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	0011513	A. BUILDING: _____ B. WING _____	R-C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE GLENDALE (THE)	4567 N 71ST ST MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 03/04/2024, Surveyor completed a standard survey, verification visit and complaint investigation at Maranatha House Glendale. As a result, the previous deficiency was corrected, and 12 new deficient practices were identified. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 6	{N 000}		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure documentation was obtained from a registered nurse, physician, physician assistant, or clinical nurse practitioner indicating 2 of 2 employees reviewed were screened for communicable disease. House Lead E's and Caregiver F's records did not contain	N 220		

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

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N 220	Continued From page 1 evidence of a communicable disease screening. Findings include: On 03/01/2024, at approximately 1:00 PM, Surveyors reviewed staff records and identified the following: House Lead E was hired on 05/24/2022. House Lead E's record did not include evidence of a communicable disease screen. Caregiver F was hired on 10/19/2023. Caregiver F's record did not include evidence of a communicable disease screen. On 03/01/2024, at 1:45 PM, Administrator C reported Administrator A needed to locate the communicable disease screening for House Lead E and Caregiver F. On 03/03/2024, at 8:29 PM, Administrator A emailed Surveyor. Administrator A reported both House Lead E and Caregiver F were screened for communicable diseases at hire. Administrator A reported the forms were missing and House Lead E and Caregiver F would be rescreened for communicable diseases.	N 220		
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	N 277		

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N 277	Continued From page 2	N 277		

training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 employee (House Lead E) completed at least 15 hours of continuing education in 2023. House Lead E received 7 hours of continuing education in 2023. House Lead E did not receive training in standard precautions, client group, prevention of abuse, neglect and misappropriation, fire safety, and first aid.

Finding include:

On 03/01/2024, at 1:30 PM, Surveyor reviewed House Lead E's employee record. House Lead E was hired 05/24/2022. House Lead E's file contained evidence of receiving 7 hours of continuing education in 2023 in the following topics:

-01/16/2023, resident rights, 30 minutes.
-02/13/2023, suicide and depression 30 minutes.
-03/13/2023, understanding individual service plans, 30 minutes.
-04/24/2023, check in on mental health of caregiver, 30 minutes, medication review, 45 minutes, verbal de-escalations, 30 minutes.
-05/15/2023, blood pressure and temperature taking protocol of member residents, 30 minutes.
-06/19/2023, check in on mental health of caregiver, 30 minutes.
-07/17/2023, diabetes care, 30 minutes.

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N 277	Continued From page 3 -08/21/2023, [electronic health record] notes and documentation, 15 minutes. -10/23/2023, mental health, 2 hours. On 03/04/2024, at 2:30 PM, Surveyor interviewed Administrator A. Administrator A confirmed staff were to receive at least 15 hours of continuing education annually. Administrator A was not aware House Lead E was missing hours and topics for continuing education in 2023. Administrator A reported s/he had staff meetings with trainings monthly to ensure staff received all continuing education topics and hours.	N 277		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 6 of 6 resident had the right to self-determination and make decisions related to activities, and other aspects of life which enhanced the resident's self-reliance and support the resident's autonomy and decision making. The kitchen door contained a lock and resident purchased food was locked in closets in the basement. Findings include:	N 355		

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N 355	Continued From page 4 On 11/06/2023, the department received a complaint regarding resident food being locked in the basement. On 03/01/2024, at 9:50 AM, Surveyor toured the facility. Surveyor observed a door to the kitchen. The door contained a locking mechanism. The locking mechanism was not engaged. Surveyor observed the refrigerator. Surveyor observed a few cans of non-diet soda in the refrigerator. Surveyor toured the basement with the House Lead E. The basement contained 2 locked closets. House Lead E unlocked the doors and Surveyor observed boxes of regular soda and Diet Mountain Dew located in one of the closets, and powdered doughnuts with Resident 7's name written on them located in the other closet. On 03/01/2024, at 10:20 AM, Surveyor interviewed Resident 2. Resident 2 reported the kitchen door was locked all the time. Resident 2 stated, "Staff need to get my snacks, sometimes I get told 'no.' I don't want to answer your questions anymore, I'll get in trouble." On 03/01/2024, at 10:45 AM, Surveyor interviewed House Lead E. House Lead E confirmed the Diet Mountain Dew was purchased by Resident 2. House Lead E confirmed the powdered doughnuts were purchased by Resident 7. House Lead E reported the resident food had always gone into the basement due to not enough room in the kitchen for all of the soda. Surveyor inquired why the resident purchased food had to be locked in the closets if there were shelving units in the basement for food storage, which the residents could access. House Lead E did not offer a response. House Lead confirmed only staff had access to the locked closets in the basement. When Surveyor inquired about the lock on the kitchen door, House Lead E reported	N 355		

