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SUNSET WOODS SENIOR LIVING	2900 S MOORLAND RD NEW BERLIN, WI 53151

(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 01/22/2026, Surveyor conducted a standard survey and 1 verification visit at Sunset Woods Senior Living. Eight deficiencies were identified. The 1 deficiency from Statement Of Deficiency (SOD) 8X1211 dated 09/10/2025 was substantially corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 41	{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 ensure the resident right to receive all prescribed medications in the dosage and at intervals prescribed by the practitioner for 6 of 6 residents reviewed. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 50 residents within the client groups of advanced aged, developmentally disabled, terminally ill,	N 352		

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

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irreversible dementia/Alzheimer's and emotionally disturbed/mental illness.

On 01/22/2026, Surveyor inspected 2 of 2 medication carts, interviewed Wellness Coordinator F and Caregiver L and reviewed records of Resident 5, Resident 7, Resident 8, Resident 9, Resident 10, and Resident 11. On 01/23/2026 at 2:29 PM, Surveyor interviewed Pharmacy Tech M.

On 01/22/2026 at 9:31 AM, while inspecting the south medication cart with Wellness Coordinator F, surveyor observed:

Example 1- Resident 7
3 bottles Zenpep DR (delayed release) 3000-10,000 Unit
Pharmacy label identified (Photos 1 and 2):
Zenpep DR 3000-10,000 Unit 1 capsule 3 times daily before meals
Quantity: 100 capsules
Dispensed: bottle 1 - 10/07/2025; bottle 2 - 12/15/2025; and bottle 3 - 01/16/2026.
Bottle 3 was unopened.
Wellness Coordinator F stated bottle 1 was approximately 1/2 full, and bottle 2 was approximately ¾ full.

Pharmacy Tech M stated the physician order for Zenpep was 3 times daily before meals, a 100-tablet bottle was dispensed on 11/11/2025, and the medication was on auto refill (meaning the provider did not have to contact pharmacy for refills).

[Note: " ...ZENPEP is a prescription medicine used to treat people who cannot digest food normally because their pancreas does not make enough enzymes ...Take ZENPEP exactly as your

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doctor tells you. Contact your doctor if you continue to have signs and symptoms of malabsorption (not absorbing nutrients from food) such as abdominal pain, abdominal distention, bloating, fatty stools, or weight loss ...Always take ZENPEP with a meal or snack ..." (Source: https://www.drugs.com/pro/zenpep.html (retrieval date 01/28/2026)).]

Resident 7 was admitted 06/07/2024. Physician orders included Zenpep DR 3000-10,000 Unit 1 capsule 3 times daily before meals for digestion (start date: 06/11/2024).

Medication Administration Record (MAR):
The MAR listed administration times of 8:00 AM, 2:00 PM and 8:00 PM (contrary to MD order on pharmacy label).
From 10/07/2025 at 8:00 AM to -1/22/2026 at 2:00 PM, staff documented administering 298 doses/tablets of Zenpap.
Note: Based on observations, only approximately 175 doses/tablets were administered when the estimated amount from bottle 1 (1/2 full) was 50 doses/tablets, bottle 2 (3/4 full) was 25 doses/tablets, and November 2025 bottle (assuming all 100 tablets were administered) was 100 doses/tablets (total of 175 doses/tablets).

Observation notes dated 10/04/2025-01/22/2026 did not address why Zenpep was documented as administered when tablets remained in the bottles.

Individual service plan (ISP) dated 08/04/2025
In the area of Medication - "Resident will receive medication as prescribed by the physician ...Staff performs medication administration ...Administer medication(s) as ordered by MD ..."

