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PRIMROSE ON 19TH A	1624 NORTH 19TH ST MILWAUKEE, WI 53205

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N 000	Initial Comments On 08/29/2024, Surveyor completed a standard survey and complaint investigation at Primrose on 19th A. As a result, 23 deficiencies were identified. The complaint was unsubstantiated. Census: 6	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 interview, the provider did not ensure an activity schedule was posted in the facility. Findings include: On 07/12/2024, at 9:42 AM, Surveyor reviewed the posted activity schedule in the dining room. The activity schedule was dated for September 2022. Surveyor did not observe another activity schedule posted. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A reported House Manager C was responsible for the activity schedule. Director A nor Manager B offered an explanation to why the activity schedule had not been updated since September 2022. Cross Reference: DHS N0427 83.38(1)(c) Leisure Time Activities	N 191		

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

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N 220	Continued From page 1	N 220		
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 2 of 3 employees (Caregiver D, and Caregiver E) were screened for communicable diseases including tuberculosis (TB) by a physician (MD), physician assistant (PA), clinical nurse practitioner (CNP) or a licensed registered nurse (RN). Caregiver D was not screened for communicable diseases, including TB. Caregiver E was not screened for communicable diseases. Findings include: On 07/12/2024, at 11:15 AM, Surveyor reviewed employee files and observed the following: Caregiver D was hired on 03/18/2022. There was no evidence Caregiver D was screened for communicable diseases including TB by an MD, PA, CNP or RN.	N 220		

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N 220	Continued From page 2 Caregiver E was hired on 02/07/2024. There was no evidence Caregiver K was screened for communicable diseases by an MD, PA, CNP or RN. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A confirmed the code requirement for all staff to be screened for communicable diseases including TB. Manager B reported s/he sent out the staff to ensure this was completed. Director A and Manager B did not report why Caregiver D's and Caregiver E's files did not evidence of the screenings.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 staff reviewed received orientation in the required topics:	N 230		

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N 230	Continued From page 3 (1) Prevention and reporting of resident abuse, neglect, and misappropriation of resident property; (2) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (3) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (4) Community Based Residential Facility (CBRF) policies and procedures; (5) Recognizing and responding to resident changes of condition. Prior to performing job duties, Caregiver D, and Caregiver E did not receive orientation training in prevention and reporting of resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); CBRF policies and procedures; recognizing and responding to resident changes of condition. Findings include: The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to serve up to 7 residents within client groups of traumatic brain injury, developmentally disabled, advanced aged, physically disabled, and emotionally disturbed/mental illness. On 07/12/2024, at 11:15 AM, Surveyor conducted a review of employee files to verify compliance with orientation training requirements. Surveyor reviewed training records and identified the following: Example 1- Caregiver D was hired on	N 230		

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N 230	Continued From page 4 03/18/2022. Caregiver D's record did not contain evidence of orientation training in prevention and reporting of resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); CBRF policies and procedures; recognizing and responding to resident changes of condition. Example 2- Caregiver E was hired on 02/07/2024. Caregiver E's record did not contain evidence of orientation training in prevention and reporting of resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); CBRF policies and procedures; recognizing and responding to resident changes of condition. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A reported Manager B was responsible to ensure training was completed. Manager B reported s/he had a checklist s/he completed with each staff and orientation requirements were on the checklist. Surveyor inquired about the checklist. Manager B reported s/he did not have the checklist with her/him, so s/he was unable to report what the checklist contained.	N 230		
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,	N 302		

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N 302	Continued From page 5 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 documentation of 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 3 of 3 residents reviewed. Findings include: On 07/12/2024, at 12:00 PM, Surveyor reviewed resident records and identified the following: - Resident 2 was admitted on 02/20/2023. Resident 2's record did not contain evidence of communicable disease screening, including TB. - Resident 3 was admitted on 02/19/2024. Resident 4's record contained a document titled "Primrose Residential Facility Health Certificate". The document identified Resident 4 had a chest x-ray on 01/18/2024 and was negative. Resident	N 302		