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N 355	Continued From page 5 s/he did not lock the kitchen door during her/his shift. House Lead E reported s/he did not know if the other rotation used the lock on the kitchen door. When Surveyor inquired why the lock was present on the kitchen door, House Lead E reported the lock had been there since s/he started her/his employment. On 03/01/2024, at 3:00 PM, Surveyor interviewed Administrator C. Administrator C reported the resident purchased food was stored in the basement because there was not enough room in the kitchen. When Surveyor inquired about why food was locked in closets and not on the shelf in the basement, Administrator C reported it was to keep the food safe. Administrator C confirmed all staff had keys to the locked closets in the basement. Administrator C confirmed Resident 2's soda was not located in the refrigerator. Administrator C reported staff were to bring up snacks and soda and put them in the cupboards and refrigerator for the residents. Surveyor inquired why residents were not allowed to keep food in their rooms, Administrator C stated, "We don't want bugs." Administrator C reported s/he would ensure residents had access to their food and soda by taking the items out of the locked closets. When Surveyor inquired about staff locking the kitchen door, Administrator C reported s/he did not lock the door when s/he was there. When Surveyor reported a resident reported the door was locked by staff, Administrator C stated, "Well [s/he] is the reason they probably lock the door." Administrator C reported s/he was unaware of why the lock was placed on the kitchen door.	N 355		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan	N 386		

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N 386	Continued From page 6 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 of 6 resident (Resident 4) had a completed individualized service plan (ISP). Findings include: On 03/01/2024, at 11:00 AM, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 12/21/2007. Resident 4's ISP, was undated. Resident 4's ISP was blank in the areas of mobility, eating, falls, activities of daily living, managing finances, shopping, transportation, and activities/social needs. On 03/01/2024, at 11:30 AM, Surveyor interviewed House Lead E. House Lead E reported s/he was aware of how to care for Resident 4 due to being in the healthcare field for a long time. House Lead E reported Resident 4 was becoming weaker and is needing more	N 386		

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N 386	Continued From page 7 assistance with mobility. On 03/01/2024, at approximately 2:30 PM, Surveyor observed Resident 4 arrive back at the facility from day programming. Resident 4 required staff assistance to walk from the bus to the facility. Surveyor observed the bus driver assist Resident 4 into the facility into a chair which was located next to the door. Surveyor observed House Lead E grabbed a walker from a closet and placed it in front of Resident 4. Resident 4 reported s/he was tired and needed to rest. On 03/01/2024, at 3:00 PM, Surveyor interviewed Administrator C. Administrator C reported Licensee G was the one who completed the ISPs for the residents. Administrator C was unaware Resident 4's ISP was incomplete.	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.	N 389		

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N 389	Continued From page 8	N 389		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 4 of 6 residents' (Resident 2, Resident 3, Resident 4, and Resident 6) Individual Service Plans (ISPs) were signed by the resident or resident's legal representative acknowledging their involvement in, understanding of, and agreement with the resident's ISP.

Findings include:

On 03/01/2024, at 11:00 AM, Surveyor reviewed resident files and identified the following:

-Resident 2 was admitted to the facility on 12/03/2013. Resident 2 was her/his own person. Resident 2's ISP, dated 03/24/2023, was signed by House Lead E and Resident 2's case manager. Resident 2's ISP was not signed by Resident 2.

-Resident 3 was admitted to the facility on 06/01/2007. Resident 3's record indicated Resident 3 had a guardian. Resident 3's ISP, dated 10/09/2023, was not signed.

-Resident 4 was admitted to the facility on 12/21/2007. Resident 4's record indicated Resident 4 had a guardian. Resident 4's ISP, undated, was not signed.

-Resident 6 was admitted to the facility on 06/13/2022. Resident 6 was her/his own person. Resident 6's ISP, dated 09/18/2023, was signed by House Lead E and Resident 6's case manager. Resident 6's ISP was not signed by Resident 6.

On 03/01/2024, at 3:00 PM, Surveyor interviewed

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N 389	Continued From page 9 Administrator C. Administrator C reported Licensee G was responsible for creating the residents' ISPs. Administrator C reported House Lead E also assisted with the ISPs. Administrator C reported s/he was unsure why the ISPs were not signed.	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 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 1 of 1 resident (Resident 2) was assessed for the desired responses and possible side effects of her/his scheduled psychotropic medication by a pharmacist, practitioner, or registered nurse (RN) for the years 2022 and 2023. Resident 2's record did not contain documentation indicating Resident 2 was assessed for desired responses or side effects. Findings include: On 03/01/2024, at 11:00 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted to	N 407		

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N 407	Continued From page 10	N 407		

the facility on 12/03/2013 with diagnoses including depression, mood disorder, and psychosis. Resident 2's medication administration record identified Resident 2 was prescribed risperidone 2 milligram (mg) tablet by mouth twice a day with a start date of 03/10/2022 and sertraline 50 mg tablet by mouth daily with a start date of 02/27/2018. Resident 2's record did not contain documentation indicating a psychotropic medication review by a pharmacist, practitioner, or RN was completed in 2022 and 2023.

