STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016509	A. BUILDING: _____ B. WING _____	R-C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN WINDS LLC	N3767 AIRPORT RD CAMBRIDGE, WI 53523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 01/06/2025, with information gathered through 01/14/2025, Surveyor conducted a verification visit and complaint investigation at Autumn Winds LLC. Sixteen deficiencies were identified. Nine of the 16 deficiencies were repeat violations (see Statement of Deficiency (SOD) FFKZ12 and SOD FFKZ11). Complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 5	{N 000}		
N 156	83.12(1)(b) Death reporting related to accident or injury Resident death related to an accident or injury. When a resident dies as a result of an incident or accident not related to the use of a physical restraint, psychotropic medication, or suicide, the CBRF shall send a report to the department within 3 working days of the resident ' s death. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Department received a written report to notify Resident 10 had passed away after a choking incident. Findings include: On 12/06/2024, the Department received a complaint alleging a resident had suffered a choking incident due to staff assisting other residents which resulted in death.	N 156		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 156	Continued From page 1 On 01/06/2025, at approximately 11:30 AM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 10 passed away during his/her scheduled shift. Caregiver D explained that Resident 10 had been sitting in the rocking chair, next to the kitchen, for approximately an hour to 1 ½ hours and at times appeared to be mumbling under his/her breath. Caregiver D stated this was not baseline for Resident 10 as s/he was able to communicate clearly. Caregiver D stated Resident 10 had been eating his/her breakfast which was Cheerios cereal. Caregiver D stated that s/he along with Resident 2 and Administrator A had been sitting in the kitchen talking while Resident 10 was sitting in the rocker. Caregiver D stated that Resident 10 appeared pale and had his/her head bent forward, so Administrator A checked on him/her and determined s/he did not have a pulse and Resident 10's family was contacted. On 01/07/2025, at approximately 11:35 AM, Surveyor interviewed Resident 10's Health Care Power of Attorney (HCPOA) E. HCPOA E stated s/he had been contacted by Administrator A at 12:22 PM on 10/22/2024 and was informed that Resident 10 had passed away. HCPOA E requested that 911 be called. HCPOA E stated Administrator A had informed him/her that s/he had left the facility to go grocery shopping and when s/he returned s/he found Resident 10 unresponsive. On 01/08/2025, Surveyor reviewed Resident 10's managed care organization (MCO) case notes provided by the MCO provider which documented: 10/22/2024 - Facility Manager ([Administrator A]) left the CBRF (community-based residential facility) to run to store during breakfast. Member	N 156		

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N 156	Continued From page 2	N 156		

was left with a bowl of Cheerios. Another staff person was in the building, assisting other residents. Member suspected to choke while other staff person was out of line of sight. Staff person passed by member, but believed member was sleeping. When facility manager returned after approximately 30 minutes, [s/he] noticed member's color looked pale and felt for a pulse. Member had no pulse. Manager called [HCPOA E] and asked if [s/he] could come to facility, reporting [Resident 10] passed. [HCPOA E] asked facility to call 911. Facility called 911 and EMS (emergency medical services) responded, nothing that there were Cheerios obstructing [his/her] airway. They attempted to revive member with no success. EMS believes member had choked 45-60 minutes prior to their arrival.

On 01/07/2024, at approximately 1:45 PM, Surveyor interviewed Administrator A. Administrator A stated s/he thought s/he had submitted a self-report form to the Department. Surveyor requested verification from Administrator A as a self-report form was not located in the Department file.

As of 01/10/2025 at 5:00 PM, Surveyor did not receive any additional documentation.

On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated s/he would review his/her emails for the submission. Surveyor stated the documentation would need to be submitted by 5:00 PM.

As of 5:00 PM on 01/14/2025, Surveyor did not receive any additional documentation.

Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect

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N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Community-Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. This had the potential to affect 5 of 5 residents who resided at the facility. Findings include: The provider received a regular license on 03/01/2018, as a class CNA (nonambulatory) CBRF able to serve up to 10 residents within the client groups advanced aged, developmentally disabled, traumatic brain injury, irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled. On 01/06/2025, with information gathered through 01/14/2025, Surveyor conducted 2 verification visits and a complaint investigation at Autumn Winds Inc. Seventeen deficiencies were identified. N0156 DHS 83.12(1)(b) Death Reporting Related to Accident Or Injury N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication. This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ12, dated 07/25/2024.	N 196		

