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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 09/16/2024, Surveyor began a standard survey and complaint investigation at Vitacare Living Rice Lake II. Data was collected through 10/08/2024. The complaint was substantiated. Twelve violations were identified. Four of 12 violations were repeat deficiencies. See Statement of Deficiency (SOD) UB0611, dated 11/21/2022. Census: 20.	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 had obtained documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse,	N 220		

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

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N 220	Continued From page 1	N 220		

indicating they had been screened within 90 days before the start of employment for clinically apparent communicable disease, including tuberculosis (TB).

This is a repeat violation. See Statement of Deficiency (SOD) UB0611, dated 11/21/2022.

Findings include:

The provider is licensed to care for 20 residents in the client groups advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease.

On 09/16/2024, Surveyor reviewed the employee records of Care Specialist (CS) A, B, and C.
-CS A, hired 04/01/2023, did not have documentation of a communicable disease screen or TB test.
-CS B, hired 07/30/2024, did not have documentation of a screen for communicable disease.
-CS C, hired 05/30/2024, did not have documentation of a screen for communicable disease and the TB test was completed 06/09/2023, approximately 1 year before hire.

On 09/17/2024 at 9:27 AM, Surveyor received an email communication from Clinical Nurse Director (CND) D that read, "Health Screen/Communicable Disease - already have identified that not all staff were screen [sic] appropriately - we have updated our policy and document regarding proper compliance with this requirement."

The provider did not screen 3 of 3 employees for communicable disease including TB.

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N 230	Continued From page 2	N 230		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 employees reviewed had completed orientation training that included job responsibilities, prevention and reporting of resident abuse, neglect and misappropriation of resident property, information regarding assessed needs and individual services for each resident for whom the employee is responsible, emergency and disaster plan and evacuation procedures, CBRF (community based residential facility) policies and procedures, and recognizing and responding to resident changes of condition before performing any job duties. This is a repeat violation. See Statement of Deficiency (SOD) UB0611, dated 11/21/2022. Findings include:	N 230		

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N 230	Continued From page 3 The provider is licensed to care for 20 residents in the client groups advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease. On 09/16/2024, Surveyor reviewed the employee records of Care Specialist (CS) A, B, and C. CS B, hired, 07/30/2024 and CS C, hired 05/30/2024 had documentation of the needs of individuals but did not include the other 5 components of orientation training. On 09/19/2024, from 12:16 to 12:29 PM, Surveyor interviewed Executive Director (ED) F, who confirmed it was Assistant Executive Director (AED) E's responsibility to ensure orientation training was assigned and completed. The provider did not ensure orientation training was completed prior to staff performing job duties.	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after	N 243		

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N 243	Continued From page 4 starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. 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 employee training as required within 90 days after starting employment. Care Specialist (CS) C did not have training in resident rights within 90 days after starting employment.	N 243		

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N 243	Continued From page 5 This is a repeat violation. See Statement of Deficiency (SOD) UB0611, dated 11/21/2022. Findings include: On 09/16/2024, Surveyor conducted a review of 3 employees to verify compliance with all employee training requirements. Surveyor requested training records from Executive Director (ED) F for CS A, B, and C. Resident Rights: The record for CS C, hired 05/30/2024, did not contain evidence of training or evidence of meeting an exemption for resident rights. On 09/19/2024 from 12:16 PM to 12:29 PM, Surveyor interviewed ED F, who confirmed it was Assistant Executive Director (AED) E's responsibility to assign and ensure completion of all employee training.	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training	N 247		

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N 247	Continued From page 6 in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees obtained all task specific training. Care Specialist (CS) B who had responsibilities for providing assistance with activities of daily living, did not have training in the provision of personal care prior to assuming these duties. This is a repeat violation. See Statement of Deficiency (SOD) UB0611, dated 11/21/2022. Findings include:	N 247		

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N 247	Continued From page 7 On 09/16/2024, Surveyor conducted a review of 3 employees to verify compliance with task specific training requirements. Surveyor requested training records from Executive Director (ED) F for CS A, B, and C. Provision of Personal Care The record for Caregiver B, hired 07/30/2024 did not contain evidence of training or evidence of meeting an exemption for personal care training. On 09/19/2024 from 12:16 PM to 12:29 PM, Surveyor interviewed ED F, who stated it was Assistant Executive Director (AED) E's responsibility to assign and ensure completion of all task specific training.	N 247		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. Findings include: On 07/10/2024, the Department received a complaint alleging there were not enough staff to care for the residents. The provider is licensed to care for 20 residents	N 396		

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in the client groups advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease.

