| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| CEDAR GROVE GARDENS II | 626 VAN ALTENA AVE CEDAR GROVE, WI 53013 |

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| N 000 | Initial Comments<br><br>On 07/13/2026, with information gathered through 07/15/2026, Surveyors investigated three (3) complaints at Cedar Grove Gardens II in Cedar Grove.<br><br>Three (3) of 3 complaints were substantiated.<br><br>As a result of the survey, 7 deficiencies were issued. One (1) of the 7 deficienices is a repeat deficiency. See SOD (Statement of Deficiency) DKWV11 dated 07/22/2024.<br><br>Census: 19 | N 000 | | |
| N 158 | 83.12(2)(a) Caregiver: Investigating abuse & neglect<br><br>Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. | N 158 | | |

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

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| N 158 | Continued From page 1<br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not investigate and document an allegation of abuse, neglect or misappropriation by a caregiver. The facility had a census of 19 at the time of survey.<br><br>Family Member G reported to Director A Resident 3's debit card incurred some unknown charges. Director A did not have documentation of the allegation of misappropriation.<br><br>Facility staff reported to Director A concerns regarding Caregiver H not providing cares to residents during an overnight shift. Director A did not have documentation of an investigation into the allegation of neglect.<br><br>Findings Include:<br><br>On 06/12/2026 and 06/29/2026, the department received a complaint regarding allegations of a caregiver neglect and misappropriation.<br><br>The facility is licensed to provide care to up to 22 residents who are terminally ill, advanced aged, physically disabled and/or have irreversible dementia/Alzheimer's.<br><br>MISAPPROPRIATION ALLEGATION<br>On 07/13/2026, Surveyor conducted an onsite investigation. A sample of resident records was reviewed, including the record of Resident 3.<br><br>Resident 3 was admitted to the facility on 08/11/2021 with diagnoses to include history of cerebrovascular accident with right hemiparesis, type 2 diabetes and chronic shoulder pain. Resident 3's most recent ISP (Individualized Service Plan) dated 11/08/2025, stated Resident | N 158 | | |

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| N 158 | Continued From page 2 | N 158 | | |

3 has an activated power of attorney (POA). The ISP also states, "Staff is NOT to ever take [Resident 3's] debit card to purchase any cigarettes, soda or anything, [family member] provides."

On 07/13/2026 at 12:30 PM, Surveyor interviewed Director A regarding debit card. Director A stated s/he heard from Resident 3's POA that some purchases were made on Resident 3's debit card and s/he was wondering how that happened. Director A stated Resident 3's POA said there were 2 different charges on the same day at the same gas station. Director A stated s/he spoke with staff and it turned out that Resident 3 asked staff to go to the gas station for him/her and purchase cigarettes, soda and a lighter. Staff did this but did not keep receipts. Director A followed up with POA and explained what happened and POA said s/he does not want staff to do that again. POA also stated that s/he went to the gas station and purchased the same items and the amount was less than the amount charged to Resident 3's debit card. Director A stated s/he apologized to POA and explained it would not happen again. Director A stated s/he did not have a written investigation into the allegation of misconduct.

On 07/14/2026 at 12:00 PM, Surveyor interviewed Family Member G. Family Member G verified s/he is the health care and financial POA for Resident 3. Family Member G stated s/he keeps a close eye on Resident 3's financials because that is his/her job as the POA. Family Member G stated s/he buys what Resident 3 needs and Resident 3 does have a debit card on him/her. Family Member G stated the expectation would be for staff to go with Resident 3 to the gas station if Resident 3 needed something. Family

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| N 158 | Continued From page 3<br><br>Member G stated s/he was reviewing Resident 3's account and noticed 2 separate charges, one for $24 and another for $3. Family Member G stated s/he immediately emailed Director A about the charges. Director A stated s/he would look into it. Director A did respond back to Family Member G and stated it was a new second shift caregiver who didn't know s/he was not supposed to do that. Director A was unsure when it happened and there was no receipt for the transactions but that the $24 transaction was for 2 packs of cigarettes and 2 sodas. The second transaction for $3 was for the lighter that the staff member forgot to get the first time. Family Member G stated s/he went the following week to the same gas station and in his/her opinion the purchases didn't add up to the amount that was taken out of account. Family Member G stated s/he told Director A about this. Family Member G it hasn't happened again and said now the facility knows I keep a close eye on Resident 3's accounts.<br><br>NEGLECT ALLEGATION<br>On 07/13/2026 at 8:15 AM, Surveyor interviewed Caregiver B. Caregiver B stated s/he works mostly on first shift (6:30am-3pm) but has worked all other shifts at times. Caregiver B indicated the facility is "very rarely in order [when s/he arrives at 6:30am], people are wet, soiled, haven't been touched all night." Caregiver B stated a few weeks ago on a weekend, it was really bad with family members even upset. Caregiver B stated s/he has told Director A about the concerns, especially related to Caregiver H not providing cares overnight to residents. Caregiver B stated Caregiver H is no longer employed at the facility.<br><br>On 07/13/2026 at 10:00 AM, Surveyor | N 158 | | |