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N 196	Continued From page 4 N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023. N0391 DHS 83.35(3)(f) Staff Access to Assessment And ISP N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs N0406 DHS 83.37(1)(g) Disposition of Medications. This is a repeat deficiency. See SOD FFKZ12, dated 07/25/2024. N0415 DHS 83.37(2)(d) Documentation of Medication Administration. This is a repeat deficiency. See SOD FFKZ12, dated 07/25/2024. N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023, and SOD FFKZ12, dated 07/25/2024. N0420 DHS 83.37(3)(d) Medication Storage: Refrigeration. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023. N0432 DHS 83.38(1)(h) Medication Administration. This is a repeat deficiency. See SOD FFKZ12, dated 07/25/2024. N0450 DHS 83.41(2)(c) Nutrition: Menus N0452 DHS 83.41(3)(b) Food Safety. This is a repeat deficiency. See SOD FFKZ12, dated 07/25/2024. N0483 DHS 83.43(2)(b) Clean, Comfortable Mattress and Pad N0489 DHS 83.44(2)(a) Rooms Clean and Free From Odors N0499 DHS 83.45(3) Toxic Substances. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023, and SOD FFKZ12, dated 07/25/2024. SPECIAL ORDERS	N 196		

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N 196	Continued From page 5 Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Autumn Winds llc: Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall ensure each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by the practitioner. The resident has the right to refuse medication unless the medication is court ordered. WITHIN 45 DAYS of receipt of this notice, the licensee will develop and implement corrective measures to address each medication administration and medication storage deficiency identified in Statement of Deficiency FFKZ12. All managers, and resident care staff with responsibilities for medication administration and management, will receive in-service training regarding the provider's corrective measures. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. Review of facility records documented three previous survey events identifying noncompliance, as follows: SOD FFKZ12 - dated 07/25/2024 On 07/22/2024, with information gathered through 07/25/2024, Surveyor conducted a verification visit at Autumn Winds LLC. Nine deficiencies were identified. N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0406 DHS 83.37(1)(g) Disposition of Medications	N 196		

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N 196	Continued From page 6 N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0417 DHS 83.37(3)(a) Medication Storage: Original Containers. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023. N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023. N0425 DHS 83.38(1)(a) Personal Care N0432 DHS 83.38(1)(h) Medication Administration N0452 DHS 83.41(3)(b) Food Safety N0499 DHS 83.45(3) Toxic Substances. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023. SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Autumn Winds llc: Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall ensure each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by the practitioner. The resident has the right to refuse medication unless the medication is court ordered. WITHIN 45 DAYS of receipt of this notice, the licensee will develop and implement corrective measures to address each medication administration and medication storage deficiency identified in Statement of Deficiency FFKZ12. All managers, and resident care staff with responsibilities for medication administration and management, will receive in-service training regarding the provider's corrective measures. Training will be documented in	N 196		

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N 196	Continued From page 7	N 196		

personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content.

SOD FFKZ11 - dated 11/16/2023
On 11/07/2023, with information gathered through 11/16/2023, Surveyor conducted a standard licensure survey at Autumn Winds LLC. Twelve deficiencies were identified.
N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan
N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes
N0394 DHS 83.35(5)(b) Annual Evaluation Of Evacuation Limits
N0412 DHS 83.37(2)(a) Self-Administered By Resident
N0415 DHS 83.37(2)(d) Documentation of Medication Administration
N0417 DHS 83.37(3)(d) Medication Storage: Refrigeration
N0420 DHS 83.38(1)(h) Medication Administration
N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented
N0499 DHS 83.45(3) Toxic Substances
N0530 DHS 83.47(3) Fire Inspection
N0531 DHS 83.47(4)(a) Fire Extinguishers: Type And Inspection
N0640 DHS 83.59\(2)(b) Solid Core Wood Doors Or Equivalent

SOD UTJG11 - dated 05/25/2021
On 05/19/2021, Surveyor conducted an abbreviated survey at Autumn Winds LLC, a CBRF located in Cambridge.
N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check
N0220 DHS 83.17(2)(a) Employees Screened

