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TALAMORE SENIOR LIVING SUN PRAIRIE	275 NORTH CITY DRIVE SUN PRAIRIE, WI 53590

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N 000	Initial Comments On 08/14/2024, with information obtained through 08/16/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation and standard licensing survey at Talamore Senior Living Sun Prairie, a community-based residential facility (CBRF) located in Sun Prairie, WI. As a result of the survey, 12 deficiencies were identified. The complaint was unsubstantiated. Census: 24	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent to the Department within 3 working days after law enforcement personnel were called to the CBRF as a result of Resident 1's behaviors. Findings include:	N 164		

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

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N 164	Continued From page 1 On 08/14/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/20/2022 with diagnoses including unspecified dementia. In reviewing Resident 1's progress notes from 05/01/2024 - 08/14/2024, Surveyor observed the following entry: - 08/08/2024 (11:26 p.m.): "11:20PM- staff called reporting resident is hitting towards staff and throwing objects. Staff report they called the cops for assistance and the cops assisted with de-escalating the situation but resident resumed hitting towards staff and throwing objects once they left..." On 08/14/2024, Surveyor reviewed Department records for the facility, which did not show any evidence of a report submitted regarding the above incident that involved law enforcement response to Resident 1's behaviors. At approximately 5:00 p.m., Surveyor interviewed Executive Director A. Executive Director A confirmed that s/he did not send a self-report and reported s/he was unaware that situation would have required a self-report.	N 164		
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	N 220		

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N 220	Continued From page 2	N 220		

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 that the CBRF obtained documentation from a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse indicating that 2 of 3 employees reviewed were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of employment.

Findings include:

On 08/14/2024, Surveyor conducted a review of 3 employees to verify compliance with communicable disease screening requirements. Surveyor requested communicable disease screens, including evidence of any tuberculosis tests, from Executive Director A for Caregivers B, C, and D.

Example 1 - Caregiver C

The employee record for Caregiver C, hired 02/16/2024, contained a communicable disease screen completed and signed by Caregiver C. The section within the screen for the medical provider or nurse to indicate their review of it was blank. There was no evidence of tuberculosis testing within Caregiver C's record.

At approximately 5:00 p.m., Surveyor interviewed Executive Director A. Executive Director A reported it was possible that Director of Nursing E

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N 220	Continued From page 3 reviewed the screen and had tuberculosis test results for Caregiver C, but confirmed Surveyor's observation that there was no evidence that the communicable disease screen document was signed by anyone other than Caregiver C. Executive Director A reported s/he wasn't sure where Director of Nursing E would keep the documentation if not in Caregiver C's record, and also reported that Director of Nursing E was out of the office on an extended leave. Example 2 - Caregiver D The employee record for Caregiver D, hired 08/17/2022, contained a communicable disease screen completed and signed by Caregiver D. The section within the screen for the medical provider or nurse to indicate their review of it was blank. There was no evidence of tuberculosis testing within Caregiver D's record. At approximately 5:00 p.m., Surveyor interviewed Executive Director A. Executive Director A reported it was possible that Director of Nursing E reviewed the screen and had tuberculosis test results for Caregiver D, but confirmed Surveyor's observation that there was no evidence that the communicable disease screen document was signed by anyone other than Caregiver D. Executive Director A reported s/he wasn't sure where Director of Nursing E would keep the documentation if not in Caregiver D's record, and also reported that Director of Nursing E was out of the office on an extended leave.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with	N 230		

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N 230	Continued From page 4 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 that 2 of 2 employees reviewed obtained orientation training that included all the required topics before performing any job duties. Caregiver B did not have training in reporting abuse, preventing and reporting resident neglect and misappropriation of property, and recognizing and responding to resident changes of condition. Caregiver C did not have training in preventing and reporting of resident abuse, neglect, and misappropriation of resident property; and recognizing and responding to resident changes of condition. Findings include: On 08/14/2024, Surveyor conducted a review of 2 employees to verify compliance with orientation training requirements. Surveyor requested training records from Executive Director A for Caregivers B and C.	N 230		

