hour]."

On 01/29/2026, Surveyor reviewed Resident 2's record, as provided by Administrator A. Resident

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2's "Move In Record" included Resident 2 was admitted to the facility on 01/02/2026 with diagnoses including, "multiple fractures of ribs, bilateral...," "multiple fracture[s] of T5-T6 [thoracic spine]...," and "unspecified fall, subsequent encounter." Resident 2's "Move In Record" included Resident 2 was responsible for making decisions on his/her own behalf.
Resident 2's ISP dated 01/05/2026 included Resident 2's, Administrator A's, and Director of Wellness [DOW] C's signature. Resident 2's ISP included Resident 2 was "independent with decisions about [Resident 2's] care and environment" and was "Independent: No apparent memory lost [sic] and oriented, able to recall or retain information (i.e. recent events, directions, time, place of situation). Makes safe judgements and functions appropriately in social situations."
Resident 2's ISP included Resident 2 required assistance with "use of toilet," with bathing, including "transferring in/out," and with mobility, including "requires assistance for: (specify needs, stairs, escorts or devices)." Resident 2's ISP included, "Fall interventions are: (specify:...personal items and call device...pendant, pull cord, call light) within reach.." and "Requires reminders for: (specify: call for assistance, use of mobility devices, use of the bathroom...)."
Resident 2's "Point of Care Audit Report" from 01/01/2026 through 01/29/2026 at 4:15 P.M., included caregiver task documentation. An example of tasks related to "Toileting: Requires Assistance" and "Mobility: Requires Assistance" documented by caregivers within a 24-hour period on 01/28/2026 was as follows:
"Scheduled time: 5:59 A.M.; Effective time: 2:04 A.M.; Documented time: 2:04 A.M."

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	0017088	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMENSIONS LIVING PEWAUKEE WEST	N26W26511 COLLEGE AVE PEWAUKEE, WI 53072

(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 425	Continued From page 59 "Scheduled time; 1:59 P.M.; Effective time: 1:59 P.M.; Documented time: 2:05 P.M." "Scheduled time; 9:59 P.M.; Effective time: 9:59 P.M.; Documented time: 10:12 P.M." Between 01/01/2026 and 01/29/2026, most 24-hour periods included 3 separate times tasks were scheduled, effective, and documented, or once per shift. Some 24-hour periods between 01/01/2026 and 01/29/2026 included 1 or 2 separate times tasks were scheduled, effective, and documented, but not more than 3 times per any 24-hour period. On 01/29/2026 at approximately 5:41 P.M., DOW C told Surveyor the daily tasks listed on each resident's "Point of Care Audit Report" were pulled from each resident's ISP. DOW C said the caregivers usually document at the end of their shift the tasks/cares provided during their entire shift, not necessarily every time an individual task was provided throughout the shift. DOW C said if a resident was provided with a task more than once per shift, that task was to be documented each time within the "Point of Care Audit Report" but that was not how caregivers were documenting tasks. On 01/29/2026 at 2:45 P.M., Surveyor conducted an interview with Caregiver J. Caregiver J said s/he had worked at the facility since his/her hire in November of 2025 and primarily worked the afternoon/evening shift from 2:00 P.M. until 10:00 P.M. Surveyor observed Caregiver J entered the meeting room with a pink electronic tablet in his/her hand. Caregiver J told Surveyor s/he normally carries the tablet with him/her all shift. Caregiver J said the tablet was currently at 26% battery life remaining and that the tablets "go dead" and "take a while for the battery to charge."	N 425		