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N 196	Continued From page 8 For Communicable Disease N0243 DHS 83.21(1)-(3) All Employee Training N0247 DHS 83.22(1)-(4) Task Specific Training N0277 DHS 83.25 Continuing Education N0416 DHS 83.37 Other Administration Given or Delegated by RN N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable N0511 DHS 83.46(3) Public Water Supply or Well Water Test N0525 DHS 83.47(2)(d) Fire Drills N0538 DHS 83.48(3)(a) Fire Detection Systems Inspected Annually On 01/12/2025 at 10:19 AM, Surveyor emailed Administrator A and Licensee C and requested to set up an exit interview on 01/14/2025 at 9:00 AM. On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated s/he understood the concerns identified.	N 196		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not administer medications prescribed by a practitioner for 3 of 5 residents.	{N 352}		

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{N 352}	Continued From page 9 This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ12, dated 07/25/2024. Resident 1 did not receive his/her potassium chloride, Triamterene and Hydrochlorothiazide (Triamt/Hctz) [high blood pressure medication], Donepezil (dementia medication), Vitamin D3, Levothyroxine (thyroid medication), and Escitalopram (medication to treat major depressive disorder) as prescribed by his/her practitioner on 12/26/2024 and 01/05/2025. Resident 2 did not receive his/her Fluticasone as prescribed by his/her practitioner. Resident 8 did not receive his/her Fluticasone as prescribed by his/her practitioner. Findings include: Example 1: Resident 1 On 01/06/2025, at approximately 10:30 AM, Surveyor observed Resident 1's blister cards of Triamt/Hctz, Donepezil, Vitamin D3, Levothyroxine, and Escitalopram which displayed the medications were still in the blister cards that correlated with the dates 12/26/2024 and 01/05/2025. On 01/06/2025, Surveyor reviewed Resident 1's December 2024 and January 2025 Medication Administration Records (MARs), dated 12/01/2024 to 01/06/2025, which documented: Triamterene - Take 1 tablet by mouth every morning Donepezil - Take 1 tablet by mouth every morning Vitamin D3 - Take 1 tablet by mouth every morning	{N 352}		

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{N 352}	Continued From page 10	{N 352}		

Levothyroxine - Take 1 tablet by mouth daily before breakfast
Escitalopram - Take 1 tablet by mouth every morning

The MARs documented that the medications had been administered.

On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A confirmed that medications are dispensed in correlation with the date on the blister card with the date of the month. Administrator A did not have a response as to why Resident 1 did not receive his/her medications on 12/26/2024 and 01/05/2025.

Example 2: Resident 2

On 01/06/2025, Surveyor reviewed Resident 2's January 2025 MAR, dated 01/01/2025 to 01/06/2025, which documented:
"Fluticasone nasal spray - Instill two sprays into each nostril every morning for allergies. Scheduled at 8:00 AM. Start Date: 02/01/2023."
The MAR documented that the medication had been administered 01/01, 01/02, 01/03, 01/04 and 01/05.

On 01/06/2025, at approximately 11:35 AM, Surveyor reviewed the med cart and did not see Resident 2's bottle of Fluticasone.

On 01/06/2025, at approximately 11:40 AM. Surveyor interviewed Caregiver D and Resident 2. Surveyor asked if Caregiver D had administered Resident 2's Fluticasone. Caregiver D stated s/he did not administer any nasal sprays when s/he completed morning medications. Resident 2 stated s/he kept his/her nasal spray in his/her room so s/he could use it when s/he

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{N 352}	Continued From page 11	{N 352}		

needed it.

On 01/06/2025, at approximately 11:50 AM, Surveyor toured Resident 2's room and was unable to locate a bottle of Fluticasone.

On 01/14/2025, Surveyor reviewed Resident 2's hospice documentation provided by the hospice provider which documented:
"Start Date: 03/21/2023. Inhale 2 sprays of fluticasone propionate into each nostril 1 x day."

On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated the bottle of Fluticasone should have been in the med cart and s/he would follow up on it.

Example 3: Resident 8

On 01/06/2025, at approximately 10:30 AM, Surveyor observed 2 unopened bottles of Resident 8's Fluticasone in the med cart. One bottle had been dispensed in 04/2024 and the other in 07/2024. Surveyor did not observe an open bottle.

On 01/06/2025, Surveyor reviewed Resident 8's January 2025 MAR, dated 01/01/2025 to 01/06/2025, which was handwritten, and did not document that s/he was prescribed Fluticasone.

On 01/14/2025, at approximately 1:05 PM, Surveyor interviewed Resident 8's managed care organization (MCO) Care Manager (CM) F. CM F stated s/he had reviewed Resident 8's medication list on file and it stated Resident 8 was prescribed Fluticasone to be used daily.