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N 230	Continued From page 5 Example 1 - Caregiver B The record for Caregiver B, hired 11/20/2023, did not contain evidence of training in recognizing and responding to resident changes of condition. One course, showing training in abuse prevention, was documented as completed, but there was no information as to whether this included information regarding reporting abuse or preventing and reporting resident neglect and misappropriation of property. At approximately 5:00 p.m., Surveyor interviewed Executive Director A. Executive Director A acknowledged Surveyor's concern that there was no evidence that Caregiver B completed training in recognizing and responding to resident changes of condition. Executive Director A reported s/he wasn't sure if the abuse prevention course also contained information about reporting abuse or information about neglect and misappropriation. Surveyor requested for any additional evidence of the abuse, neglect, and misappropriation training, such as a course outline or slides, to be provided by 12:00 p.m. on 08/15/2024 in order to verify the content. On 08/15/2024, at approximately 10:21 a.m., Executive Director A reported s/he was unable to find additional training records. Example 2 - Caregiver C The record for Caregiver C, hired 02/16/2024, did not contain evidence of training in preventing and reporting of resident abuse, neglect, and misappropriation of resident property; and recognizing and responding to resident changes of condition.	N 230		

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N 230	Continued From page 6 At approximately 5:00 p.m., Surveyor interviewed Executive Director A. Executive Director A acknowledged Surveyor's concern that there was no evidence that Caregiver C completed training in recognizing and responding to resident changes of condition or in preventing and reporting abuse, neglect, and misappropriation. On 08/15/2024, at approximately 10:21 a.m., Executive Director A reported s/he was unable to find additional training records.	N 230		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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N 239	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 3 employees reviewed obtained all department approved training as required. Caregiver B did not have training in fire safety or first aid and choking within 90 days after starting employment. Findings include: On 08/14/2024, Surveyor conducted a review of 3 employees to verify compliance with department-approved training requirements. Surveyor requested training records from Executive Director A for Caregivers B, C, and D. The record for Caregiver B, hired 11/20/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety or first aid and choking training. On 08/14/2024, at approximately 5:00 p.m., Surveyor interviewed Executive Director A. Executive Director A confirmed the provider did not have evidence that Caregiver B completed or met an exemption for fire safety training or first aid and choking training. On 08/14/2024, Surveyor verified Caregiver B was not on the Community-Based Care and Treatment training registry for fire safety or first aid and choking.	N 239		
N 243	83.21(1)-(3) All employee training.	N 243		

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N 243	Continued From page 8 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 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.	N 243		

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N 243	Continued From page 9	N 243		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 2 employees reviewed obtained all training as required within 90 days after starting employment.

Caregiver B did not have training in resident rights or recognizing, preventing, managing, and responding to challenging behaviors within 90 days after starting employment.

Findings include:

On 08/14/2024, Surveyor conducted a review of 2 employees to verify compliance with all employee training requirements. Surveyor requested training records from Executive Director A for Caregivers B and C.

Resident Rights

The record for Caregiver B, hired 11/20/2023, did not contain evidence of training or evidence of meeting an exemption for resident rights training.

On 08/14/2024, at approximately 5:00 p.m., Surveyor interviewed Executive Director A. Executive Director A reported s/he thought there maybe was additional training records for Caregiver B showing completion of the required training. Surveyor gave a deadline of 12:00 p.m. on 08/15/2024 to receive any additional records.

