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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING STOUGHTON CBRF	2220 LINCOLN AVE STOUGHTON, WI 53589

(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 05/15/2024, with information gathered through 05/29/2024, Surveyor conducted a standard licensure survey, a verification visit and a complaint investigation at Milestone Senior Living Stoughton CBRF. Nine deficiencies were identified. One of the 9 deficiencies was a repeat violation (see Statement of Deficiency (SOD) BL1M13). Complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 15	{N 000}		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a complete Resident Assistant background check was conducted	N 219		

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

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N 219	Continued From page 1 every four years for 1 of 1 (Med Passer R) employee records reviewed. The complete background check is to include the background information disclosure form (BID), the criminal history search form from the department of justice (DOJ), and the information maintained by the department of safety and professional service regarding a person's credentials (IBIS). Findings include: On 05/20/2024, Surveyor requested and reviewed Med Passer R's employee file. Med Passer R was hired on 03/18/2020 and his/her record included the BID, DOJ or IBIS dated 03/18/2020. Surveyor noted the 4-year background check was due in 03/2024. On 05/29/2024 at 1:00 PM, Surveyor interviewed Regional Director D, Clinical Risk Manager J, Executive Director I, Health Care Coordinator S and Regional Nurse Specialist V. Clinical Risk Manager J confirmed this was a deficiency.	N 219		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material.	N 239		

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N 239	Continued From page 2 Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 2 of 3 staff records reviewed obtained all department approved training as required. Resident Assistant T and Resident Assistant U did not have training in fire safety within 90 days after starting employment. Findings include: On 05/15/2024, from approximately 10:00 AM to 2:00 PM, Surveyor toured the facility. Surveyor observed Resident Assistant T and Resident Assistant U providing cares for residents. Surveyor requested their employment records. On 05/20/2024, Surveyor conducted a review of Resident Assistant T's and Resident Assistant U's employment file.	N 239		

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N 239	Continued From page 3 The record for Resident Assistant T, hired 08/07/2023, contained the CBRF (Community-Based Residential Facility) training registry which documented that Resident Assistant T did not receive training in Fire Safety. The record did not contain evidence of training or evidence of meeting an exemption for Fire Safety. The record for Resident Assistant U, hired 09/10/2022, contained the CBRF training registry which documented that Resident Assistant U did not receive training in Fire Safety. The record did not contain evidence of training or evidence of meeting an exemption for Fire Safety. On 05/20/2024, Surveyor verified through the CBRF training registry that Resident Assistant T and Resident Assistant U had not received required Department approved training in Fire Safety. On 05/29/2024 at 1:00 PM, Surveyor interviewed Regional Director D, Clinical Risk Manager J, Executive Director I, Health Care Coordinator S and Regional Nurse Specialist V. Clinical Risk Manager J confirmed this was a deficiency.	N 239		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities 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 observation, record review and interview, the Individual Service Plan (ISP) for 1 of 2 resident was not updated when there was a change in resident needs and abilities.

Resident 13's ISP was not updated to include interventions/guidelines regarding his/her refusals of cares, his/her sleeping patterns, and his/her paranoia.

Findings include:

On 05/15/2024, at approximately 1:30 PM, Surveyor observed Resident 13 walking in the hallway with Executive Director (ED) I. Resident 13 displayed concerns that s/he needed to call his/her son/daughter, Resident 13 had an unkempt appearance with his/her hair looking like it had not been washed. Surveyor requested Resident 13's record.

On 05/20/2024, Surveyor reviewed Resident 13's record.

Resident 13 admitted to the facility, 07/27/2023, with diagnoses including psychophysiological insomnia, amnesia, dementia, psychotic disturbance, mood disturbance, and anxiety.

