STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017737	A. BUILDING: _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA CARE 5TH AVE	175 WESTFIELD OSHKOSH, WI 54902

(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
M 000	INITIAL COMMENTS On 06/19/2025, with information gathered through 06/27/2025, Surveyor conducted a standard licensure survey and a complaint investigation at Vista Care 5th Ave. Five deficiencies were identified. Complaint was substantiated. Census: 2	M 000		
M 342	88.05(4)(d)1 FIRE SAFETY EVACUATION PLAN The licensee shall have a written plan for the immediate and safe evacuation of all occupants of the home in the event of a fire. The plan shall identify an external meeting place. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not have a written plan for the immediate and safe evacuation of all occupants of the home in the event of a fire or natural disaster. Resident 1 was a Hoyer Lift transfer assist and would not be evacuated from the home if s/he was not in his/her wheelchair. Findings include: The provider can provide cares for up to 4 residents in the client groups: traumatic brain injury, physically disabled, emotionally disturbed/mental illness, and developmentally disabled. On 03/17/2025, the Department received a concern that residents were not safely transferred	M 342		

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

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M 342	Continued From page 1	M 342		

when utilizing a Hoyer lift.

On 06/19/2025, at approximately 10:40 AM, Surveyor arrived at the home and was greeted by Caregiver D, who was working independently.

On 06/19/2025, at approximately 10:50 AM, Surveyor observed Resident 1 in his/her bedroom. Resident 1 was lying in his/her hospital bed and his/her Hoyer lift and electric wheelchair were next to the wall, across from his/her bed.

On 06/19/2025, at approximately 11:00 AM, Surveyor interviewed Caregiver D. Surveyor asked for clarification on how s/he performed a Hoyer transfer independently. Caregiver D stated, "I won't transfer [him/her] independently, that is wrong, you should always have two people when you use a Hoyer. I will call an on-call staff member to come in and assist me. [Resident 1] gets really stiff when you try to transfer [him/her]." Surveyor asked how Resident 1 would be evacuated in an emergency. Caregiver D stated, "If [Resident 1] is in bed, then we place a fire blanket over [him/her] as we evacuate those that are not in bed." Caregiver D explained that Resident 1 would be a point-of-rescue if s/he was not in his/her wheelchair during an emergency evacuation.

On 06/19/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home 03/05/2025.

Resident 1's individual service plan, dated 06/12/2025, documented:
"Staff will safely use Hoyer lift to transfer [Resident 1] throughout the day. Staff will report any safety concerns with using the Hoyer lift."

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M 342	Continued From page 2 Resident 1's "Resident Evacuation Assessment," dated 03/04/2025, documented: "The resident has exhibited STRONG RESISTANCE. Resident may offer resistance that requires the full attention of one or more staff members." "VERY SLOW means the time necessary for the resident to prepare to leave and travel from his/her bedroom to the exit is so long that the staff cannot permit the resident to evacuate unassisted. Specifically, if the resident cannot leave and exit within 150 seconds." "NEEDS FULL ASSISTANCE means the resident may require physical assistance from a staff member during most of the evacuation or the total time required for staff assistance and for the resident to evacuate the facility, is greater than the required evacuation time for the facility." "Individual is unable to get herself from bed to power chair." On 06/19/2025, Surveyor reviewed the provider's fire drills which documented: 05/14/2025 - Two individuals have limited mobility and staff simulated the use of a protective fire blanket. The other individual evacuated along with staff in 48 seconds. Some verbal prompting needed to assist with individual evacuation but otherwise successful 04/09/2025 - Fire Drill was successful. Ordered new fire proof point of rescue blankets for each individual. [Caregiver D] and [Caregiver I] administered point of rescue fire proof blankets due to lack of mobility in residents 03/25/2025 - [Resident 2]: point of rescue, but was pushed out in [his/her] wheelchair [Resident 3]: point of rescue, tried to get out of the house and re-direct to his room but would not do either	M 342		