On 08/15/2024, at approximately 10:21 a.m.,

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N 243	Continued From page 10 Executive Director A reported s/he was unable to find additional training records. Recognizing, Preventing, Managing, and Responding to Challenging Behaviors The record for Caregiver B, hired 11/20/2023, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 08/14/2024, at approximately 5:00 p.m., Surveyor interviewed Executive Director A. Executive Director A reported s/he thought there maybe was additional training records for Caregivers B showing completion of the required training. Surveyor gave a deadline of 12:00 p.m. on 08/15/2024 to receive any additional records. On 08/15/2024, at approximately 10:21 a.m., Executive Director A reported s/he was unable to find additional training records.	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 11 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 2 employees reviewed obtained all task specific training as required. Caregiver 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. Findings include: On 08/14/2024, Surveyor conducted a review of 2	N 247		

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N 247	Continued From page 12 employees to verify compliance with task specific training requirements. Surveyor requested training records from Executive Director A for Caregivers B and C. On 08/14/2024, at approximately 9:15 a.m., Surveyor interviewed Caregiver B. Caregiver B reported s/he currently was conducting the medication pass, but had assisted with resident cares earlier that morning. Caregiver B reported that s/he typically conducted resident cares during his/her shifts. The record for Caregiver B, hired 11/20/2023, did not contain evidence of training or evidence of meeting an exemption for personal care training. On 08/14/2024, at approximately 5:00 p.m., Surveyor interviewed Executive Director A. Executive Director A confirmed Caregiver B is responsible for providing personal cares. Executive Director A reported s/he thought there maybe was additional training records for Caregiver B showing completion of the required training. Surveyor gave a deadline of 12:00 p.m. on 08/15/2024 to receive any additional records. On 08/15/2024, at approximately 10:21 a.m., Executive Director A reported s/he was unable to find additional training records.	N 247		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum,	N 277		

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N 277	Continued From page 13 all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 1 resident care staff reviewed received at least 15 hours of continuing education in 2023 in all the required topics. Records of training completed by Caregiver D in 2023 consisted of 3 team meetings that s/he attended. None of his/her attended meetings contained information regarding the hours of continuing education completed. Outlines of the meetings s/he attended did not contain evidence of training in all the required topics. Findings include: On 08/14/2024, Surveyor conducted a review of 1 employee to verify compliance with continuing education requirements. Surveyor requested 2023 training records from Executive Director A for Caregiver D. On 08/14/2024, at approximately 11:00 a.m., Executive Director A reported that there were no online training records for training completed by Caregiver D in 2023. Executive Director A reported that all of Caregiver D's training records consisted of monthly team meetings in which various training topics were covered. Executive	N 277		

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N 277	Continued From page 14 Director A then provided Surveyor sign-in rosters, meeting outlines, and PowerPoint slides for meetings completed in 2023. Of the monthly meeting records provided, Surveyor observed 5 records in which Caregiver D was documented as having an excused absence (and was therefore, not present) during the training. Within those meeting records, there was no evidence that follow up training was conducted with Caregiver D. Surveyor observed 3 meetings in which Caregiver D signed as attending. None of the meetings contained evidence of the number of training hours completed. Within the meeting outlines of meetings that Caregiver D attended, Surveyor did not observe any evidence of training in standard precautions, client group related training, resident rights, preventing and reporting of abuse, neglect, and misappropriation; and fire safety and emergency procedures, including first aid. At approximately 5:00 p.m., Surveyor interviewed Executive Director A. Executive Director A reported that Director of Nursing E sometimes reviewed the meeting discussion and trainings with staff who were not able to attend the meetings. Executive Director A confirmed Surveyor's observation that based on the records provided there was no evidence that this follow up training was completed by Caregiver D. Executive Director A acknowledged Surveyor's concern that none of the meetings Caregiver D attended contained evidence of training hours completed. Executive Director A acknowledged Surveyor's concern that the meetings attended by Caregiver D did not contain evidence of training in all the required continuing education topics.	N 277		

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N 389	Continued From page 15	N 389		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that when there was a change in Resident 1's needs, including his/her increased fall risk and bed rail use, as well as a change in who was responsible for providing Resident 1's showers, that his/her individual service plan (ISP) was updated to reflect this information. Findings include: On 08/14/2024, at approximately 9:55 a.m., Surveyor interviewed Caregiver B regarding resident care needs. Caregiver B reported that the provider's staff were responsible for completed resident showers unless residents received hospice services. For residents who received hospice services, Caregiver B reported that hospice staff typically completed those showers. Caregiver B then showed Surveyor a	N 389		

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document from the staff's front desk area within the CBRF which showed resident shower schedules. For the residents receiving hospice services, the document indicated that hospice completed the showers. Caregiver B reported that Resident 1 had received a shower and gotten dressed with hospice that morning.