On 03/01/2024, at 1:30 PM, Surveyor interviewed Administrator C. Administrator C placed a phone call to Registered Nurse (RN) D. Administrator C reported RN D was working on the psychotropic medication reviews and would send them to Surveyor when RN D was home from his/her other job.

On 03/04/2024, at 8:15 AM, Surveyor reviewed documentation sent by RN D. The documentation sent to Surveyor was titled "Psychotropic Medication Regiment Review Worksheet" which reported what medication Resident 2 was prescribed, who the prescriber was, start date of the medication, dose and schedule of the medication and last appointment with the prescriber of the medication. The second piece of documentation was titled "Classification of Psychotropic Medication Diagnoses" which reported any depressive symptoms, physically aggressive symptoms, physical non-aggressive symptoms, verbally aggressive symptoms or socially withdrawal symptoms. The documentation did not contain information Resident 2 was assessed for possible side effects or desired responses of the prescribed psychotropic medications. The dates of documentation were 02/20/2023, 05/14/2023,

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N 407	Continued From page 11 09/26/2023, 12/28/2023 and 02/27/2024. On 03/04/2024, at 2:30 PM, Surveyor interviewed Administrator A. Administrator A reported RN D completed all of the psychotropic medication reviews. When Surveyor inquired about the code requirement of the information which should have been included in the psychotropic medication reviews, Administrator A reported Surveyor was being "nitpicky" due to the provider admitting residents with very difficult behaviors, and Surveyor should have taken that into consideration. Surveyor inquired if Administrator A was aware of the documentation RN D sent to Surveyor. Administrator A reported s/he would have to look at the documentation. Administrator A confirmed the psychotropic medication reviews should have been in the resident files.	N 407		
N 420	83.37(3)(d) Medication storage: refrigeration Refrigeration. Medications stored in a common refrigerator shall be properly labeled and stored in a locked box. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all medications were securely stored in the common refrigerator for 1 of 1 refrigerator. Resident 3's, Resident 4's, and Resident 5's insulin pens were stored in an unlocked box in the common refrigerator. Findings include: On 03/01/2024, at 10:00 AM, Surveyor observed the common refrigerator. There was a black box on the shelf. The box was equipped with a combination lock. When Surveyor pressed the	N 420		

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N 420	Continued From page 12 button, the box opened. Inside the box contained insulin pens for Resident 3, Resident 4, and Resident 5. Surveyor observed 8 Novolin pens labeled with Resident 3's name inside the box. There were 4 Basaglar pens with Resident 4's name on them. There was 1 Trulicity pen with Resident 5's name on it. Surveyor observed residents moving freely around the facility. On 03/01/2024, at 10:30 AM, Surveyor interviewed House Lead E. House Lead E confirmed the medication box was required to be locked. House Lead E reported s/he must have forgotten to lock the box after administering medications. On 03/01/2024, at 3:00 PM, Surveyor interview Administrator C. Administrator C confirmed medications were to be securely stored. Administrator C reported s/he would ensure staff locked the medication box after use.	N 420		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of	N 454		

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N 454	Continued From page 13 significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s.	N 454		

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	0011513	A. BUILDING: _____ B. WING _____	R-C 03/04/2024

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N 454	Continued From page 14 DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain documentation for 2 of 2 resident records (Resident 7 and Resident 8). Resident 7's record did not contain an individual service plan (ISP). Resident 8's record did not contain an ISP or an annual assessment. Finding include: On 03/01/2024, at 11:00 AM, Surveyor reviewed resident records and identified the following: Resident 7 was admitted on 06/05/2023. Resident 7's record did not contain an ISP. Resident 8 was admitted on 06/21/2023. Resident 8's record did not contain an ISP or assessment. On 03/01/2024, at approximately 1:30 PM, Surveyor interviewed House Lead E and Administrator C. Administrator C confirmed the resident records needed to contain an ISP and assessment. House Lead E reported s/he was unsure if Resident 7's ISP was completed. Administrator C reported s/he was unsure where the documents were located for Resident 7 and	N 454		

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N 454	Continued From page 15 Resident 8. Administrator C reported s/he would speak with Administrator A. On 03/03/2024, at 8:29 PM, Administrator A emailed Surveyor Resident 7's first page of her/his ISP and the signature sheet. Administrator A reported s/he was unable to locate Resident 8's ISP or assessment. On 03/04/2024, at 2:30 PM, Surveyor interviewed Administrator A. Administrator A reported House Lead E found Resident 7's ISP "somewhere." Administrator A did not know why Resident 7's ISP was not located in her/his file during the survey. Administrator A reported Resident 8's assessment and ISP were completed but was unsure of where the documentation was. Administrator A confirmed the resident records were required to contain the ISPs and assessments.	N 454		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all toxic substances and cleaning compounds were securely stored in 3 of 3 areas. Findings include: On 03/01/2024, at 9:45 AM, Surveyor toured the facility and observed the following:	N 499		

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N 499	Continued From page 16	N 499		

Living room - a can of Lysol disinfecting spray and Febreze air mist were on top of a cabinet. On an end table was a bottle of Members Mark glass cleaner. The can of Lysol and Febreze air mist remained out for the duration of the survey.

