STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015887	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A NURTURING HOME AWAY FROM HOME INC	8225B N 107TH ST MILWAUKEE, WI 53224

(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 09/24/2024, Surveyors conducted a standard survey and complaint investigation at A Nurturing Home Away From Home, a Community-Based Residential Facility (CBRF) in Milwaukee, WI. Fourteen deficiencies identified. One of 14 was a repeat deficiency (see Statement of Deficiency (SOD) TQRG12, dated 09/09/2021). Complaint substantiated. Census: 8	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a caregiver background check (CBC) was completed for 1 of 2 employees (Resident Assistant C) reviewed. Resident Assistant C did not have a completed CBC on	N 219		

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

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N 219	Continued From page 1 file. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete CBC, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check" letter from the Department of Health Service, also referred to as the Integrated Background Information System (IBIS). On 09/24/2024 at approximately 11:47 AM, Surveyors reviewed employee records. Resident Assistant C was hired on 05/09/2024. His/her record did not include a DOJ and IBIS. On 09/24/2024 at approximately 12:00 PM, Surveyors interviewed Manager A. Manager A stated s/he usually completed the background checks, and if s/he did, it would have been in the record. Manager A stated s/he would run a background check immediately for Resident Assistant C.	N 219		
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:	N 277		

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N 277	Continued From page 2 (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure 1 of 1 caregiver reviewed (Supervisor B) received 15 hours per calendar year of continuing education beginning with the first calendar year of employment including standard precautions, client group related training, medications, resident rights, prevention and reporting of abuse, neglect and misappropriation and fire safety and emergency procedures, including first aid. Findings include: On 09/24/2024, Surveyors requested to review Supervisor B's employee record. Supervisor B was hired on 04/22/2022. Surveyors located Supervisor B's continuing education for calendar year 2023. Supervisor B only had 13 hours of continuing education and did not have continuing education training in the following required topics: standard precautions, fire safety and emergency procedures, including first aid. On 09/24/2024, at approximately 12:00 PM, Surveyors interviewed Administrator A and Supervisor B. Administrator A and Supervisor B confirmed Supervisor B should have had training in those topics for 2023, but they could not locate	N 277		

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N 277	Continued From page 3 any documentation that s/he received the training in required topics and a total of 15 hours of training for calendar year 2023.	N 277		
N 305	83.28(6) Resident rights, grievance procedure, rules Resident rights, grievance procedure, and house rules. Before or at the time of admission, the CBRF shall provide and explain resident rights, the house rules of the CBRF as required under s. DHS 83.32 (2), and the grievance procedure, including written information regarding the names, addresses and telephone numbers of all resident advocacy groups serving the client groups in the facility, including the long term care ombudsman program and the protection and advocacy services of Disability Rights Wisconsin, Inc. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed was provided and explained resident rights before or at the time of admission (Resident 1). Findings include: On 09/24/2024 at 9:00 AM, Surveyors reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 07/17/2024. Resident 1's record did not include documentation Resident 1 received information about resident rights and grievance procedure. On 09/24/2024, at approximately 11:30 AM, Surveyors interviewed Administrator A and Supervisor B. Administrator A stated Resident 1	N 305		

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N 305	Continued From page 4 should have had resident rights and grievance procedure acknowledgment in his/her record like the other residents did. S/he stated s/he was not sure why it was not completed but moving forward would ensure all were filled out upon admission.	N 305		
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 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)	N 310		

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N 310	Continued From page 5 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 2 of 2 residents (Resident 1 and Resident 2) admission agreements was signed by the resident or the resident's legal representative. Findings include: On 09/24/2024, Surveyors reviewed Resident 1 and Resident 2's record. Surveyors identified the following: -Resident 1 was admitted on 07/17/2024. Resident 1 was his/her own decision maker. Resident 1's record did not contain an admission agreement. -Resident 2 was admitted on 05/23/2023 and was his/her own decision maker. Resident 2's record contained an admission agreement and was dated 07/23/2023 but had no signature from Resident 2. On 09/24/2024, at approximately 12:00 PM, Surveyors interviewed Manager A and Supervisor B. Manager A and Supervisor B confirmed Resident 1 and Resident 2 was his/her own decision maker and acknowledged the admission agreement should have been signed by the each of the residents.	N 310		

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N 346	Continued From page 6	N 346		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 6 of 6 residents' (Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7) information was kept secured and confidential. Surveyors observed Resident 2's, Resident 3's, Resident 4's, Resident 5's, Resident 6's, and Resident 7's private information posted on the wall outside their rooms. Findings include: On 09/24/2024 at approximately 9:52 AM, Surveyors toured the facility and observed the following: Resident 2: - Shower schedule posted on the wall outside of	N 346		

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N 346	Continued From page 7	N 346		

room.
- Shower schedule included the following information: Resident 2's name, stated Resident 2 needs to be reminded shower days, staff needs to assist Resident 2 when showering to make sure Resident 2 is showering, Resident 2 needs to use the x-large shower chair at all times, Resident 2 only shower on 1st or 2nd shift only, Resident 2 can wash clothes on his/her own staff needs to assist with starting washer, change Resident 2's bedding on shower days and Resident 2's linen changes should be done on shower days or if needed before shower days.