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N 302	Continued From page 6 3's record did not contain evidence Resident 3 was screened for communicable diseases. - Resident 4 was admitted on 03/25/2024. Resident 4's record contained a document titled "Primrose Residential Facility Health Certificate". The document identified Resident 4 had a chest x-ray on 03/02/2024 and was positive for latent TB and on medications. The document was not signed. Resident 4's record did not contain evidence of communicable disease screening. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A and Manager B reported they shared the responsibility. Director A confirmed awareness of the code requirement to ensure residents were screened for TB and communicable diseases.	N 302		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a	N 310		

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N 310	Continued From page 7 resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident, or their responsible party, signed an admission agreement prior to or at the time of admission for 2 of 3 residents. Resident 2 and Resident 3 did not sign an admission agreement. Findings include: On 07/12/2024, at 12:00 PM, Surveyor reviewed resident records and identified the following: Resident 2 was admitted on 02/20/2023. Resident 2 was her/his own decision maker. Resident 2's admission agreement was not signed. Resident 3 was admitted on 02/19/2024. Resident 3 was her/his own decision maker.	N 310		

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N 310	Continued From page 8 Resident 3's admission agreement was not signed. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A and Manager B reported they shared the responsibility of ensuring admission agreements were signed. Director A and Manager B did not offer an explanation regarding the unsigned admission agreements.	N 310		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents (Resident 2, Resident 3, and Resident 4) had a completed preadmission assessment. Findings include: On 07/12/2024, at 12:00 PM, Surveyor reviewed resident records and identified the following:	N 381		

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N 381	Continued From page 9 - Resident 2 was admitted on 02/20/2023. Resident 2's record did not contain any annual assessments identifying Resident 2's needs, abilities, and physical and mental conditions. - Resident 3 was admitted on 02/19/2024. Resident 3's record did not contain any annual assessments identifying Resident 3's needs, abilities, and physical and mental conditions. - Resident 4 was admitted on 03/25/2024. Resident 4's record did not contain any annual assessments identifying Resident 4's needs, abilities, and physical and mental conditions. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A and Manager B did not provide an explanation regarding their assessment process and why the records did not contain assessments for the residents.	N 381		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record.	N 393		

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N 393	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 4) was evaluated, using the form provided by the department, within 3 days of the resident's admission to determine whether the resident was able to evacuate the community based residential facility (CBRF) within 2 minutes. Findings include: On 07/12/2024, 12:00 PM, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 03/25/2024. Resident 4's record contained a blank Resident Evaluation Assessment, DQA Form, F-62373. Resident 4's record did not contain evidence of a completed resident evacuation assessment. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A reported they shared the responsibility. Director A confirmed the code requirement.	N 393		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not evaluate each resident's mental or physical capability to respond to a fire alarm at least annually for 1 of 2 residents. Resident 2 was	N 394		

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N 394	Continued From page 11 not evaluated in February 2024. Findings include: On 07/12/2024, 12:00 PM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 02/20/2023 with a diagnosis of schizoaffective disorder. Resident 2's initial evacuation evaluation assessment was completed on 02/21/2023. Resident 2 was due for an annual evacuation evaluation assessment in 02/21/2024. Resident 2's record did not contain evidence Resident 2 was evaluated annually for evacuation evaluation assessment. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A reported they shared the responsibility. Director A confirmed the code requirement.	N 394		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents' medications were securely stored in the medication closet. A box and bag of medications was stored in the living room for 3 days. This had the potential to affect 6 of 6 residents. Findings include: On 07/12/2024, at 9:20 AM, Surveyors toured the facility and observed a cardboard box and a red bag on a desk in the living room. Surveyor	N 419		

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opened the box observed resident's medications inside.

Surveyor observed the following prescription cycle medications for 2 of 6 residents, located in the box:

Resident 1: oxybutynin extended release (ER) 5 milligram (mg), levetiracetam 1000 mg, phenytoin 50 mg, acetaminophen ER 650 mg, aspirin 81 mg, atorvastatin 40 mg, calcium carbonate 600 mg, chlorthalidone 25 mg, citalopram 20 mg, donepezil 10 mg, folic acid 1 mg, memantine 10 mg, quetiapine 25 mg, trazodone 100 mg, venlafaxine ER 150 mg, vitamin D2 25 mg, gabapentin 400 mg, phenytoin ER 100 mg, lacosamide 100 mg and senna 8.6/50 mg.