Resident 13's "Progress Notes," dated 01/01/2024 to 05/15/2024, documented: "01/06/2024 - After dinner [Resident 13] became

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very agitated, then worked [him/herself] up into a panic attack, crying and shaking ... called [family] and [Resident 13] calmed down some but after the call [s/he] became agitated again. Stating someone was going to kill [him/her]."
"01/08/2024 - Resident noted to be more irritable today. Fixed on where [his/her] meds are, when [s/he] gets the, confronting the med passer stating that [s/he] is supposed to be taking [his/her] meds by [him/herself]. When staff attempt to explain or redirect, gets frustrated and walks away from staff."
"03/25/2024 - Staff reporting that resident has been more paranoid over the last several days. Reporting to staff about being raped and being scared of the [fe/male] that comes through [his/her] window at night."
"04/28/2024 - Resident has been having panic attacks, [s/he] has been paranoid, following staff around, [s/he] is calling [his/her] family multiple times per night because [s/he] is afraid to be alone and is not sure where to sleep. [S/he] is not sleeping well."
"05/02/2024 - Resident continues to be paranoid, and not trusting staff. [S/he] begins to have an increase in these behaviors around 2-3pm and they go on through the night."

Resident 13's May 2024 "Monthly Task Log," dated 05/01/2024 to 05/10/2024 documented: Level of Assistance - Bathing: Moderate. Resident requires assistance with bathing, requires assistance or cueing with parts of bathing including assistance getting in/out of tub/shower. Every week on Wednesday and Friday. Resident was scheduled to receive his/her shower assist on 05/01 (documented as refused), 05/03, 05/08, 05/10 (documented as refused).

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N 389	Continued From page 6 Resident 13's ISP, dated 07/25/2021, documented: "Bathing: Resident will receive bathing/showering assistance 1 time(s) a week. Resident prefers-transfers in/out; steading; cueing to wash self; cueing to dry self; shampooing/rinsing/drying hair; applying lotion." "Grooming/Oral Hygiene: Is independent with personal hygiene with/without use of assistive devices." "Cognition: Observe and report mood changes to the nurse. History of going into others rooms, resist redirection at times. Offer food, fluid, and bathroom. Has mild to moderate disorientation or difficulty recalling/retaining information. Needs cueing. Demonstrates deficits in judgement related to safety. Mental Status/Well Being. Resident has hallucinations/delusions of people/family visiting here or [s/he] went places with people/family." On 05/29/2024 at 1:00 PM, Surveyor interviewed Regional Director D, Clinical Risk Manager J, Executive Director I, Health Care Coordinator S and Regional Nurse Specialist V. Clinical Risk Manager J confirmed this was a deficiency. Health Care Coordinator S stated, "[Resident 13] always refuses, won't even let us do skin checks. We changed [his/her] shower times to line up with [his/her] favorite caregiver." Clinical Risk Manager confirmed the ISP's "need to show the real picture of the resident."	N 389		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that	N 409		

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N 409	Continued From page 7 contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and interview, the provider did not audit daily residents scheduled II narcotics. Findings include: On 05/15/2024, Surveyor reviewed the provider's "Pharmacy Annual Medication Cart Inspection," dated 04/15/2024, which documented: "Schedule 2 controlled drugs stored in separate locked box and counted every shift - No logs for counting every shift." On 05/15/2024, at approximately 1:10 PM, Surveyor and Executive Director I, Med Passer R and Health Care Coordinator S, reviewed the provider's "Shift Change Narcotic Count Sheet," dated 05/01/2024 to 05/15/2024, which required narcotic counts on NOC OFF, AM ON, AM OFF, PM ON, PM OFF and NOC ON. Med Cart A's sheet did not document narcotic counts: 05/01 NOC OFF, AM ON, AM OFF 05/02 AM ON, AM OFF 05/03 AM ON, AM OFF 05/05 PM ON, PM OFF 05/06 AM ON 05/07 AM ON, AM OFF 05/11 AM ON, AM OFF	N 409		