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M 342	Continued From page 3 [Resident 1]: point of rescue, was in her bed and fire blanket placed over [him/her] On 06/24/2025 at 2:30 PM, Surveyor interviewed Chief of Staff A, Area Director B, and Regional Residential Manager C. Surveyor asked for clarification on how Resident 1 was evacuated during an emergency evacuation. Area Director B explained that if Resident 1 was in bed s/he would be considered a 'point of rescue' and staff would place a fire blanket over him/her, shut his/her solid core door, and evacuate the other residents who were not also in bed.	M 342		
M 408	88.06(3)(c) ASSESSMENT IDENTIFY NEEDS & ABILITIES The assessment shall identify the person's needs and abilities in at least the areas of activities of daily living, medications, health, level of supervision required in the home and community, vocational, recreational, social and transportation. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not assess the needs and abilities in the areas of activities of daily living for 1 of 1 resident reviewed. Resident 1's assessment and Individualized Service Plan (ISP) did not identify if s/he was a one-person assist or a two-person assist when	M 408		

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M 408	Continued From page 4 utilizing his/her Hoyer. Findings include: The provider can provide cares for up to 4 residents in the client groups: traumatic brain injury, physically disabled, emotionally disturbed/mental illness, and developmentally disabled. On 03/17/2025, the Department received a concern that residents were not safely transferred when utilizing a Hoyer lift. On 06/19/2025, at approximately 10:40 AM, Surveyor arrived at the home and was greeted by Caregiver D, who was working independently. On 06/19/2025, at approximately 10:50 AM, Surveyor observed Resident 1 in his/her bedroom. Resident 1 was lying in his/her hospital bed and his/her Hoyer lift and electric wheelchair were next to the wall, across from his/her bed. On 06/19/2025, at approximately 11:00 AM, Surveyor interviewed Caregiver D. Surveyor asked for clarification on how s/he performed a Hoyer transfer independently. Caregiver D stated, "I won't transfer [him/her] independently, that is wrong, you should always have two people when you use a Hoyer. I will call an on-call staff member to come in and assist me. [Resident 1] gets really stiff when you try to transfer [him/her]." Surveyor asked if s/he was aware staff transferring Resident 1 independently with a Hoyer lift. Caregiver D explained, "Yes, on 03/07/2025, I was working, along with [Caregiver E]. [Regional Residential Manager (RRM) C] was also here. I had run next door to ask staff something about meals I believe. I was only gone	M 408		

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M 408	Continued From page 5	M 408		

a couple of minutes. Caregiver E I believe was assisting another resident. Anyways, [RRM C] transferred [Resident 1] independently into [his/her] shower chair and I heard [RRM C] yell out, so I went into the room and [Resident 1] was on the floor and it was obvious there was a head trauma, [s/he] was bleeding profusely. I called 911 and advised [RRM C] to put pressure on the wound." Surveyor asked how Resident 1 would be evacuated in an emergency. Caregiver D stated, "If [Resident 1] is in bed, then we place a fire blanket over [him/her] as we evacuate those that are not in bed." Caregiver D explained that Resident 1 would be a point-of-rescue if s/he was not in his/her wheelchair during an emergency evacuation.

On 06/19/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home 03/05/2025.

Resident 1's individual service plan, dated 06/12/2025, documented:
"Staff will safely use Hoyer lift to transfer [Resident 1] throughout the day. Staff will report any safety concerns with using the Hoyer lift."

On 06/22/2025, surveyor reviewed Resident 1's "Incident Report" and "T-Log" report provided by Chief of Staff A, which documented:
"03/07/2025 Incident Report - Writer was prepping [Resident 1] for shower. Writer had assisted [Resident 1] in getting into the hoyer swing to be lifted from the bed to the shower chair. Writer had positioned [Resident 1] in the shower chair with the hoyer swing still attached to hoyer. Writer began to unhook the straps from the hoyer and the shower chair tipped backwards with [Resident 1] still in the chair. [Resident 1's]

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back of head hit the foot pedals of [his/her] power chair that was charging in the corner of [his/her] room."
"03/07/2025 T-Log report - [Resident 1] started [his/her] morning off in bed. [S/he] was waiting on RRS (RRM C) for shower. [S/he] did end up having a fall and hitting [his/her] head which ended in a ER (emergency room) visit and 3 staples."

