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ANITAS GARDENS	117 E VAN BUREN PORT WASHINGTON, WI 53074

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N 000	Initial Comments On 08/16/2024, with information gathered through 08/21/2024, Surveyor conducted a standard licensing survey and a complaint investigation at Anitas Gardens. Nine deficiencies were identified. Complaint was substantiated. Census: 12	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 2 of 3 resident. Resident 2's Brimonidine Tartrate-Timolol (glaucoma eye drops) and Systane (eye drops) were not administered due to unavailability. Resident 3's Alendronate Sodium (osteoporosis medication) and albuterol were not administered due to unavailability. Findings Include: Example 1: Resident 2 On 08/16/2024, at approximately 2:00 PM,	N 352		

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

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Surveyor reviewed Resident 2's medications in the med cart. Surveyor observed a bottle of Resident 2's Brinzolamide, with a fill date of 06/12/2024. The bottle did not contain an open date.

On 08/16/2024, Surveyor reviewed Resident 2's record.

Resident 2 admitted to the facility on 12/17/2022.

Resident 2's July and August 2024 Medication Administration Record (MAR), dated 07/01/2024 to 08/15/2024, documented:
"Brimonidine Tartrate-Timolol - Instill 1 drop to Right Eye 2 Times a day (glaucoma). Scheduled at 8:00 AM and 8:00 PM."
8:00 AM dose documented as 'Other' on 07/08, 07/11 to 07/29, 07/31 to 08/02, 08/05 to 08/07 with some including a rationale of unavailable.
8:00 PM dose documented as 'Other' on 07/12 to 08/01. 08/03 to 08/07 with some including a rationale of unavailable.

"Discard the eye drops 4 weeks after opening." (Source: Medsafe website, Consumer Medicine Information - Arrow-Brimonidine, May 04, 2017, https://www.medsafe.govt.nz/consumers/cmi/a/arrowbrimonidine.pdf (retrieval date - August 21, 2024).)

Resident 2's July 2024 MAR documented:
"Systane (eye drops) - Use as directed in affected eye(s) 4 times a day. Scheduled at 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM. Start Date: 04/03/2024."
8:00 AM dose documented as 'Other' on 07/03 to 07/11, 07/13 with some including a rationale of unavailable.
12:00 PM dose documented as 'Other' on 07/02,

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N 352	Continued From page 2 07/03, 07/05 to 07/11 with some including a rationale of unavailable. 4:00 PM dose documented as 'Other' on 07/03, 07/07, 07/08, 07/09, 07/11 with some including a rationale of unavailable. 8:00 PM dose documented as 'Other' on 07/01, 07/02, 07/04 to 07/10 with some including a rationale of unavailable. On 08/16/2024, at approximately 4:00 PM, Surveyor interviewed Administrator A and Program Manager B. Administrator A stated there had been concerns with medications being available for residents and s/he would continue to follow up on the concerns. Example 2: Resident 3 On 08/16/2024, Surveyor reviewed Resident 3's record. Resident 3 admitted to the facility on 05/15/2013. Resident 3's June 2024 MAR documented: "Alendronate Sodium - Take 1 tablet by mouth at 6AM once weekly on Thursday (osteoporosis) ** take immediately upon arising in the morning with 8oz of water; stay upright for 30 minutes; take 30 minutes or more before first medication, food or beverage (othe4r than water) of the Day ** Scheduled at 6:00 AM. Start Date: 11/28/2023." 06/06 - Other - not available 06/13 - Other - not available 06/20 - Other 06/27 - Other "Albuterol 0.083% - Inhale contents of 1 vial via handheld nebulizer 4 times a day. Scheduled at 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM."	N 352		

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N 352	Continued From page 3 06/07 4:00 PM - Other - Not here been order 06/07 8:00 PM - Other - Not here 06/08 12:00 PM - Other - Not available 06/08 4:00 PM - Other - Not here 06/08 8:00 PM - Other - Not here 06/09 8:00 AM - Other - Not available 06/09 12:00 PM - Other - Not available 06/10 8:00 AM - Other - Not here 06/10 12:00 PM - Other - Not here 06/10 4:00 PM - Other - Not available On 08/16/2024, at approximately 4:00 PM, Surveyor interviewed Administrator A and Program Manager B. Administrator A stated there had been concerns with medications being available for residents and s/he would continue to follow up on the concerns. Cross Reference: N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 352		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident received adequate treatment after displaying a change-in-condition. Resident 6 was determined to be lying on the floor in his/her bedroom for approximately 10	N 353		