At approximately 12:35 p.m., Surveyor toured the environment. Surveyor observed Resident 1 in his/her bed, laying sideways across it. Resident 1's bed had a right quarter rail on it, observed in the up position.

At approximately 3:40 p.m., Surveyor toured the environment again. Surveyor observed Resident 1 laying in his/her bed again, sideways across it. Resident 1's right quarter bedrail was observed in the up position.

On 08/14/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/20/2022 with diagnoses including unspecified dementia.

Surveyor reviewed a document titled "WI Master Assessment" dated 06/13/2023 which was an overall assessment completed for Resident 1. Within the first page, the following was documented: "Indicate any significant medical concerns the resident has experienced since the last assessment:" Underneath that, "A. Falls (Describe)" was documented. However, later in the assessment, it was documented that Resident 1 was a minimal risk for falls.

Surveyor reviewed Resident 1's progress notes from 05/01/2024 - 08/14/2024 and observed the following entries:

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N 389	Continued From page 17 - 05/05/2024 (9:49 p.m.): Entry documenting a fall that occurred earlier that evening at 8:50 p.m. with information including, "Resident got up from chair walking in common area loss balance and fell backward." Two entries the following day documented concerns of a potential left wrist fracture sustained after the fall and later confirmation of the fracture. A follow up entry documented on 05/09/2024, regarding a follow up nurse visit that occurred on 05/06/2024, also documented a new "3x3 bruise to [Resident 1's] left hip." - 05/29/2024 (12:41 p.m.): Entry documenting that a member of Resident 1's hospice team saw Resident 1 the previous day for a routine visit as well as a fall visit, with no injuries noted - 06/21/2024 (10:05 a.m.): Entry documenting a fall that occurred on 06/02/2024 at 9:55 a.m. with information including, "...Resident kept getting out of wheelchair...Staff picked up resident from floor, took vitals and contacted hospice checked resident for injury and kept resident in wheelchair..." - 06/21/2024 (10:07 a.m.): Entry documenting a fall that occurred on 06/02/2024 at 3:26 a.m. with information including, "...Resident was just done eating, and got up from [his/her] wheelchair. [S/he] fell down when [s/he] tried to look back while working." - 06/21/2024 (10:08 a.m.): Entry documenting a fall that occurred on 05/28/2024 at 3:00 p.m. with information including, "...resident was found sitting on the floor asking for help..." - 07/01/2024 (5:55 a.m.): "witnessed fall...this on call was contacted at 05:53 regarding resident	N 389		

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with witnessed fall. per [sic] care staff resident was unsteady on feet and had come out of apartment in the nude. Staff were attempting to redirect and resident became upset and combative and lost balance hitting arm on wall and falling landing on left side...resident has no complaints of pain and is able to move arms and legs...Resident scraped arm on wall and has slight bleeding. Staff cleaned area and placed bandage on it..."

- 07/19/2024 (6:49 a.m.): Entry documenting a fall that occurred that morning at 6:15 a.m. with information including that staff "were doing walk through and found [him/her] on the floor next to [his/her] bed no injuries at this moment..."

- 07/25/2024 (9:00 a.m.): Entry documenting that a fall occurred on 07/24/2024 at 7:45 p.m. with information including, "I heard a big noise from the dining room, and when I looked there, [s/he] was on the floor..."