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| N 158 | Continued From page 4<br><br>interviewed Activities Director D. Activities Director D stated s/he also is a caregiver and helps out on the floor when needed. Activities Director D stated s/he has noticed when s/he fills in residents are not changed like they should be which is every 2 hours. Activities Director D stated s/he has brought concerns to Director A about staff not providing cares to residents in a timely manner.<br><br>On 07/13/2026 at 2:15 PM, Surveyor interviewed Director A. Director A verified staff have come to him/her with concerns about staff not providing cares to residents in a timely manner. Director A stated, "It's he said, she said because when I interview staff they say they check on residents." Director A verified Caregiver H is no longer an employee at the facility, however, Caregiver H was not terminated. Caregiver H had put in a 2 week notice due to the travel distance from his/her home to the facility. Caregiver H only worked a few days in the facility and spent the majority of his/her time in the sister facility next door. Director A stated s/he has no documentation of staff grievance or investigation into the neglect allegations by Caregiver H or other staff members. Director A stated s/he did interview caregivers but did not keep a record of those interviews. | N 158 | | |
| N 352 | 83.32(3)(h) Rights of Residents: Receive medication<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication | N 352 | | |

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| N 352 | Continued From page 5<br>is court ordered.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 1 (Resident 2) residents reviewed received all prescribed medications in the dosage and at intervals prescribed by the practitioner.<br><br>Resident 2 had an order for Ipratropium/Albuterol sulfate to inhale the contents of 1 vial per nebulizer every 8 hours for shortness of breath/wheezing. Resident 2 did not receive the nebulizer at the prescribed intervals.<br><br>Findings Include:<br><br>On 05/11/2026 and 06/12/2026, the Department received complaints regarding residents not receiving medications as prescribed.<br><br>RESIDENT 2<br>Resident 2 was admitted to the facility on 03/13/2024 with diagnoses to include dementia without behavioral disturbance, type 2 diabetes, asthma, seasonal allergic rhinitis, and cardiomegaly.<br><br>On 07/13/2026 at 12:15 PM, Surveyor interviewed Resident 2. Resident 2 stated "I'm supposed to have my nebulizer treatments 3 times a day. Sometimes I get it 3 times, sometimes 2 times, sometimes 1 time and sometimes not all all." Resident 2 stated s/he had covid and pneumonia a while ago and his/her lungs "took a beating." Resident 2 stated, "It depends on who is on." when referring to how frequent s/he gets the nebulizer treatments.<br><br>Surveyor reviewed Resident 2's record. Resident | N 352 | | |

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| N 352 | Continued From page 6<br><br>2 had an order for Ipratropium/Albuterol Sulfate 0.5-3(2.5)mg (milligrams)/3 to inhale the contents of 1 vial per nebulizer every 8 hours for shortness of breath/wheezing.<br><br>Surveyor reviewed Resident 2's June and July MAR (Medication Administration Record). Resident 2 did not receive his/her nebulizer treatments on the following days:<br>*6AM - 06/16/2026, 06/23/2026, 06/24/2026, 07/01/2026, 07/02/2026, 07/03/2026, 07/04/2026, 07/05/2026 and 07/10/2026.<br>*2PM - 06/01/2026, 06/02/2026, 06/05/2026, 06/06/2026, 06/07/2026, 06/09/2026, 06/10/2026, 06/11/2026, 06/12/2026, 06/19/2026, 06/20/2026, 06/21/2026, 06/22/2026, 06/25/2026, 07/01/2026, 07/02/2026, 07/05/2026, 07/09/2026<br>*10PM - 06/15/2026, 06/25/2026, 07/03/2026, 07/09/2026<br><br>On 07/15/2026 at 1:00 PM, Surveyor conducted exit meeting with Director A. Director A acknowledged Surveyor's findings above. | N 352 | | |
| N 388 | 83.35(3)(c) Implement, follow the individual service plan<br><br>Implementation. The CBRF shall implement and follow the individual service plan as written.<br><br>This Rule is not met as evidenced by:<br>Based on resident and staff interviews and record review the provider did not follow the ISP (Individualized Service Plan) and implement the exercise program for 1 out of 1 resident (Resident 4) reviewed.<br><br>Findings include: | N 388 | | |