Resident 2: cetirizine 10 mg, olanzapine 5 mg, pantoprazole 40 mg, sertraline 50 mg, acamprosate 333 mg, acetaminophen 325 mg, fenofibrate 145 mg, ferrous sulfate 325 mg, gabapentin 600 mg, magnesium oxide 400 mg, multivitamin with minerals, propranolol 40 mg, vitamin B complex, vitamin D3 50 mg, benztropine 1 mg, lacosamide 100 mg, and carbamazepine ER 100 mg.

Surveyor observed residents moving freely throughout the facility.

On 07/16/2024, at 2:46 PM, Surveyor interviewed Pharmacy Technician G. Pharmacy Technician G reported the medications were delivered on 07/09/2024 at 3:30 PM.

On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A confirmed medications were to be securely stored.

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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 insulin pens were stored in an unlocked box in the common refrigerator. Findings include: On 07/12/2024, at 10:34 AM, Surveyor observed the common refrigerator. There was a black box on the shelf. The box was equipped with a keyed locking mechanism. The key was inserted in the box and the box was locked. Surveyor turned the key and observed the following insulin pens for Resident 3: 9 Humalog insulin pens and 4 Lantus insulin pens. Surveyor observed residents moving freely around the facility. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A confirmed medications were to be securely stored.	N 420		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of	N 427		

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N 427	Continued From page 14 the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a daily activity program to meet the interest and capabilities of 6 of 6 residents was provided. Findings include: On 07/12/2024, at 9:20 AM, Surveyor conducted a tour of the facility. At 9:42 AM, Surveyor observed the activity calendar. The activity calendar labeled "September 2022". At 9:05 AM, Surveyor observed residents bring in groceries which were on the front porch prior to Surveyor's arrival. At 10:00 AM, Surveyor observed House Manager C in the kitchen on her/his phone. During the survey, Surveyor did not observe any activities being offered to the residents. On 07/12/2024, at 10:40 AM, Surveyor interviewed Resident 2 and Resident 3. Resident 2 and Resident 3 reported activities were not offered in the facility. Resident 2 and Resident 3 reported they were friends and would hang out with each other. On 07/12/2024, at 1:35 PM, Surveyor interviewed Visitor H. Visitor H reported s/he lived at the facility next door. Visitor H reported s/he only	N 427		

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N 427	Continued From page 15 watched television when s/he had to come over. Visitor H reported there were no activities offered. Cross Reference: DHS N0191 83.13(3)(d) Posting Activity Schedule	N 427		
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 record review, observation, and interview, the provider did not make menus available to 6 of 6 residents. Findings include: On 07/12/2024, at 9:42 AM, Surveyor reviewed the posted menu in the dining room area. The menu was labeled with dated of 04/01/2024 - 04/07/2024. Surveyor reviewed lunch was, "sloppy joe on bun, pasta salad, mixed vegetable, peaches, kool aid/water." On 07/12/2024, at approximately 12:50 PM, Surveyor observed residents eating lunch. Surveyor observed the residents were served hot dogs and chips. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A	N 450		

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N 450	Continued From page 16 reported House Manager C was responsible for the menus.	N 450		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the environment was safe, clean, comfortable, and homelike for 6 of 6 residents. The living room did not contain enough furniture to sit on, the carpeting was stained, the walls needed repair and painting. The kitchen, dining room, bathrooms, hallways, and resident rooms flooring required cleaning and repair. The kitchen cabinets and stove vent contained a thick sticky substance. There were what appeared to be mouse droppings on shelving units in the basement which contain dry food storage. Findings include: On 07/12/2024, at 9:20 AM, Surveyor conducted a tour of the home and identified the following: Living Room: - The living room contained an entertainment center, 2 end tables, a coffee table, a tan folding lawn chair, and a wheeled office chair. No other furniture was available for residents to sit on.	N 481		