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N 353	Continued From page 4 hours without receiving assistance. Findings include: On 05/03/2024, the Department received a concern alleging a resident did not receive adequate treatment when s/he displayed a change-in-condition on 04/30/2024. On 08/16/2024, Surveyor reviewed Resident 6's record. Resident 6 moved into the facility, 05/04/2023, with diagnoses including severe vascular dementia with agitation (Frequent agitation may occur as people become less able to interpret their environment and control or express their feelings), metabolic encephalopathy (a group of neurological disorders that cause brain dysfunction due to chemical imbalances in the blood), hypertensive urgency (a condition where a person's blood pressure is very high, but they have few or no symptoms and no signs of organ damage), and gross hematuria (a condition where blood is visible in the urine, usually causing it to turn pink, red, purplish-red, brownish-red, or tea-colored. Resident 6's progress notes documented: 02/23 - Third Shift - Slept most of the night. In and out of the bathroom. Checked on [him/her] frequently. 02/26 - Third Shift - Sleep when arrived. Up at 2AM. 02/27 - Third Shift - Slept all night. 02/28 - Third Shift - Up and down until 3AM then slept. 02/29 - Third shift - Up and down until 1AM slept all night 03/01 - Third shift - Up and down entire night.	N 353		

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N 353	Continued From page 5 03/02 - Third shift - Slept on and off. In and out of the bathroom few times. 03/03 - Third Shift - Slept all night 03/04 - Third Shift - Sleeping when arrived slept until 2AM 04/24 - 11:00 AM - Resident sent out via ambulance earlier this morning due to resident telling staff that [s/he] felt like 'this is the end, and I am going to die.' ... found to have a prolapsed rectum. 04/25 - Third Shift - Sleeping when arrived but up and down throughout the night. 04/26 - Second Shift - Didn't eat much dinner. Took meds. Had like 5 briefs on at once, took them all off put one on and a pair of pants was keeping on and off. 04/27 - First Shift - Had all meals and meds in [his/her] room. Kept sitting in the chair in the hallway to sleep and made a mess of poop all over the bathroom by [his/her] bedroom. 04/27 - Second Shift - Has a prolapsed anus again. 04/27 - Third Shift - Slept entire night. 04/28 - First Shift - Ate in room but says [s/he's] very cold. 04/28 - Second Shift - Resident was naked and refused to get clothes on. 04/28 - Third Shift - Resident was naked still and around 1AM [s/he] was paging nonstop to help [him/her] leave the facility. I was able to calm [him/her] down and get [his/her] clothes on. 04/29 - First Shift - Stayed in room, moody 04/29 - Third Shift - Slept on floor but up throughout the night. 04/30 - 7:00 AM - Night shift caregiver calling writer earlier this morning to report that resident had a restless night and insisted on sleeping on [his/her] floor in [his/her] room. Caregiver also reporting that resident was having increased pain/discomfort to [his/her] rectal area this	N 353		

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morning around 5AM. Writer advising caregiver to transfer resident to [hospital] for eval.
04/30 - First Shift - Hospital

Resident 6's "Fall Risk Evaluation," dated 06/20/2023, documented:
Cognitive Status/Behavioral Indicators: No
Continence Status: Independent and continent.
Mobility Status: Ambulates without problems and with no devices.
Interventions: Resident is monitored daily for changes in condition.

Resident 6's "Individual Service Plan (ISP)," dated 11/02/2023, documented:
"Mobility and Transferring: Currently ambulatory independently without the use of any mobility aids. Resident has no known history of any falls."
"Toileting: Continent of bowel and bladder and independent with all toiletings needs."
The ISP did not document what Resident 6's baseline was for sleeping behaviors and if there were concerns.

On 08/16/2024, at approximately 4:00 PM, Surveyor interviewed Administrator A and Program Manager B. Program Manager B confirmed s/he had arrived for his/her shift while the ambulance was at the facility for Resident 6. Program Manager B stated Resident 6 did not normally sleep on the floor. Administrator A informed Surveyor s/he was not employed by the provider during this incident but based on Resident 6's documentation staff should have reached out to management and/or 911 when resident would not get off of the floor. Resident 6 appeared to be having a change-of-condition starting 04/28/2024. Surveyor stated the complaint documentation stated that resident had bruising on his/her back, a swollen left knee and

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an abrasion but the documentation reviewed, does not document any falls and/or address any injuries of unknown origin. Administrator A and Program Manager B could not respond to that concern.

