STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016487	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE COMMUNITY LIVING LLC	6278 W VILLA LN BROWN DEER, WI 53223

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M 000	INITIAL COMMENTS On 08/19/2026, Surveyors conducted a standard survey and four complaint investigations, at Best Choice Community Living LLC, an Adult Family Home (AFH) in Brown Deer, WI. Nine deficiencies were identified. Three of 4 complaints substantiated. One of 4 complaints unsubstantiated. Census: 4	M 000		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by:	M 262		

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

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M 262	Continued From page 1 Based on observation, record review, and interview, the provider did not ensure all doorways/openings had a clear opening of at least 32 inches or bathrooms had sufficient room for wheelchair bound residents. Findings include: The facility was licensed on 04/12/2017, to serve up to 4 residents in the areas of developmentally disabled, irreversible dementia/Alzheimer's, advanced age, traumatic brain injury, emotionally disturbed/mental illness, physically disabled, and terminally ill. On 08/19/2026, at 2:15 PM, Surveyors toured the facility and observed the following: - The openings from the kitchen to the dining room/living room a clear opening of 30 inches. - The bathroom clearance from the sink cabinet to the raised shower was 43.4 inches Surveyors observed Resident 2 in his/her room. Resident 2 utilized a motorized wheelchair for ambulation. On 08/19/2026, at approximately 1:45 PM, Surveyor interviewed Resident 2. Surveyor inquired how Resident 2 utilized the bathroom with her/his wheelchair. Resident 2 reported s/he drives straight into the bathroom and transfers laterally into the shower and then back into/her his chair. Resident 2 reported s/he cannot turn her/his wheelchair around in the bathroom or turn her/his wheelchair to face the sink. On 08/19/2026, at approximately 2:25 PM, Surveyors interviewed Licensee A. Licensee A	M 262		

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M 262	Continued From page 2 confirmed Resident 2 does not have a turn radius in the common bathroom. Licensee A confirmed Resident 2 pulls straight in and backs straight out of the common bathroom.	M 262		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was well-maintained, clean, and a homelike environment for 4 of 4 residents. The kitchen, bathroom and hallways required cleaning and maintenance. Findings include: On 08/19/2026 at 9:15 AM, Surveyor toured the facility and observed the following: Kitchen - Flooring peeling up in two locations near the floor trim. - A buildup of gray matter, similar to dust along floor baseboards and vents. Hallway -Air return vents were covered contained grayish substances similar to dust	M 276		

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M 276	Continued From page 3 Bathroom - The bathroom did not contain hand towels or paper towels for handwashing. - The bathroom did not contain toilet paper. - The base of the shower contained multiple orange spots similar to rust from the shower chair in the shower. - The door contained an approximately 2 inch x 2 inch hole. On 08/19/2026, at approximately 2:25 PM, Surveyors interviewed Licensee A. Surveyors relayed concerns of the condition of the home. Licensee A reported the hole in the door was from a wheelchair. Licensee A reported caregivers clean the facility during their shifts. Licensee A reported Caregiver D stocked the bathroom with supplies during the survey. Surveyors informed Licensee A the bathroom was not stocked with toilet paper or paper towels from approximately 9:15 AM until approximately 2:00PM when Caregiver D restocked it. Manager B confirmed house needed cleaning in other areas of the home.	M 276		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a description of the services	M 412		

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M 412	Continued From page 4	M 412		

in the Individual Service Plan (ISP) the licensee would provide to meet the assessed needs of 1 of 1 resident (Resident 4). Resident 4 had a history of refusal of care. Resident 4's ISP did not identify what services staff were to provide to manage his/her refusal of care.

Findings include:

On 01/27/2026, the Department received a complaint indicating a concern that a resident at the home went into the community with no pants or undergarments on.

On 08/19/2026, Surveyors reviewed Resident 4's record and identified the following:

-Resident 4 was admitted to the provider's home on 10/23/2018 with diagnoses including bipolar disorder and major depressive disorder.

-Resident 4 discharged from the provider's home on 05/04/2026.

-Resident 4's Incident Report, dated 01/27/2026, written by Licensee A, documented the following: "[Adult Protective Services] showed up to the house and it was brought to our attention a week ago [Resident 4] had gone to [his/her] mom's place with no pants on but with a blanket. Investigation conducted and [Caregiver C] states that [Resident 4] was in the living area in [his/her] scooter and noticed a van outside. [Resident 4] stated driving [his/her] scooter to the bus while [Caregiver C] tried to stop [him/her] to first dress up appropriately. [Resident 4] became verbally aggressive and continued to drive [his/her] scooter to the van. [Caregiver C] rushed inside the house and grabbed pants and a blanket and ran inside the bus and told [Resident 4] to at least

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M 412	Continued From page 5	M 412		

take the items with [him/her] and also informed the van driver. [Caregiver C] was given a verbal warning."

