STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017054	A. BUILDING: _____ B. WING _____	C 08/01/2024

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MILESTONE SENIOR LIVING RAILROAD CBRF	2332 RAILROAD ST EAGLE RIVER, WI 54521

(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 07/23/2024, Surveyors conducted a standard licensure survey and complaint investigation (x2) at Milestone Senior Living Railroad CBRF. Data collection continued through 08/01/2024. The complaints (x2) were substantiated. 9 deficiencies were identified. Three deficiencies were repeat violations. See Statement of Deficiency (SOD) THH611, dated 02/04/2019, and SOD QX8P11, dated 11/23/2022. Census: 19	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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This Rule is not met as evidenced by:
Based on interview and record review, the provider did not investigate and document allegations of resident health concerns and staff neglected to follow up when the allegations were first reported.

Findings include:

On 05/22/2024, the Department received a complaint alleging the facility nurse was not following up on resident concerns and the concerns were not being addressed by management.

The provider is licensed to care for up to 21 residents in the client groups of advanced aged and irreversible dementia/Alzheimer's disease.

On 07/23/2024 at approximately 12:07 PM, Surveyor interviewed Director A. Director A reported that s/he took over for Former Director (FD) C on 06/21/2024. Director A confirmed that Director A started a neglect investigation involving Facility Nurse (FN) D on 07/19/2024. Director A reported that FN D was suspended on 07/19/2024, pending an investigation for neglect.

On 07/23/2024, Surveyor reviewed an internal investigation, dated 07/19/2024, provided by Director A. In the investigation, Director A noted, "I spoke with [Caregiver G] this morning who put in [his/her] notice. [S/He] said [s/he] is not willing to stay no matter what I do and it is because [s/he] has seen this building 'go through it,' and s/he doesn't want to do that again. [S/He] said that [s/he] is leaving because [s/he] has concerns about the nurse. [S/He] said that things are

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reported to [him/her] and [s/he] does not do anything and then things get really bad and residents are sent to the hospital when it could have been handled and should have been handled much sooner."

On 07/23/2024 at approximately 2:30 PM, Surveyor interviewed Caregiver E. Surveyor asked Caregiver E if Caregiver E had any concerns about resident cares. Caregiver E stated, "I make sure cares are done." Caregiver E reported that Caregiver E brought concerns about resident cares and health concerns (skin breakdown, sores/wounds, urinary tract infections) to FN D and FD C in May 2024 , but FN D and FD C did not follow up on the concerns. Caregiver E reported that s/he brought the ongoing care concerns to Director A in July 2024. Caregiver E reported that Director A started an investigation into resident care concerns on 07/19/2024.

On 07/23/2024 at approximately 4:25 PM, Surveyor interviewed Caregiver F. Surveyor asked Caregiver F if Caregiver F had any concerns about resident cares. Caregiver F indicated that Caregiver F brought concerns about resident cares to FN D and FD C over the past few months. Caregiver F stated that FN D said s/he would follow up on the concerns but never really did anything. Caregiver F reported that Director A started a "neglect investigation" last week.

On 07/29/2024 at approximately 11:02 AM, Regional Nurse (RN) B provided Surveyor with a self-report, dated 07/26/2024, and a misconduct incident report (MIR), dated 07/26/2024, via e-mail. RN B noted, "I have attached the internal investigation, MIR and State Report. After a

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N 158	Continued From page 3 thorough investigation the findings of possible neglect are substantiated, and the nurse has been termed (terminated)." The self-report, read, in part, "A social media post surfaced on 07/18/2024 alleging residents at the community being abused and neglected by staff. The post also suggested that several medical concerns were brought to the attention of the nurse repeatedly and were not addressed, resulting in physiological harm to residents. Upon addressing staff on administrator's open-door policy, staff began expressing their concerns to the administrator. The incident was investigated by the the administrator as well as the regional nurse specialist. Residents and staff were interviewed and resident's files reviewed. Investigation [sic] determined that the community nurse failed to appropriately follow community procedures and follow up on resident concerns. No [sic] permanent negative outcomes have occurred. Residents did not express concerns over toileting or lack of assistance with ADLs (activities of daily living)." On 08/01/2024 at approximately 3:00 PM, Surveyor interviewed Director A and RN B. Surveyor asked if the provider (FD C and FN D) conducted an investigation involving resident health concerns prior to 07/19/2024. RN B reported, "No, we don't have anything."	N 158		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident.	N 165		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not send a written report to the Department after a resident sustained a fall with a laceration to his/her head, that required emergency room treatment.

