STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016736	A. BUILDING: _____ B. WING _____	C 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE MEMORY CARE OF WAUSAU	7704 FRANCISCAN WAY WESTON, WI 54476

(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 04/22/2026, Surveyor conducted a standard licensure survey and complaint investigation at Primrose Memory Care Of Wausau. Data was collected through 04/27/2026. The complaint was unsubstantiated. Eight deficiencies were identified. Four of the 8 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) 8S3V11, dated 09/13/2021, and SOD 8S3V13, dated 04/19/2023. Census: 23	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees reviewed were screened for communicable	N 220		

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

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N 220	Continued From page 1 disease including tuberculosis (TB) using standards set by the Centers for Disease Control and Prevention (CDC) within 90 days before the start of their employment. This is a repeat deficiency. See Statement of Deficiency (SOD) 8S3V11, dated 09/13/2021. Findings include: The CDC states: "All U.S. health care personnel should be screened for tuberculosis (TB) upon hire (i.e., preplacement). This process includes a risk assessment, symptom evaluation, and TB blood test or TB skin test." Retrieved from: https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm on 04/01/2026. On 04/22/2026, Surveyor reviewed the employee files for Caregiver C, Caregiver D, and Caregiver E. Caregiver C's date of hire was 08/01/2023. Surveyor did not locate a TB blood or skin test in Caregiver C's file. Caregiver D's date of hire was 04/02/2026. Surveyor did not locate a TB blood or skin test in Caregiver D's file. Caregiver E's date of hire was 04/08/2026. Surveyor did not locate a TB blood or skin test in Caregiver E's file. On 04/22/2026 at approximately 2:10 p.m., Director of Nursing (DON) F told Surveyor s/he did not have TB tests for Caregiver C, Caregiver D, and Caregiver E.	N 220		

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N 220	Continued From page 2 The provider did not ensure all caregivers were tested for TB before the start of employment.	N 220		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees reviewed obtained all department approved training as required.	N 239		

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N 239	Continued From page 3 Caregiver D, who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these duties. This is a repeat deficiency. See Statement of Deficiency (SOD) 8S3V11, dated 09/13/2021. Findings include: On 04/22/2026, Surveyor conducted a review of 3 employees to verify compliance with department approved training requirements. Surveyor requested training records for Caregiver C, Caregiver D, and Caregiver E. The record for Caregiver D, hired 04/02/2026, did not contain evidence of training or evidence of meeting an exemption for standard precautions. On 04/22/2026, at approximately 2:10 p.m., Surveyor interviewed Director of Nursing (DON) F. DON F confirmed Caregiver D performed job tasks that may expose the employee to blood or other bodily fluids. DON F confirmed the provider did not have evidence Caregiver D completed or met an exemption for standard precaution training prior to assuming these job duties. On 04/22/2026, Surveyor verified Caregiver D was not on the Community-Based Care and Treatment training registry for standard precautions.	N 239		
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	N 389		

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N 389	Continued From page 4	N 389		

or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure the individual service plan (ISP) was reviewed and revised for 2 of 2 residents reviewed (Resident 1 and Resident 2) when they had a change in their condition.

This is a repeat deficiency. See Statement of Deficiency (SOD) 8S3V11, dated 09/13/2021.

Findings include:

RESIDENT 1
On 04/22/2026 at approximately 10:30 a.m., Surveyor observed Resident 1 sleeping in a recliner with an alarm on.

On 04/22/2026, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 04/10/2023. S/he had multiple diagnoses including Alzheimer's disease and osteoarthritis.

Resident 1's assessment, dated 12/23/2025,

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indicated Resident 1 used a body alarm, walker, and wheelchair. The assessment read, in part: "Resident is at HIGH risk for falls and requires regular staff INTERVENTION to prevent falls."

Resident 1's ISP, dated 12/23/2025, indicated Resident 1 was non-ambulatory and used the following devices: body alarm, walker, and wheelchair.