On 09/16/2024 at approximately 11:20 AM, Surveyor interviewed Care Specialist (CS) A, hired 04/01/2024, who confirmed there were always 2 staff scheduled per shift. CS A stated that currently Resident 3 and Resident 4 required a 2-person assist.

On 09/19/2024, from 11:57 AM to 12:14 PM, Surveyor interviewed CS I, who stated s/he could recall at least 6 shifts that were single staffed. CS I stated s/he could not recall the date but stated CS G had been left alone on a 2:00 to 10:00 PM shift. CS I stated it was rare there were 2 staff working on the NOC (nighttime) shift. CS I stated that currently, Resident 3 and Resident 4 required a 2-person assist.

On 09/19/2024, from 3:11 PM to 3:28 PM, Surveyor interviewed CS G, who stated there had been shifts with only 1 staff scheduled. CS G stated Assistant Executive Director (AED) E and Executive Director (ED) F helped fill in when short-staffed. CS G stated that overall, s/he finds staffing had been difficult for the company. CS G stated that currently Resident 3 and Resident 4 required a 2-person assist.

On 09/19/2024 from 12:16 PM to 12:29 PM, Surveyor interviewed ED F, who confirmed that in July 2024, Resident 1 and Resident 3 required 2 staff to assist with care. ED F also stated it was probably accurate that there was 1 staff working on NOC shift.

On 09/16/2024, Surveyor reviewed the records for Resident 1, 3, and 4.

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N 396	Continued From page 9 Resident 1 was admitted on 05/09/2018 and had diagnoses of repeated falls, Downs syndrome, diabetes mellites Type 2, recurrent yeast infections, hypertension, major depressive disorder, weakness, and adult failure to thrive. Resident 3 was admitted 08/07/2024 and had diagnoses of heart failure, sleep apnea, polyneuropathy, diabetes mellites Type 2, acute congestive heart failure, pressure ulcer of sacral region, anxiety disorder, hemolytic anemia, neutropenia, decreased white blood cell count, aortic ectasia, restless leg syndrome, atrial fibrillation, acute respiratory failure with hypoxia, lymphedema, dysphagia, hypertensive heart and renal failure, Poly osteoarthritis, venous insufficiency, muscle wasting and atrophy, chronic kidney disease Stage 4, morbid obesity, and pneumonia. Resident 4 was admitted on 12/11/2017 and had diagnoses of dementia, hypothyroidism, chronic kidney disease, hypotension, chronic depression, and history of CVA (cerebrovascular accident). On 10/08/2023 from 1:56 PM to 2:55 PM, ED F confirmed that in July 2024, Resident 1 and Resident 4 required a 2-person assist, and currently Resident 3 and Resident 4 required a 2 person assist. On 10/08/2024 at 3:57 PM, Surveyor received an email communication from ED F that included a document titled, All Time Entries, for all shifts employees were clocked in and clocked out of their shifts. Surveyor counted 6 shifts in July on the NOC shift where only 1 employee was clocked in and clocked out.	N 396		

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N 396	Continued From page 10 The provider did not ensure adequate staff to manage resident cares.	N 396		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain a current written schedule for staffing the community based residential facility (CBRF), that included each employee' s full name, job assignment, and time worked. Findings include: The provider is licensed to care for 20 residents in the client groups advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease. On 09/16/2024, Surveyor requested a copy of the June and July 2024 schedule, including any schedule changes. The copies provided were 1-page documents laid out like a calendar that only listed the staff first names. Both the June and July schedules had many days and shifts that were left blank. June's schedule listed 1 day with only 1 staff scheduled and 6 days with only 2 staff scheduled. July's schedule listed 3 days with no staff working and 6 days with only 1 staff working. At approximately 1:00 PM, Assistant Executive	N 399		