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N 425	Continued From page 60 Caregiver J said the charging station was on the dining room counter. Caregiver J said s/he would not be able to hear pendant calls coming in to the tablet if it were charging and s/he was away from the dining room. Caregiver J told Surveyor s/he worked yesterday afternoon/last evening, 01/28/2026. Caregiver J said Resident 2 did complain to him/her yesterday of not having his/her call pendant answered and having to wait "a long time" to be assisted off of the toilet. Caregiver J said s/he did not assist Resident 2 yesterday afternoon/last evening, 01/28/2026, because Caregiver E was assigned to provide cares to Resident 2. On 01/29/2026 at approximately 2:55 P.M., Surveyor conducted an interview with Caregiver E. Caregiver E said s/he had worked at the facility since his/her hire in November of 2023 and primarily worked the afternoon/evening shift from 2:00 P.M. until 10:00 P.M. Caregiver E told Surveyor s/he worked with Caregiver J yesterday afternoon/last evening. Caregiver E said Resident 2 did complaint to him/her yesterday afternoon of pushing his/her all pendant yesterday for over an hour and it was not answered. Caregiver E said s/he believed it did not get answered for that long of time during the day shift or over the shift change. Caregiver E said s/he checked Resident 2's call pendant and it was working yesterday. Caregiver E said Resident 2 did not clear his/her own pendant after using it to call for assistance. Caregiver E and Surveyor reviewed the documented print out of Resident 2's call pendant use, as provided by Maintenance Director D, specially the documentation dated "January 28, 2026 [at] 3:14 P.M." when Resident 2's call was not acknowledged for "2:14 hrs [hours]" after	N 425		

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N 425	Continued From page 61 Resident 2 pushed the pendant. The documentation included, "accident" as the "reason" for the call. Caregiver E said documentation of "accident" meant Resident 2 called for assistance to go to the bathroom. Caregiver E said that "accident" or any documented "reason" was entered in to the electronic tablet by the caregiver clearing the pendant. Caregiver E said the tablet provides different "reasons" to chose from for documentation, such as "toilet" or "accident." Example 2: Resident 4's call pendant On 01/29/2026 at 12:39 P.M., Surveyor conducted an interview with Resident 4. Surveyor observed Resident 4 was seated in and utilized his/her electric wheelchair. Resident 4 told Surveyor s/he had lived at the facility since November 2024. Resident 4 told Surveyor s/he experienced a "stroke" in 2013 affecting the left side of his/her body requiring him/her to be dependent on caregiver assistance with most cares, including mobility and repositioning. Resident 4 told Surveyor s/he required full assistance with all transfers from caregivers utilizing a mechanical lift. Resident 4 told Surveyor s/he usually received caregiver assistance with evening cares and was transferred to bed right after dinner, at approximately 6:30 P.M. every evening. Resident 4 told Surveyor s/he liked to be up and ready at approximately 5:00 A.M. everyday because s/he liked to be up early and s/he went to an appointment outside of the facility every Monday, Wednesday, and Friday. Resident 4 told Surveyor s/he had reported to Administrator A several times his/her concerns regarding his/her call pendant not being answered	N 425		

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by caregivers in a timely fashion, or not at all. Resident 4 told Surveyor Administrator A had even pushed his/her call pendant to test it. Resident 4 told Surveyor s/he had "given up using" his/her call pendant because of the wait time for a response and nothing changes. Resident 4 said s/he usually called after s/he was assisted to bed and in the middle of the night because s/he was unable to move independently in bed reach something s/he needed or to go to the bathroom. Resident 4 said s/he had left his/her call pendant "ring for hours" and sometimes until the next day after pushing the button. Resident 4 said s/he knows how to clear the pendant and would "just clear it" when a caregiver did not respond to assist him/her.

On 01/29/2026 at 11:48 A.M., Surveyor conducted an interview with Maintenance Director D. Maintenance Director D explained the call pendant process including a resident pushes the button on their pendant to call for assistance and a red light blinks on the pendant and the pendant vibrates quietly until it is cleared. Maintenance Director D said the call then communicated with 2 electronic tablets the caregivers were to have within hearing distance while they were on duty. Maintenance Director D said the caregivers were to use a magnet held against the resident's call pendant to clear and reset the pendant, preferably, when they respond to the resident. Maintenance Director D said the activated call pendant button could also be held down until a blue light flashes to clear and reset the pendant. Maintenance Director D said s/he ran a test to check average call pendant response times once a week and physically checked a random resident's call pendant once weekly to ensure it was functioning. Maintenance