The ISP read, in part:
Need - "Fall Risk Assistance - High Risk Interventions"
Goal - "I will have a reduction in the number of avoidable falls and remain free of injury."
Intervention - "Staff to regularly perform interventions with resident who is at high risk for falls."

No specific interventions were listed.

Need - "Spot Checks - Regular Interval"
Goal - "I will remain safe and accounted for within the premises."
Intervention - "Staff will provide welfare checks on resident to promote safety and ensure resident's need are being met during the day ... Frequency: 12 Times per Day. Resident requires 2 HOURS checks."

An incident log from 01/22/2026 - 04/22/2026, indicated Resident 1 fell on 02/19/2026, 03/19/2026, and 04/16/2026.

On 04/22/2026 at 3:00 p.m., Surveyor interviewed Director of Memory Care (DMC) B. Director of Nursing (DON) F and Clinical Support Specialist (CSS) G were present. Surveyor reviewed additional documentation that needed to be reviewed. Surveyor requested documentation

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related to Resident 1's falls including circumstances around the falls, who was notified, when they were notified, and what interventions were put into place. DMC B told Surveyor the requested information was documented in the reports.

On 04/23/2026, Administrator A emailed Surveyor additional documentation including the incident reports for Resident 1's falls.

On 02/19/2026, Resident 1 had an unwitnessed fall. The report read, in part: "VI. FACTS OBSERVED AT SCENE Writer observed resident laying on [his/her] right side in hallway VII. INTERVENTIONS IMPLEMENTED TO MINIMIZE RECURRENCE Remain in eyesight of staff ..."

On 03/19/2026, Resident 1 had an unwitnessed fall. The report read, in part: "VI. FACTS OBSERVED AT SCENE Resident was found on the floor laying on [his/her] right side VII. INTERVENTIONS IMPLEMENTED TO MINIMIZE RECURRENCE Q2 (every 2) spot checks, staff to anticipate residents [sic] needs i.e. toileting, fluids, snacks."

On 04/16/2026, Resident 1 had an unwitnessed fall. The report read, in part: "VI. FACTS OBSERVED AT SCENE Resident was observed laying on [his/her] right side with [his/her] arm underneath [his/her] body. Residents wheel chair [sic] was facing [his/her] recliner and in front of [his/her] body. Wheel chair [sic] breaks [sic] were unlocked. Resident did have [his/her] grip socks on. VII. INTERVENTIONS IMPLEMENTED TO MINIMIZE RECURRENCE Frequent checks, make sure resident has personal alarm on."

On 04/23/2026, Surveyor received an updated

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N 389	Continued From page 7 ISP for Resident 1, dated 04/23/2026, which included the following: "Make sure resident has personal alarm on during wake hours, frequent checks, staff to anticipate needs i.e. toileting, offer fluids, snacks." Resident 1's ISP, dated 12/23/2025, was not updated after his/her falls until 04/23/2026. RESIDENT 2 On 04/22/2026 at approximately 10:00 a.m., Surveyor observed Resident 2 walking independently around the common area. On 04/22/2026, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 03/13/2026. S/he had a diagnosis of advanced stage Alzheimer's disease. Resident 2's pre-admission assessment, dated 03/03/2026, indicated the following: Resident 2 was ambulatory. Required redirection or cueing due to behavioral expression. Required stand-by supervision or cueing assistance with ambulation, mobility, and/or transfers. Resident 2 did not use any mobility devices. Resident was at high risk for falls and required regular staff intervention to prevent falls. Intervention was for staff to anticipate needs of resident. Resident 2's BIMS (brief interview for mental status) score indicated severe cognitive impairment. Resident 2's ISP, dated 03/03/2026, read, in part: Need - "Wanders - Does Not Wander"	N 389		