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N 399	Continued From page 11 Director (AED) E provided Surveyor with a thick packet of papers and stated this was the entire June and July 2024 schedule. AED E stated there had been issues with printing the schedule. AED E stated this was the best they could do, that s/he knew the document was difficult to read, and there had been challenges working with the new scheduling system and getting a printed schedule to post. At approximately 1:15 PM, Surveyor asked Executive Director (ED) F to provide a schedule for June and July 2024, based on staff timecards. On 10/08/2024 at 3:57 PM, Surveyor received an email communication from ED F that included a spread sheet titled, All Time Entries for June and July 2024. On 9/19/2024 at approximately 12:15 PM, Surveyor interviewed ED F, who stated they used an application (app) for scheduling but were not able to print a schedule to post and this was something they were working to fix. ED F stated a new scheduling system was introduced in June and July 2024. ED F stated when there were shift shortages s/he and AED E worked the floor, but their times were never added to the schedule. On 10/08/2024, from 5:30 to 6:26 PM, Surveyor interviewed ED F and Clinical Nurse Director (CND) D, who confirmed the 1-page calendar document was posted and was often incomplete. CN D also confirmed staff could access the schedule on the app, and that shifts or hours ED F and AED E filled were not added to the schedule. The provider did not maintain a current written schedule.	N 399		

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N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not keep medicine cabinets locked and the key available only to personnel identified by the CBRF (community based residential facility). Findings include: The provider is licensed to care for 20 residents in the client groups advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease. On 09/16/2024, Surveyor toured the facility and observed the medication room. The medication room was accessed by going through the kitchen. The kitchen had a door that Surveyor observed propped open during the entire survey. At approximately 9:30 AM, Surveyor observed Care Specialist (CS) A in the medication room setting up to check Resident 1's blood sugar. CS A stated Resident 1 was in his/her room and his/her blood sugar could be checked. CS A exited the medication room and shut the door. Surveyor attempted to open the mediation room door to see if it was locked and the door opened. At approximately 10:00 AM, Surveyor observed CS A set up medications to be administered to Resident 2. Resident 2 was sitting in the dining room. CS A exited the medication room, left the door open, and entered the dining area. At 10:17 AM, Surveyor observed CS A exit the	N 419		

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medication room and shut the door. Surveyor attempted to open the door, which opened as it was unlocked.

At 11:14 AM, Surveyor observed in the unlocked medication room:
- a container of Resident 3's insulin sitting on the counter,
-a pink binder with cover that read '[FACILITY NAME] BM (bowel movement) Daily Monitoring Charting, and inside the binder were resident names and resident wheelchair weights,
-an unlocked drawer that had 14 bottles of Polyethylene Glycol with prescription labels that included resident names and 9 bottles of Milk of Magnesia with prescription labels that included resident names,
-a clear plastic bin with unlabeled aspirin, body wash, naproxen sodium, and triple antibiotic,
-open shelving, including a bottle of Vitamin D and a bottle of acetaminophen labeled 'Staff," and a bottle of Drug Disposal solution.

On 09/19/2024, from 3:11 PM to 3:28 PM, Surveyor interviewed CS G, who stated the kitchen door was always open and the medication door was usually left open. CS G stated s/he thought the medication door lock was not working. CS G stated the residents know they are not allowed in the medication room, except s/he recalled 1 female resident who had severe dementia walked into the area but was redirected.

On 09/19/2024, from 11:57 AM to 12:14 PM, Surveyor interviewed CS I, who stated the door to the medication room was open and there were privacy concerns.

The provider did not ensure residents' medications were securely locked.