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N 352	Continued From page 3 Example 2- Resident 8 3 bottles of polyethylene glycol (poly glycol) 3350 powder Pharmacy label identified (Photo 3): Polyethylene glycol powder, dissolve 17 grams in 8 oz fluid and drink twice daily Quantity- 510 grams, 30 doses per bottle Dispense date: 1 bottle dispensed 02/19/2025 and 2 bottles dispensed 03/06/2025. Wellness Coordinator F stated the 02/19/2025 bottle was 1/8 full, each of 03/06/2025 bottles were 2/3 full, and there were no additional bottles of Resident 8's poly glycol at facility. Pharmacy Tech M stated a 30-dose bottle of polyglycol was last dispensed 04/02/2025, it was not on auto refill and the prescription expired 08/18/2025. Resident 8 was admitted 06/16/2023. Physician orders included polyethylene glycol powder, dissolve 17 grams in 8 oz fluid and drink twice daily (start 07/10/2024). MAR: From 10/01/2025 AM to 01/21/2026 PM (113 days), staff documented administration of 226 doses. Observation notes dated 10/01/2025-01/22/2026 did not address why poly glycol was documented as administered when left in the bottles. ISP dated 08/12/2025 In the area of Medication- "Resident will receive medication as prescribed by the physician ..." Example 3- Resident 9 1 bottle of polyethylene glycol 3350 powder Pharmacy label identified (Photo 4):	N 352		

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N 352	Continued From page 4 Polyethylene glycol powder, dissolve 17 grams in 8 oz fluid and drink twice daily Quantity- 510 grams, 30 doses Dispense date: 08/25/2025 Wellness Coordinator F stated the bottle was approximately ¾ full and Resident 9 had no additional bottles of poly glycol at facility. Wellness Coordinator F stated Resident 9 was recently hospitalized for 2 weeks. Pharmacy Tech M stated a 30-dose bottle was last dispensed on 08/25/2025 and the medication was not on auto refill. Resident 9 was admitted 06/16/2023. Physician orders included polyethylene glycol powder, dissolve 17 grams in 8 oz fluid and drink daily (start date 08/27/2025). (Note: physician order contradicts pharmacy label.) MAR: From 10/01/2025 AM - 01/22/2026, staff documented administration of 104 doses. Observation Notes dated 10/10/2025-01/22/2026 did not address why poly glycol was documented as administered when left in the bottle. Example 4- Resident 10 2 Spiriva Respimat inhalers Pharmacy label identified (Photos 5 and 6) Spiriva Respimat 2.5 MCG inhaler, inhale 2 sprays daily Quantity- 60 metered inhalations per inhaler Dispensed 11/18/2025(opened) and 12/19/2025 (unopened) The meter on the opened inhaler displayed approximately 28 inhalations remaining.	N 352		

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N 352	Continued From page 5 Resident 10 was admitted 05/20/2024. Diagnoses included chronic obstructive pulmonary disease (COPD). Physician orders included Spiriva Respimat 2.5 MCG inhaler, inhale 2 sprays daily. MAR- From 11/18/2025-01/22/2026, staff documented administration of Spiriva 66 days (132 inhalations). Observation notes dated 11/18/2025-01/22/2026 did not address why Spriva was documented as administered when doses remained in the inhalers. ISP dated 04/01/2025: In the area of Medications- " ...Resident will receive medication as prescribed by the physician ...Staff performs medication administration ..." Example 5- Resident 11 3 Spiriva Respimat inhalers (1 opened, and 2 in unopened boxes) Pharmacy label identified (Photo 7) Spiriva Respimat 2.5 MCG inhale 2 puffs into lungs daily Quantity- 60 metered inhalations per inhaler (Note: 30-day supply) Dispensed- 10/04/2025, unopened; 01/05/2026, unopened; and 11/03/2025, opened. The meter on the opened inhaler displayed approximately 44 inhalations remained. Pharmacy Tech M stated the inhalers were on auto refill. Resident 11 was admitted 05/31/2024. Diagnoses included COPD. Physician orders included Spiriva Respimat 2.5 MCG inhale 2 puffs (inhalations) into lungs daily (start 09/05/2024).	N 352		