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N 389	Continued From page 8 Goal - "I will have the freedom to move about the community and will remain safe." Intervention - "Staff to provide redirection as needed." Need - "Behavior Intervention" Goal - "I will behave appropriately within the community." Intervention - "Staff will monitor resident's behavior and redirect them and/or encourage alternate behaviors." Need - "Fall Risk Assistance - High Risk Interventions" Goal - "I will have a reduction in the number of avoidable falls and remain free of injury. Intervention - "Staff to regularly perform interventions with resident who is at risk for falls ... Intervention(s): Staff to anticipate needs of resident." Need - "Spot Checks - Regular Interval" Goal - "I will remain safe and accounted for within the premises." Intervention - "Staff will provide welfare checks on resident to promote safety and ensure resident's need are being met during the day ... Frequency: 12 Times per Day. Identify specific instructions: [blank]" Resident 2's ISP did not indicate s/he had any alarms. An incident report log indicated Resident 2 fell on 03/20/2026 and 03/27/2026. On 04/12/2026, Resident 2 had an altercation with another resident. On 04/22/2026 at 3:00 p.m., Surveyor interviewed DMC B. DON F and CSS G were present.	N 389		

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N 389	Continued From page 9 Surveyor reviewed additional documentation that needed to be reviewed. Surveyor requested documentation related to Resident 2's incidents including circumstances, notifications, and interventions that were put into place. DMC B told Surveyor the requested information was documented in the reports. On 04/23/2026, Administrator A emailed Surveyor the additional information, which included the incident reports and an updated ISP for Resident 2 that was signed 04/23/2026. The incident reports indicated the following: On 03/20/2026, Resident 2 had an unwitnessed fall. The report read, in part: "VI. FACTS OBSERVED AT SCENE Resident was laying [sic] at [his/her] bedside with the blankets over [his/her] and the blanket was scrunched up like resident was using it as a pillow also. VII. INTERVENTIONS IMPLEMENTED TO MINIMIZE RECURRENCE hourly checks, make sure bed alarm is on and working." On 03/27/2026, Resident 2 had an unwitnessed fall. The report read, in part: "VI. FACTS OBSERVED AT SCENE Resident had an unwitnessed fall, was laying face down VII. INTERVENTIONS IMPLEMENTED TO MINIMIZE RECURRENCE Q2 (every 2) spot checks and make sure resident isn't walking into things." On 04/12/2026, Resident 2 had an altercation with another resident. The report read, in part: "VI. FACTS OBSERVED AT SCENE Resident slapped another resident in the face by the fireplace. VII. INTERVENTIONS IMPLEMENTED TO MINIMIZE RECURRENCE Keep resident separated, if in the common areas redirect resident away from other resident."	N 389		

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N 389	Continued From page 10 Resident 2's ISP, signed 04/23/2026, was updated to indicate the following: "Wanders - Intrusively and easily redirected ... Resident is often looking for [spouse] and wanders into other residents [sic] apartments ...NOT capable of independent decision making or exhibits bad judgement; Anxious/paranoid or suspicious tendencies; Demonstrates obsessive/repetitive tendences or needs repetitive reassurances ...Nurse to notify PCP (primary care provider) of any changes. Resident has PRN (as needed) Lorazepam 1 mg (milligram) for ANXIETY/RESTLESSNESS Staff to try non-pharmacological interventions for behaviors prior to using PRNs. Behaviors include refusal to toilet, perform cares, trying to bite, hit, or scratch staff/other residents, pulling on other residents, resident also get increasingly agitated after [spouse] leaves for the day ... Staff to regularly perform interventions with resident who is at high risk for falls. Intervention(s): Staff to anticipate needs of resident, ensure all floors are free of clutter, increase spot checks on resident, ensure bed alarm is in proper working order ... Staff will provide welfare checks on resident to promote safety and ensure resident's needs are being met during the day. Frequency: 12 Times per Day. Identify specific instructions: Resident to have 2 hours safety checks ..." Resident 2's ISP was not updated after each incident to minimize recurrence of that incident. On 04/27/2026, Surveyor interviewed DMC B on the phone. Surveyor explained concerns that residents' ISPs were not updated after each incident to prevent further incidents from occurring until after Surveyor requested additional information. DMC B confirmed understanding.	N 389		