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| N 388 | Continued From page 7 | N 388 | | |

Surveyor reviewed Resident 4's medical record on 07/13/2026. Resident 4 was admitted to the facility on 07/10/2024 with diagnoses of Emphysema, Cerebral Palsy, malignant neoplasm of adrenal gland and left lung, history of sudden cardiac arrest, and history of a pulmonary embolism. Resident 4 was designated as his/her own decision maker.

During an interview with Surveyor on 07/13/2026 at 9 AM, Resident 4 indicated s/he did not get his/her exercises as order to help with his/her Cerebral Palsy. Resident 4 said s/he had orders for staff to help him/her with ham string stretches and standing in the EZ stand for strengthening muscles.

Resident 4's physician orders included to assist with hamstring stretches twice daily and staff to place resident in the sit to stand machine 3 times per day and have resident stand as long as possible each time. Resident 4's June MAR showed the hamstring stretches were not signed out as done on 06/02 at 8 AM, on 06/18 at 8 AM and 8 PM, and on 06/19 at 8 AM. The EZ stand trials were not signed out as done on 06/04 for 2 PM, on 06/18 at 6 AM, on 06/19 at 6 AM, on 06/26 at 2 PM, on 06/27 at 6 AM, on 06/28 at 6 AM, on 06/29 at 6 AM, and on 06/30 at 6 AM.

Resident 4's ISP last updated 07/16/2025 indicated EZ stand transfer assist and exercises to be completed BID. No questions or concerns were voiced. Will continue to update yearly.

In an interview with Surveyor on 07/13/2026 at 12:30 PM CG (Caregiver) - B confirmed that when exercises are done they should be initialed by staff on the MAR. If not initialed, they might not have been done. In interviews with the

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| N 388 | Continued From page 8<br>Surveyor on 07/13/2026 at 1:30 PM and 3:00 PM, DIR (Director) - A confirmed staff were trained to sign/initial when meds or ordered exercises are given. | N 388 | | |
| N 389 | 83.35(3)(d) Service plans updated annually or on changes<br><br>Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not review and revise the ISP (individual service plan) when there was a change in the resident's needs, abilities or physical or mental condition for 1 of 1 (Resident 5) residents reviewed.<br><br>Resident 5 was noted to wander into resident rooms and make sexual comments towards staff. Resident 5's ISP was not reviewed or revised to include these behaviors.<br><br>This a repeat deficiency. See SOD (Statement of Deficiency) DKWV11 dated 07/22/2024 for | N 389 | | |

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| N 389 | Continued From page 9 | N 389 | | |

additional details.

Findings Include:

On 07/13/2026 at 10:15 AM, Surveyor interviewed Family Member I. Family Member I indicated s/he was the family member of Resident 6. While interviewing Family Member I in Resident 6's room, Surveyor noted a motion detector. Surveyor asked Family Member I about the motion detector. Family Member I said it detects movement in Resident 6's room so if Resident 6 would fall, the detector alarm goes off. Family Member I said it also notified staff if someone is in Resident 6's room. Family Member I stated that Resident 6 would say someone was in his/her room or bed. Family Member I acknowledged that Resident 6 is not always a good historian so are not sure what Resident 6 was trying say, however, when family asked staff about it staff reported that Resident 5 was found in Resident 6's room more than once. Family Member I reported that staff informed family they found Resident 5 over Resident 6's bed in the middle of the night. Family Member I stated Resident 5's room was right next to Resident 6's. Family Member I also has asked if Resident 5 can be moved to the other side of the facility where more male residents are located versus the current side where there are more females. Family Member I stated that has not happened.

Surveyor reviewed Resident 5's record. Resident 5 was admitted to the facility on 04/16/2026 with diagnoses to include dementia with Lewy Body with behavioral disturbance, fibromyalgia and chronic insomnia. Resident 5's most recent ISP dated 04/17/2026 indicated Resident 5 required some supervision and assistance and did not have an advanced directive. In addition, the ISP

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| N 389 | Continued From page 10 | N 389 | | |

stated Resident 5 was situational appropriate, interacts independently without conflict, is alert and oriented but disoriented at times/forgetful. This ISP notes Resident 5 does have hallucinations. Resident 5 is independent with dressing, transferring/mobility and toileting. Resident 5 requires the assist of 1 staff for hygiene and bathing which could be supervision or help with setup.