Resident 3:
- Shower schedule posted on the wall outside of room.
- Shower schedule included the following information: Resident 3's name, Resident 3 independently showers but staff needs to go with him/her to make sure s/he is showering, staff needs to assist Resident 3 with shaves, Resident 3 needs prompting on changing his/her clothes and brushing his/her teeth on a daily, change Resident 3's bedding on shower days and Resident 3's linen changes should be done on shower days or if needed before shower days.

Resident 4:
- Shower schedule posted on the wall outside of room.
- Shower schedule included the following information: Resident 4's name, Resident 4 independently need walker remind Resident 4 to use walker, Resident 4 should be using walker when showering and around home, staff should remind Resident 4 to change his clothes daily, staff should remind Resident 4 to apply lotion to legs 2 times a day morning and night, cue Resident 4 to change bedding on shower days,

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N 346	Continued From page 8	N 346		

Resident 4 can put clothes in washer and dryer staff needs to standby to assist and Resident 4's linen changes should be done on shower days or if needed before shower days.

Resident 5:
- Shower schedule posted on the wall outside of room.
- Shower schedule included the following information: Resident 5's name, Resident 5 is independent s/he can make his/her own choices, Resident 5 knows how to wash his/her clothes, staff should change Resident 5's bedding on shower days and Resident 5's linen changes should be done on shower days or if needed before shower days.

Resident 6:
- Shower schedule posted on the wall outside of room.
- Shower schedule included the following information: Resident 6's name, Resident 6 can shower on his/her own s/he uses the shower chair, Resident 6 needs assistance with washing clothes, staff needs to remind Resident 6 to put lotion on feet daily, staff should change Resident 6's bedding on shower days and Resident 6's linen changes should be done on shower days or if needed before shower days.

Resident 7:
- Shower schedule posted on the wall outside of room.
- Shower schedule included the following information: Resident 7's name, Resident 7 needs assist from staff when showering and getting dressed, Resident 7 needs to be reminded to use the urinal, staff needs to make sure Resident 7 always have on a brief, Resident 7 needs to be reminded to have on clothes when

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N 346	Continued From page 9 coming out of his room, staff should change Resident 7's bedding on shower days and Resident 7's linen changes should be done on shower days or if needed before shower days. On 09/24/2024 at approximately 12:00 PM, Surveyors interviewed Manager A. Manager A stated s/he understood and would immediately address the concerns. Manager A did not state why the information was posted outside the wall of their rooms.	N 346		
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 assess 1 of 2 residents (Resident 2) reviewed for resident's needs, abilities, and physical and mental condition before admitting the person to the facility. There was no evidence of a completed assessment prior to admission for Resident 2.	N 381		

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N 381	Continued From page 10 Findings include: The facility is licensed as a Class ANA (non-ambulatory) facility for 8 residents with programs in emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, developmentally disabled, alcohol/drug dependent, physically disabled, advanced age and traumatic brain injury. On 09/24/2024, Surveyors reviewed Resident 2's record and identified the following: Resident 2 was admitted to the facility on 05/23/2023. There was no written documentation in Resident 2's record to indicate Resident 2 was assessed prior to admission to determine Resident 2's needs, abilities, and physical and mental condition. On 09/24/2024, at approximately 12:00 PM, Surveyors interviewed Manager A and Supervisor B. Manager A stated s/he remembered completing the assessment but s/he could not find the documentation of it.	N 381		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with	N 386		

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N 386	Continued From page 11 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 and staff interview, the provider did not develop a comprehensive individual service plan (ISP) for 1 of 1 resident reviewed (Resident 1) within 30 days. Findings include: On 09/24/2024, Surveyors reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the facility on 07/17/2024 and was his/her own decision maker. -Resident 1's record did not include an ISP. On 09/24/2024, at approximately 12:00 PM, Surveyors interviewed Manager A and Supervisor B. Manager A stated s/he was typically responsible for care plans but had been busy with their other facility and must not have completed Resident 1's ISP within 30 days of admission.	N 386		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal	N 387		

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illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.

This Rule is not met as evidenced by:
Based on record review and staff interview, the provider did not involve 1 of 1 resident reviewed (Resident 2) and the resident's legal representative, as appropriate, in developing the individual service plan (ISP) and did not have the plan signed acknowledging their involvement in, understanding of, and agreement with the plan.