-Resident 4's ISP, dated 02/06/2026, documented the following:

"Bathing - Full Assistance. Directions: Provide full assistance bathing/showering. Assist with dressing and undressing, wash, shampoo and with all required physical assistance. Complete showers as scheduled and as needed. Schedule: Weekly [Mon, Wed, Fri] @ 7:00 AM. Resident's Needs/Preferences: Requires full assistance including physical and verbal assistance. Resident's Desired Goals & Outcomes: Maintain personal hygiene and cleanliness with assistance from the staff. Service Provider Responsibilities: Staff should perform bed baths daily @ 8 AM and 8 PM and as needed, and complete showers @ 8 AM on Mondays, Wednesday and Fridays. Staff should shampoo and condition hair 3xs per week with showers and shaving. Measurable Goals, Outcomes and Review: To complete showers at least 3 times per week.

Dressing - Full Assistance. Directions: Assist choosing proper attire and with dressing/undressing. Schedule: Daily @ wake up, bedtime. Resident's Needs/Preferences: Requires full assistance with getting dressed and undressed each morning and night. Resident's Desired Goals & Outcomes: To receive assistance with dressing and undressing upon wake up and at bedtime. Service Provider Responsibilities: Staff should assist with dressing in weather appropriate attire daily @ 8 AM and changing into sleeping attire @ bedtime. Measurable Goals, Outcomes and Review: To be properly dressed and receive assistance with

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M 412	Continued From page 6 dressing daily." -Resident 4's ISP did not include information from Resident 4's Behavior Support Plan (BSP) regarding refusal of care. -Resident 4's BSP, dated 11/16/2022, documented the following: "Behavior: Refusal of care. [Resident 4] will refuse to have [his/her] depend changed, peri-care and bed bath completed, clothes changed, and other personal care activities completed. Function: This behavior is a function of not getting [his/her] way. Desired Behavior: [Resident 4] will refrain from refusing any cares provided by staff and will communicate [his/her] desire to have cares completed at a later time if need be. Proactive Plan: [Resident 4] will inform staff when [s/he] is upset and ask that they come back at a later time to complete cares. Staff will accommodate request as appropriate. Reactive Plan: If [Resident 4] refuses care staff will [sic] at a later time. Staff will remind [Resident 4] of the importance of having [his/her] cares completed and ask [him/her] when [s/he] would like to have them done. Data Collections: Staff will document all behaviors on the behavior management form and flow sheet. Staff will report behaviors to manager. Notes: Manager will discuss behaviors with [Resident 4] the next business day and will also be available by phone to assist in deescalating behavior." On 08/19/2026, at approximately 11:09 AM, Surveyors interviewed Manager B. Manager B confirmed Resident 4's ISP did not identify what services staff were to provide to manage his/her refusal of care. Manager B confirmed Resident 4's ISP did not include information from Resident	M 412		

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M 412	Continued From page 7 4's BSP regarding refusal of care. Manager B reported s/he did not update Resident 4's ISP to reflect the BSP.	M 412		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents' (Resident 1) Individual Service Plans (ISP) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 1's ISPs did not include a signed statement of agreement with all parties involved. Findings include: On 08/19/2026, Surveyors reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's home on 03/29/2018. -Resident 1 had a legal guardian. -Resident 1's ISPs dated 05/16/2024, 09/22/2025, 02/22/2026, and 08/06/2026, were not signed by his/her legal guardian. On 08/19/2026, at approximately 10:19 AM,	M 420		

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M 420	Continued From page 8 Surveyors interviewed Manager B. Manager B confirmed Resident 1's ISPs were not signed by his/her legal guardian. Manager B reported moving forward s/he would ensure Resident 1's guardian sign his/her ISP.	M 420		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were destroyed when medications were expired for 2 of 4 residents (Resident 2 and former Resident 5). Resident 2's medication bin contained expired medications. Resident 5's medications were not removed or destroyed after s/he was discharged form the facility. Findings include: On 08/19/2026, at approximately 09:15 AM, Surveyor toured the facility and observed the following in the medication closet:	M 458		