On 08/21/2024, Surveyor requested and reviewed Resident 6's emergency medical services documentation which stated:
"04/29/2024 - 6:16AM with patient - Upon arrival to the facility a staff member gave paperwork and reported the patient was found on the ground when [s/he] came in at 1900 (7:00 PM) the previous night and was still on the ground because "[s/he] likes being on the ground." EMS (emergency medical services) confirmed again from staff that pt (patient) did not fall out of bed due to EMS concerns about pt being on the ground. Staff confirmed [s/he] did not fall out of bed and [s/he] was not injured. The patient was seen 3 days ago at the Emergency Department for a prolapsed rectum and "it came out again over the weekend". One EMS crew member took the cot up to the second floor in the elevator and the other crew member took the stairs to the second floor. Upon arrival to the patient's room the patient was found on [his/her] R (right) side on the floor next to [his/her] bed with no clothes on but a brief that was soaked in urine. Carpet under the patient was also saturated with urine. No pillow or blanket were on or near the patient and the patient's bed was still made. EMS initial assessment of the patient was there were two bilateral lines of petechial bruising seen on the patient's back approximately 6" long. The patient's thighs were red, irritated, sore upon palpation and wet around where the brief was sitting. The patient's L (left) knee was red and a little swollen with abrasions. The patient's skin was hot/warm to touch. The pt appeared unable

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N 353	Continued From page 8 to get up from the ground on [his/her] own when asked to do so. The patient was lifted off the floor by the two staff members under [his/her] arms and the EMS cot was placed behind the patient by one EMS crew member. Other EMS crew member quickly tried to grab and hold onto the patient while [s/he] was being placed on the EMS cot by the facility staff members. Once the patient was on the EMS cot the staff members left the patient's room without assisting EMS any further. Due to the urgency of removing the patient from the facility and unwillingness of the staff to assist EMS further, EMS was unable to examine for the prolapsed rectum. Patient was secured to the ambulance cot and given blanket and pillow for comfort. When given a blanket patient displayed great appreciation to EMS. Vitals were obtained and showed the heart rate was jumping so the paramedic partner performed a 12 lead ECG (medical test that measures the heart's electrical activity to check for irregular or dangerous heartbeats) on the patient. According to paramedic pt appeared to be in a sinus arrhythmia but pt has a hx (history) of sinus node dysfunction in [his/her] paperwork. On the way out to the ambulance a staff member identifying [him/herself] as the manager stated that "[s/he] just came to them a month ago and is uncooperative and [s/he] never lets us get vitals or anything" (speaking to the Paramedic partner when [s/he] asked about pt's hx of heart dysrhythmia). While in the back of the ambulance patient vitals were obtained and an assessment was performed. EMS findings during the patient assessment was patient was AOx2 (alert and oriented - knows who they are and where they are, but not what time it is or what is happening to them) to [him/herself] and where [s/he] was. Due to the lack of information in staff report and information EMS asked of staff about	N 353		

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N 353	Continued From page 9 the patient, EMS did not receive a normal baseline mental status of the patient or a verbal history. Patient declined chest pain, difficulty breathing and when asked if patient was in pain anywhere else patient could tell EMS [s/he] was in pain but couldn't define to EMS where this pain was. During assessment patient was able to answer questions to the best of [his/her] ability but as the assessment progressed the patient became more lethargic. While enroute to [hospital] EMS gave phone report to ED (emergency department) staff. Transport was uneventful with patient resting. ... EMS gave report to the receiving RN (registered nurse) and voiced the concerns of how the patient was found at the facility by EMS. The receiving RN asked EMS to repeat the information and concerns given to the RN who would be treating the patient going further."	N 353		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.	N 389		