This is a repeat deficiency. See Statement of Deficiency (SOD) TQRG12, dated 09/09/2021.

Findings include:

On 09/24/2024, Surveyors reviewed Resident 2's record. Resident 2's record identified the following:

-Resident 2 was admitted to the facility on 07/27/2023 with diagnoses including morbid obesity, need for assistance with personal cares, depression, and anxiety.
-Resident 2 was his/her own decision maker.
-Resident 2's current ISP, dated 08/27/2023, had no resident signature.

On 09/24/2024, at approximately 12:00 PM, Surveyors interviewed Manager A and Supervisor

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N 387	Continued From page 13 B. Manager A confirmed Resident 2 was his/her own person and s/he did not have them sign the ISP when they went over it on 08/27/2023.	N 387		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Community-Based Residential Facility's, (CBRF) medication administration and storage system were reviewed by a physician, pharmacist, or registered nurse at least annually in 2022, 2023, and to date in 2024. The provider had not had a review of the	N 404		

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N 404	Continued From page 14 medication storage system since 01/23/2017. Findings include: On 09/24/2024 at approximately 9:45 AM, Surveyors reviewed the provider's environmental and safety records. There was no evidence of a pharmacist review of the provider's medication administration and storage system for 2022, 2023, and to date in 2024. On 09/24/2024 at approximately 10:30 AM, Surveyors interviewed Manager A and Supervisor B about their medication administration and storage system review. Manager A stated s/he was not aware they needed to have one so they have not had one since they opened in 2017. Manager A stated s/he would call the pharmacy they use and get them to complete one as soon as possible.	N 404		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.	N 415		

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N 415	Continued From page 15 This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not have documentation of the time of medication administration, the person administering the medication or treatment and the name, dosage, date, and time of medication taken or treatments performed and initialed in the medication administration record (MAR) for 1 of 1 resident (Resident 3). Findings include: On 09/24/2024 at 10:30 AM, Surveyors reviewed Resident 3's record and identified the following: Resident 3 was admitted to the facility on 11/01/2019 and had diagnoses including intellectual disability, diabetes mellitus, hypertension, anxiety, depression, and visual impairment. Resident 3's September 2024 MAR, dated 09/06/2024 to 10/03/2024, had a total of 40 blank entries for administering his/her medications. Resident 3's MAR stated Resident 3 was prescribed the following medications: -Glucose Meter, daily at 12:00 PM -Levothyroxine 75 micrograms (MCG) tablet (tab), take one tab daily at 7:00 AM -Lisinopril/hydrochlorothiazide (HCTZ) 10/12.5 milligrams (MG), take one tab daily at 8:00 AM -Metformin extended release (ER) 500 MG tab, take one tab, twice daily before meals at 8:00 AM and 4:00 PM -Metoprolol ER 50 MG, take one tab, once daily at 8:00 AM -Triamcinolone ointment 0.5%, apply topically to area twice daily at 8:00 AM and 8:00 PM	N 415		

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N 415	Continued From page 16 Resident 3's MAR had missing entries on the following dates: -Glucose Meter, daily at 12:00 PM (9 entries from 09/15/2024-09/23/2024) -Levothyroxine 75 MCG tab, take one tab daily at 7:00 AM (3 entries from 09/19/2024-09/21/2024) -Lisinopril/HCTZ 10/12.5 MG, take one tab daily at 8:00 AM (6 entries from 09/16/2024-09/21/2024) -Metformin ER 500 MG tab, take one tab, twice daily before meals at 8:00 AM and 4:00 PM (1 entry on 09/13/2024 at 8:00 AM and 6 entries from 09/16/2024-09/21/2024 at 4:00 PM) -Metoprolol ER 50 MG, take one tab, once daily at 8:00 AM (7 entries from 09/16/2024-09/21/2024 and 09/23/2024) -Triamcinolone ointment 0.5%, apply topically to area twice daily at 8:00 AM and 8:00 PM (6 entries from 09/16/2024-09/21/2024 at 8:00 AM and 2 entries from 09/19/2024-09/20/2024 at 8:00 PM) On 09/24/2024 at 10:30 AM, Surveyors interviewed Manager A about missing entries on Resident 3's MAR. Manager A stated s/he was not sure why that caregiver would not have documented that they gave the medication to Resident 3. Manager A stated s/he did not see the medication in the medication cart, so it must have been given but not documented. Manager A stated Supervisor B was the caregiver who typically gave the morning medications and s/he would be re-educating them on the importance of documentation.	N 415		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living	N 481		