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N 352	Continued From page 6 MAR: From 10/04/2025-01/22/2026 (111 total days/222 inhalations), staff documented administration of 218 inhalations (Note: Based on observation, from 10/04/2025-01/22/2026, staff administered 16 doses (Full inhaler contained 60 inhalations minus 44 inhalations remaining per meter = 16 inhalations administered). Observation notes dated 10/04/2025-01/22/2026 did not address why Spiriva was documented as administered when doses remained in the inhalers. ISP dated 08/09/2025- In the area of Medications- " ...Resident will receive medication as prescribed by the physician ...staff performs medication administration ..." Example 6- Resident 5 On 01/22/2026 at 10:03 AM while inspecting the medication room's refrigerator with Wellness Coordinator F, Surveyor observed 5 bottles of Resident 5's liquid gabapentin. Pharmacy labels identified (Photos 8, 9, and 10): Gabapentin 250 MG/ML 5 ML once daily for pain Quantity: 150 ML (30 doses) Dispensed 08/26/2025, 10/23/2025, 11/21/2025, 12/15/2025, and 01/13/2026 Wellness Coordinator F stated the 08/26/2025 bottle was approximately ¼ full, 10/23/2025 was approximately 1/8 full, 11/21/2025 was approximately 2/3 full, 12/15/2025 was approximately ¾ full and 01/13/2026 was approximately ¾ full and s/he did not know why multiple bottles containing gabapentin were in the	N 352		

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N 352	Continued From page 7 refrigerator. Pharmacy Tech M stated liquid gabapentin was last dispensed 1/13/2026, a 150 ML bottle contained 30 doses, and the medication was not on auto refill. On 01/22/2026 at 10:24 AM, while inspecting the north medication cart with Med Tech L, Surveyor observed: (Example 6- Resident 5 continued) 1 bottle polyethylene glycol 3350 powder Pharmacy label identified (Photo 13) Polyethylene glycol 3350 dissolve 17 grams in 4-8 oz. of liquid and drink daily Quantity 510 grams (30 doses) Dispensed date: 08/15/2025 (handwritten opened date 08/18/2025) Ipratropium Bromide Pharmacy label identified (Photos 11 and 12): Ipratropium bromide 0.03% spray 1 spray in each nostril 2 times daily Quantity 30 ML, 345 metered sprays Dispensed 07/05/2025, (and handwritten on box was opened date of 07/05/2025) Caregiver L stated the bottle of poly glycol was approximately ¾ full and Resident 5 frequently refused it due to loose stools so an order change from scheduled to as needed was being obtained. Pharmacy Tech M stated polyglycol was last dispensed 08/15/2025, ipratropium bromide was last dispensed 12/3/2025, a 30 ML bottle of ipratropium bromide contained 345 sprays and polyglycol and ipratropium bromide were not on auto refill.	N 352		

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Resident 5 was admitted 07/06/2023. Physician orders included gabapentin 250 MG/ML 5 ML once daily for pain (start date 08/04/2023), polyethylene glycol 3350 dissolve 17 grams in 4-8 oz. of liquid and drink daily (start date 06/06/2024), and ipratropium bromide 0.03% spray 1 spray in each nostril 2 times daily (start date 06/30/2023).

MAR:
From 10/01/2025-01/22/2026 (113 days), staff documented administration of the following number of doses:
Gabapentin 250 MG/ML = 93 doses
Polyethylene glycol = 93 doses

Ipratropium Bromide = From 10/01/2025-12/02/2025, staff documented administration of 1 spray in each nostril twice daily (4 sprays daily) = 183 sprays

Note: If beginning 07/05/2025, 4 sprays were administered daily from a total of 345 total sprays, the bottle would have depleted in approximately 86.25 days on/around 09/30/2025.
From 10/1-12/02/25 168 doses were documented as administered but the provider did not receive a new bottle for administration until 12/3/25.

Observation notes dated 07/01/2025-01/21/2026 did not address why staff documented administration of gabapentin 250 MG/ML, poly glycol and ipratropium bromide when medication remained in the bottles.

ISP dated 01/14/2025
In the area of Medications- " ...Resident will receive medication as prescribed by the physician ...Staff performs medication administration ..."