On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated the

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{N 352}	Continued From page 12 Fluticasone no longer printed on the MARs, so s/he assumed the medication he been discontinued. Administrator A stated Resident 8 had a medical appointment this week and s/he would verify with his/her primary care physician if s/he was to be receiving the Fluticasone.	{N 352}		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's Individual Service Plan (ISP) was signed by the resident or resident's legal representative acknowledging their involvement in, understanding of, and in agreement with the plan for 3 of 4 resident records (Resident 4, Resident 8, and Resident 9) reviewed.	N 387		

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N 387	Continued From page 13 Findings include: On 01/14/2025, Surveyor reviewed Resident 4's and Resident 9's record. Resident 4 was admitted on 11/28/2022. Resident 4 was represented by Guardian G. Resident 4's available ISP, dated 11/12/2023, did not contain Guardian G's signature. Resident 8 was admitted on 06/21/2024. Resident 8 was represented by Guardian H. Resident 8's available ISP, dated 06/28/2024, did not contain Guardian H's signature. Resident 9 was admitted on 08/16/2023 and was his/her own person. Resident 9's available ISP, dated 09/13/2023 and 03/13/2024, did not contain Resident 9's signature. On 01/14/2025 at 9:00 AM., Surveyor interviewed Administrator A. Administrator A stated s/he would request the resident representatives to sign the ISPs or show proof that the ISPs have been provided to them.	N 387		
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	N 389		

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N 389	Continued From page 14	N 389		

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 observation, record review and interview, the provider did not ensure that the Individualized Service Plan (ISP) was updated when there was change in needs and physical or mental condition for 4 out of 4 residents reviewed.

This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ11, dated 11/16/2023.

Resident 4's ISP did not identify s/he required a Hoyer for transfers.
Resident 8's ISP did not identify his/her potential behaviors.
Resident 9's ISP did not identify his/her sleeping behaviors or that s/he required an EZ stand for transfers.
Resident 10's ISP did not identify his/her potential to elope from the facility, his/her fall risk, and that s/he could display verbal aggression.

Findings include:

Example 1: Resident 4

On 01/13/2025, at approximately 1:05 PM, Surveyor interviewed Resident 4's managed care organization (MCO) Care Manager (CM) F. CM F stated Resident 4 required a Hoyer for all transfers. Surveyor requested Resident 4's MCO documentation.

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N 389	Continued From page 15 On 01/13/2025, Surveyor reviewed Resident 4's record provided by Administrator A. Resident 4 moved into the facility 11/28/2022 with diagnoses including intellectual and developmental disabilities and spastic tetraplegia (quadriplegic). Resident 4's "Evacuation Assessment," dated 02/15/2024, documented: "Needs Full Assistance From Two Staff means the resident requires assistance from two persons during most of the evacuation." Resident 4's ISP, dated 11/12/2023, which was unsigned, documented: "Physical Disabilities - Unable to walk. Uses wheelchair with seatbelt and foot peddles [sic: pedals]." The ISP did not provide guidance regarding transfers. On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated s/he would review the ISP to ensure individuality. Example 2: Resident 8 On 01/13/2025, Surveyor reviewed Resident 8's managed care organization (MCO) documentation provided by the MCO which documented: "Mobility - Needs Assistance - Formal/Natural Supports/Needs to Find Helper. Walker" "Toileting - Member requires assistance to complete toileting tasks. Formal supports assist the mem er to complete toileting tasks at this time." "Behaviors - Biting self to the point of injury when [s/he] doesn't get [his/her] way or misplaces an	N 389		

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item. Member has formal BSP (behavior support plan) in place that includes supervision, maintaining routine, anticipating and explaining changes in routine, redirection to meaningful activities, assistance with finding lost items, reassurance, keeping a safe distance during behaviors. Property destruction, physical aggression towards other."

On 01/13/2025, Surveyor reviewed Resident 8's record which was provided by Administrator A.

Resident 8 moved into the facility 06/21/2024 with diagnoses including developmental disorder, abnormal gait and mobility, intellectual disabilities, and mood disorder.

Resident 8's ISP, dated 06/21/2024, documented:
"Mobility is not identified in the ISP."
"Toileting - Completes task independently."
"Behavior Patterns: Self-Abuse Behavior - Not at this time; Destructive of property or self, physically or mentally abusive - Not at this time."

On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated s/he would review the ISP to ensure individuality.

Example 3: Resident 9

On 01/06/2025, at approximately 12:40 PM, Surveyor observed Caregiver D utilize Resident 9's EZ stand to transfer him/her to the restroom.