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N 481	Continued From page 17 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 facility was maintained in a safe clean, comfortable, and homelike environment. This had the potential to affect 8 of 8 residents. Findings include: The facility is licensed as a class ANA facility for 8 residents with programs in developmentally disabled, traumatic brain injury, physically disabled, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and alcohol/drug dependent. On 09/24/2024, Surveyors conducted a tour of the facility. Surveyors observed the following: Resident 2's Room: - Window blinds were dirty and bent - Fan on stand did not have a fan cover - Floor was stained and marked with black and brown marks - Ceiling tile had brown spots consistent with water spots - Walls were dirty - Microwave was dirty and dusty - Refrigerator was dirty and dusty - Door was dirty - Red faded and dirty chair - Ceiling tile was uneven	N 481		

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N 481	Continued From page 18 - Bedding was dirty Kitchen: - The ceiling vents had an accumulation of dust - Ceiling tiles had brown spots - (2) fly ribbons were hanging from ceiling tile Hallway: - Ceiling tiles had brown spots consistent with water spots On 09/24/2024 at approximately 12:00 PM, Surveyors interviewed Manager A. Manager A confirmed there were concerns in the home which needed to be fixed.	N 481		
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 cleaning compounds and toxic substances were stored in a secure area. Cleaning supplies and toxic compounds were observed in an unlocked storage cabinet in laundry room. This had the potential to affect 8 of 8 residents. Findings include: The facility is licensed as a class ANA facility for 8 residents with programs in developmentally disabled, traumatic brain injury, physically disabled, emotionally disturbed/mental illness,	N 499		

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N 499	Continued From page 19 advanced aged, irreversible dementia/Alzheimer's, and alcohol/drug dependent. On 09/24/2024 at approximately 9:52 AM, Surveyors conducted a tour of the facility, Surveyors observed an unlocked storage cabinet in laundry room. Surveyors observed the following chemicals in the storage cabinet: - (4) 121-ounce bottles of Clorox bleach - 12-ounce spray bottle of window cleaner - 18.75-ounce can of hot shot flying insect killer - 32-ounce spray bottle of Oxydol foaming bathroom cleaner with bleach - 21-ounce can of Comet with bleach - 32-ounce bottle of Lysol advanced power clinging gel - 4-pound container of Tomcat Bait Chunx - 88-ounce bottle of gain liquid laundry detergent - 67.6-ounce bottle of Nanc concentrate bathroom cleaner - 18-ounce can of Shout advanced grease busting foam - (12) bottles of Zep high traffic floor polish - 19-ounce can of Lysol disinfectant spray Residents had free access to the storage cabinet. On 09/24/2024 at approximately 12:00 PM, Surveyors interviewed Manager A. Manager A stated staff should have kept the storage cabinet locked at all times. Manager A stated s/he was unaware of why the storage cabinet was left unlocked.	N 499		
N 530	83.47(3) Fire inspection.	N 530		

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N 530	Continued From page 20 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 staff interview, the provider did not ensure the fire inspection by the local fire authority or certified fire inspector was completed for 2 of 2 calendar years (2022 and 2023). Findings include: On 09/24/2024 at approximately 9:30 AM, Surveyors requested the annual fire inspection for calendar year 2023 from Supervisor B. Supervisor B gave Surveyors a binder which did not have the annual fire inspection for calendar years 2022 and 2023 (and to date in 2024). On 09/24/2024 at approximately 10:30 AM, Surveyors interviewed Manager A and Supervisor B. Manager A stated s/he was not aware the local fire department was supposed to come out and do an inspection as well. Manager A called local fire department and they directed Manager A who to call to get a fire inspection. Manager A stated s/he had not had one completed since the facility was licensed in 2017. Manager A stated s/he would set one up as soon as possible.	N 530		
N 532	83.47(4)(b) Fire extinguishers: locations. A fire extinguisher shall be mounted on a wall or a post or in an unlocked wall cabinet used exclusively for that purpose. Fire extinguishers	N 532		

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N 532	Continued From page 21	N 532		

shall be clearly visible. The route to the fire extinguisher shall be unobstructed and the top of the fire extinguisher shall not be over 5 feet high. The extinguisher shall not be tied down, locked in a cabinet or placed in a closet or on the floor. Fire extinguishers on upper floors shall be located at the top of each stairway. Extinguishers shall be located so the travel distance between extinguishers does not exceed 75 feet. The extinguisher on the kitchen floor level shall be mounted in or near the kitchen.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 2 of 3 fire extinguishers were mounted on a wall or stored in an unlocked cabinet.

Findings include:

On 09/24/2024 at approximately 9:52 AM, Surveyors toured the provider's facility and observed 2 fire extinguishers, near the front entrance and in the kitchen, sitting on the floor rather than being mounted to the wall.

On 09/24/2024 at approximately 12:00 PM, Surveyors interviewed Manager A. Manager A stated that s/he would ensure fire extinguishers were mounted on the wall. Manager A was unsure why the fire extinguishers were not mounted.