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N 352	Continued From page 9 On 01/22/2026 at 6:54 PM, Surveyor discussed concern regarding remaining medications when staff documented they were administered with Executive Director K who stated only the current medication container should be in the medication cart or refrigerator. Executive Director K stated Wellness Coordinator F had not been conducting the weekly cart audits. On 01/28/2026 at 2:33 PM, Surveyor interviewed Executive Director K who stated the physician sends orders directly to pharmacy, pharmacy then emails order to facility. The wellness coordinator, wellness director or executive director checks the emailed order. When medication is delivered to facility, staff checks the medication's pharmacy label against the order that is to be entered into the MAR including the time the medication is to be administered. Executive Director K stated Resident 7's original Zenpep physician order was entered into the MAR by a facility nurse in 2024, and s/he did not know why the conflicting administration time was not caught sooner. Executive Director K stated they would do a full medication audit during next cycle fill.	N 352		
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	N 389		

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resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure when there was a change in resident's needs, abilities, physical or mental condition the individual service plan (ISP) was revised.

Resident 6's ISP was not updated to address behaviors of resisting and combative with staff during cares, hitting and touching other residents, going into other resident's rooms, and climbing over gates to get into kitchen.

Findings include:
On 01/22/2026, Surveyor reviewed Resident 6's record. S/he was admitted 04/07/2025. Diagnoses included unspecified dementia, moderate with anxiety.

Observation notes dated 10/01/2025-11/22/2026 included (summarized):
10/08/2025 8:42 AM- argumentative and combative with staff, swinging and swearing at them.
10/18/2025 1:54 PM- hitting another resident.
11/17/25 9:01 AM- not sleeping at night, wanders, climbs over kitchen gates, enters other resident's rooms, hit another resident on head, hugged another resident from behind and rubbed his/her arm, verbally aggressive with redirection.
12/19/2025 1:12 PM - During Christmas program, resident was rubbing the legs of resident seated next to him/her, other resident was moved.

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N 389	Continued From page 11 ISP dated 09/18/2025- In the area of Behavior Care- " ...elopement risk ...encourage to participate in activities ...will try to open door when [s/he] sees some one [sic] trying to enter or leave community ...do frequent safety checks on residents location ...communicate when resident is leaving from side of community and returning to other side ...monitor behavior: resident exit seeking, sadness, crying, isolation, worry , fear, decrease in appetite, decrease in participation in activities, ...is an elopement risk staff will distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book or residents [sic] toy cat, Quarterly psychotropic med review ... Effective interventions: validate feelings, ask open ended questions, redirect, reassure BEHAVIOR MONITORING." On 01/22/2026 at 6:54 PM, Surveyor discussed concern of Resident 6's ISP with Executive Director K who stated they were working with the managed care organization to create a behavioral support plan.	N 389		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential	N 407		

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N 407	Continued From page 12 benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure when a scheduled psychotropic medication was prescribed, the resident was reassessed by a pharmacist, practitioner or registered nurse at least quarterly for the desired responses and possible side effects of the medication. All 2025 quarterly psychotropic medication reviews were not completed for 3 of 3 residents reviewed. Findings include: Per 83.02(41) "Psychotropic medication means a prescription drug, as given in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior". On 01/22/2026 at 10:56 AM, Surveyor requested Resident 5's, Resident 6's and Resident 7's records including the 2 most recent quarterly reviews of scheduled psychotropic medications from Executive Director K. On 01/22/2026, Surveyor reviewed Resident 5's, Resident 6's, and Resident 7's records. Example 1- Resident 5 Resident 5 was admitted 07/06/2023. Diagnoses included mild cognitive impairment, restlessness and agitation, depression and anxiety. Physician orders included donepezil 5 MG 1 tablet daily for altered mental status (start date	N 407		

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08/04/2023), and sertraline 50 MG 1 tablet daily for depression and anxiety (start date 07/13/2023).

The 2 most recent quarterly psychotropic reviews were not provided to Surveyor.

Example 2- Resident 6
Resident 6 was admitted 04/07/2025. Diagnoses included unspecified dementia, moderate, with anxiety and major depressive disorder, recurrent, moderate.

Physician orders included divalproex DR 250 MG 1 tablet 3 times daily with 125 MG tablet and 125 MG 1 tablet 3 times daily with 250 MG tablet (to equal 375 MG) (start date 04/04/2025), and sertraline 50 MG 1 tablet daily (start date 04/04/2025).

The record contained a quarterly psychotropic medication review for sertraline and as needed lorazepam (it did not include divalproex) dated 09/28/2025. There was no 4th quarter review in the record.