On 06/24/2025 at 2:30 PM, Surveyor interviewed Chief of Staff A, Area Director B, and Regional Residential Manager C. Surveyor asked for clarification regarding staffing the home with one caregiver when there was a resident who required a Hoyer for transferring. Chief of Staff A stated that a Hoyer lift did not require 2 staff members to safely transfer a resident. Chief of Staff A and Area Director B explained that the injury Resident 1 sustained on 03/07/2025 was not due to being transferred independently in a Hoyer but that the shower chair was not the proper shower chair for Resident 1; the shower chair flipped over as the sling was being unhooked from the Hoyer. Surveyor asked for clarification why one staff member utilized the Hoyer, when there were other staff available, when there were concerns regarding the safety of the shower chair. Chief of Staff A and Area Director B explained staff did not believe the chair would flip over and the other staff were assisting other residents. Surveyor asked if staff, who are uncomfortable with transferring a resident who utilize a Hoyer independently have contacted additional staff for assistance. Area Director B stated s/he was contacted numerous times to provide assistance. Area Director B stated, "There is always on-call staff available to assist staff." Area Director B stated that the Hoyer that was utilized in the home was designed for a one-person transfer.

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M 408	Continued From page 7 Surveyor requested the manual for the Hoyer lift being utilized in the home and Resident 1's assessments. On 06/25/2025, Surveyor reviewed the provided documentation. Resident 1's assessment, undated, documented: "Resident requires full assistance from staff to ambulate. Operates a electric chair. [S/he] uses a Hoyer, shower chair and ostomy bag. Resident is 1 person assist with a full mechanical lift. Resident requires staff assistance with all positioning needs. Resident requires a mechanical lift for transfers. If Sit-to-Stand or Hoyer: one or two person assist?" "Patient Lift - Owner's Manual & Instructions" documented: "Lifting the Patient: ... When moving the patient lift away from the bed, turn patient so that [s/he] faces attendant operating the patient lift" "Transferring to a Wheelchair: Drive recommends that two (2) attendants be used when transferring a patient to a wheelchair. ... With one (1) attendant behind the chair and the other operating the patient lift, the attendant behind the chair will pull back on the handle or sides of the sling to place the patient into the back of the chair. This will maintain a good center of balance and prevent the chair from tipping forward." "Transporting Patient for Use of Bathroom Facilities: The patient ... Refer to Transferring to a Wheelchair. After this has been accomplished refer to the following: ... 3. With the help of both assistants, guide the patient onto the standard commode. On 06/25/2025 at 12:54 PM, Surveyor	M 408		

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M 408	Continued From page 8 interviewed Resident 1's managed care organization (MCO) Provider Quality Supervisor (PQS) F. Surveyor asked for clarification on what Resident 1's care managers expectations were regarding how many staff members were to be utilized when transferring Resident 1 in his/her Hoyer. PQS F stated s/he would reach out to Registered Nurse Care Manager G and Care Manager H. On 06/27/2025 at 12:35 PM, Surveyor interviewed Area Director B. Surveyor stated that the owner's manual for the Hoyer being utilized in the home stated that it was recommended 2 attendants operate the Hoyer. Area Director B stated, "It is a recommendation, not a requirement." On 06/27/2025 at 1:25 PM, PQS F emailed Surveyor with Registered Nurse Care Manager G's and Care Manager H's responses: "(Registered Nurse Care Manager G): At every facility I have ever worked in a Hoyer lift is a 2 person assist. I don't think it would be safe for a one person transfer." "(Care Manager H): They are supposed to have at least two staff in the facility at all times and should be able to do this with 2 staff. I don't think we were aware that they didn't transfer with 2."	M 408		
M 438	88.07(2)(b) SERVICES DIRECTED TO GOALS Services shall be directed to the goal of assisting, teaching and supporting the resident to promote his or her health, well-being, self-esteem, independence and quality of life. The services shall include but are not limited to:	M 438		

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This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure services determined to be provided by the provider and resident's managed care organization (MCO) were provided for 1 of 1 resident reviewed.