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N 481	Continued From page 17 - The carpet was brown in color and was worn and contained visibly stained, which caused these areas to appear black. One area of staining measured approximately 18 inches in width and 36 inches in length. - The front window was covered in plastic, so the window was unable to be opened. - The cold air return on the north wall contained clumps of gray like material consistent with dust. Kitchen: - The ceiling above the stove contained a substance consistent with food or grease splatter. - The range hood was covered in what appeared to be greasy substance and a dust like substance. The substance was slick when Surveyor touched it. - The cabinet doors contained a thick, sticky substance on the bottom corner area of the doors. Surveyor could scratch the substance off with her/his fingernail. - The set on back splash on the countertops, were covered in a thick dust like substance, which appeared gray in color. Dining Room: - The window blinds had 10 broken slats. - The linoleum tiles contained 2 areas where the tiles were broken, and the subfloor was exposed. One area measured 10 inches by 2 inches, the second area measured 4 inches by 3 inches. The tiles had multiple cracks running the length of the tiles. - The flooring around the table had black markings under the dining table folding chairs, consistent with the chairs being moved around the table. - The exit door had an area of approximately 2	N 481		

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feet in length where there was no paint. This area started around the doorknob and went up towards the ceiling.

North Bathroom:

- The linoleum type flooring in the bathroom was light brown and cream in coloring. The tiles appeared black in coloring.
- In the corners of the walls around the toilet, there was greenish spots, consistent with mold.
- The paint appeared to be chipping around the baseboards.

South Bathroom:

- The furnace vent in the bathroom, next to the toilet, appeared rusted and bent inward. The top of the furnace vent contained a thick layer of brown dust like substance.
- The wall between the shower and tub appeared to be missing a covering. The area had what appeared to be a type of dried glue and a drywall mud on the exposed wall.
- The lights above the mirror contained sockets for 12 bulbs. Two sockets were missing lightbulbs, and 5 lightbulbs were burnt out.

Hallway:

- The hallway tiles were a light coloring. There were black marks, approximately 44 inches in width in some places, and down the length of the hallway.

Basement:

- A metal shelving unit, on the south side of the basement, contained a white grayish granule material on the shelf. Embedded in the granule

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material was black specks, consistent with mouse feces. There was a bag of flour on the shelf.

Bedroom 2

- Missing piece of tile, under a foot of the bed, approximately 9 inches in length. The subflooring was exposed.

Bedroom 3

- The flooring consisted of tiles, which were grayish white in color. The tiles from the doorway to the bed and dresser areas were covered in black smearing with what appeared to be shoe print outlines. The path was consistent with a walkway. The width was approximately 19 inches across, and 120 inches in length.

Bedroom 4

- The flooring was white and blue patterned tile. The tiles appeared brownish in color. The subflooring was exposed in the middle of the bedroom, the area measured approximately 5.5 inches by 4 inches.
- The outlet cover, behind the door was broken.

On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Manager B reported cleaning was done daily and floors were mopped during the night. Manager B reported there were some issues with bed bugs and the furniture had to be thrown out to ensure the infestation did not spread. Manager B reported they got the "all clear" the bed bugs were gone but wanted to be sure before bringing in the new furniture. Surveyor expressed concern about the cleanliness of the facility, the repairs, and the lack of furniture for the residents to

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N 481	Continued From page 20 utilize, Director A and Manager B did not offer an explanation about the condition of the facility when observed.	N 481		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 clothes dryer in the laundry room had vent tubing of rigid material, with a fire rating that exceeded the temperature rating of the dryer. The clothes dryer was observed to have the flexible foil type vent tubing. Findings include: On 07/12/2024, at 9:30 AM, Surveyor toured the laundry room. The clothes dryer had approximately 2 feet of flexible foil accordion style vent tubing from the residential clothes dryer to the outside vent. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Manager B reported s/he thought the dryer vent was of rigid material. Manager B confirmed the code requirement. Manager B reported s/he would look at the dryer vent after the survey closing interview. Manager B reported s/he may have been thinking about a different home.	N 488		

