STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011364	A. BUILDING: _____ B. WING _____	R-C 06/17/2026

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{N 000}	Initial Comments On 06/17/2026, Surveyor completed a verification visit, complaint, and standard survey at Argonne. As a result, 12 deficiencies were identified. One of the 12 deficiencies was a repeat violation (see Statement of deficiency 2TX612, dated 03/26/2025). One of the 12 deficiencies is being cited for a third time (see Statement of Deficiencies 2TX612, dated 03/26/2025 and 2TX613, 11/21/2025). One of 1 complaint was unsubstantiated. Under statutory provisions of Wis. Stat. C. 50, a $200 revisit fee is being assessed. Census: 5	{N 000}		
N 191	83.13(3)(d) Posting activity schedule. The CBRF shall post all of the following: Activity schedule as required under s. DHS 83.38(1)(c). This Rule is not met as evidenced by: Based on observation and interviews, the provider did not ensure a current activity schedule was posted in the facility. This had the potential to affect 5 of 5 residents in the facility. Findings include: On 06/10/2026 between approximately 8:48 AM and 11:00 AM, Surveyor toured the facility. Surveyor did not observe an activity calendar posted within the facility.	N 191		

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

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N 191	Continued From page 1 On 06/10/2026 at approximately 11:00 AM, Surveyor interviewed Direct Support Professional (DSP) K. DSP K denied an activity calendar was posted within the facility. DSP K reported an employee, who no longer works with the company, used to complete and hang the activity calendar. Since the employee left, activities have been resident driven. On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B reported Program Director H was the program director for the facility. Program Director H was in their role for about a year before he/she went on leave in March 2026. Area Director B stated Interim Program Director L would have been responsible for ensuring the activity calendar was completed and hung at the facility. Area Director B reported he/she would have a conversation with Program Director B regarding the activity calendar.	N 191		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.	N 277		

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N 277	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 (Direct Support Professional (DSP) K) of 3 caregivers reviewed received 15 hours annual training in all required areas. DSP K did not receive continue education training in fire safety and emergency procedures in 2024. DSP K did not receive continuing education training in resident rights and preventing and reporting abuse in 2025. Findings include: On 06/17/2026, at approximately 7:00 AM, Surveyor reviewed DSP K's record. DSP K was hired on 09/25/2023. DSP K's record did not contain evidence he/she received continue education training in fire safety and emergency procedures in 2024 or continuing education training in resident rights and preventing and reporting abuse in 2025. On 06/15/2026 at approximately 10:51 AM, through electronic mail (e-mail) correspondence, Talent Development Senior (TDS) N acknowledged DSP K did not complete continue education training in fire safety and emergency procedures in 2024 or continuing education training in resident rights and preventing and reporting abuse in 2025. On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B reported the company has an "A1 policy: Condition of Employment." A part of the policy is that employees are to complete their continuing education training on a timely basis.	N 277		

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N 277	Continued From page 3 Area Director B acknowledged the company does not always follow their A1 policy. However, typically every quarter, the talent development department will send out an e-mail with the list of staff who still need to complete their required trainings. The program director would then ensure staff complete their assigned trainings.	N 277		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a screening for clinically apparent communicable disease, including tuberculosis (TB), by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before or 7 days after admission for 2 (Resident 1 and Resident 7) of 4 residents reviewed.	N 302		

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N 302	Continued From page 4 Findings include: On 06/10/2026 at approximately 9:00 AM, Surveyor reviewed resident's records and identified the following: Resident 1 was admitted to the home on 05/31/2024. Resident 1's record did not contain evidence of a completed communicable disease screening, including TB. Resident 7 was admitted to the home on 11/13/2023. Resident 7's record did not contain evidence of a completed communicable disease screening, including TB. On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B reported Resident 1 was admitted with police intervention as Resident 1's previous placement would not surrender Resident 1. Resident 1's previous placement refused to take Resident 1 to their medical provider to complete a TB test or be screened for clinically apparent communicable disease. Area Director B reported Resident 1 was seen often by their primary care physician upon admission but could not locate within any of the medical documents that Resident 1 received a TB test or was screened for clinically apparent communicable disease. Area Director B reported Resident 7 was an internal transfer from the company's apartments. Area Director B believed Resident 7's original TB test results and communicable disease screening was within the computer system; however, Area Director B could not locate either document. Area Director B could not state if Resident 7 was screened for clinically apparent communicable disease, including tuberculosis (TB), 90 days before or 7 days after admission into the	N 302		