Resident 1 utilized a Hoyer lift and only one staff member was present in the home.

Findings include:

The provider can provide cares for up to 4 residents in the client groups: traumatic brain injury, physically disabled, emotionally disturbed/mental illness, and developmentally disabled.

On 03/17/2025, the Department received a concern that residents were not safely transferred when utilizing a Hoyer lift.

On 06/19/2025, at approximately 10:40 AM, Surveyor arrived at the home and was greeted by Caregiver D, who was working independently.

On 06/19/2025, at approximately 10:50 AM, Surveyor observed Resident 1 in his/her bedroom. Resident 1 was lying in his/her hospital bed and his/her Hoyer lift and electric wheelchair were next to the wall, across from his/her bed.

On 06/19/2025, at approximately 11:00 AM, Surveyor interviewed Caregiver D. Surveyor asked for clarification on how s/he performed a Hoyer transfer independently. Caregiver D stated, "I won't transfer [him/her] independently, that is wrong, you should always have two people

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when you use a Hoyer. I will call an on-call staff member to come in and assist me. [Resident 1] gets really stiff when you try to transfer [him/her]." Surveyor asked if s/he was aware staff transferring Resident 1 independently with a Hoyer lift. Caregiver D explained, "Yes, on 03/07/2025, I was working, along with [Caregiver E]. [Regional Residential Manager (RRM) C] was also here. I had run next door to ask staff something about meals I believe. I was only gone a couple of minutes. Caregiver E I believe was assisting another resident. Anyways, [RRM C] transferred [Resident 1] independently into [his/her] shower chair and I heard [RRM C] yell out, so I went into the room and [Resident 1] was on the floor and it was obvious there was a head trauma, [s/he] was bleeding profusely. I called 911 and advised [RRM C] to put pressure on the wound." Surveyor asked how Resident 1 would be evacuated in an emergency. Caregiver D stated, "If [Resident 1] is in bed, then we place a fire blanket over [him/her] as we evacuate those that are not in bed." Caregiver D explained that Resident 1 would be a point-of-rescue if s/he was not in his/her wheelchair during an emergency evacuation.

On 06/19/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home 03/05/2025.

Resident 1's individual service plan, dated 06/12/2025, documented:
"Staff will safely use Hoyer lift to transfer [Resident 1] throughout the day. Staff will report any safety concerns with using the Hoyer lift."

On 06/22/2025, surveyor reviewed Resident 1's "Incident Report" and "T-Log" report provided by

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Chief of Staff A, which documented:
"03/07/2025 Incident Report - Writer was prepping [Resident 1] for shower. Writer had assisted [Resident 1] in getting into the hoyer swing to be lifted from the bed to the shower chair. Writer had positioned [Resident 1] in the shower chair with the hoyer swing still attached to hoyer. Writer began to unhook the straps from the hoyer and the shower chair tipped backwards with [Resident 1] still in the chair. [Resident 1's] back of head hit the foot pedals of [his/her] power chair that was charging in the corner of [his/her] room."
"03/07/2025 T-Log report - [Resident 1] started [his/her] morning off in bed. [S/he] was waiting on RRS (RRM C) for shower. [S/he] did end up having a fall and hitting [his/her] head which ended in a ER (emergency room) visit and 3 staples."