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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 toxic substances and cleaning compounds were securely stored in 3 of 3 unsecured areas. Cleaning compounds and toxic substances were not securely stored in the laundry room, and the 2 bathroom areas. Findings include: The facility was licensed on 09/01/2022, to care for 7 residents in the client groups of physically disabled, traumatic brain injury, developmentally disabled, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, and advanced age. On 07/12/2024, at 9:20 AM, Surveyor toured the facility and observed the following: Laundry room The door did not contain a locking mechanism. The following toxic substances and cleaning compounds were found on the counter in the laundry room: bottle of Fabuloso multipurpose cleaner, bottle of Kroger glass cleaner, can of Glade air freshener, a box of Arm & Hammer carpet odor eliminator, a bottle of Arm & Hammer plus Oxi Clean laundry detergent and a bottle of Great Value bleach. On the floor next to the counter was a bottle of Great Value bleach, a bottle of Purex laundry detergent and a can of Glade air freshener.	N 499		

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N 499	Continued From page 22 North side bathroom The bathroom door contained a locking mechanism which appeared to be broken. When Surveyor attempted to lock the bathroom door, Surveyor was unable to push the button in due to the button was missing; therefore, the locking mechanism was not engaged. On the counter inside the bathroom contained a can of Comet cleaning powder, a bottle of Kroger glass cleaner, and a can of Glade air freshener. Southside bathroom The bathroom door contained a locking mechanism. The locking mechanism was not engaged. The bathroom counter had a bottle of Great Value multi-purpose cleaner. Surveyor observed residents moving freely throughout the facility. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A and Manager B did not provide an explanation.	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 on interview, the provider did not ensure combustible materials were not placed within 3 feet of 1 of 1 water heater. A black garbage bag which contained a blanket, a plastic tote and 2 oxygen takes were stored less than 3 feet from the water heater.	N 507		

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N 507	Continued From page 23 Findings include: On 07/12/2024, at 10:15 AM, Surveyor toured the basement. Surveyor observed the water heater. There was a black garbage bag which contained a blanket stored 32 inches from the water heater, a plastic tote was 17 inches from the water heater, and 2 oxygen tanks were 33 inches from the water heater. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A and Manager B did not provide an explanation.	N 507		
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 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	N 525		

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provider did not ensure fire drills were conducted quarterly in 2023 and 2024. There were no fire drills conducted in the 1st and 4th quarters of 2023. There were no fire drills conducted in the 2nd quarter of 2024. Five of 5 fire drills conducted in 2022, 2023, and 2024 did not contain a date each drill was conducted.

Findings include:

On 07/12/2024, at 12:30 PM, Surveyor reviewed safety records and identified the following:

Example 1

Two fire drills were conducted in 2023, on 04/2023, and 09/2023. There were no fire drills conducted in the 1st and 4th quarter of 2023.

One fire drill was conducted on 01/2024. There were no fire drills conducted in the 2nd quarter of 2024.

Example 2

Safety Records identified the following fire drills:

09/2022
12/2022
04/2023
09/2023
01/2024

Surveyor did not review what dates the fire drills were conducted on.

On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A reported s/he was aware of the requirement. Director A reported s/he thought Surveyor had all

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N 525	Continued From page 25 the fire drills. Director A did not offer an explanation to the missing dates on the fire drill documentation.	N 525		
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 years (calendar years 2022 and 2023). Findings include: On 07/12/2024, at 12:30 PM, 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 of 2022 and 2023. On 07/12/2024, at 2:00 PM, Surveyor requested Director A to email Surveyor the fire inspections from 2022 and 2023. On 07/15/2024, at 12:02 PM, Director A emailed Surveyor and reported s/he was unable to locate the fire inspections. Director A did not indicate if the fire inspections were completed in 2022 and 2023.	N 530		
N 538	83.48(3)(a) Fire detection systems inspected annually.	N 538		

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N 538	Continued From page 26 After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for an annual fire detection system to be inspected for 2 of 2 years (calendar years 2022 and 2023). Findings include: On 07/12/2024, at 12:30 PM, Surveyor reviewed facility safety code documentation. There was no documentation the fire detection system had been inspected for the years of 2022 and 2023. On 07/12/2024, at 2:00 PM, Surveyor requested Director A to email Surveyor the fire detection system inspections from 2022 and 2023. On 07/15/2024, at 12:02 PM, Director A emailed Surveyor and reported s/he was unable to locate the fire detection system inspections. Director A did not indicate if the fire detection system inspections were completed in 2022 and 2023.	N 538		
N 613	83.55(4)(a) Bath and toilet areas: privacy. Bath and toilet rooms shall have door locks to ensure privacy, except where the toilet, bath or shower room is accessed only from a resident room that is occupied by one person. All door locks shall be operable from both sides.	N 613		