Findings include:

The provider is licensed to care for up to 21 residents in the client groups of advanced aged and irreversible dementia/Alzheimer's disease.

On 07/24/2024, Surveyor reviewed Resident 1's record.

A note, dated 05/24/2024, read: "On 5/24/2024 at 827 [sic] PM staff notified triage that they went to [sic] in to administer HS (bedtime) medications and the resident was sitting with blood on [his/her] head. RA (resident assistant) reports [s/he] is actively bleeding... Staff called EMS (emergency medical services) and sent resident to ER (emergency room) with emergency packet..."

A note, dated 05/30/2024, read: "PCP (primary care physician) in facility today and visited resident. PCP will leave a staple remover so writer can remove staples on the 3rd. Order obtained to remove suture when due..."

On 07/24/2024, Surveyor emailed Regional Nurse (RN) B and asked if Resident 1's fall that required staples was reported to the Department. On 07/24/2024, RN B replied: "For what I can see [Former Director C] did not report this fall.

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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 record review and interview, the provider did not ensure each resident's individual service plan (ISP) was reviewed and revised when there was a change in condition. Resident 1 had multiple falls. Resident 1's ISP did not include an intervention after each fall to prevent future falls. Resident 2 had wounds to his/her leg that developed methicillin-resistant staphylococcus aureus (MRSA). Resident 2's ISP did not identify interventions or precautions for staff to properly monitor his/her skin. Findings include: On 05/22/2024, the Department received 2 complaints alleging the facility nurse did not	N 389		

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address caregiver's concerns related to residents' wounds and infections.

RESIDENT 1

On 07/24/2024 and 07/31/2024, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 11/09/2023 with multiple diagnoses, including Alzheimer's disease, metabolic syndrome, type 2 diabetes, and congestive heart failure.

Resident 1's ISP, last modified 07/29/2024, read, in part:
Need: "FALLS"
Goal: "Resident will not sustain any injuries related to falls."
Action: "Ensure resident is wearing proper footwear. Ensure resident is wearing proper footwear. [sic] 6/12/24 UWF (unwitnessed fall) POA (power of attorney) encouraged to provide resident with gripper socks. Fall interventions are: 5/24/2024: resident sent to Er (emergency room) for evaluation. Fall interventions are: 5/24/2024: Resident sent to Er for evaluation [sic]. 6/22/24 continue visual checks, monitor for any changes call triage back with any worsening changes. Remind to call for assistance. Remind to call for assistance [sic]. Visual reminder to call for assistance in room."

Need: "Fall Potential"
Goal: "Resident will maintain an/or maximize current level of functioning with fall potential."
Action: "Ensure resident is wearing proper footwear, walkways are free of clutter. Remind resident to call for assistance if needed. Environmental safety issue: None. Resident does not have any other environmental safety issues in

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apartment. Fall Potential Resident's Parkinson's will be evaluated by PCP (primary care physician) due to frequent falls and increase shaking. Resident will call for assistance as needed."

From 04/24/2024 - 07/24/2024, Resident 1 had 7 falls. The provider did not determine a root cause for each fall with an added intervention to prevent future falls.

On 05/24/2024, Resident 1 had an unwitnessed fall, which resulted in a laceration to his/her head. S/he was sent to the emergency department and had staples placed to close the laceration.

On 08/01/2024 at approximately 3:00 p.m., Surveyor interviewed Director A, Regional Nurse (RN) B, and Corporate Compliance H. Surveyor reviewed Resident 1's multiple falls and ISP. RN B told Surveyor it was a standard of practice for the nurses to determine the root cause of a fall and implement an intervention to prevent future falls. RN B said the nurses have been educated on this and it is the nurse's responsibility to review and revise ISPs.

RESIDENT 2

On 07/23/2024 at approximately 10:30 a.m., Surveyor interviewed Caregiver I and asked if any residents required wound care. Caregiver I told Surveyor Resident 2's legs can get irritated and s/he saw a specialist for this. S/he said Resident 2 did not currently have any open areas on his/her legs.