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M 458	Continued From page 9 Resident 2' s medication bin contained the following expired medication: - 2 medication cards of Tizanidine hydrochloride (HCL) 2 milligram(mg) tablet, 45 tablets remaining, discard date May 2026 Resident 5's medication bin contained the following medications: - 2 bottles of liquid acetaminophen 160mg/ 5 milliliters (ml) - 2 bottles of polyethylene glycol 3350 - 1 container of midodrine 2.5mg On 08/19/2026, at approximately 2:25 PM, Surveyor interviewed Licensee A. Licensee A reported caregivers go through the medication bins weekly and removed expired medications. Surveyor inquired when Resident 5 was discharged from the facility. Licensee A reported Resident 5 was discharged from the facility approximately 10 months ago. Licensee A reported s/he would ensure expired medications were disposed of properly by staff members.	M 458		
M 470	88.07(4)(a) NUTRITION A licensee shall provide each resident with a quantity and variety of foods sufficient to meet the resident's nutritional needs and preferences and to maintain the resident's health. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure each resident received a variety of food that met their individual preferences and maintained resident health.	M 470		

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M 470	Continued From page 10 There was a limited amount of food options available that were easily accessible by residents and food items available were expired. Findings include: The provider was licensed, 07/12/2021, to provide cares for up to 4 residents in the client groups traumatic brain injury, physically disabled, advanced aged, irreversible dementia/Alzheimer's, developmentally disabled and emotionally disturbed/mental illness. On 08/19/2026, at approximately 9:15 AM, Surveyors toured the home. -Surveyors observed the refrigerator which contained: 2 gallons of milk, a jar of jelly, a jar of garlic, bread buns, two packages of cheese, a large box of eggs, various condiments, a half of watermelon (uncovered on a plate), a half of a green bell pepper in the door uncovered an unwrapped, and a bag of carrots -Surveyors observed the freezer which contained frozen shredded and formed hashbrowns, frozen pancakes, and a box of breakfast sandwiches, -Surveyors observed the pantry items which consisted of: oatmeal, two boxes of Dinty Moore Beef Stew, three cans of corn, and pancake mix Surveyors observed a chest freezer which contained: Frozen bread, frozen beef, breakfast sausage, frozen waffles, and frozen pancakes. Surveyors did not observe fresh vegetables or edible fruit available to residents. On 08/19/2026, at approximately 9:30 AM,	M 470		

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M 470	Continued From page 11 Surveyor interviewed Resident 2. Resident 2 reported s/he was served only oatmeal for breakfast. Resident 2 reported the facility serves potatoes every day for every meal. Resident 2 reported there have been days when the only food served was potatoes. Resident 2 reported s/he observed Resident 3 ask for an alternate meal when potatoes were served and Caregiver D states "... no, you're not special. If you don't eat this, you don't get anything else...". On 08/19/2026, at approximately 12:30 PM, Surveyors observed lunch. Lunch consisted of a bowl of boiled potatoes with beef stew over the top. According to the USDA Center for Nutrition Policy and Promotion, "Food group amounts for 2000 Calories per day ...the daily recommended amounts for each food group: fruits 2 cups, vegetables 2 ½ cups, grains 6 ounces, protein 5 ½ ounces, dairy 3 cups." (Source: MyPlate Plan: 2000 calories, Age 14+, December 2020, https://www.dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf (retrieval date: February 13, 2025).) On 08/19/2026, at approximately 2:25 PM, Surveyors asked Licensee A for clarification on where the food items were purchased and what was available to the residents. Licensee A reported s/he had groceries delivered weekly to the facility. Licensee A showed Surveyors his/her grocery list that s/he utilized when s/he went grocery shopping. The order was for approximately $130.00 dollars and was delivered to the facility on 08/14/2026. The ordered contained beef, juices and milk, and frozen foods. Surveyors relayed concerns of food options and balanced nutrition for residents.	M 470		

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M 570	Continued From page 12	M 570		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure water temperatures were kept at a safe temperature for 1 of 1 bathroom. The hot water temperature in the common resident bathroom was 124.7° Fahrenheit (F). Findings include: The facility was licensed on 04/12/2017, to serve up to 4 residents in the areas of developmentally disabled, irreversible dementia/Alzheimer's, advanced age, traumatic brain injury, emotionally disturbed/mental illness, physically disabled, and terminally ill. On 08/19/2026, at approximately 9:15 AM, Surveyor tested the water temperature in the common bathroom faucet. The water temperature was 124.7°F. "Exposure to hot water is a potential	M 570		