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N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide an opportunity to complete an evaluation, at least annually, of the resident's level of satisfaction with the provider's services, for 1 (Resident 1) of 1 resident reviewed that resided at the facility for greater than a year. Findings include: On 04/22/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/10/2023. Surveyor did not locate a satisfaction evaluation in Resident 1's record. On 04/22/2026 at 3:00 p.m., Surveyor interviewed Director of Memory Care (DMC) B. Director of Nursing F and Clinical Support Specialist G were present. Surveyor reviewed additional documentation that was needed to be reviewed, this included a satisfaction evaluation On 04/23/2026, Administrator A emailed Surveyor Resident 1's satisfaction evaluation, dated 04/23/2026.	N 392		

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N 392	Continued From page 12 On 04/27/2026 at 11:00 a.m., Surveyor interviewed DMC B on the phone. Surveyor explained the requirement for resident evaluation surveys to be completed annually. DMC B confirmed understanding.	N 392		
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 1 (Resident 1) of 1 resident reviewed, that resided at the facility for longer than a year, at least annually for his/her mental or physical capability to respond to a fire alarm. Findings include: On 04/22/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/10/2023. His/her Resident Evacuation Assessment was dated 05/17/2024. The assessment indicated Resident 1 required only 1 staff member to assist in evacuating. Resident 1's individual service plan, dated 12/23/2025, indicated Resident 1 required 2 staff members to assist with mobility and transfers.	N 394		

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N 394	Continued From page 13 On 04/22/2026 at 3:00 p.m., Surveyor interviewed Director of Memory Care (DMC) B. Director of Nursing F and Clinical Support Specialist G were present. Surveyor reviewed additional documentation that was needed to be reviewed, this included a review of Resident 1's evacuation assessment. On 04/23/2026, Administrator A emailed Surveyor the additional documentation. The email read, in part: "Attached are the requested documents." The additional documentation included an updated evacuation assessment, dated 04/23/2026, for Resident 1. On 04/27/2026 at 11:00 a.m., Surveyor interviewed DMC B on the phone. Surveyor reviewed requirements for reviewing each residents' evacuation assessment at least annually and with changes in condition. DMC B confirmed Resident 1's evacuation assessment was not reviewed until after Surveyor requested the documentation.	N 394		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service	N 408		

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	0016736	A. BUILDING: _____ B. WING _____	C 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE MEMORY CARE OF WAUSAU	7704 FRANCISCAN WAY WESTON, WI 54476

(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 408	Continued From page 14 plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan (ISP) for each resident that was prescribed a PRN (as needed) psychotropic medication included the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication for 1 of 2 (Resident 1) residents reviewed. The provider did not ensure the administrator, or designee, monitored at least monthly for the inappropriate use of the PRN (as needed) medications and for presence of any adverse effects from the medications, for 1 of 2 residents reviewed (Resident 1) with orders for PRN psychotropic medications that resided at the facility for longer than a month. Findings include: RESIDENT 1 On 04/20/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/10/2023. S/he had a diagnosis of Alzheimer's disease.	N 408		

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N 408	Continued From page 15 His/her physician's order sheet indicated s/he had the following PRN psychotropic medications ordered: Lorazepam 0.5 milligrams (mg) - Take 1 tablet, by mouth, every 6 hours as needed, for restlessness. Start date 12/17/2025. Haloperidol 0.5 mg - Take 1 tablet, by mouth, every 4 hours as needed. Start date 04/15/2026. Previously s/he had an order for haloperidol concentrate 2 mg/ milliliter (ml) - Take 0.5 ml (1 mg), by mouth, every 4 hours as needed for anxiety and restlessness. This had a start date of 12/17/2025 and an end date of 04/16/2026, when the tablet form was ordered. Resident 1's ISP, dated 12/23/2025, read, in part: Need - "Controlled substances and/or PRN medications" Goal - "My medications will be administered in accordance with physician's orders by staff." Intervention - "Staff will administer all medications in accordance with physician's orders for controlled substances and/or PRN medications .... Nurse to notify PCP (primary care provider) of any changes." Need - "Anti-Psychotic Medications" Goal - "My anti-psychotic medication regimen will be administered safely and per physician's orders." Intervention - "Staff to be aware of resident's anti-psychotic medications ... Nurse to notify PCP of any changes." Resident 1's ISP did not include a rationale for use and a detailed description of the behaviors which indicate the need for administration of lorazepam or haloperidol.	N 408		