On 06/24/2025 at 2:30 PM, Surveyor interviewed Chief of Staff A, Area Director B, and Regional Residential Manager C. Surveyor asked for clarification regarding staffing the home with one caregiver when there was a resident who required a Hoyer for transferring. Chief of Staff A stated that a Hoyer lift did not require 2 staff members to safely transfer a resident. Chief of Staff A and Area Director B explained that the injury Resident 1 sustained on 03/07/2025 was not due to being transferred independently in a Hoyer but that the shower chair was not the proper shower chair for Resident 1; the shower chair flipped over as the sling was being unhooked from the Hoyer. Surveyor asked for clarification why one staff member utilized the Hoyer, when there were other staff available, when there were concerns regarding the safety of the shower chair. Chief of Staff A and Area Director B explained staff did not believe the chair would flip over and the other

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staff were assisting other residents. Surveyor asked if staff, who are uncomfortable with transferring a resident who utilize a Hoyer independently have contacted additional staff for assistance. Area Director B stated s/he was contacted numerous times to provide assistance. Area Director B stated, "There is always on-call staff available to assist staff." Area Director B stated that the Hoyer that was utilized in the home was designed for a one-person transfer. Surveyor requested the manual for the Hoyer lift being utilized in the home and Resident 1's assessments.

On 06/25/2025, Surveyor reviewed the provided documentation.

Resident 1's assessment, undated, documented: "Resident requires full assistance from staff to ambulate. Operates a electric chair. [S/he] uses a Hoyer, shower chair and ostomy bag. Resident is 1 person assist with a full mechanical lift. Resident requires staff assistance with all positioning needs. Resident requires a mechanical lift for transfers. If Sit-to-Stand or Hoyer: one or two person assist?

"Patient Lift - Owner's Manual & Instructions" documented:
"Lifting the Patient: ... When moving the patient lift away from the bed, turn patient so that [s/he] faces attendant operating the patient lift"
"Transferring to a Wheelchair: Drive recommends that two (2) attendants be used when transferring a patient to a wheelchair. ... With one (1) attendant behind the chair and the other operating the patient lift, the attendant behind the chair will pull back on the handle or sides of the sling to place the patient into the back of the chair. This will maintain a good

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center of balance and prevent the chair from tipping forward."
"Transporting Patient for Use of Bathroom Facilities: The patient ... Refer to Transferring to a Wheelchair. After this has been accomplished refer to the following: ... 3. With the help of both assistants, guide the patient onto the standard commode.

On 06/25/2025 at 12:54 PM, Surveyor interviewed Resident 1's managed care organization (MCO) Provider Quality Supervisor (PQS) F. Surveyor asked for clarification on what Resident 1's care managers expectations were regarding how many staff members were to be utilized when transferring Resident 1 in his/her Hoyer. PQS F stated s/he would reach out to Registered Nurse Care Manager G and Care Manager H.

On 06/27/2025 at 12:35 PM, Surveyor interviewed Area Director B. Surveyor stated that the owner's manual for the Hoyer being utilized in the home stated that it was recommended 2 attendants operate the Hoyer. Area Director B stated, "It is a recommendation, not a requirement."

On 06/27/2025 at 1:25 PM, PQS F emailed Surveyor with Registered Nurse Care Manager G's and Care Manager H's responses:
"(Registered Nurse Care Manager G): At every facility I have ever worked in a Hoyer lift is a 2 person assist. I don't think it would be safe for a one person transfer."
"(Care Manager H): They are supposed to have at least two staff in the facility at all times and should be able to do this with 2 staff. I don't think we were aware that they didn't transfer with 2."

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M 462	Continued From page 14	M 462		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure that 2 of 2 residents received the correct dosage of medication at the correct time and followed physician guidelines. Census 2. Resident 1's Lansoprazole (reduces the amount of acid your stomach makes), Famotidine (prevent and treat heartburn), Escitalopram (antidepressant), and Baclofen (muscle relaxer) were not administered as prescribed. Resident 2's Venlafaxine (antidepressant), Quetiapine (psychotropic), Oxybutynin (medication for overactive bladder), and Buspirone (medication to treat anxiety) were not administered as prescribed. Findings include: On 06/19/2025, at approximately 11:30 AM, Surveyor and Caregiver D observed Resident 1's and Resident 2's medications in the med closet. Surveyor asked Caregiver D when the med cycle	M 462		

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started for the medications. Caregiver D stated the first of the month.