On 07/13/2026 at 1:00 PM, Surveyor interviewed Caregiver B regarding Resident 5. Caregiver B stated Resident 5 is independent with all activities of daily living other than s/he has creams that need to be applied to groin area. Caregiver B stated when applying cream one day, Resident 5 made the comment to Caregiver B, "you look good on your knees." Caregiver B stated now s/he brings another caregiver in the room when applying the creams and Resident 5 has not made another comment like that. Caregiver B also stated at night, Resident 5 makes his/her way through resident rooms, so now those rooms have motion detectors in them. Caregiver B stated Resident 6's room is the room Resident 5 walks into most often but has heard s/he has tried to go in several different rooms.

On 07/13/2026 at 1:15 PM, Surveyor interviewed Caregiver C regarding Resident 5. Caregiver C stated s/he has heard of Resident 5 going into female resident rooms but hasn't seen Resident 5 do it. Caregiver C stated Resident 6 has specifically complained that Resident 5 was in his/her room watching him/her.

On 07/14/2026 at 1:00 PM, Surveyor conducted an exit meeting with Director A. Director A stated s/he was unaware of Resident 5's wandering into resident rooms and inappropriate sexual

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| N 389 | Continued From page 11<br>comments toward staff. Director A acknowledged Resident 5's ISP was not updated to include any behaviors related to wandering or sexuality. | N 389 | | |
| N 415 | 83.37(2)(d) Documentation of medication administration.<br><br>Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure medication administration was documented in the resident record to include the name, dosage, date, and time of medication taken and initial the medication administration record (MAR) for 1 of 1 (Resident 4) residents reviewed. Additionally, the facility did not document the resident need for a PRN medication or the resident response to include whether the medication was effective for 1 of 1 (Resident 2) residents reviewed.<br><br>Resident 4 had an order for Ipratropium/Albuterol Sulfate 0.5-3(2.5) MG/3. Inhale the contents of 1 vial per nebulizer four times daily and as needed. Resident 4 had documentation of receiving the | N 415 | | |

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| N 415 | Continued From page 12 | N 415 | | |

medication for 106 out of 120 doses. 14 doses were not documented as given and had no reason documented for not receiving the medication.

Resident 2 had an order for Acetaminophen 500mg (milligrams) tablet to take 1-2 tablets by mouth every 6 hours as needed. Resident received the medication 22 out of 31 days in May 2026 and 17 out of 30 days in June 2026. Resident 2's record did not include documentation of the resident's need for a PRN medication or response/effectiveness of the PRN medication.

Findings include:

On 05/11/2026 and 06/12/2026, the Department received a complaint regarding medication administration.

RESIDENT 4
On 07/13/2026 Surveyor reviewed Resident 4's record. Resident 4 had a physician's order for Ipratropium/Albuterol Sulfate 0.5-3(2.5) MG/3. Inhale the contents of 1 vial per nebulizer four times daily and as needed. Resident 4 had documentation of receiving the medication for 106 out of 120 doses in June 2026. There were 14 doses not signed out and no reason documented for not receiving the medication as ordered.

Resident 4's June 2026 MAR showed no documentation of scheduled vials given on 06/01 at 8 PM, on 06/04 at 4 PM and 8 PM, on 06/05 at 8 AM and 12 PM , on 06/07 at 12 PM and 4 PM, on 06/08 at 8 PM, on 06/09 at 6 PM, on 06/20 at 2 PM, on 06/26 at 6 AM, on 06/27 at 2 PM on 06/27 at 10 AM, on 06/28 at 2 PM.