On 01/13/2025, at approximately 1:05 PM, Surveyor interviewed Resident 9's managed care organization (MCO) Care Manager (CM) F. CM F stated Resident 4 refused to sleep in his/her bed; s/he sleeps in his/her wheelchair.

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N 389	Continued From page 17 On 01/13/2025, Surveyor reviewed Resident 9's record provided by Administrator A. Resident 9 moved into the facility 08/16/2023 with diagnoses including cerebral infarction (stroke) and disorders of multiple cranial nerves. Resident 9's ISP, dated 11/12/2023, which was unsigned, documented: "Physical Disabilities - Unable to walk. Uses wheelchair with seatbelt and foot peddles [sic: pedals]." The ISP did not provide guidance regarding transfers or his/her sleeping habits. On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated s/he would review the ISP to ensure individuality. Example 4: Resident 10 On 01/09/2025, Surveyor reviewed Resident 10's MCO "Member Centered Plan," dated 06/01/2024, provided by the MCO provider that documented: "Member has a history of wandering around and out of the facility." "Member can become verbally aggressive, swearing and yelling at people, when [s/he] is confused and disoriented." "High Fall Risk" On 01/13/2025, Surveyor reviewed Resident 10's record provided by Administrator A. Resident 10 moved into the facility 09/19/2024. Resident 10's ISP, dated 10/04/2024, documented: "Wandering - No"	N 389		

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N 389	Continued From page 18 "Self-Abusive Behavior - No" "Destructive of Property or Self, Physically or Mentally Abusive - No" "Aggressive/Combative - N/A (not applicable)" The ISP did not identify that /she was a fall risk. On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated Resident 10 could display behaviors and s/he would review the ISP to ensure individuality. Cross Reference: N0391 DHS 83.35(3)(f) Staff Access to Assessment And ISP Cross Reference: N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs	N 389		
N 391	83.35(3)(f) Staff access to assessment and ISP Availability. All employees who provide resident care and services shall have continual access to the resident ' s assessment and individual service plan. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all employees who provide resident care and services have continual access to the resident's assessment and individual service plan (ISP). Caregiver D did not have access to resident assessments and ISPs. Findings include: On 01/06/2025, at approximately 10:20 AM, Surveyor entered the facility. Caregiver D was the only staff member present. Caregiver D explained to Surveyor that Administrator A was not in the facility that day and s/he was the only staff member present. Caregiver D stated s/he would	N 391		

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not be able to assist Surveyor with resident records as s/he was not aware they were stored but s/he had contacted Administrator A and s/he was on his/her way.

On 01/06/2025, at approximately 10:30 AM, Surveyor observed Resident 2 sitting at the kitchen table utilizing oxygen. Surveyor walked over to read the oxygen level registered on the concentrator. The level read approximately 2.5 Liters. Surveyor asked Caregiver D if s/he knew what the oxygen level should be set at. Caregiver D stated, "I do not touch that, and I do not know. I just assume it is set correctly." Surveyor asked if Caregiver D would be able to review Resident 2's individual service plan (ISP) to determine what the oxygen level should be set at. Caregiver D did not know where the ISPs were.

On 01/06/2025 at 12:57 PM, Surveyor emailed Administrator A and requested resident ISPs that were not available in the resident binders.

Surveyor left the facility at approximately 1:30 PM and Administrator A had not arrived at the facility.

On 01/07/2025 at 1:44 PM, Surveyor called Administrator A to follow up on requested documentation. Administrator A explained to Surveyor that s/he was having difficulty accessing the ISPs as they were stored on his/her computer and the computer was malfunctioning.

On 01/13/2025, Surveyor reviewed Resident 8's managed care organization (MCO) documentation provided by the MCO which documented:
"10/17/2024 - Member has formal BSP (behavior support plan). [Caregiver] was not aware that member has a history of behaviors."