Example 1: Resident 1

Resident 1's 8:00 AM blister cards of Lansoprazole, Famotidine, Escitalopram, and Baclofen showed that 18 of the 19 medication opportunities, between 06/01/2025 to 06/19/2025, had been dispensed. Surveyor asked Caregiver D if Resident 1 had been out of the home during med administration in June. Caregiver D stated s/he was not aware of Resident 1 being unavailable for med administration.

On 06/24/2025, Surveyor reviewed Resident 1's record.

Resident 1's MAR, dated 06/01/2025 to 06/19/2025, documented:
Lansoprazole - Take 1 capsule per g-tube once every day. Start Date: 03/07/2025.
Famotidine - Take 1 tablet per g-tube twice daily. Start Date: 03/07/2025.
Escitalopram - Take 1 tablet per g-tube once every day for generalized anxiety disorder/major depressive disorder. Start Date: 03/07/2025.
Baclofen - Take 1 tablet per g-tube four times daily before meals and at bedtime for muscle spasticity/cerebral palsy. Start Date: 03/13/2025.

The MAR documented that the medication had been administered at all opportunities.

Example 2: Resident 2

Resident 2's 8:00 AM blister cards of Venlafaxine, Quetiapine, Oxybutynin, and Buspirone showed that 18 of the 19 medication opportunities, between 06/01/2025 to 06/19/2025, had been

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dispensed. Surveyor asked Caregiver D if Resident 2 had been out of the home during med administration in June. Caregiver D stated s/he was not aware of Resident 2 being unavailable for med administration.

On 06/24/2025, Surveyor reviewed Resident 2's record.

Resident 2's MAR, dated 06/01/2025 to 06/19/2025, documented:
Venlafaxine - Take 1 tablet via g-tube twice daily in the morning and evening with meals (8AM and 5PM). Start Date: 05/07/2025.
Quetiapine - Take 1 tablet via g-tube every morning. Start Date: 03/07/2025.
Quetiapine - Take 2 tablets via g-tube every night for mood disorder. Start Date: 03/07/2025.
Oxybutynin - Take 1 tablet via g-tube twice daily (8AM, 4PM). Start Date: 03/07/2025.
Buspirone - Take 1 tablet via g-tube every morning (8AM). Start Date: 04/19/2025.
Buspirone - Take ½ tablet via g-tube every evening (8PM). Start Date: 03/07/2025.

The MAR documented that the medication had been administered at all opportunities.

On 06/24/2025 at 2:30 PM, Surveyor interviewed Chief of Staff A, Area Director B, and Regional Residential Manager C. Surveyor explained his/her observation. Regional Residential Manager C stated they would need to review the documentation to determine if a med error had occurred.

On 06/27/2025 at 12:35 PM, Surveyor interviewed Area Director B. Area Director B stated it had been determined that med administration did not occur on 06/08/2025. Area

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M 462	Continued From page 17 Director B stated staff have been re-educated.	M 462		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure accurate records were kept of all prescription medications administered for 1 of 2 residents. The amount dispensed of Resident 1's as-needed (PRN) Hydroxyzine HCL (hydrochloride) did not align with the Medication Administration Record (MAR) documentation. Findings include: On 06/19/2025, at approximately 11:30 AM, Surveyor and Caregiver D observed Resident 1's medications in the med closet. Surveyor observed Resident 1's blister card of PRN Hydroxyzine HCL with handwritten dates stating a dose had been dispensed on 05/19/2025, 06/15/2025, 06/16/2025, and 06/17/2025. One dose had also been dispensed but did not have a date written to it.	M 466		