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| N 415 | Continued From page 13<br><br>In an interview with Surveyor on 07/13/2026 at 12:30 PM CG (Caregiver) - B confirmed that when meds are done they should be initialed by staff. In interviews with the Surveyor on 07/13/2026 at 1:30 PM and 3:00 PM, DIR (Director) - A confirmed staff were trained to sign/initial when meds are given.<br><br>RESIDENT 2<br>On 07/13/2026, Surveyor reviewed the Resident 2's record. The resident was admitted on 03/13/2024. Resident 2's Physician's Orders included an order for Acetaminophen 500mg (milligrams) tablet to take 1-2 tablets by mouth every 6 hours as needed. Resident 2's ISP (Individual Service Plan) dated 04/11/2026 indicated medications are administered by the facility staff.<br><br>Surveyor reviewed Resident 2's May and June MAR. The MARs reflected Resident 2 received Acetaminophen PRN doses on the following days: 05/02/2026, 05/03/2026, 05/04/2026, 05/05/2026, 05/06/2026, 05/07/2026, 05/09/2026, 05/10/2026, 05/11/2026, 05/12/2026, 05/15/2026, 05/16/2026, 05/17/2026, 05/18/2026, 05/19/2026, 05/20/2026, 05/21/2026, 05/22/2026, 05/23/2026, 05/24/2026, 05/25/2026, 05/26/2026, 06/01/2026, 06/03/2026, 06/04/2026, 06/08/2026, 06/10/2026, 06/12/2026, 06/13/2026, 06/14/2026, 06/16/2026, 06/17/2026, 06/18/2026, 06/19/2026, 06/20/2026, 06/21/2026, 06/26/2026, 06/27/2026, 06/28/2026. Resident 2 had not received any PRN doses in July 2026 through survey date. Resident 2's record did not include documentation of the resident's need for the PRN medication or response/effectiveness of the PRN medication.<br><br>On 07/13/2026 at 1:30 PM, Surveyor interviewed | N 415 | | |

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| N 415 | Continued From page 14<br>Director A. Director A stated medication passers should be documenting the reason and effectiveness of the PRN administration on the back of the MAR. Director A verified Resident 2's MAR did not have the reason or effectiveness of the Acetaminophen PRN that was administered on the above dates. | N 415 | | |
| N 419 | 83.37(3)(c) Medication storage: locked cabinet.<br><br>Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview and record review, the provider did not keep medications in a locked cabinet.<br><br>Resident 3's room contained a bottle of Biofreeze ointment and Capacisin Cream located on top of Resident 3's refrigerator cabinet.<br><br>Findings Include:<br><br>Resident 3 was admitted to the facility on 08/11/2021 with diagnoses to include history of cerebrovascular accident with right hemiparesis, type 2 diabetes and chronic shoulder pain. Resident 3's most recent ISP (Individualized Service Plan) dated 11/08/2025, stated Resident 3 has an activated power of attorney (POA). The ISP indicated Resident 3 is forgetful at times but oriented to person, place and time. Resident 3's ISP stated "Medications administered by CBRF [Community Based Residential Facility] staff. In addition, the ISP stated "Biofreeze PRN[as needed] shoulder pain." | N 419 | | |

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| N 419 | Continued From page 15<br>Resident 3 had a physician order for the following medications:<br>*Arthritis pain relief 0.075% cream Capsaicin apply topically to affected area twice daily as needed with gloves<br>*Biofreeze Colorless Gel 4% Menthol apply topically to shoulder twice daily as needed for pain<br><br>On 07/13/2026 at 2:00 PM, Surveyor interviewed Resident 3 in Resident 3's room. While in room, Surveyor observed the following on top of the refrigerator cabinet:<br>*A 1 quart bottle of Biofreeze Professional cololess gel (Menthol-pain relieving gel)<br>*A 1.5 ounce tube of Capsaicin Cream (topical analgesic)<br>Surveyor asked Resident 3 if s/he puts the gel or cream on him/herself. Resident 3 stated "no, you need gloves for that."<br><br>On 07/13/2026 at 3:00 PM, Surveyor interviewed Director A regarding the Biofreeze and Capsaicin Cream. Director A verified there is no self administration order in Resident 3's record for those ointments. Director A stated s/he removed the ointments from Resident 3's room. | N 419 | | |
| Y3244 | 50.09(1)(L) Care<br><br>(1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to<br><br>(l) Receive adequate and appropriate care within the capacity of the facility. | Y3244 | | |

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This Rule is not met as evidenced by:
Based on observation, interview and record review, the provider did not ensure 1 of 1 (Resident 1) received adequate and appropriate care within the capacity of the facility.

Resident 1 was not toileted for over 10 hours, resulting in Resident 1 sitting in urine soaked clothes and recliner.

Findings Include:

On 06/12/2026 and 06/29/2026, the department received complaints indicating residents were not receiving adequate care.

On 07/13/2026, Surveyors conducted an onsite visit. A sample of residents were selected, including the record of Resident 1.