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M 570	Continued From page 13 environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g. second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017) On 08/19/2026, at approximately 2:25 PM, Surveyors interviewed Licensee A and Manager B. Manger B reported s/he tests the water temperature. Manager B confirmed the code requirement. Manger B reported s/he would ensure the water temperature was rechecked after it was drained and refilled.	M 570		
M 572	88.10(3)(m) Freedom from Abuse Freedom from abuse. To be free from physical, sexual or mental abuse, neglect, and financial exploitation or misappropriation of property. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee permitted an existence of a condition in the home which placed the safety and welfare of residents at substantial risk of harm. The Licensee did not conduct a thorough investigation and allowed a caregiver to work in the facility during an investigation related to alleged abuse of a resident.	M 572		

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M 572	Continued From page 14 Findings include: The Department received a complaint on 07/21/2026 alleging a caregiver physically abused a resident on 07/10/2026. The alleged abuse was heard by another resident. Record Review On 08/19/2026, at approximately 10:15 AM, Surveyor reviewed Resident 3's file. Resident 3 was admitted to the facility on 05/04/2026. Resident 3's file contained an individual service plan (ISP), dated 06/22/2026. Resident 3's ISP indicated s/he utilized a wheelchair for mobility, required full assistance with toileting and dressing, and had an extensive history of aggressive and combative behaviors. Resident 3's file contained a behavior support plan (BSP) dated 01/01/2026. On 08/19/2026, at approximately 1:30 PM, Surveyor reviewed an incident report dated 07/16/2026. The report indicated the following: ".... Location: Resident's room Describe the incident, Please be as detailed as possible. Use the back of this sheet if necessary. Resident [Resident 3] told writer that caregiver had roughed her/him[CK2.1] up. Writer [Licensee A] asked the resident what led to this? Resident stated that s/he had told caregiver that s/he does not want to be changed. Resident 3 stated that s/he was wet but did not want to be changed. Writer spoke to the other resident and asked if s/he was aware of anything going on between the two. [Resident 2] stated that s/he was in her/his room and heard caregiver saying I have to change you and [Resident 3] shouted back saying	M 572		

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	0016487	A. BUILDING: _____ B. WING _____	C 08/19/2026

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"don't touch me". Caregiver was reeducated about resident rights. Caregiver verbalizes understanding..."

The incident report had an attached handwritten report dated 07/17/2026 which stated,

"I was changing [Resident 3's] diaper and the [sic] was poop all over the bed and s/he was refusing then I changed her/him. By [Caregiver D]"

Interview

On 08/19/2026, at approximately 9:30 AM, Surveyor interviewed Resident 2. Surveyor inquired if Resident 2 observed a staff member physically abusing another resident. Resident 2 reported "yeah". Resident 2 reported "...every morning they (Resident 3 and Caregiver D) had been yelling and arguing....it was building up..... [Resident 3] had told other people and her/his case manager.... I heard an altercation and heard a pop pop pop. I could tell they were fighting....". Resident 2 reported Resident 3 spoke to her/him later that day and told her/him "...man s/he (Caregiver D) just started wailing on her/him.." Resident 2 confirmed "wailing" meant hitting her/him. Resident 2 confirmed this incident occurred on or around 07/10/2026. Surveyor inquired if Resident 2 or any other resident reported the alleged abuse to the owner or staff. Resident 2 reported yes, but the manager was out of town on vacation, but s/he was notified of the incident. Resident 2 reported Caregiver D continued to work in the facility after the incident. Surveyor inquired if Resident 2 felt safe in the facility, Resident 2 reported "yes" but also stated "I feel like yea it could happen to me".

On 08/19/2026, at approximately 12:30 PM,

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M 572	Continued From page 16 Surveyor interviewed Licensee A. Licensee A reported s/he was on vacation and when s/he returned s/he was made aware of the incident regarding Resident 3 and Caregiver D. Surveyor inquired if an investigation was conducted and if Caregiver D continued to work in the facility. Licensee A reported an investigation was completed but Caregiver D continued to work during the investigation. On 08/19/2026, at approximately 2:15 PM, Surveyors interviewed Licensee A and Caregiver D regarding the alleged abuse. Licensee A reported s/he was made aware of the alleged abuse on 07/16/2026. Licensee A reported her/his understanding of the situation was Resident 3 refused care and Caregiver D did not stop and reapproach, s/he continued to change Resident 3. Surveyor inquired why further investigation into Resident 3 being "roughed up" was not further investigated. Licensee A reported s/he found it to be untrue but did not provide further explanation or details. Licensee A confirmed Caregiver D worked in the facility on 07/16/2026 and 07/17/2026 during the investigation. Licensee A reported s/he did not report the alleged abuse to the Department. Cross Reference M0610 88.11(1) Reporting Of Abuse and Neglect	M 572		
M 610	88.11(1) REPORTING OF ABUSE AND NEGLECT A licensee or service provider who knows or has reasonable cause to suspect that a resident has been abused or neglected as defined in s. 46.90 or 940.285, Stats., shall	M 610		

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immediately contact the licensing agency. Providing notice under this subsection does not relieve the licensee or other person of the obligation to report an incident to law enforcement authorities. If the licensee has reason to believe a crime has been committed, the incident shall immediately be reported to law enforcement authorities.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the licensee did not report alleged abuse of a resident for 1 of 4 residents. Resident 3 informed Licensee A about a caregiver who harmed him/her on 07/16/2026 and the incident was not reported to the Department.