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N 408	Continued From page 16 Surveyor did not locate documentation of monthly review of Resident 1's PRN psychotropic medications. On 04/22/2026 at 3:00 p.m., Surveyor interviewed Director of Memory Care (DMC) B. Director of Nursing F and Clinical Support Specialist G were present. Surveyor reviewed additional documentation that was needed to be reviewed, this included the monthly reviews of PRN psychotropic medications for Resident 1. On 04/23/2026, Administrator A emailed Surveyor the additional documentation. The email read, in part: "Attached are the requested documents." The additional documentation did not include monthly reviews for PRN psychotropic medications. The documentation did include an updated ISP for Resident 1, dated 04/23/2026. The updated ISP included the following statement: "Lorazepam 0.5 mg for RESTLESSNESS behaviors include increased self transfers resulting in harm to self or others." The updated ISP did not include the rationale for use of PRN haloperidol and a detailed description of behaviors for when staff should use the PRN haloperidol. On 04/27/2026 at 11:00 a.m., Surveyor interviewed DMC B on the phone. Surveyor reviewed requirements for residents on PRN psychotropic medications. DMC B confirmed s/he did not have the monthly reviews for PRN medications.	N 408		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating	N 504		

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N 504	Continued From page 17 system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a heating contractor or local utility company completed maintenance service on the gas furnace at least every 3 years. Findings include: The provider is licensed to care for up to 32 residents in the client groups of advanced age, irreversible dementia/Alzheimer's disease, and terminally ill. On 04/22/2026, Surveyor reviewed the provider's safety reports. Surveyor did not locate a furnace inspection in the reports. On 04/22/2026 at approximately 1:30 p.m., Surveyor interviewed Director of Memory Care (DMC) B and requested additional information including the furnace inspection. On 04/23/2026, Administrator A emailed Surveyor additional documentation. A furnace inspection was not included.	N 504		

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N 504	Continued From page 18 On 04/27/2026 at approximately 11:00 a.m., Surveyor interviewed DMC B on the phone. Surveyor asked if s/he was able to locate the last furnace inspection. DMC B told Surveyor s/he was not. S/he said s/he believed it was last inspected in 2019. DMC B said s/he is having a contractor come out in May 2026 for the inspection.	N 504		
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 provider did not conduct fire drills by evacuating the residents and recording the total evacuation time for the residents. The provider used horizontal evacuation during fire drills without	N 525		

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N 525	Continued From page 19 prior approval from the Department. This is a repeat deficiency. See Statement of Deficiency (SOD) 8S3V13, dated 04/19/2023. Findings include: The provider is licensed to care for up to 32 residents in the client groups of advanced age, irreversible dementia/Alzheimer's disease, and terminally ill. On 04/22/2026, Surveyor reviewed the provider's safety reports including fire drill reports for 2025 and 2026. After 07/11/2025, none of the fire drills indicated residents were evacuated and a total evacuation time. On 04/22/2026 at 1:30 p.m., Surveyor interviewed Director of Memory Care (DMC) B. DMC B told Surveyor they used horizontal evacuation when doing fire drills by moving residents within the facility to a different fire zone. S/he said in the event of a large fire, they would evacuate the residents to the neighboring community based residential facility. Surveyor asked if they had approval from the Department to use horizontal evacuation. DMC B told Surveyor s/he was not aware of that. Surveyor asked how often residents were evacuated horizontally during the fire drills. DMC B told Surveyor they should be evacuating the residents quarterly for the fire drills. Surveyor reviewed the fire drill reports with DMC B, which did not indicate residents were being evacuated after 07/11/2025; and the reports did not indicate a total evacuation time after 07/11/2025.	N 525		