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N 409	Continued From page 8 05/15 AM ON Med Cart B's sheet did not document narcotic counts: 05/01 NOC OFF, AM ON, AM OFF, PM ON, PM OFF 05/02 AM ON, AM OFF, PM ON, PM OFF, NOC ON 05/03 NOC OFF, AM ON, AM OFF 05/05 AM ON, AM OFF, PM ON, PM OFF 05/06 AM ON, AM OFF 05/08 AM ON, AM OFF 05/09 AM ON, AM OFF 05/10 AM ON, AM OFF 05/11 AM ON, AM OFF 05/12 NOC ON 05/13 NOC OFF, AM ON, AM OFF 05/14 AM ON, AM OFF, PM ON, PM OFF Surveyor asked if staff were to count the narcotics every shift. Executive Director I stated staff were required to complete that task. Executive Director I, Med Passer R, and Health Care Coordinator S could not explain why the narcotic counts had not been completed. Executive Director I stated this concern would be addressed with staff. On 05/29/2024 at 1:00 PM, Surveyor interviewed Regional Director D, Clinical Risk Manager J, Executive Director I, Health Care Coordinator S and Regional Nurse Specialist V. Clinical Risk Manager J confirmed this was a deficiency.	N 409		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or	N 410		

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over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not document all errors in the administration of 1 of 1 resident's medication or report the error to a licensed practitioner, supervising nurse or pharmacist immediately.

Resident 11 was administered an extra dose of Lorazepam for four days before the provider realized the medication error and reported it to Resident 11's primary care physician.

Findings include:

On 05/15/2024, Surveyor reviewed Resident 11's record.

Resident 11 moved into the facility, 12/29/2022, with diagnoses including moderate Alzheimer's dementia with mood disturbance, recurrent major depressive disorder, and anxiety.

Resident 11's "Progress Notes" documented: "[Resident 11] has a new incident added - Resident was given extra doses of Lorazepam. It

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was noted on 03/07/2024. When the medications arrived from the pharmacy the Lorazepam for 4PM was labeled as an HS medication (hours of sleep - 8:00 PM). Staff was given the Lorazepam at 8PM without an order. They were also giving scheduled Lorazepam at 8AM, 12Noon, and 4PM. So, resident was receiving an extra dose of Lorazepam during at 8PM. Writer filed incident report, notified director, PCP (primary care physician), and family."

Resident 11's incident documentation, dated 03/07/2024, documented:
"Writer was notified by [Resident Assistant (RA) V]. Writer told [Executive Director I]. Writer and [Executive Director I] pulled the administration record for the days that patient was given the extra doses of Lorazepam to figure out the staff members who were working the shifts. Writer and [Executive Director I] will speak to staff members working each day that the 8PM dose was given. Instant in-service will be done with staff."
Resident 11's incident documentation, dated 03/022/2024, documented:
"Pharmacy sent new Lorazepam cards to facility on 03/02/2024. Staff who received the new cards put them in the narc box and labeled the controlled substance record as 8PM. Card sent from pharmacy are labeled for HS and AM. Resident has orders for Lorazepam for 0.5 MG (milligram) give 1 tablet at 8AM and 4PM. Lorazepam 0.5 MG give 2 tablets at 12noon. Staff gave an 8PM dose to resident on 03/02/2024, 03/03/2024, 03/04/2024, and 03/05/2024."

Resident 11's March 2024 Medication Administration Record documented:
Lorazepam 1 MG - Give 1 tablet by mouth two

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times a day for anxiety. Scheduled at 8:00 AM and 4:00 PM. Start Date: 02/20/2024.
Lorazepam 1 MG - Give 2 tablet by mouth in the afternoon for anxiety. Scheduled at 8:00 PM. Start Date: 02/20/2024.
The MAR did not document a physician order scheduling an 8:00 PM dose. The MAR did not document that the additional dose was given by staff on 03/02/2024, 03/03/2024, 03/04/2024, and 03/05/2024."