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N 389	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents' Individual Service Plans (ISP) were updated when there was a change of condition in the resident's physical and/or mental condition. Resident 5's ISP was not updated to provide care guidelines for his/her behaviors regarding self-harm. Findings include: On 08/16/2024, Surveyor reviewed a written report that had been submitted to the Department on 04/08/2024 which documented: "This letter is to inform you of a recent incident in which [Resident 5] threatened to commit suicide. [Resident 5] ... with a history of depression and bipolar disorder. ...On 04/07/2024, [Resident 5] was upset for not being able to have an extra non-alcoholic beer, which is something that has been a directive from [his/her] guardian. [S/he] then proceeded to yell at staff and asked for [his/her] lunch. Staff told [Resident 5] that lunch was not ready yet, [Resident 5] then told staff that by the end of the shift [s/he] was going to commit suicide and walked back into [his/her] room. For [Resident 5's] safety, the police, paramedics, social worker, and POA (power of attorney) were called. The police cleared [him/her] to be alright after speaking with [him/her]. ... no additional changes were made to [his/her] care plan at this time." On 08/16/2024, Surveyor reviewed Resident 5's record. Resident 5 moved into the facility, 01/27/2022, with diagnoses including depression and bipolar	N 389		

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disorder.

Resident 5's "Individual Service Plan," dated 12/05/2023, documented:
"Self-Abusive Behavior: Not Applicable"
"Suicidal Tendencies: Not Applicable"
"Attitude: Not Applicable"
"Mental Illness: Resident has diagnosis of schizophrenia with hallucinations. [S/he] is on oral medications daily to help control this. [S/he] currently is not experiencing any active hallucinations. [S/he] is pleasant and social when spoken with."
"Leisure Time Activities: Remains able to pick and choose which activities [s/he] likes to participate in daily. [Resident 5] likes to watch TV in [his/her] room such as sports or westerns. [S/he] also has participated in group exercises, Bingo, and Happy Hour."
Handwritten note: "04/09/2024 - Per Resident 5's [POA], [Resident 5] can have two (2) NA (non-alcoholic) beers per day. Resident on weekends also ok to have one (1) real (alcoholic) beer (if requested) while [s/he] is watching a sporting event."
Surveyor noted the handwritten note occurred after the 04/07/2024 incident. Prior to that, staff were not provided guidance on Resident 5's verbal outbursts and/or his/her ability to have non-alcoholic and/or alcoholic beverages. Surveyor noted guidelines were not added to address threats of self-harm.

On 08/16/2024, at approximately 4:00 PM, Surveyor interviewed Administrator A and Program Manager B. Administrator A stated, "In that situation, staff could have addressed [Resident 5's] concerns in another format, such as allowing the additional beer, and addressing the concern with the POA afterwards. This is a

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N 389	Continued From page 12 situation, where we need to be mindful of the resident's rights; it was a non-alcoholic beer." Administrator A stated Resident 5's ISP would be updated to address his/her verbal behaviors and possible attention seeking responses.	N 389		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure proper documentation on the Medication Administration Record (MAR) for 2 of 3 residents reviewed. Resident 2's MARs documented 'Other' for medication administration for his/her prescribed Brimonidine Tartrate - Timolol (glaucoma eye drops) and did not include a rationale. Resident 4's MARs documented 'Other' for medication administration for his/her prescribed UTI-Stat (medication for urinary tract infections [UTI]) and did not include a rationale.	N 415		

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N 415	Continued From page 13 Findings include: Example 1: Resident 2 On 08/16/2024, Surveyor reviewed Resident 2's record. Resident 2 admitted to the facility on 12/17/2022. Resident 2's July and August 2024 Medication Administration Record, dated 07/01/2024 to 08/15/2024, documented: "Brimonidine Tartrate-Timolol - Instill 1 drop to Right Eye 2 Times a day (glaucoma). Scheduled at 8:00 AM and 8:00 PM." 8:00 AM dose documented as 'Other' with no rationale: 07/08, 07/11, 07/13, 07/14, 07/15, 07/18, 07/19, 07/24, 07/25, 07/26, 07/27, 07/28,9, 07/31, 08/01, 08/02, 08/05, 08/06, 08/07. 8:00 PM dose documented as 'Other' with no rationale: 07/12, 07/13, 07/14, 07/16, 07/18, 07/19, 07/23, 07/25, 07/27, 07/28, 07/30, 08/01, 08/03, 08/04, 08/05, 08/06, 08/07. On 08/16/2024, at approximately 4:00 PM, Surveyor interviewed Administrator A and Program Manager B. Administrator A stated staff would be re-educated on the importance of proper medication administration documentation. Example 2: Resident 4 On 08/16/2024, Surveyor reviewed Resident 4's record. Resident 4 admitted to the facility on 04/04/2012. Resident 4's July and August 2024 Medication Administration Record, dated 07/01/2024 to	N 415		