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N 425	Continued From page 63 Director D said s/he had observed the electronic tablets kept on at the charging station on the dining room counter "a lot." Maintenance Director D said the caregivers either need to be close to a tablet to hear it announce an activated call pendant, or check the tablet often. Maintenance Director D said s/he was aware of long pendant wait times and have discussed this with Administrator A. On 01/29/2026 at 1:49 P.M., Maintenance Director D provided Surveyor with a documented print out of any evidence of call pendant use for Resident 4 during from 01/15/2026 through 01/29/2026, as requested. Maintenance Director D explained Resident 4 called for assistance twice during this timeframe including a documented call on Thursday evening, "January 15, 2026 [at] 7:27 P.M." Maintenance Director D explained Resident 4's call was acknowledged at the tablet and known by a caregiver at "5 secs [seconds]" after Resident 4 pushed the pendant or activated the bathroom call cord. Maintenance Director D explained Resident 4's call was not cleared as documented for "1 day 02:39 hrs [hours]." Maintenance Director D said it appeared Resident 4's call was not answered and cleared for 1 day, 2 hours, and 39 minutes after calling for assistance. Maintenance Director D said it should have continued to ring for that timeframe and does not know why it was not cleared appropriately. Maintenance Director D provided Surveyor with a documented print out of the facility's call system's average calls and response times for the past 7 days and past 30 days. Within the past 7 days, "75 total requests [calls]" were activated/received with an average response time of "4:18 hrs [4 hours and 18 minutes]." Within the past 30 days,	N 425		

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N 425	Continued From page 64 "222 total requests" were activated/received with an average response time of "9:50 hrs [9 hours and 50 minutes]." On 01/29/2026 at 2:45 P.M., Surveyor conducted an interview with Caregiver J. Caregiver J said s/he had worked at the facility since his/her hire in November of 2025 and primarily worked the afternoon/evening shift from 2:00 P.M. until 10:00 P.M. Surveyor observed Caregiver J entered the meeting room with a pink electronic tablet in his/her hand. Caregiver J told Surveyor s/he normally carries the tablet with him/her all shift. Caregiver J said the tablet was currently at 26% battery life remaining and that the tablets "go dead" and "take a while for the battery to charge." Caregiver J said the charging station was on the dining room counter. Caregiver J said s/he would not be able to hear pendant calls coming in to the tablet if it were charging and s/he was away from the dining room. Caregiver J told Surveyor s/he usually assisted Resident 4 with evening cares between 5:30 P.M. and 6:30 P.M. per Resident 4's request. Caregiver J said s/he knows Resident 4's routine well enough and checked on Resident 4 so that Resident 4 did not "usually" call for assistance when Caregiver J was on duty. On 01/29/2026, Surveyor reviewed Resident 4's record, as provided by Administrator A. Resident 4's "Move In Record" included Resident 4 was admitted to the facility on 11/05/2024 with multiple diagnoses including, "Hemiplegia [paralysis] and hemiparesis [weakness] following other cerebrovascular disease affecting left, non-dominant side," diabetes, and "restless legs syndrome." Resident 4's "Move In Record" included Resident 2 was responsible for making	N 425		

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decisions on his/her own behalf.
Resident 4's ISP dated 07/01/2025 included Resident 4's, Administrator A's, and Previous Director of Wellness [DOW] F's signature. Resident 4's ISP included, "Staff to assist with turning and positioning," "Requires assistance [with] sit to stand lift for toileting, needs staff assistance for peri-care and to adjust clothing after toileting," Resident 4's ISP did not include Resident 4's possession and use of a call pendant.

On 01/29/2026 at 5:53 P.M., Administrator A told Surveyor Director of Maintenance D had reported long wait times for response to pendant calls for assistance. Administrator A said the caregivers may not have been clearing the pendants appropriately, which was a problem. Administrator A said caregivers were provided with a small magnet to carry with them while on duty to easily clear the resident's pendant calls. Administrator A said the magnet method was more effective than holding the pendant button until it cleared. Administrator A said s/he provided a new carrier for both tablets to make it easier for both caregivers to keep the tablet on hand during their shift. Administrator A said each caregiver was to supposed to carry a tablet with them at all times while on duty. Administrator A said s/he had made requests from corporate for small devices for the caregivers to carry related to call pendant notification. Administrator A said expects each resident's call for assistance using the call system to be answered or responded to within 10 to 15 minutes, maximum.

On 02/17/2026 at 2:55 P.M., Surveyor conducted a final interview with Administrator A and DOW C.