On 05/15/2024, at approximately 12:30 PM, Surveyor interviewed Executive Director I, Health Care Coordinator S, and Regional Nurse Educator W. Surveyor reviewed Resident 11's MAR and progress notes and asked where staff were documenting the additional dose of Lorazepam given at 8:00 PM as the MAR did not reflect that dose. Surveyor did not receive a response. Surveyor requested the pharmacy delivery reports to determine when Resident 11's scheduled Lorazepam's had been delivered. Surveyor received a delivery report dated 02/07/2024 and 03/22/2024 which did not reflect the Lorazepam that had been delivered on 03/02/2024. Surveyor asked how many tablets were remaining in Resident 11's 4:00PM blister card to determine if s/he had received the 4PM dose, since it was reported that the replacement 4:00PM blister card was inadvertently labeled HS. Executive Director I stated s/he would have to review the documentation. Surveyor asked what the medication review process was when checking medications into the system. Surveyor did not receive a response.

On 05/29/2024 at 1:00 PM, Surveyor interviewed Regional Director D, Clinical Risk Manager J, Executive Director I, Health Care Coordinator S and Regional Nurse Specialist V. Surveyor asked

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N 410	Continued From page 12 who is responsible for auditing the medications as they arrive in the facility. Regional Nurse Specialist V stated the nurse is responsible for reviewing the meds when they arrive on the 28-day auto cycle fill, unless they delegate someone else. Surveyor asked how the medication error was detected. Health Care Coordinator S stated a staff member, who passes medications on a consistent basis, determined there should be no 8PM dose of Resident 13's Lorazepam. Health Care Coordinator S stated, "We aren't looking at orders, we need to make corrections. We are now doing weekly audits, making sure refills are completed timely.	N 410		
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 observation, record review and interview, the provider did not ensure proper documentation of the Medication Administration Record (MAR) for 1 of 1 resident reviewed.	N 415		

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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 415	Continued From page 13 This is a repeat deficiency. See Statement of Deficiency (SOD) BL1M11, dated 07/05/2022, and BL1M12, dated 01/17/2023. Resident 12's documented blood sugar (BS) levels did not identify how many units of Humalog (sliding scale insulin) were administered. Findings include: On 05/15/2024, Surveyor reviewed Resident 12's record. Resident 12 was admitted to the facility, 01/09/2024, with a diagnosis including diabetes. Resident 12's May 2024 Medication Administration Record (MAR) documented the following medication: "Novolog (insulin) - Inject 16 units breakfast, 9 units lunch, 24 units supper. Plus correction 1 unit for every 50 points > (greater) than 150 before meals and >200 at bedtime." Surveyor noted that the MAR did not document how many units of sliding scale Novolog was administered to Resident 12. Executive Director I provided Surveyor with a separate report that documented Resident 12's Blood Sugar (BS) levels, but it did not document units of sliding scale insulin administered. On 05/15/2024, at approximately 12:30 PM, Surveyor interviewed Executive Director I, Health Care Coordinator S, and Regional Nurse Educator W. Executive Director I stated s/he would need to contact the software company to determine if a report could be run with that information, as s/he was not able to determine how many units of sliding scale insulin had been	N 415		

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	0017056	A. BUILDING: _____ B. WING _____	R-C 05/29/2024

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N 415	Continued From page 14 administered to Resident 12. On 05/29/2024 at 1:00 PM, Surveyor interviewed Regional Director D, Clinical Risk Manager J, Executive Director I, Health Care Coordinator S and Regional Nurse Specialist V. Health Care Coordinator S stated they were able to adjust the software program to enter the blood sugar readings and the units of insulin administered onto the MAR during medication administration.	N 415		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide services to manage 1 of 1 resident behavior patterns that affected the resident and other persons. Resident 12 had eloped from the facility and was sent out for a Geri Psych consult. When resident returned to the facility, s/he eloped 5 days later. Findings include: On 04/10/2024 and 04/22/2024, the provider submitted to the Department a written report that	N 433		