Findings include:

The Department received a complaint on 07/21/2026 alleging a caregiver physically abused a resident on 07/10/2026. The alleged abuse was heard by another resident.

"...Abuse is any of the following acts committed by a caregiver: 1. An act or repeated acts by a caregiver or non-client resident, including but not limited to restraint, isolation, or confinement that when contrary to the entity's policies and procedures, when not a part of the client's treatment plan, and when done intentionally to cause harm does any of the following: a. Causes or could be reasonably expected to cause pain or

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injury to a client or the death of a client and the act does not constitute self-defense as defined in Wis. Stat. § 939.48. b. Substantially disregards a client's rights under Wis. Stat. chapters 50 or 51, or a caregiver's duties and obligations to a client. c. Causes or could reasonably be expected to cause mental or emotional damage to a client, including harm to the client's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, a fear of harm or death, or a combination of these behaviors. This subdivision does not apply to permissible restraint, isolation, or confinement implemented by order of a court or as permitted by statute... Examples of abuse include, but are not limited to: o Physical abuse - hitting, slapping, pinching, and kicking...; o Verbal abuse - threats of harm, saying things to intentionally frighten a client; and Mental abuse - humiliation, harassment, and intimidation with threats of punishment or threats of depriving care or possessions...

Mandated Incident Reporting
All incidents, suspected incidents, allegations, and occurrences of caregiver misconduct must be reported to DQA. The entity must report the incident to DQA using the Misconduct Reporting System (MIRS)..." (DQA Publication-00038, Wisconsin Background Check And Misconduct Investigations Manual, October 2025)

Record Review

On 08/19/2026, at approximately 10:15 AM, Surveyor reviewed Resident 3's file. Resident 3 was admitted to the facility on 05/04/2026. Resident 3's file contained an individual service plan (ISP), dated 06/22/2026. Resident 3's ISP indicated s/he utilized a wheelchair for mobility,

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required full assistance with toileting and dressing, and had an extensive history of aggressive and combative behaviors. Resident 3's file contained a behavior support plan (BSP) dated 01/01/2026.

On 08/19/2026, at approximately 1:30 PM, Surveyor reviewed an incident report dated 07/16/2026. The report indicated the following:

"....
Location: Resident's room
Describe the incident, Please be as detailed as possible. Use the back of this sheet if necessary. Resident [Resident 3] told writer that caregiver had roughed her/him up. Writer [Licensee A] asked the resident what led to this? Resident stated that s/he had told caregiver that s/he does not want to be changed. Resident stated that s/he was wet but did not want to be changed. Writer spoke to the other resident and asked if s/he was aware of anything going on between the two. [Resident 2] stated that s/he was in her/his room and heard caregiver saying I have to change you and [Resident 3] shouted back saying 'don't touch me'. Caregiver was reeducated about resident rights. Caregiver verbalizes understanding..."

The incident report had an attached handwritten report dated 07/17/2026 which stated, "I was changing [Resident 3's] diaper and the [sic] was poop all over the bed and s/he was refusing then I changed her/him. By [Caregiver D]"

Interview

On 08/19/2026, at approximately 12:30 PM, Surveyor interviewed Licensee A. Licensee A reported s/he was on vacation and when s/he

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M 610	Continued From page 20 returned s/he was made aware of the incident regarding Resident 3 and Caregiver D. On 08/19/2026, at approximately 2:15 PM, Surveyors interviewed Licensee A and Caregiver D regarding the alleged abuse. Licensee A reported s/he was made aware of the alleged abuse on 07/16/2026. Licensee A reported her/his understanding of the situation was Resident 2 refused care and Caregiver D did not stop and reapproach, s/he continued to change Resident 2. Surveyor inquired why further investigation into Resident 3 being "roughed up" was not further investigated. Licensee reported s/he found it to be untrue but did not provide further explanation or details. Licensee A confirmed s/he did not report the alleged abuse to the Department. Cross Reference M0572 88.10(3)(m) Freedom From Abuse	M 610		