On 07/23/2024 at approximately 12:45 p.m., Surveyor interviewed Resident 2. Resident 2 told Surveyor s/he had a new vein put in his/her right leg 3 or 4 years ago and s/he has had problems

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with that leg since. Resident 2 said his/her leg was "pretty much healed." S/he did confirm his/her leg becomes "weepy" at times.

On 07/23/2024 at approximately 3:15 p.m., Surveyor interviewed Caregiver E. Caregiver E said s/he had gone to Facility Nurse (FN) D with concerns related to Resident 2's leg swelling and infected sores on his/her leg, that s/he did not feel were addressed timely.

On 07/24/2024 and 07/31/2024, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the facility on 01/16/2019, with multiple diagnoses, including chronic peripheral venous insufficiency, chronic kidney disease, diabetes, and mild dementia.

Surveyor reviewed the following notes related to Resident 2's leg wounds.

On 02/22/2024 - "Resident remains on oral ABT (antibiotic) for chronic cellulitis (skin infection) to lower extremity."

02/29/2024 - "Resident is prescribed Cephalexin Oral Capsule [sic] 500 MG (milligrams) po (by mouth) daily for cellulitis of the right lower extremity."

03/07/2024 - "Resident started on Keflex bid (2x/day) for 10 days then restart the daily dose.

04/08/2024 - "Staff contacted triage reporting resident right leg is swollen, hard, red, warm to touch. Staff reports resident has 'HIVES' to both arms ..."

04/11/2024 - "PCP (primary care physician) is

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going to change medication for ABT due to continued redness to right lower extremity. Resident is encouraged to not apply body lotion and heated blanket to right lower extremity ..."

04/14/2024 - "Staff contacted triage reporting the following: Resident requested to be sent out for medical attention. Resident states right leg pain and right leg is very swollen. Red blotches on both arms ..."

04/15/2024 - "Will require stronger antibiotic that covers MRSA - will start Clindamycin 300 mg 1 capsule by mouth every 6 hours for 7 days - diagnosis Cellulitis [sic] ..."
04/21/2024 - "Resident was seen in the ER (emergency room) today. Sent back with discharge paperwork. Instruction to keep lower extremity wrapped. Change dressing as needed when dressing becomes soiled. Complete antibiotics as prescribed. Resident will need to f/u (follow up) with PCP to ensure infection is resolving. Stopped daily aspirin, continue Plavix in addition to Eliquis ... [Resident 2] should elevate [his/her] right leg as much as possible to help with swelling ... Diagnoses: DVT (deep vein thrombosis) of popliteal vein, rash, peripheral edema, and pruritis."

06/06/2024 - "Resident is receiving Home Health RN (registered nurse), PT (physical therapy), and OT (occupational therapy) services ... RN encouraged resident to wear Tubi grips and elevate legs ..."

Resident 2's ISP, last modified on 05/31/2024, did not include Resident 2's history related to his/her right leg having chronic cellulitis infections, MRSA in the wound, or DVT. Interventions listed in the nurse's notes, such as not applying lotions,

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N 389	Continued From page 10 heated blankets, elevating legs, and Tubi grips were not included in the ISP. Precautions for MRSA were not included in the ISP. On 07/31/2024, Surveyor emailed Director A and RN B. Surveyor asked if Resident 2's leg wound was positive for MRSA, referring to the 04/15/2024 note when Resident 2's antibiotic was changed to cover a MRSA infection. Surveyor asked if Resident 2's history of infections and DVT were included in Resident 2's ISP as Surveyor could not locate this information. On 08/01/2024, RN B emailed Surveyor. RN B indicated that after review, it was determined Resident 2 was positive for MRSA. The email read, in part: "Upon review that is correct. Precautions are added while wound(s) are open to follow contact precautions." RN B said Resident 2's ISP was now updated to include his history of leg infections.	N 389		
N 431	83.38(1)(g) Health monitoring. 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 the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an	N 431		

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N 431	Continued From page 11 advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor the health of each resident and make arrangements for physical health services when Resident 1's blood sugar readings were below parameters. Resident 1 had numerous low blood sugar readings. Staff did not consistently report the low readings to a nurse. The nurse did not consistently notify the physician. Findings include: The provider's policy and procedure, revised December 2023, on testing a resident's blood sugar includes the following: "Refer to individualized glucose parameters, if present, or to the community parameters to determine if further action and/or nurse	N 431		

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notification is necessary (i.e., if the blood glucose is lower than 70 or higher than 200, hypo - or hyperglycemic protocols become effective)."