Example 3- Resident 7
Resident 7 was admitted 06/07/2024. Diagnoses included depression, bipolar disorder and dementia.

Physician orders included: citalopram 40 MG 1 tablet daily for depression (start 06/11/2024); quetiapine 100 MG 1 tablet twice daily for bipolar disorder (start dated 03/09/2025); rivastigmine tartrate 6 MG 1 capsule twice daily for dementia (start 06/11/2024); and trazadone 150 MG 1 tablet nightly for depression (start 07/13/2024).

The record contained a quarterly psychotropic

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET WOODS SENIOR LIVING	2900 S MOORLAND RD NEW BERLIN, WI 53151

(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 407	Continued From page 14 medication dated 09/29/2025. There was no 4th quarter review in the record. On 01/22/2026 at 6:54 PM, Surveyor interviewed Executive Director K who stated no 2025 4th quarter psychotropic reviews were completed.	N 407		
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 that at the time of medication administration, the person administering the medication or treatment documented in the resident record the name, dosage, date and time of medication taken. Staff did not document the number of units of sliding scale administered in Resident 7's record. Findings include: On 01/22/2026, Surveyor reviewed Resident 7's record. S/he was admitted 06/07/2024.	N 415		

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N 415	Continued From page 15 Diagnoses included type II diabetes mellitus with hyperglycemia. Physician orders included Lyumjev 100 Unit/ML Kwikpen sliding scale insulin: Breakfast- If blood sugar (BS) 71-90 give 6 Units only, 91-150 = 12 Units, 151-200 = 13 Units, 201-250 = 14 Units, 251-300 = 15 Units, 301-350 =16 Units, 351-400 = 17 Units, 401-450 = 18 Units, 451 or above = 19 Units (start date 11/24/2025) Lunch- IF BS 71-90 give 6 Units only, 91-150 = 14 Units, 151-200 =15 Units, 201-250 = 16 Units, 251-300 = 17 Units, 301-350 = 18 Units, 351-400 = 19 Units, 401-450 =20 Units, 450 or above = 21 Units (start date 11/24/2025) Supper- If BS 91-150 = 11 Units, if 150-200 =12 Units, 201-250 = 13 Units, 251-300 = 14 Units, 301-350 =15 Units, if 351-400 = 16 Units, if 401-450 = 17 Units, greater than 451=18 Units Bedtime- if BS 71-250 = 0 unit, 251-300 = 2 Units, 301 or greater = 3 Units and if greater than 400, recheck in 30 minutes (start date 11/24/2025). Medication administration record dated 11/24/2025-01/22/2026: From 11/24/2025-01/22/2026, staff did not document number of units of Lyumjev sliding scale insulin administered. On 01/22/2026 at 5:56 PM, Surveyor interviewed Executive Director K who stated staff did not document number of units of sliding scale insulin administered. On 01/22/2026 at 6:54 PM, Surveyor discussed concern of staff not documenting number of units of sliding scale insulin with Executive Director K who stated the MAR will be updated to prompt	N 415		

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N 415	Continued From page 16 staff to document the number of units administered.	N 415		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure health monitoring was provided for 1 of 2 residents reviewed.	N 431		

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N 431	Continued From page 17 Resident 6's health was not monitored when staff did not check his/her blood pressure and pulse as ordered by the physician. Findings include: On 01/22/2026, Surveyor reviewed Resident 6's record. S/he was admitted 04/07/2025. Diagnoses included unspecified atrial flutter. Physician orders included metoprolol tart 50 MG 1 tablet twice daily, hold for systolic (top number) blood pressure greater than 100 or heart rate (pulse) less than 60 (start 09/09/2025). Resident 6's record did not contain blood pressure or pulse readings. On 01/22/2026 at 6:54 PM, Surveyor discussed concern of not monitoring Resident 6's blood pressure and pulse with Executive Director K who stated these vitals were not taken because the electronic medication administration record (MAR) did not prompt staff to take them due to the metoprolol's parameters not entered into the MAR.	N 431		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by:	N 488		