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N 433	Continued From page 15 stated Resident 12 had eloped from the facility. On 05/20/2024, Surveyor reviewed Resident 12's record. Resident 12 was admitted, 01/09/2024, with diagnoses including depression and dementia. Resident 12's "Progress Notes" documented: "04/10/2024 at 4:05 PM - Resident has been very irritable today. [S/he] has been talking with other residents about calling the cops because [s/he] is 'being held here against my will.' Resident haws asked several staff members to get [him/her] out of this place. Resident has been yelling at staff, and not easily redirected. Resident several times went to the locked doors to try and get out. Staff have been continually redirecting resident as needed." "04/10/2024 at 4:16 PM - Writer was coming out of memory care doors when an [hospice staff] was walking in. [S/he] told writer 'I just saw a guy going out one the windows in the front.' Writer ran back into memory care to ask staff when they had last seen resident, staff started looking around building. Resident was seen from a facility window walking down the highway. The Director immediately went out the front exit to search for resident and saw that [s/he] was too far down the road to catch on foot. ... The RA (resident assistant) got into [his/her] car and drove to go pick resident up. Resident got into [his/her] car without any resistance and came back to the facility. When resident got back to facility [s/he] told staff, 'I almost got away.' Resident was agitated about being back at facility and began yelling at staff. In doing incident follow up, the resident had been trying to open doors and going into empty rooms to look out windows all day. [S/he] broke the safety locks off the	N 433		

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window in [Room 17], so that [s/he] could open the window all the way and get out the lower quarter of the window. Resident climbed out of window in room 17."
"04/11/2024 9:24 AM - Resident was taken to the ER (emergency room) by [his/her] family to be evaluated after elopement. Resident was also evaluated for [his/her] medications by Geri Psych. Resident was admitted to the Geri Psych floor at [hospital] for paranoia and behaviors."
"04/17/2024 11:43 AM - Resident has been brought back to the facility after [his/her] stay at the Geri Psych unit."
"04/22/2024 11:33 AM - Around 7:30 PM resident was seen outside of the building walking down [highway] on the opposite side of the road. Staff member got in [his/her] car and immediately went to pick resident up and bring back to facility."
"04/22/2024 12:01 PM - Resident has been exit seeking all morning long. [S/he] continues to walk by the door to the memory care, and try to push on it to see if it will open. [S/he] is walking into open rooms and looking out windows, trying to see how [s/he] can 'get out.' Resident yelled at writer this morning stating that [s/he] was being held hostage and needed to 'get the [explicative word] out of here.' ... Resident is jiggling door handles of rooms/closets that are locked. Resident has been locking [him/herself] in [his/her] bedroom and isolating [him/herself] from staff and residents."
"05/09/2024 12:13 PM - Resident was in [his/her] room trying to open the windows, [s/he] was yelling at the staff because [s/he] feels like [s/he] is being 'kept hostage.'"
"05/13/2024 10:23 AM - On 05/10/2024 staff heard window alarms going off in resident's room. Staff went into [his/her] room, resident had a pair of scissors and was messing with the alarms on the windows."

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N 433	Continued From page 17 "05/14/2024 12:33 PM - Staff member was helping resident [room number] with using the bathroom and do cares. Other resident had followed staff and [room number] into the bathroom [sic]. Staff asked resident to step out of the bathroom to provide privacy for other resident. Resident got upset and choked RA. RA was able to get resident's hands off of [him/her] and staff redirected resident to [his/her] room to calm down." Resident 12's ISP, dated 03/25/2024, documented: "Psychosocial: Occasional anxiety issues; frequent awareness issues; frequent behavior issues - Resident has current or history of frequent disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper; frequent hallucination/delusion issues - Resident has become more paranoid. Afternoon and nighttime seem to be the worst time for [him/her]. [S/he] often thinks people are stealing [his/her] car or are coming to harm [him/her]; frequent poor judgement issues; occasional mood and depression issues; moderate wandering issues - Resident has current or history of wandering. Current or history of wandering within the residence of the facility. May wander outside; health or safety may be jeopardized, but participant is not combative about returning." "Neurocognitive: Resident often wonders [sic: wanders] around facility at nighttime. [S/he] will knock on other resident doors, and wonder [sic: wander] into rooms that are not [his/her]; Communication - Moderate impairment. Resident has current or history of frequent difficulty communicating and receiving information; cannot follow instructions; Orientation - Severe impairment. Resident is	N 433		