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N 425	Continued From page 66 Administrator A verbally confirmed the only location of a pull-type call cord in each resident's apartment/room was in the wall next to each resident's bathroom toilet and each resident was provided with an individual call pendant. Administrator A told Surveyor in addition what Administrator A shared on 01/29/2026 at 5:53 P.M., every morning s/he has a "stand up" meeting with Maintenance Director D to discuss call times. Administrator A said concerns regarding response time for calls for assistance were also discussed with residents. Administrator A said the caregivers have been provided with education and reminders regarding their response times for resident calls for assistance. Example 3: Resident 2's Shower assistance On 01/29/2026 at approximately 10:04 A.M., Surveyor conducted an interview with Resident 2. Resident 2 told Surveyor s/he had required full assistance with personal cares, including showers, and transfers utilizing a sit-to-stand mechanical lift since before his/her admission to the facility at the beginning of January 2026. Resident 2 told Surveyor s/he was no longer ambulatory and was dependent on the use of wheelchair. Resident 2 told Surveyor s/he required full assistance with showers and had not been assisted with a shower since his/her admission to the facility. On 01/29/2026 at approximately 10:11 A.M., Surveyor observed Caregiver G and Caregiver H transfer Resident 2 to the toilet utilizing a sit-to-stand mechanical lift. Following this observation, Caregiver H told Surveyor Resident 2 was scheduled to be assisted by a caregiver with	N 425		

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N 425	Continued From page 67 a shower on Mondays and Thursdays during the evening shift, between 2:00 P.M. and 10:00 P.M. Caregiver said caregivers were to document assistance with showers/bathing within the facility's electronic documentation system regarding resident care tasks. On 01/29/2026 at approximately 2:55 P.M., Surveyor conducted an interview with Caregiver E. Caregiver E said s/he had worked at the facility since his/her hire in November of 2023 and primarily worked the afternoon/evening shift from 2:00 P.M. until 10:00 P.M. Caregiver E told Surveyor Resident 2 required caregiver assistance with the use of a sit-to-stand mechanical lift for all transfers. Caregiver E said s/he had not assisted Resident 2 with a shower since his/her admission to the facility because s/he did not have a shower chair available. On 01/29/2026 at approximately 3:49 P.M., Administrator A, Director of Wellness (DOW) C, and Surveyor observed Resident 2's shower stall including one shower chair with a seat and no arms rests, no back rest, and no wheels, and a bench attached to the wall of the shower stall. Administrator A told Surveyor Resident 2 would be able to be transferred utilizing the sit-to-stand mechanical lift to a seated position on either device. Administrator A told Surveyor Resident 2 had upper body strength and would be able to use the hand rails attached to the shower stall wall in back of and to the left of the shower chair. Administrator A said Resident 2 would be able to use either the shower chair or the shower bench after being transferred using the sit-to-stand lift. Photos #1 and #2	N 425		

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N 425	Continued From page 68 On 01/29/2026, Surveyor reviewed Resident 2's record, as provided by Administrator A. Resident 2's "Move In Record" included Resident 2 was admitted to the facility on 01/02/2026 with diagnoses including, "multiple fractures of ribs, bilateral...," "multiple fracture[s] of T5-T6 [thoracic spine]...," and "unspecified fall, subsequent encounter." Resident 2's "Move In Record" included Resident 2 was responsible for making decisions on his/her own behalf. Resident 2's ISP dated 01/05/2026 included Resident 2's, Administrator A's, and DOW C's signature. Resident 2's ISP included Resident 2 was "independent with decisions about [Resident 2's] care and environment" and was "Independent: No apparent memory lost [sic] and oriented, able to recall or retain information (i.e. recent events, directions, time, place of situation). Makes safe judgements and functions appropriately in social situations." Resident 2's ISP included Resident 2 required assistance with bathing, including "transferring in/out," "steadying," and "uses/requires shower chair/bench." Resident 2's "Point of Care Audit Report" from 01/01/2026 through 01/29/2026 at 4:15 P.M., included caregiver task documentation. Resident 2's report did not include documentation of shower assistance being provided to Resident 2 during this timeframe. On 01/29/2026 at approximately 5:41 P.M., DOW C told Surveyor the daily tasks listed on each resident's "Point of Care Audit Report" were pulled from each resident's ISP. DOW C said s/he did not know why Resident 2's daily task report did not include shower assistance documentation. DOW C said Resident 2 should be offered assistance with a shower twice weekly.	N 425		

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N 425	Continued From page 69 Cross Reference: N0386 DHS 83.35(3)(a) Comprehensive Service Plan	N 425		