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(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 439	83.39(1) Infection control program. The licensee shall establish and follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. Findings include: The provider is licensed to care for 20 residents in the client groups advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease. On 09/16/2024 at approximately 9:40 AM, Surveyor observed Care Specialist (CS) A conduct medication administration for Resident 1. CS A sanitized his/her hands and put on gloves and explained Resident 1 was still in his/her room and his/her blood sugar test would be completed there. CS A proceeded to touch the following items while wearing the same gloves: -pulled open a drawer on the medication cart, -removed supplies to conduct blood sugar testing, -closed the medication cart drawer, -used keys to ensure the medication cart was locked, -knocked on Resident 1's room door and opened the door, -removed a blood sugar test strip from the	N 439		

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container and inserted into glucometer,
-opened an alcohol toilette and wiped Resident 1's finger,
-poked Resident 1's finger with a lancet,
-squeezed Resident 1's finger to help the blood drop form,
-used the same alcohol wipe that was previously used to wipe off finger,
-put the supplies away and pushed Resident 1's wheelchair into the dining room.

CS A then entered the medication room, removed his/her gloves, disposed of the gloves, and sanitized his/her hands. CS A stated s/he needed to take Resident 1 back to his/her room to administer the insulin. CS A donned gloves and touched the following:
-opened medication drawer for insulin supplies,
-touched computer,
-shut medication cart drawer,
-locked the medication cart,
-shut the medication room door,
-wheeled Resident 1 back to his/her room,
-opened the door to Resident 1's room,
-pulled up Resident 1's shirt and handled his/her lower abdomen skin to prepare for the insulin injection,
-put the needle on the insulin pen,
-injected the insulin while holding onto Resident 1's stomach fold.

Surveyor did not observe CS A sanitize the area where the insulin needle was injected. CS A wheeled Resident 1 to the dining room and returned to the medication room, removed the gloves, and donned new gloves and began to set-up Resident 1's medications. CS A unlocked the medication cart, handled the mouse multiple times, and opened the medication cart drawer. Surveyor observed CS A remove the medications

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from the bubble packs, pop each medication into his/her gloved hand, and then put the medication into the medication cup. The medications that were removed from the bubble packs directly into CS A's gloved hand were:
-Acetaminophen
-Atorvastatin
-Cetirizine
-Citalopram
-Docusate Sodium
-Famotidine
-Furosemide
-Losartan
-Methazolamide

A Viactiv Chew was removed from the labeled container and carried by CS A to the table where Resident 1 was sitting.

CS A locked the medication cart, procured a plastic glass of water from the kitchen, went to the dining area where Resident 1 was sitting, touched the edge of the water glass when handing it to Resident 1 and observed Resident 1 take his/her medication. CS A then removed the plastic wrap from the Viactiv Caramel Chew and handed it to Resident 1.

At approximately 10:02 AM, Surveyor observed CS A set-up Resident 2's medications by popping the medications out of the bubble packs directly into his/her gloved hand after s/he touched multiple surfaces such as the computer, medication cart drawer, and mouse. Those medications were:
-Amlodipine
-Aspirin
-Fluoxetine
-Furosemide
-Levothyroxine

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N 439	Continued From page 17 -Losartan -Metformin -Metoprolol Succinate -Potassium Resident 2 was sitting in the dining room. CS A explained to Surveyor that Resident 2 got nervous taking medications, so staff watched him/her from the kitchen area. CS A handed Resident 2 the medication cup and walked to the kitchen. Resident 2 proceeded to pour the medications on the table and line them up. At approximately 10:15 AM, Surveyor interviewed CS A asking to verbally walk Surveyor how s/he would administer an eye drop. CS A was clear that s/he would don his/her gloves right before touching the resident eye area. The provider did not ensure proper infection control procedures.	N 439		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving.	N 452		

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This Rule is not met as evidenced by:
Based on observation and interview, the provider, did not ensure food was stored under sanitary conditions and that food was handled in a sanitary manner.

Findings include:

The provider is licensed to care for 20 residents in the client groups advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease.

The 2022 Food Code from The U.S. Food and Drug Administration reads, in part, "Except when APPROVAL is obtained from the REGULATORY AUTHORITY ...EMPLOYEES are preventing cross-contamination of READY-TO-EAT FOOD with bare hands by properly using suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves ..."

On 09/16/2024 at approximately 10:17 AM, Surveyor observed Care Specialist (CS) H making toast per Resident 2's request. Surveyor observed CS H remove 2 pieces of bread from the bread package with hands that were not gloved and insert the bread in the toaster. Surveyor observed CS H remove the toast with hands that were not gloved and prepare the toast while continuing to touch the bread pieces.