On 07/24/2024 and 07/31/2024, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 11/09/2023 with multiple diagnoses, including Alzheimer's disease, metabolic syndrome, and type 2 diabetes.

Surveyor reviewed Resident 1's blood sugar readings from 05/24/2024 - 07/24/2024. Resident 1's blood sugars dropped below 70 on the following dates and times:

05/26/2024 at 6:57 a.m. - 53
05/27/2024 at 1:00 p.m. - 67
05/269/2024 at 7:32 a.m. - 56
06/18/2024 at 77:48 a.m. - 69
06/19/2024 at 12:27 p.m. - 64
06/20/2024 at 7:33 a.m. - 62
06/22/2024 at 8:01 a.m. - 59
06/23/2024 at 7:30 a.m. - 54
06/23/2024 at 12:18 p.m. - 53
06/23/2024 at 4:18 p.m. - 53
06/24/2024 at 1:34 p.m. - 55
07/03/2024 at 5:11 p.m. - 69
07/07/2024 at 2:20 p.m. - 63
07/13/2024 at 5:05 p.m. - 56
07/14/2024 at 10:03 a.m. - 53
07/15/2024 at 4:11 p.m. - 58
07/16/2024 at 7:37 a.m. - 44
07/17/2024 at 12:24 p.m. - 55
07/18/2024 at 11:12 a.m. - 53
07/19/2024 at 1:38 p.m. - 41
07/20/2024 at 4:48 p.m. - 53

Surveyor reviewed Resident 1's progress notes

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	0017054	A. BUILDING: _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING RAILROAD CBRF	2332 RAILROAD ST EAGLE RIVER, WI 54521

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N 431	Continued From page 13	N 431		

from 05/24/2024 - 07/24/2024. The following notes were documented related to Resident 1's blood sugar readings.

06/28/2024 - "Resident returned from [name] hospital. Changes to medication list has been to decrease glipizide from bid (2x/day) to daily ..."

07/19/2024 at 11:43 a.m. - "Staff updated writer that resident's blood glucose was reading low. PCP (primary care physician) is aware of low blood sugars and notified today of today's low reading. PCP emailed latest blood glucose readings ..."

07/19/2024 at 12:28 p.m. - "Writer spoke with PCP. Resident's vitals and med (medication) list sent to PCP. PCP will review and notify writer of any changes ..."

07/19/2024 at 4:08 p.m. - "Verbal order obtained from PCP. Check blood glucose level at 8 pm. If blood glucose level is below 100mg/dl (milligrams/deciliter) hold 8 pm Lantus 40 units. Provider will review readings next week ..."

On 07/24/2024, Surveyor emailed Regional Nurse (RN) B and requested any documentation to Resident 1's PCP related to his/her blood sugars.

On 07/25/2024, Surveyor received a fax from RN B that included documentation of an email the provider sent to Resident 1's PCP.

The email, dated 06/24/2024, read: "[Resident 1] has been having low blood sugars. I placed an order for snack at HS (bedtime). [His/her] blood sugars have been in the 50's. I will check on this and we can review next time you're here. Thanks. Let me know if there's any further orders."

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N 431	Continued From page 14 Resident 1's PCP emailed back to the provider on 06/25/2024, "Can you send me a med list maybe we need to adjust meds." There was no further documentation to indicate if the medication list was sent or not. Documentation from Resident 1's record indicated on 06/24/2024 that Resident 1 had right-sided facial droop and was subsequently hospitalized with a stroke. Resident 1 returned to the facility on 06/28/2024 with orders to decrease Resident 1's glipizide. On 08/01/2024 at approximately 3:00 p.m., Surveyor interviewed Director A, RN B, and Corporate Compliance H. RN B told Surveyor staff were to notify the nurse if a resident's blood sugar was less than 70. It was the nurse's responsibility to notify the PCP with the low blood sugars. Surveyor reviewed Resident 1's multiple low blood sugar readings with only 2 notifications to Resident 1's PCP. RN B confirmed that was correct. RN B said they have started education related to notifications on blood sugar parameters.	N 431		
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	N 525		