Kitchen - the cabinet under the kitchen sink contained a cable type locking mechanism. The locking mechanism was not engaged. The cabinet contained a bottle of Clorox bleach, Member's Mark glass cleaner, 2 bottles of Old English furniture polish, 2 bottles of Clorox cleaner and bleach, 3 containers of Member's Mark disinfecting wipes, can of Comet cleaner with bleach, Glass Plus glass wipes, a container of Lysol disinfecting wipes, LA's Totally Awesome foaming bathroom cleaner, Chase's heavy duty all-purpose cleaner and a bottle of Comet foam bath cleaner with bleach. The locking mechanism remained disengaged during the duration of the survey.

In a closet located in the kitchen, the locking mechanism was not engaged. The closet contained a can of Comet cleaner with bleach, Member's Mark disinfecting wipes, and a bottle of Windex. The closet door remained unlocked during the duration of the survey.
Resident bathroom - the cabinet under the bathroom sink did not contain a locking mechanism. There was a container of Member's Mark disinfecting wipes.

Surveyor observed residents moving freely throughout the facility.

On 03/01/2024, at 10:30 AM, Surveyor interviewed House Lead E. House Lead E confirmed all toxic substances and cleaning compounds were to be securely stored. House

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N 499	Continued From page 17 Lead E reported s/he was going to start cleaning before Surveyor arrived at the facility and must have left them out. On 03/01/2023, at 3:00 PM, Surveyor interviewed Administrator C. Administrator C confirmed all toxic substances and cleaning compounds were to remain securely stored. Administrator C reported s/he would remind staff to ensure all cleaning compounds were locked.	N 499		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible materials were not placed within 3 feet 1 of 1 water heater. Soda boxes were stored within 6 inches of the water heater. Findings include: On 03/01/2024, at 10:50 AM, Surveyor toured the basement with House Lead E. House Lead E unlocked the doors to the rooms which stored the furnace and water heater. Surveyor observed 2 boxes of soda within 6 inches of the water heater. On 03/01/2023, at 3:00 PM, Surveyor interviewed Administrator C. Administrator C reported s/he was unaware combustibles needed to be stored 3 feet from the water heater or furnace. Administrator C reported they would ensure the boxes were moved out of the locked room.	N 507		

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N 530	Continued From page 18	N 530		
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 of 2 calendar years. The provider did not retain documentation indicating a fire inspection completed for the years 2022 and 2023. Findings include: On 03/01/2024, at 11:09 AM, Surveyor reviewed facility safety code documentation. There was no documentation the facility had been inspected by the local fire department or certified fire inspector for the years 2022 and 2023. The last fire inspection was conducted on 09/16/2021. On 03/01/2024, at 3:00 PM, Surveyor interviewed Administrator C. Administrator C reported s/he thought the fire inspections were conducted. Administrator C reported s/he would speak with Administrator B and the documentation would be sent to Surveyor by 03/02/2024. As of 03/04/2024, at 12:00 PM, no documentation was received. Cross Reference N0666 83.59(7)(a) Emergency Egress Lighting Provided	N 530		

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N 666	Continued From page 19	N 666		
N 666	83.59(7)(a) Emergency egress lighting provided All exit passageways and stairways shall be provided with emergency egress lighting with a stand-by power source. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure all exit passageways were provided with emergency egress lighting with a stand-by power source for 3 of 4 emergency egress lighting. Findings include: On 03/01/2024, at 9:45 AM, Surveyor toured the facility. Surveyor observed and tested 4 emergency egress lighting units. The egress lighting located on the north side of the facility near the office, the east egress lighting in the living room and the south egress lighting in the kitchen did not turn on when tested. On 03/01/2024, at 11:09 AM, Surveyor reviewed a fire inspection report dated 09/16/2021. The fire inspection report stated, "Emergency lights not working [sic] repair." On 03/01/2024, at 3:00 PM, Surveyor interviewed Administrator C. Administrator C reported the emergency egress lighting was tested monthly. Administrator C reported s/he did not know where the testing was documented. Administrator C reported s/he was not aware the emergency egress lighting was not working and was unsure for how long the egress lighting was not working. Cross Reference N0530 83.47(3) Fire Inspection	N 666		