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N 302	Continued From page 5 community based residential facility.	N 302		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure 1 (Resident 8) of 4 residents reviewed had a completed individualized service plan (ISP) within 30 days of admission. Findings include: On 06/10/2026 at approximately 9:00 AM, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the home on 01/28/2025. Resident 8's record contained an ISP dated 02/20/2026. Resident 8's record did not contain evidence of an ISP being completed within 30 days of Resident 8's admission.	N 386		

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N 386	Continued From page 6 On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B acknowledged the only ISP available within Resident 8's record was dated, 02/20/2026. Area Director B could not state why Resident 8 did not have a comprehensive ISP within 30 days of their admission.	N 386		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 3 of (Resident 1, Resident 7, and Resident 9) 4 residents reviewed had an updated individual service plan (ISP) when there was a change in her/his needs or that each ISP was reviewed on an annual basis. Resident 1's ISP was not reviewed in 2025, nor was it updated when Resident 1 was ordered to	N 389		

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N 389	Continued From page 7 wear a boot on his/her right leg. Resident 8's ISP was not updated when there was a change in his/her day program and schedule. Resident 9's ISP did not address who was to assist with his/her activities of daily living (ADLs), behaviors related to his/her chronic skin picking behavior, or intervention to deter Resident 9 from removing his/her bandages. This is a repeat deficiency. See Statement of Deficiency 2TX612, dated 03/26/2025. Findings include: On 06/10/2026 at approximately 8:48 AM, Surveyor interviewed Lead Direct Support Professional J and inquired if all residents were within the home. Lead Direct Support Professional J confirmed all residents were within the home at the time of this Surveyor's onsite visit. On 06/10/2026 between 8:48 AM and 11:30 AM, while this Surveyor was onsite, Surveyor observed the following: Resident 1 had a boot on his/her right leg. Resident 9 had what appeared to be a post-operative soft stretch facial wrap on his/her head. Resident 9 had a wound on his/her right hand. On 06/10/2026 at approximately 9:00 AM, Surveyor reviewed resident's records. The following was identified:	N 389		

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Resident 1 was admitted to the home on 05/31/2024. Resident 1's file contained an ISP dated, 06/06/2024, 12/05/2024 and 02/26/2026. Resident 1's file did not contain an ISP from 2025. At minimum, Resident 1's ISP should have been reviewed on or before 12/05/2025. Resident 1's ISP, dated 02/26/2026 did not address why Resident 1 wore a boot on his/her right leg.

Resident 8 was admitted into the home on 01/28/2025. Resident 8's ISP, dated 02/20/2026, indicated Resident 8 attended day program at Milwaukee Center for Independence (MCFI), Monday through Friday.

On 06/10/2026 at approximately 9:00 AM, as Surveyor reviewed Resident 8's record, Surveyor interviewed Lead Direct Support Professional J and interim Program Director L and Program Director M. Lead Direct Support Professional J denied Resident 8 attended day program Monday through Friday or that Resident 8 attended day program at MCFI. Interim Program Director L reported Resident 8 attended day program at Underwood on Tuesdays and Thursdays. Lead Direct Support Progressional J reported Resident 8 began attending Underwood in February 2026.

Resident 9 was admitted to the home on 01/12/2026. Resident 9's ISP, dated 02/20/2026, stated, " ...Activities of Daily Living (ADL) [Resident 9] may need reminders for ADLs, is cooperative when reminded ..." Resident 9's ISP does not address what ADLs Resident 9 may need assistance with or who is responsible for providing the assistance. Resident 9's ISP, dated 02/20/2026 indicated Resident 9 had a wound on his/her face from "constant picking." Resident 9's ISP did not address the facial wrap on his/her

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N 389	Continued From page 9 head. Lastly, Resident 9's ISP did not address his/her wound on his/her right hand. On 06/10/2026 at approximately 9:00 AM, as Surveyor reviewed Resident 9's record, Surveyor interviewed Direct Support Professional K. Direct Support Professional K reported the facial wrap was to help deter Resident 9 from taking his/her bandages off his/her face. Direct Support Professional K reported Resident 9 not only picks at his/her face but picked at his/her ear and hand. On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B reported Resident 1 wore a boot on his/her right leg as Resident 1 sprained his/her right ankle in May 2026. Resident 1 was seen by an orthopedic doctor on 05/19/2026 who ordered that Resident 1 wear a boot while ambulating, but to take the boot off while sleeping. Area Director B could not state if Resident 1's ISP was reviewed in 2025 but confirmed providing this Surveyor with all ISPs that were in Resident 1's file. Area Director B disclosed that the program director was responsible for completing all ISP reviews and updating ISPs with changes. Area Director B could not state why Resident 1's, Resident 8's or Resident 9's ISP was not updated.	N 389		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the	N 407		