Surveyor observed from the above entries 7 falls sustained by Resident 1 between 05/05/2024 - 07/25/2024, 2 of which Resident 1 was documented to have injuries (left hip bruising and left wrist fracture after 1, unspecified arm scrape after the other). No other fall prevention interventions were documented in the records provided.

Surveyor reviewed Resident 1's most recent ISP on hand, provided by Executive Director A, which was dated 06/14/2023 (over 1 year prior to the survey and prior to a known period of Resident 1's fall risk, hospice agency involvement, and bed rail use).

At approximately 5:00 p.m., Surveyor interviewed

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N 389	Continued From page 19 Executive Director A. Executive Director A acknowledged Surveyor's concern that Resident 1's ISP was not updated to reflect information regarding his/her bed rail use, updated information regarding his/her hospice shower provision, and information including fall prevention interventions that met his/her demonstrated increased fall risk. Executive Director A said nothing further. On 08/15/2024, Surveyor reviewed an additional ISP for Resident 1, e-mailed by Executive Director A. In the e-mail, sent at 10:20 a.m., Executive Director A reported that this ISP was Resident 1's most recent care plan, which was reviewed in June of 2024. Surveyor then reviewed the ISP, dated 06/24/2024. There was no information regarding Resident 1's bed rail use, information regarding his/her showering needs and the provision of them by his/her hospice agency, or any information regarding his/her fall risk and fall prevention interventions.	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary	N 408		

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N 408	Continued From page 20 to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plan (ISP) for Resident 1, who was prescribed as needed (PRN) lorazepam, included the rationale for use and a detailed description of the behaviors which indicated the need for its administration. Findings include: On 08/14/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/20/2022 with diagnoses including unspecified dementia. In reviewing Resident 1's progress notes from 05/01/2024 - 08/14/2024, Surveyor observed the following entries: - 05/06/2024 (5:36 p.m.): "The hospice nurse came for a visit, X-ray result came back which confirmed a fracture. Lorazepam was ordered for [his/her] restlessness...Called the pharmacy, and they confirmed we will receive [his/her] meds tonight..." - 05/06/2024 (5:58 p.m.): "LORAZEPAM 0.5MG TABLET TAKE 1 TABLET BY MOUTH EVERY 4 HOURS AS NEEDED FOR FOR [sic] ANXIETY OR NAUSEA/VOMITING OR RESTLESSNESS..."	N 408		

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N 408	Continued From page 21 - 06/12/2024 (3:59 p.m.): "Res very anxious, received lorazepam, effective, no lethargy noted..." - 07/18/2024 (1:58 a.m.): "Call received from [resident assistant] at 1:50 PM to report increased behaviors and agitation despite interventions. PRN medication reviewed with staff. Staff instructed to administer PRN Lorazepam for agitation per orders..." - 4 entries, on 07/28/2024 (3:55 a.m.), 07/29/2024 (4:45 a.m.), 08/02/2024 (1:10 a.m.), and 08/08/2024 (11:26 a.m.), document various concerns Resident 1 demonstrated - combativeness, aggression, agitation, anxiety - in which clinical staff documented approval for caregiving staff to administer Resident 1 his/her PRN lorazepam Surveyor reviewed Resident 1's medication administration records (MARs) from 07/01/2024 - 08/14/2024 and observed the following 8 occasions in which staff documented administering Resident 1's PRN lorazepam: - 07/01/2024 (6:13 a.m.) - 07/18/2024 (2:56 a.m.) - correlated with annotation above - 07/19/2024 (6:55 a.m.) - 07/24/2024 (10:18 p.m.) - 07/28/2024 (12:27 a.m.) - correlated with annotation above - 07/29/2024 (5:25 a.m.) - correlated with annotation above - 08/02/2024 (1:10 a.m.) - correlated with annotation above - 08/08/2024 (11:31 p.m.) - correlated with annotation above	N 408		