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N 415	Continued From page 14 08/15/2024, documented: "UTI-Stat 30 ML (milliliter) - Take 30 ML PO (by mouth) daily: UTI Prevention." Documented as other, with no rationale, on 07/19, 07/22, 07/24, 07/25, 07/27, 07/28, 08/01, 08/02, 08/05. On 08/16/2024, at approximately 4:00 PM, Surveyor interviewed Administrator A and Program Manager B. Administrator A stated staff would be re-educated on the importance of proper medication administration documentation.	N 415		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 2 residents received prescribed medications prior to expiration dates. Resident 3's Latanoprost (glaucoma eye drops) had an open date of 06/11/2024 and was being currently administered. Latanoprost is to be discarded after 6 weeks.	N 432		

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N 432	Continued From page 15 Resident 4's Dorzolamide-Timolol Maleate (eye drop), Prednisolone (eye drop), and Timolol Maleate (eye drops) did not have open dates written on the bottle and were being currently administered. Findings include: Example 1: Resident 3 On 08/16/2024, at approximately 2:00 PM, Surveyor observed Resident 3's Latanoprost in the medication cart which had an open date of 06/11/2024. On 08/16/2024, Surveyor reviewed Resident 3's record. Resident 3's June, July, and August 2024 Medication Administration Record (MAR), dated 06/01/2024 to 08/15/2024, documented: "Latanoprost - Instill 1 drop into each eye at bedtime (glaucoma)." Surveyor noted there were no other bottles of Latanoprost available for Resident 3. "You may keep the opened bottle in the refrigerator or at room temperature for up to 6 weeks. (Source: Mayo Clinic website, Latanoprost (Ophthalmic Route), February 01, 2024, https://www.mayoclinic.org/drugs-supplements/latanoprost-ophthalmic-route/ (retrieval date - August 21, 2024).) Surveyor noted Resident 3's Latanoprost should have been replaced in August 2024. On 08/16/2024, at approximately 4:00 PM.	N 432		

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N 432	Continued From page 16	N 432		

Surveyor interviewed Administrator A and Program Manager B. Administrator A stated s/he would re-educate staff on dating medications when they are opened to ensure they are not administered after expiration. Administrator A stated most eye drop medications, available in a bottle, expire approximately 30 days after the bottle has been opened.

Example 2: Resident 4

On 08/16/2024, at approximately 2:00 PM, Surveyor observed Resident 4's medications in the med cart which included:
A bottle of Dorzolamide-Timolol Maleate with a dispensed date of 06/11/2024, no open date.
A bottle of Prednisolone Moxifloxacin-Bromfenac with a dispensed date of 05/23/2024, no open date.
A bottle of Timolol Maleate 0.5%, with a dispensed date of 03/04/2024, no open date.
Surveyor noted there were no other bottles of Dorzolamide-Timolol Maleate, Prednisolone Moxifloxacin-Bromfenac, and Timolol Maleate available for Resident 4.

Resident 4's July and August 2024 MARs, dated 07/01/2024 to 08/15/2024, documented:
"Dorzolamide-Timolol - Instill 1 drop in both eyes 2 times a day. Start Date: 04/02/2024."
"Prednisolone Moxifloxacin-Bromfenac Instill one drop into the left eye three times a day for 2 weeks. Scheduled at 8:00 AM, 12:00 PM, 8:00 PM. Start Date: 07/02/2024 to 07/23/2024. Start Date: 07/23/2024 to 08/06/2024. Start Date: 08/07/2024 to 08/20/2024."
"Timolol Maleate - Instill 1 drop in both eyes in the morning. Start Date: 05/28/2024."

"Dorzolamide/Timolol should be used within 28

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N 432	Continued From page 17 days after the bottle is first opened. Therefore, you must throw away the bottle 4 weeks after you first opened it, even if some solution is left. To help you remember, write down the date that you opened it in the space on the carton and the bottle." (Source: Electronic Medicines Compendium website, Package Leaflet: Information for the User, 12/2022, https://www.medicines.org.uk/emc/files/pil.10111.pdf (retrieval date - August 21, 2024).) "Sterile items should be discarded 28 days after initial opening." (Source: Glaucoma Care Center website, Prednisolone, Moxifloxacin, Bromfenac, undated, https://glaucomacarecenter.com/wp-content/uploads/2021/12/Pred-Moxi-Brom-Patient-Leaflet.pdf (retrieval date - August 21, 2024).) "Discard the bottle 28 days after opening, even if there is solution remaining." (Source: Electronic Medicines Compendium website, Package Leaflet: Information for the User, 02/2020, https://www.medicines.org.uk/emc/files/pil.459.pdf (retrieval date - August 21, 2024).) On 08/16/2024, at approximately 4:00 PM. Surveyor interviewed Administrator A and Program Manager B. Administrator A stated s/he would re-educate staff on dating medications when they are opened to ensure they are not administered after expiration. Administrator A stated most eye drop medications, available in a bottle, expire approximately 30 days after the bottle has been opened.	N 432		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures	N 490		