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M 466	Continued From page 18 On 06/24/2025, Surveyor reviewed Resident 1's record. Resident 1's May and June 2025 Medication Administration Records (MARs), dated 05/01/2025 to 06/24/2025, documented: Hydroxyzine HCL 25 MG (milligram) - Take 1 tablet per G-tube every 8 hours as needed for anxiety. Start Date: 03/13/2025. The MARs documented dispensed dates on 05/19, 06/09, 06/12, 06/13, 06/14, 06/16. The MARs documented 6 dispensed dates when 5 doses had been dispensed. The dates of administration documented on the MAR did not align with the dates staff had documented on the blister card next to each dispensed tablet. On 06/24/2025 at 2:30 PM, Surveyor interviewed Chief of Staff A, Area Director B, and Regional Residential Manager C. Surveyor explained his/her observation. Regional Residential Manager C stated they would need to review the documentation to determine if a med error had occurred.	M 466		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner. This Rule is not met as evidenced by: Based on observation and interview, the provider did not store food under sanitary conditions.	M 474		

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M 474	Continued From page 19 Surveyor found food items in the refrigerator that were not properly sealed to avoid contamination and food items in the freezer that were not properly sealed to avoid freezer burn. The provider did not implement a system to identify when opened food was to be discarded for the prevention of food borne illnesses. Findings include: The provider can provide cares for up to 4 residents in the client groups: traumatic brain injury, physically disabled, emotionally disturbed/mental illness, and developmentally disabled. On 06/19/2025, at approximately 11:00 AM, Surveyor toured the kitchen and observed: Refrigerator: -An opened 16 ounce container of sliced black forest ham that was not dated -An opened package of ham steaks that was not dated or sealed. The packaging stated, "Once Opened - Use Within 5 Days." The packaging had a 'Use-By' date of 05/25/2025. -A package of red raspberries that had a white fuzz like substance covering them -A package of strawberries that appeared brown in color -A package of grapes that appeared brown in color Freezer: -An opened bag of beef burgers that was not sealed -An opened bag of garlic bread that was not sealed -An opened bag of fried potatoes that was not sealed	M 474		

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M 474	Continued From page 20 -An opened bag of meatballs that was not sealed -An opened bag of waffles that was not sealed "Time/temperature control for safety (TCS) guidelines indicate food prepared in a food establishment and held longer than a 24 hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Refrigerated, RTE (ready-to-eat)/TCS food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed or discarded." (US Food and Drug Administration (FDA) Food Code, 2022, Section 3-501.17) "Ready-to-eat TCS food (foods that need time and temperature control for safety) can be stored for only seven days if it is held at 41 degrees Fahrenheit or lower. The count begins on the day the food was prepared or a commercial container was open. TCS foods includes milk and dairy products, eggs, meat (beef, pork, and lamb), poultry, fish, shellfish and crustaceans, baked potatoes, tofu or other soy protein, sprouts and sprout seeds, sliced melons, cut tomatoes, cut leafy greens, untreated garlic-and-oil mixtures, and cooked rice, beans, and vegetables." (ServSafe Coursebook, 7th edition, 2017, p. 1-7, p. 1-8, and p. 7-3) "Proper packaging helps maintain quality and prevent freezer burn. Aluminum foil, freezer paper, plastic containers, and plastic freezer bags will help food maintain optimum quality in the	M 474		

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M 474	Continued From page 21 freezer. Plastic wrap alone will not provide enough protection by itself, but can be used to separate foods within another package. When packaging food, press out as much air as possible to prevent freezer burn, and wrap tightly." (Source: USDA (United States Department of Agriculture) website, How should food be packaged for the freezer?, https://ask.usda.gov (retrieval date - June 27, 2025).) On 06/24/2025 at 2:30 PM, Surveyor interviewed Chief of Staff A, Area Director B, and Regional Residential Manager C. Surveyor explained his/her observation. Area Director B stated the concern would be addressed with staff. On 06/27/2025 at 12:35 PM, Surveyor interviewed Area Director B. Area Director B stated there was only one resident who resided in the home that ate 'table' food and s/he passed away and staff did not monitor the refrigerator and freezer after that time.	M 474		