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medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 4 (Resident 1, Resident 7, Resident 8, and Resident 9) of 4 residents reviewed were assessed for the desired responses and possible side effects of her/his scheduled psychotropic medication by a pharmacist, practitioner, or registered nurse (RN) quarterly for the years 2024, the 1st quarter of 2025 and the 1st quarter of 2026.

Findings include:

On 06/10/2026 at approximately 9:00 AM, Surveyor reviewed resident's records. The following was identified:

Resident 1 was admitted to the home on 05/31/2024 with diagnoses including cannabis use, sedative hypnotic or anxiolytic abuse, cerebral palsy, and traumatic brain injury. Resident 1's record contained the following physician orders:

duloxetine - 60 milligrams, take 1 capsule by mouth twice daily
gabapentin - 300 milligrams, take 2 capsules by mouth 3 times daily

Resident 1's record did not contain documentation indicating a psychotropic medication review by a pharmacist, practitioner,

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N 407	Continued From page 11	N 407		

or RN was completed in the 3rd and 4th quarter of 2024, the 1st quarter of 2025 and the 1st quarter of 2026.

Resident 7 was admitted to the home on 11/13/2023 with diagnoses including anxiety, other developmental disorders of speech and language. Resident 7's record contained the following physician orders:

paroxetine - hydrochloride 40 milligrams, take 1 tablet by mouth 2 times a day

Resident 7's record did not contain documentation indicating a psychotropic medication review by a pharmacist, practitioner, or RN was completed quarterly in 2024, the 1st quarter of 2025 and the 1st quarter of 2026.

Resident 8's was admitted to the home on 01/28/2025 with diagnoses including Schizophrenia, depressive disorder, and behavior disorder. Resident 8's record contained the following physician orders:

buspirone - 10 milligrams, take 1 tablet by mouth in the morning and 1 tablet in the evening
citalopram - 40 milligrams, take 1 tablet by mouth once a day
risperidone - 3 milligrams, take 1 tablet two times daily

Resident 8's record did not contain documentation indicating a psychotropic medication review by a pharmacist, practitioner, or RN was completed the 1st quarter of 2025 and the 1st quarter of 2026.

Resident 9 was admitted to the home on 01/12/2026 with diagnoses including paranoid

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N 407	Continued From page 12 schizophrenia, bipolar disorder, anxiety, other specified behavioral and emotional disorder, and traumatic brain injury. Resident 9's record contained the following physician orders: Depakote extended release - 500 milligrams, give 2 tablets by mouth at bedtime Depakote extended release - 500 milligrams, give 1 tablet by mouth daily venlafaxine hydrochloride extended release - 75 milligrams, give 1 capsule by mouth daily Resident 9's record did not contain documentation indicating a psychotropic medication review by a pharmacist, practitioner, or RN was completed quarterly in the 1st quarter of 2026. On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B reported Genoa Pharmacy completed quarterly psychotropic medication reviews in 2024 and 2025. Area Director B did not state why scheduled psychotropic medication reviews were not completed in 2024 and 1st quarter of 2025. Area Director B reported as of January 2026, the provider switched their pharmacy to ALPS. During this survey, it was discovered that the provider's contract with ALPS did not include quarterly psychotropic medication reviews.	N 407		
{N 415}	83.37(2)(d) Documentation of medication administration. 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,	{N 415}		

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{N 415}	Continued From page 13 dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have documentation of the time of medication administration, the person administering the medication or treatment and the name, dosage, date and time of medication taken or treatments performed and initialed in the medication administration record (MAR) for 3 (Resident 1, Resident 8, and Resident 9) of 3 residents reviewed. The provider did not accurately document when Resident 1, Resident 8, and Resident 9 was administered medications. This requirement is being cited for the third time. See Statement of Deficiency (SOD) 2TX612, dated 03/26/2025 and SOD 2TX613, dated 11/21/2025. Findings include: On 06/10/2026 at approximately 9:00 AM, Surveyor reviewed resident's records. The following was identified: Resident 1 was admitted to the home on 05/31/2024 with diagnoses including diagnoses including cannabis use, sedative hypnotic or anxiolytic abuse, cerebral palsy, and traumatic	{N 415}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 415}	Continued From page 14	{N 415}		

brain injury. Resident 1's individual service plan (ISP), dated 02/26/2026, indicated staff assisted Resident 1 with medication management and administration. Resident 1 had a physician order for the following medications:

Azithromycin - 250 milligrams, take 2 tablets by mouth at bedtime for 1 day then take 1 tablet by mouth at bedtime for 4 days. Start date: 03/24/2026

Resident 1's March 2026 MAR did not indicate Resident 1 was administered Azithromycin on 03/24/2026, 03/25/2026, and 03/26/2026 as no initials were observed on the MAR.

Resident 8 was admitted to the home on 01/28/2025 with diagnoses including Schizophrenia, depressive disorder, and behavior disorder. Resident 8's ISP, dated 12/04/2025, indicated staff assisted Resident 8 with medication management and administration. Resident 8 had a physician order for the following medications:

apixaban - 5 milligrams, take 1 tablet by mouth 2 times daily. Start date: 05/18/2026
ferrous sulfate - 325 milligrams, take 1 tablet by mouth daily. Start date: 05/18/2026
pantoprazole - 40 milligrams, take one tablet by mouth 2 times a day. Start date: 05/18/2026

Resident 8's May 2026 MAR did not indicate Resident 8 was administered apixaban between 05/18/2026-05/31/2026, ferrous sulfate between 05/18/2026-05/31/2026, and pantoprazole between 05/18/2026-05/31/2026 as no initials were observed on the MAR. Resident 8's June 2026 MAR did not indicate Resident 8 was administered apixaban between

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{N 415}	Continued From page 15 06/01/2026-06/07/2026, ferrous sulfate between 06/01/2026-06/07/2026, and pantoprazole between 06/01/2026-06/07/2026 as no initials were observed on the MAR . Resident 9 was admitted to the home on 01/12/2026 with diagnoses including paranoid schizophrenia, bipolar disorder, anxiety, other specified behavioral and emotional disorder, and traumatic brain injury. Resident 9's ISP, dated 02/20/2026 indicated staff administered and managed Resident 9's medications. Resident 9 had a physician order for the following medications: Cephalexin - 500 milligrams, take 1 capsule by mouth 4 times daily for 7 days. Start date: 02/19/2026 Lisinopril - 20 milligrams, take 1 tablet by mouth daily. Start date: 02/17/2026 Cephalexin - 500 milligrams, take 1 capsule by mouth 4 times daily for 7 days. Start date: 03/21/2026 Resident 9's February 2026 MAR did not indicate Resident 9 was administered cephalexin 02/20/2026 and lisinopril between 02/17/2026-02/19/2026 as no initials were observed on the MAR. Resident 9's March 2026 MAR did not indicate Resident 9 was administered cephalexin between 03/21/2026-03/26-2026 as no initials were observed on the MAR. On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B disclosed the provider recently hired individuals to complete quality assurance tasks within the company. During the spring of 2026, it was discovered that the administration of	{N 415}		

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{N 415}	Continued From page 16 medication the caregivers signed off on while using Therap's (electronic medical record application) cell phone application did not carry over into the desktop version of the Therap application. Because of this, the MARs appear to be incomplete. Since the discovery, caregivers were educated to not use Therap's cell phone application to document the administration of medication.	{N 415}		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not make reasonable adjustments to the menu for individual residents' food likes or document any deviations from the planned menu for 5 of 5 residents. Findings include: On 06/10/2026 at approximately 8:48 AM, Surveyor toured the community based residential facility (CBRF). Surveyor observed the weekly menu located on the refrigerator within the kitchen. Surveyor observed the weekly menu to state, "Week 1." Per "Week 1" menu, the following was to be served for lunch: "Bag Lunch." At approximately 11:30 AM, Surveyor	N 450		

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N 450	Continued From page 17 heard Direct Support Professional K inform Resident 9 that pizza was going to be served for lunch. On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B believed "Bag Lunch" would be a "picnic style lunch. Such as a sandwich, fruit, chips." Area Director B reported Lead Direct Support Professional J is responsible for documenting any changes to the menu as Lead Direct Support Professional J completes all of the grocery shopping for the CBRF.	N 450		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by:	N 452		