At approximately 10:20 AM, Surveyor observed

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N 452	Continued From page 19 the commercial grade side-by-side refrigerators located in the main kitchen. On the bottom shelf was a large tube of thawing hamburger lying on the bottom shelf. There were multiple bloody paper towels pushed up next to the meat package and blood pooling around the meat. The following food items were located on the same shelf next to the bloody meat: a case of raw chicken wings, a case of produce, a case of eggs, 3 gallons of milk, a gallon of salsa, and approximately 3 more gallon containers of various condiments. Approximately an hour later, Surveyor observed the hamburger meat had been removed from the refrigerator and the bloody paper towels pushed up to the cardboard box of raw chicken wings. On 09/19/2024, from 3:11 PM to 3:28 PM, Surveyor interviewed CS G, who stated it was standard practice to wash hands and wear gloves when handling food. CS G stated s/he taught his/her colleagues to do so as well. The provider did not ensure sanitary conditions when handling and storing food.	N 452		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic substances were stored in a secure area.	N 499		

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N 499	Continued From page 20 Findings include: The provider is licensed to care for 20 residents in the client groups advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease. On 09/16/2024 at approximately 9:30 AM, Surveyor observed the kitchen area. Surveyor observed that the door to the kitchen was propped open throughout the entire survey. At approximately 11:15 AM, Surveyor opened the 2 unlocked doors under the kitchen sink. Stored in the unlocked cabinet were: -A gallon of Mechanical Dish Detergent. The label read, "Keep out of reach of children." -A gallon of Automatic Rinse Aid. The label read, "Warning, keep out of reach of children." -A container of Pot detergent -A bottle of Drano. The label read, "Danger keep out of reach of children." On 09/19/2024 at approximately 12:00 PM, Surveyor interviewed Care Specialist (CS) I who stated the kitchen door was always propped open. The provider did not ensure toxic substances were securely stored.	N 499		
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.	N 525		

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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 ensure fire evacuation drills were conducted at least quarterly, with both employees and residents, and documentation included the date and time of the drill and the CBRF 's (community based residential facility) total evacuation time.

Findings include:

The provider is licensed to care for 20 residents in the client groups advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease.

On 09/16/2024, Surveyor requested the fire evacuation drills for 2023. At approximately 1:00 PM, Executive Director (ED) F stated s/he was unable to locate the paperwork for fire drills completed in 2023.

On 09/16/2024 at 3:03 PM, Surveyor received an email communication from ED F, with documents that included:

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N 525	Continued From page 22 -"After-Action Review of an Emergency or Drill...5/14/24 1:15 - [ED F]..." The document listed 3 staff who participated and indicated the type of drill. The document also read, on 08/21/2024, to conduct an emergency or disaster evacuation drill but did not indicate the drill was completed. On 09/17/2024 at 9:27 AM, Surveyor received an email communication from Clinical Nurse Director (CND) D that read, in part, "Fire Drills for 2023 or 2024 ...unable to find any documentation or drills from 2023 ...fire drills ...have been assigned to appropriate supervisors." CND D stated Assistant Executive Director (AED) E and Executive Director (ED) F were assigned and responsible to complete these drills. The provider did not ensure quarterly fire drills were completed in 2023.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure other evacuation drills such as tornado, flooding, or other emergency or disaster evacuation drills, were conducted semi-annually. Findings include: The provider is licensed to care for 20 residents in the client groups advanced aged, terminally ill,	N 526		

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N 526	Continued From page 23 physically disabled, and irreversible dementia/Alzheimer's disease. On 09/16/2024, Surveyor requested the other evacuation drills for 2023. On 09/17/2024 at 9:27 AM, Surveyor received an email communication from Clinical Nurse Director (CND) D that read executive Director (ED) F and Assistant Executive Director (AED) E were assigned and responsible for completion of other emergency drills. As of 09/17/2024, Surveyor had not received any documentation of completed "other" evacuation drills. The provider did not ensure "other" evacuation drills were conducted semi-annually in 2023.	N 526		