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N 408	Continued From page 22 For all the above entries, staff documented the reason for administration was "ANXIETY." Surveyor reviewed Resident 1's most recent ISP on hand, provided by Executive Director A, which was dated 06/14/2023. The ISP documented that all of Resident 1's medications were to be administered by staff, but did not contain any information regarding Resident 1's lorazepam use or a detailed description of Resident 1's behaviors that indicated the need for its administration. At approximately 5:00 p.m., Surveyor interviewed Executive Director A. After reviewing the regulation with Surveyor, Executive Director A acknowledged Surveyor's concern regarding the missing information in Resident 1's ISP, but said nothing further. On 08/15/2024, Surveyor reviewed an additional ISP for Resident 1, e-mailed by Executive Director A. In the e-mail, sent at 10:20 a.m., Executive Director A reported that this ISP was Resident 1's most recent care plan, which was reviewed in June of 2024. Surveyor then reviewed the ISP, dated 06/24/2024. There was no information regarding Resident 1's lorazepam use or a detailed description of Resident 1's behaviors that indicated the need for its administration.	N 408		
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	N 488		

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N 488	Continued From page 23 temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 1 of 2 clothing dryers contained dryer vent tubing of rigid material. Findings include: On 08/14/2024, at approximately 10:08 a.m., Surveyor observed the provider's laundry room. Of the 2 dryers located on the back wall, Surveyor observed that 1 of them contained flexible dryer vent tubing. At approximately 5:00 p.m., Surveyor interviewed Executive Director A. Executive Director A acknowledged Surveyor's concern regarding the dryer vent tubing and reported s/he would have maintenance staff address it.	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 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	N 525		

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N 525	Continued From page 24 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 that 2 of 4 quarterly fire evacuation drills in 2023 were conducted and that all fire drill records for 2023 and 2024 contained the CBRF's total evacuation time. Findings include: On 08/14/2024, Surveyor conducted a review of fire evacuation drills to verify compliance with fire evacuation drill requirements. Surveyor requested all 2023 and 2024 fire evacuation drill records from Executive Director A. In the records provided, Surveyor observed drills conducted in various locations within the facility - some within the CBRF and some within the connected residential care apartment complex as well as areas outside the CBRF. At approximately 10:20 a.m., while reviewing fire drill records provided, Surveyor interviewed Executive Director A about how fire drills were conducted. Executive Director A reported that due to having fire-rated doors that separated memory care from the rest of the facility, CBRF resident evacuation was only conducted when the simulated fire was reported to be within the CBRF. In reviewing the records where a simulated fire was documented as specifically occurring in the CBRF, Surveyor did not observe evidence of fire evacuation drills having been completed in the first and third quarters of 2023. Of the 2023 and	N 525		

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N 525	Continued From page 25 2024 fire evacuation drill records provided, there was no evidence of the CBRF's total evacuation time documented. At approximately 5:00 p.m., Surveyor interviewed Executive Director A. Surveyor reviewed fire evacuation drill regulatory requirements and Executive Director A reported s/he would work with his/her staff to ensure going forward that quarterly fire evacuation drills would be completed for the CBRF residents and that the evacuation times would be documented.	N 525		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for an annual inspection by the local fire authority or certified fire inspector. The provider's last fire inspection was dated 07/20/2022. Findings include: On 08/14/2024, Surveyor conducted a review of the provider's fire inspections to verify compliance with annual inspection requirements. Surveyor requested the provider's last 2 years' worth of fire inspections from Executive Director A. At approximately 1:40 p.m., Surveyor reviewed a	N 530		

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N 530	Continued From page 26 record provided by Director of Maintenance F and interviewed him/her and Executive Director A about the record. Surveyor observed that the record documented a fire inspection conducted by the local fire department that occurred on 07/20/2022. Director of Maintenance F confirmed this was the most recent fire inspection s/he could find. Director of Maintenance F reported that s/he had spoke with the fire inspector who told him/her they were behind on fire inspections but were planning to come out later that month.	N 530		