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N 490	Continued From page 18 shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident bathrooms were clean and in good working order. Findings include: On 08/16/2024 from approximately 11:15 AM to 12:30 PM, Surveyor conducted a tour of the facility and observed the following: -Bathroom cabinets wood finish was peeling, causing a catching hazard on resident clothing and/or skin. -(5) bathroom light fixtures contained burned out light bulbs. -Metal grab bars appeared to be rusting. -Electric baseboards had a film of dust along the tops. -Toilet seat cover finishes were peeling off. -A rod to hang a towel on was missing the bar between the brackets. -Bathtubs had a buildup of what appeared to be soap scum. -Bathtub faucets were leaking and could not be tightened to stop the water leaking. On 08/16/2024, at approximately 3:30 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would address the concerns with management and staff.	N 490		
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.	N 499		

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N 499	Continued From page 19	N 499		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure that cleaning compounds and toxic substances were stored in a secure area.

Findings include:

On 08/16/2024 from approximately 11:15 AM to 12:30 PM, Surveyor conducted a tour of the facility and observed the following unsecured cleaning compounds and toxic substances:

Resident Bathrooms:
-20 ounce spray can of foaming bubble bathroom cleaner
-32 fluid ounce bottle of all purpose cleaner, lemon breeze scent

Kitchen Sink:
-23 fluid ounce bottle of window cleaner
-14.5 ounce spray can of oven cleaner
-24 ounce bottle of toilet bowl cleaner
-22 fluid ounce bottle of kitchen antibacterial cleaner

Laundry Room:
-Gallon jug of disinfectant
-24 ounce bottle of toilet bowl cleaner
-22 ounce spray can of foaming carpet cleaner

Maintenance Room
-Shelves full of paint cans, spray cans of paint, tubes of caulk, cleaners with bleach, furniture polish, wood cleaner, weed killer, ant killer, etc.

On 08/16/2024, at approximately 4:00 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would address the

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N 499	Continued From page 20 concerns with management and staff.	N 499		
N 539	83.48(3)(b) Sensitivity testing performed Sensitivity testing shall be performed at intervals in accordance with NFPA 72. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the smoke and heat detection system had sensitivity testing for each device performed at intervals in accordance with NFPA (National Fire Alarm and Signaling Code) 72 requirements. Findings include: On 08/16/2024, Surveyor reviewed the facility life safety code documentation. There was no documentation found that the smoke and heat detection system had sensitivity testing in 2022 or 2023. On 08/16/2024, at approximately 3:00 PM, Surveyor asked Administrator A if there was documentation indicating sensitivity testing had been conducted in 2022 or 2023 or had a positive testing in the last 5 years. Licensee A and Surveyor reviewed the documentation that had been provided where the language stated, "If the sensitivity testing had been completed." Administrator A and Surveyor were unable to determine if the sensitivity testing had been completed. Administrator A stated s/he would contact the vendor and have them send over verification. As of 08/21/2024 at 4:00 PM, Surveyor did not	N 539		

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N 539	Continued From page 21 receive any additional documentation.	N 539		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a solid core wood door or an equivalent fire resistive door was provided at the interior stair between the basement and the first floor. Findings include: On 08/16/2024, at approximately 11:00 AM, Surveyor toured the facility. Surveyor observed two stairwells leading to the basement with ½ doors, that were opened towards the individual. The ½ doors were not self-closing. Surveyor walked to the basement and observed the laundry room, utility room and a conference room/office room. The definition of a fire-resistant door: A fire door is a door with a fire-resistance rating used as part of a passive fire protection system to reduce the	N 640		

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N 640	Continued From page 22 spread of fire and smoke between separate compartments of a structure and to enable safe egress from a building or structure or ship. On 08/16/2024, at approximately 4:30 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would review the concern with the management team.	N 640		