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N 613	Continued From page 27 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 2 bathroom doors had working locks to ensure privacy. The bathroom doorknob was equipped with push button locking mechanisms which were compressed all the way and unable to lock. Findings include: On 07/12/2024, at 9:20 AM, Surveyor toured the facility. Surveyors observed the north side resident bathroom. The bathroom door on each bathroom was equipped with a push button locking mechanism. Surveyors attempted to push in the push button lock. The push button lock cover was missing, and the lock mechanism was compressed all the way and would not release. The bathroom door was unable to lock. Surveyor was able to open the bathroom doors from the outside when the lock button was compressed all the way. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A and Manager B did not provide an explanation.	N 613		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency.	N 617		

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N 617	Continued From page 28 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 resident bathrooms had a safe water temperature. The water temperature in the north bathroom was 121.3° Fahrenheit (F). The water temperature in the south bathroom was 122.7° F. Findings include: The facility was licensed on 09/01/2022, to care for 7 residents in the client groups of physically disabled, traumatic brain injury, developmentally disabled, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, and advanced age. On 07/12/2024, at 9:47 AM, Surveyor tested the water temperature in the north bathroom. The temperature was 121.3° F. The water temperature in the south bathroom was 122.7° F. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Director A reported the water was tested monthly. Director A reported s/he was responsible, or s/he would delegate it out to staff.	N 617		
N 668	83.60(1) Total/openable window area Minimum size. Every habitable room shall have at least one outside window with a total window area of at least 8% of the floor area in the room. The window shall be openable from the inside without the use of tools or keys. The openable area of the window shall be not less than 4% of the floor area of the room.	N 668		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019057	A. BUILDING: _____ B. WING _____	C 08/29/2024

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N 668	Continued From page 29 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that each habitable room had a window that was openable from the inside. The living room window was covered in plastic and unable to be opened. Findings include: On 07/12/2024, at 12:57 PM, Surveyor observed the living room window. The living room window was covered in plastic. Surveyor was unable to open the window. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Manager B reported the plastic was on the window when they purchased the facility, and they just kept it up to help with the cold.	N 668		
Y3235	50.09(1)(f) Privacy (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to:	Y3235		

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Y3235	Continued From page 30	Y3235		

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility did not maintain resident's right to privacy for 6 of 6 residents of the facility. Visitor H who was not a resident of the facility, was required to be in the home during the week for staff to supervise.

Findings include:

On 07/12/2024, at 9:20 AM, Surveyor entered the facility. Surveyor observed Visitor H in the living room. Visitor H was seated in a lawn type chair, with a pillow behind her/him. Visitor H had her/his feet propped on a swivel desk chair. Surveyor observed Visitor H throughout the survey. Visitor H did not get up from the chair. Visitor H did not eat lunch when lunch was made. Surveyor did not observe anyone interact with Visitor H.

On 07/12/2024, at 1:35 PM, Surveyor interviewed Visitor H. Visitor H reported s/he lived at the CBRF next door. Visitor H stated, "They tell me they don't have any staff for 1st shift, so they make me come over here ...I don't wanna come over here, I wanna stay home." Visitor H reported her/his housemates go to day programming, so s/he was the only resident who was at the home all day.

On 07/12/2024, at 1:50 PM, Surveyor interviewed House Manager C. House Manager C confirmed

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Y3235	Continued From page 31 Visitor H lived next door. On 08/29/2024, at 10:30 AM, Surveyor interviewed Director A and Manager B. Manager B reported Visitor H would come over to the facility because s/he did not want to attend a day program. Manager B reported Visitor H had the option of going to her/his family member's house or to the facility. Manager B reported Visitor H was unable to stay in the facility without staff. Manager B reported at times Visitor H would say s/he was going to go to her/his family member's house, but last minute would change her/his mind. Manager B reported there was no staff scheduled during the day on Mondays, Wednesdays, and Fridays due to the other residents go to day programming. On 08/29/2024, Surveyor reviewed the resident roster. The resident roster indicated Visitor H was not a resident of the facility.	Y3235		