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N 433	Continued From page 18 frequently disoriented and requires frequent supervision and oversight. The ISP did not contain updated guidelines regarding his/her elopement behaviors when s/he returned from Geri Psych, On 05/29/2024 at 1:00 PM, Surveyor interviewed Regional Director D, Clinical Risk Manager J, Executive Director I, Health Care Coordinator S and Regional Nurse Specialist V. Surveyor asked what additional guidelines were put into place for Resident 12 regarding his/her elopement behaviors. Health Care Coordinator S stated Resident 12 returned from Geri Psych on an as-needed (PRN) prescription of Trazadone. Health Care Coordinator S stated, "Staff may not have understood how to administer the PRN, as staff understood it as a medication to assist [Resident 13] when s/he could not sleep. [Resident 12] is now on a scheduled Trazadone which seems to be helping. [S/he] is still on 15-minute checks and staff have recognized his/her signs of agitation which leads to elopement, pacing up and down the hallway extremely agitated. We are making sure vacant room doors are locked. Family is also taking him out more often." Regional Nurse Specialist V stated Resident 12 had been issued a 30-day notice.	N 433		
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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evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not conduct quarterly fire drills with both employees and residents in 2022 and 2023, with documentation including total evacuation time for each event.

Findings include:

The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to serve up to 22 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's.

On 05/15/2024, at approximately 10:15 AM, Surveyor interviewed Maintenance Director Q and requested the fire evacuation drills for 2022 and 2023. Surveyor was provided:
01/11/2023 at 1:00 PM: residents who participated was not listed and evacuation time was 4:48 sec.
05/07/2023: no time of drill documented, and evacuation time was documented as "15 - 30 minutes."
12/14/2023 at 4:00 AM: evacuation time was not

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N 525	Continued From page 20 documented. Surveyor asked Maintenance Director (MD) Q if residents actively participated in the fire drills. MD Q stated residents did participate, residents evacuated to the outdoors except during sleep hours. MD Q stated, "Our fire department stated residents did not need to be evacuated outside during a mock fire drill during sleep hours. We move the residents to the common area." Surveyor asked if there were any additional fire drill documentation for 2022 and 2023. MD Q stated that prior to his/her employment, the provider was behind in conducting these required drills. As of 05/16/2024 at 4:00 PM, no further documentation was provided.	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 evacuation drills, such as tornado, flooding or other emergency or disaster, were completed at least semi-annually. The provider's record did not include drills for 2022 and 2023. Findings include: The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to serve up to 22	N 526		

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N 526	Continued From page 21 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's. On 05/15/2024, at approximately 10:15 AM, Surveyor interviewed Maintenance Director Q and requested the other evacuation drills for 2022 and 2023. Maintenance Director Q stated s/he was unsure of where that documentation was and could not state if it had been completed. On 05/29/2024 at 1:00 PM, Surveyor interviewed Regional Director D, Clinical Risk Manager J, Executive Director I, Health Care Coordinator S and Regional Nurse Specialist V. Executive Director I stated, "I am positive we did a tornado drill in 2023. I will forward that documentation." On 05/29/2024 at 3:00 PM, Executive Director I emailed Surveyor with one 2023 tornado drill and stated s/he was unable to locate other evacuation drills for 2022.	N 526		