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N 525	Continued From page 15 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 conduct fire evacuation drills at least quarterly with both employees and residents in 2022 and 2023. This is a repeat violation, cited for the third time. See Statement of Deficiency (SOD) THH611, dated 02/04/2019 and SOD QX8P11, dated 11/23/2022. Findings: This facility serves up to 21 residents in the client groups of advanced age and irreversible dementia/Alzheimer's disease. On 07/23/2024, Surveyor conducted a review of provider records for fire evacuation drills for the past two years (2022 and 2023). The provider had documented fire drills on 05/11/2023 and 05/25/2023. On 07/23/2024 at approximately 4:06 PM, Surveyor interviewed Director A. Director A informed Surveyor that Director A was unable to locate documentation of additional fire drills in 2022 and 2023. Director A confirmed quarterly fire drills were not conducted in 2022 and 2023.	N 525		

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N 526	Continued From page 16	N 526		
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 conduct a tornado, flooding, or other emergency or disaster evacuation drill at least semi-annually in 2022 and 2023 This is a repeat deficiency, cited for the third time. See Statement of Deficiency (SOD) THH611, dated 02/04/2019 and SOD QX8P11, dated 11/23/2022. Findings include: This facility serves up to 21 residents in the client groups of advanced age and irreversible dementia/Alzheimer's disease. On 07/23/2024, Surveyor conducted a review of provider records for emergency or disaster evacuation drills. The provider did not have a record to show emergency or disaster evacuation drills were conducted in 2022 and 2023. On 07/23/2024 at approximately 4:06 PM, Surveyor interviewed Director A. Director A confirmed the provider did not conduct semi-annual emergency or disaster evacuation drills in 2022 and 2023.	N 526		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an	N 530		

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N 530	Continued From page 17 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 conduct a fire inspection in 2022 and 2023. Findings: This facility serves up to 21 residents in the client groups of advanced age and irreversible dementia/Alzheimer's disease. On 07/23/2024, Surveyor conducted a review of provider records for fire inspections. The provider did not have documentation of conducting fire inspections in 2022 and 2023. On 07/23/2024 at approximately 4:06 PM, Surveyor interviewed Director A. Director A reported that s/he was unable to locate fire inspections for 2022 and 2023. Director A verified that fire inspections were not conducted in 2022 and 2023.	N 530		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every	N 535		

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N 535	Continued From page 18 other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct smoke detector tests every other month in 2022 and 2023. Findings: This facility serves up to 21 residents in the client groups of advanced age and irreversible dementia/Alzheimer's disease. On 07/23/2024, Surveyor conducted a review of provider records for smoke detector tests. The provider did not have documentation of conducting smoke detector tests every other month in 2022 and 2023. On 07/23/2024 at approximately 4:06 PM, Surveyor interviewed Director A. Director A reported that s/he was unable to locate smoke detector tests for 2022 and 2023. Director A verified that smoke detector tests were not conducted at least every other month in 2022 and 2023.	N 535		
N 538	83.48(3)(a) Fire detection systems inspected annually. 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.	N 538		

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N 538	Continued From page 19 This Rule is not met as evidenced by: Based on interview and record review, the facility did not ensure that the interconnected smoke and fire detection system was inspected, cleaned, and tested in 2023 by a certified or trained and qualified person in accordance with NFPA 72 and the manufacturer's specifications and procedures. This is a repeat violation cited for the second time. See Statement of Deficiency (SOD) THH611, dated 02/04/2019. Findings: This facility serves up to 21 residents in the client groups of advanced age and irreversible dementia/Alzheimer's disease. On 07/23/2024, Surveyor conducted a review of the facility's 2022 and 2023 documentation of required inspections. There was no documentation showing that the facility's interconnected smoke and fire detection system had been inspected, cleaned, and tested annually by a certified or trained and qualified person in 2023. On 07/23/2024, at approximately 4:06 PM, Surveyor interviewed Director A. Director A verified that the smoke and fire detection system was inspected in April 2022. Director A reported that s/he was unable to find a smoke and fire inspection report for 2023.	N 538		