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N 488	Continued From page 18 Based on observation and interview, the provider did not ensure the clothes dryer's vent consisted of rigid material. Two of 2 dryers were vented with flexible vents. Findings include: The facility is licensed as a Class CNA (nonambulatory CBRF) able to serve up to 50 residents within the client groups of advanced aged, developmentally disabled, terminally ill, irreversible dementia/Alzheimer's and emotionally disturbed/mental illness. On 01/22/2026 at 6:44 PM while touring facility with Executive Director K, Surveyor observed 2 of 2 dryers vented with flexible vents (Photos 17 and 18). Executive Director K stated s/he was not aware the dryers were not vented with rigid vents. On 01/22/2026 at 6:54 PM, Surveyor discussed concern of flexible dryer vents with Executive Director K who stated s/he would inform maintenance as soon as possible. Cross Reference: N0525 83.47(2)(d) Fire Drills N0637 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways	N 488		
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	N 525		

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N 525	Continued From page 19 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 ensure staff recorded residents total evacuation time or identified residents requiring greater than 4 minutes to evacuate (if any) and the type of assistance they needed. Five of 11 fires drills conducted in 2024 and 2025 had a total evacuation time greater than 4 minutes and did not identify residents who required greater than 4 minutes to evacuate or the type of assistance they required to evacuate. Documentation of the 6 remaining drills did not include total evacuation times. Findings include: The facility is licensed as a Class CNA (nonambulatory CBRF) able to serve up to 50 residents within the client groups of advanced aged, developmentally disabled, terminally ill, irreversible dementia/Alzheimer's and emotionally disturbed/mental illness. In 01/22/2026, Surveyor reviewed 2024 and 2025 fire drill documentation. Evacuation times	N 525		

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N 525	Continued From page 20 documented: 01/03/2024- 6 minutes 05/30/2024- none 07/19/2024- 6 minutes, 16 seconds 10/16/2024- none 04/03/2025- 6 minutes 06/27/2025- none 07/21/2025- 16 minutes 08/05/2025- none 09/02/2025- none 10/03/2025- 9 minutes, 32 seconds 11/24/2025- none On 01/22/2026 at 6:54 PM, Surveyor discussed concern regarding fire drill documentation with Executive Director K who stated s/he was not aware the fire drill documentation was lacking the required information. Executive Director K stated they had a point of rescue list used to inform fire fighters which residents required assistance to evacuate. Cross Reference: N0488 83.43(1)(c) Clothes Dryers Enclosed and Vented N0637 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways	N 525		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only	N 637		

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N 637	Continued From page 21	N 637		

ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure all exits used for exiting were kept free of ice, snow, and obstructions.

Two emergency exits were obstructed by snow.

Findings include:

The facility is licensed as a Class CNA (nonambulatory CBRF) able to serve up to 50 residents within the client groups of advanced aged, developmentally disabled, terminally ill, irreversible dementia/Alzheimer's and emotionally disturbed/mental illness.

The building's south unit consisted of 2 hallways of resident room (rooms 1-11 in 1 hallway and rooms 12-20 in the other). Rooms 9 and 13 were situated across from each other, separated by an outside patio.

On 01/22/2026 at 9:02 AM and 9:03 AM, Surveyor observed emergency exit doors near

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rooms 9 and 13. Signage on the door identified them as emergency exits. The doors exited out to the shared patio. The patio was covered with snow of varying depths up to several inches (Photos 14 and 16).

On 01/22/2026 at 9:02 AM, Surveyor inspected the posted emergency exit diagram which identified the exits near rooms 9 and 13 as emergency exits (Photo 15).

On 01/22/2026 at 12:35 PM, Surveyor returned to the emergency exit near room 9 and observed the patio was still covered with snow.

On 01/22/2026 at approximately 6:00 PM while touring facility with Executive Director K, Surveyor observed the patio still covered with snow. Executive Director K stated it most recently snowed on 01/20/2026, maintenance had shoveled the patio 01/20/2026 and again on 01/22/2026 AM.

On 01/22/2026 at 6:54 PM, Surveyor discussed concern of snow blocking the emergency exit with Executive Director K who stated the maintenance shoveled within 24 hours of snow fall.

Cross Reference:
N0488 83.43(1)(c) Clothes Dryers Enclosed and Vented
N0525 83.47(2)(d) Fire Drills