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N 452	Continued From page 18 Based on observation and interview, the provider did not ensure all foods were properly stored. The kitchen freezer contained undated, unlabeled, and unsealed food items, and the resident refrigerator in the kitchen contained unlabeled and undated. Findings include: On 06/10/2026 at approximately 8:48 AM, Surveyor toured the facility kitchen and observed the following: Kitchen Freezer: One small Ziplock bag that contained what appeared to be 2 bratwursts. The Ziplock bag was not labeled or dated. One opened box of fully cooked sausage patties. The box was not sealed or dated with an open date. One open bottle of Gatordae without an open date. One bag of opened fully cooked sausage patties in a Ziploc bag without an open date. Resident refrigerator: A gallon size Ziplock bag that contained an open package of Usinger's Ring bologna and an open pack of Saltine crackers without a date. Aluminum foil that contained an unknown substance, was located inside the refrigerator door without a label or date. A bowl that contained an unknown content, sealed inside a gallon size Ziploc bag, without a label or date. 2 grocery bags, 1 located on the top shelf, and the second bag located on the second shelf contained unknown contents, without a label or	N 452		

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N 452	Continued From page 19 date. According to the Wisconsin Food Code, the Federal Department of Agriculture's Food Code, and ServSafe standards, date marking is necessary to indicate when food must be consumed or discarded. These standards indicate refrigerated, readt to eat (RTE), potentially hazardous food (PHF), and time/temperature controlled for safety (TCS) foods that are removed from manufacturer packaging and/or prepared for consumption must be date marked and discarded within 7 days. Refrigerated, RTE, PHF, and TCS foods prepared and packaged in a food processing plant shall also be date-marked when opened in the facility (date not to exceed 7 days). (ServSafe Coursebook, 7th Ed., 2017, p. 5-23) On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B reported Lead Direct Support Professional J was responsible for checking the refrigerator and freezer for any undated, unlabeled, or unsealed items. Area Director B stated he/she would follow-up with Lead Direct Support Professional J regarding the above items.	N 452		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed	N 525		

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N 525	Continued From page 20 under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted quarterly for 3 of 4 quarters in 2024 and 2025. In addition, no nighttime simulated fire drill was conducted in 2024 and 2025. Findings include: On 06/11/2026 at approximately 3:00 PM, Surveyor reviewed the provider's fire drills. The following was identified: 12/30/2024 at 3:09 PM: Fire Drill 01/26/2025 at 1:16 PM: Fire Drill 02/27/2025 at 3:41 PM. Fire Drill Fire drills were not completed during the 1st, 2nd, and 3rd quarter of 2024. No nighttime simulated fire drill was conducted in 2024. Fire drills were not completed during the 2nd, 3rd, or 4th quarter of 2025. No nighttime simulated fire drill was conducted in 2025. On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B disclosed the provider recently hired	N 525		

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N 525	Continued From page 21 individuals to complete quality assurance tasks within the company. In the fall of 2025, it was discovered the provider was out of compliance with completing the required fire drills. As of January 2026, the facility has been completing monthly fire drills.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster drills were conducted semi-annually for 2 (2024 and 2025) of 2 years. Findings include: On 06/11/2026 at approximately 3:00 PM Surveyor reviewed the provider's other evacuation drills for 2024 and 2025. The following was identified: 01/26/2025: Tornado Drill 02/27/2025: Tornado Drill The provider did not complete other evacuation drills in 2024 or during the second half of 2025. On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B disclosed the provider recently hired individuals to complete quality assurance tasks within the company. In the fall of 2025, it was discovered the provider was out of compliance	N 526		

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N 526	Continued From page 22 with completing other evacuation drills. Since January 2026, the provider has been conducting monthly other evacuation drills.	N 526		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for an annual fire inspection for 2 (2024 and 2025) of 2 years reviewed. Findings include: On 06/11/2026, at approximately 3:00 PM, Surveyor reviewed the provider's safety file. Surveyor did not locate evidence of a fire inspection conducted in 2024 or 2025. On 06/17/2026 at approximately 10:30 AM, Surveyor interviewed Area Director B. Area Director B does not believe a fire inspection was completed in 2024 or 2025. Area Director B reported that the office manager was responsible for scheduling all fire inspections, however, the office manager position has been vacant. Area Director B has since contacted the local fire department and scheduled a fire inspection to be completed within the month.	N 530		