Resident 1 was admitted to the facility on 02/11/2025 with diagnoses to include chronic kidney disease stage 2, chronic pain, dementia, diabetes type 2, history of hip fracture. Resident 1 is under court appointed guardianship and requires 24 hour supervision. Resident 1's most recent ISP (individualized service plan) with a yearly review date of 02/11/2026 stated Resident

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1 requires assist of 1 staff person for transfers/mobility, dressing and hygiene/bathing. Resident 1 has frequent incontinence of bowel and bladder therefore Resident 1 is on a toileting schedule of every 2 hours and as needed and requires staff to assist to bathroom. In addition, Resident 1 wears incontinence products and staff are to perform peri-care. Resident 1 likes to sleep in his/her recliner.

On 07/13/2026 at approximately 8:00 AM, Surveyor interviewed Cook E. Cook E stated s/he used to be a caregiver in the facility but then moved into the kitchen so now is the cook. Cook E indicated s/he is primarily in the kitchen but does still pick up caregiver shifts when needed. Cook E stated "[Caregiver B] was telling me how bad it (residents left soiled by overnight staff) was this morning."

On 07/13/2026 at 8:15 AM, Surveyor interviewed Caregiver B. Caregiver B stated s/he "clocked in" at 6:20am and Caregiver F had mentioned that s/he was not able to get Resident 1 cleaned up this morning and was "soiled in chair." Caregiver B confirmed Resident 1 needs assistance from staff to transfer to the bathroom.

On 07/13/2026 at 8:45 AM, Surveyor observed Resident 1 sitting in his/her recliner in Resident 1's room. Resident 1 was noted to be reclined in the recliner with the footrest up and sleeping. Surveyor observed a strong urine like odor. Resident 1 had a white "chux" (incontinence pad) pad under him/her. Surveyor observed a yellow stain on the white chux under Resident 1. Surveyor noted Resident 1's breakfast tray was sitting on the over-the-bed table untouched.

On 07/13/2026 at 9:00 AM, Surveyor observed

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Caregiver B passing medications to residents and Caregiver C cleaning up the dining room after the breakfast. Surveyor interviewed Caregiver B who stated s/he is going to help Caregiver C in getting another resident up and then will shower Resident 1.

On 07/13/2026 at 9:20 AM, Surveyor observed Caregiver B enter Resident 1's room. Surveyor interviewed Caregiver B, who verified the room had a urine like odor which was not typical for Resident 1's room. Caregiver B also verified Resident 1 still had his/her pajamas on. Caregiver B helped assist Resident 1 to a standing position. Surveyor observed Resident 1's pajamas were a darker blue and wet up to the middle of his/her back. Caregiver B stated s/he is "pretty wet, wet up to halfway of back." Caregiver B verified Resident 1's chux pad was soiled along with Resident 1's recliner. Caregiver B stated no one has been in to change Resident 1 since before 6:30am today. Caregiver B assisted Resident 1 to the toilet and then gave Resident 1 a shower.

On 07/13/2026 at 9:30 AM, Surveyor interviewed Caregiver C. Caregiver C s/he is part time and typically works the first shift (6:30am-3:00pm). Caregiver C stated normally there are 3 caregivers but today on first shift there are only 2 caregivers. Caregiver C verified s/he had not gone in to change Resident 1 this morning. Caregiver C stated the first time Resident 1 was changed was with Caregiver B.

On 07/13/2026 at 2:15 PM, Surveyor interviewed Director A, who acknowledged the above event.

On 07/14/2026 at 12:35 PM, Surveyor interviewed Caregiver F. Caregiver F verified s/he worked the overnight shift from 07/12/2026 to

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| Y3244 | Continued From page 19<br><br>07/13/2026 (10:30pm-6:30am). Caregiver F indicated s/he would have punched out at 6:30am on 07/13/2026. Caregiver F stated s/he was the only caregiver working the overnight shift due to another staff calling in. Caregiver F indicated Resident 1 needs assistance to the bathroom, wears incontinence products and is on 2 hour checks. Caregiver F stated s/he helped Resident 1 to the bathroom one time during the night which was around 11:20/11:30pm. Caregiver F stated when there are 2 caregivers working, they split the residents and the other caregiver normally provides the cares to Resident 1. Caregiver F stated Resident 1 was really sleepy in the morning and Caregiver F couldn't get Resident 1 up and toileted. Caregiver F stated "I believe I let first shift know" Resident 1 needed to be toileted. Caregiver F stated Resident 1 is normally toileted every 2-3 hours but "I was by myself so I had to do what was best for me." | Y3244 | | |