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N 391	Continued From page 20 On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated s/he had been trained to keep the ISPs on the computer but that proved difficult to access. Administrator A stated s/he would print out the ISPs and ensure that staff had reviewed the ISPs and knew where they were kept.	N 391		
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 ensure enough employees were provided to meet the 24-hour needs of residents. The provider staffed only 1 caregiver when 3 of 5 residents required assistance of 2 caregivers for personal care needs or emergency evacuation. Findings include: On 01/06/2025, at approximately 10:20 AM, Surveyor arrived at the facility and was greeted by Caregiver D. Caregiver D stated s/he was the only staff member currently scheduled. On 01/06/2025, at approximately 12:30 PM, Surveyor observed Caregiver D start to perform cares on Resident 9 who was in an electric wheelchair, in his/her room. On 01/06/2025, at approximately 12:55 PM, Surveyor observed Resident 2 sitting at the kitchen table sleeping and Resident 1 had	N 396		

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wheeled him/herself over to Surveyor who was sitting on a couch in the common area and asked to be transferred into his/her recliner. Caregiver D was assisting Resident 9. Surveyor observed Resident 1 attempt to scoot to the front of his/her wheelchair. Caregiver D had walked over earlier and stated, "I know [Resident 1], you are waiting for me." Caregiver D assisted Resident 1 into his/her recliner at approximately 1:25 PM.

On 01/13/2025, Surveyor reviewed Resident 4's, Resident 9's, and Resident 10's record that had been provided by Administrator A.

Resident 4

Resident 4 moved into the facility 11/28/2022 with diagnoses including intellectual and developmental disabilities and spastic tetraplegia (quadriplegic).

On 01/13/2025, at approximately 1:05 PM, Surveyor interviewed managed care organization (MCO) Care Manager (CM) F. CM F stated that the provider had struggled with staffing levels. CM F stated Resident 4 required a Hoyer transfer.

Resident 4's "Evacuation Assessment," dated 02/15/2024, documented:
"Needs Full Assistance From Two Staff means the resident requires assistance from two persons during most of the evacuation."

Resident 9

Resident 9 moved into the facility 08/16/2023 with diagnoses including cerebral infarction (stroke) and disorders of multiple cranial nerves.

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N 396	Continued From page 22 Resident 9's ISP, dated 11/12/2023, which was unsigned, documented: "Physical Disabilities - Unable to walk." Resident 9's "Evacuation Assessment," dated 02/15/2024, documented: "Needs Full Assistance From Two Staff means the resident requires assistance from two persons during most of the evacuation." Resident 10 On 12/06/2025, the Department received a concern that a resident experienced an episode of choking while staff member was assisting another resident resulting in death. Resident 10 moved into the facility 09/19/2024. Resident 10's managed care organization (MCO) documentation which had been provided by his/her MCO provider documented: "10/22/2024 - Per initial reports, member suspected to have choked on Cheerios during breakfast. Facility manager [Administrator A] left the CBRF (facility) to run to store during breakfast. ... Another staff person was in the building, assisting other residents. Member suspected to choke while other staff person was out of line of sight. ..." Resident 10's MCO Managed Care Plan, dated 06/01/2024, documented: Behaviors Requiring Intervention: They always ensure member is in line of sight by encouraging member to sit in common areas, engage in conversation and activities with member. Resident 10's Incident Report, dated 10/22/2024, written by Administrator A, documented:	N 396		

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N 396	Continued From page 23 "[Administrator A] ran to [store] in town around 11:30 AM. Returned about noon ..." On 01/14/2025 at 9:00 AM. Surveyor interviewed Administrator A. Administrator A stated that there had been staffing concerns but had been trying to ensure there were usually 2 staff members scheduled. Administrator A stated that when Surveyor was in the building 01/06/2025, another staff member was to arrive at noon but was running late and did not arrive until around 2:00 PM. Administrator A confirmed it was best practice to have Hoyer transfers completed by two staff members for resident safety.	N 396		
{N 406}	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name,	{N 406}		

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{N 406}	Continued From page 24 strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications that had been changed, discontinued, or expired were removed from the medication cart and disposed of within 30 days. This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ12, dated 07/25/2024. A bottle of aspirin and a bottle of chewable multivitamins, which were expired, were stored with the current resident medications. Resident 4's expired 'as needed' (PRN) acetaminophen and bisacodyl (suppository) were stored with his/her current medications. Findings include: Example 1: House Medications On 01/06/2025, at approximately 10:30 AM, Surveyor observed the medication cart and observed a 120-count bottle of aspirin which expired 02/2018 and a 60-count bottle of black elderberry immune complex chewables which expired 08/2023. The bottles were stored with the residents' medications and did not contain pharmacy labels. On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated since those medications were not labeled, they were 'house' medications and should have been disposed of when they expired.	{N 406}		

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{N 406}	Continued From page 25 Example 2: Resident 4 On 01/06/2025, at approximately 10:30 AM, Surveyor observed the medication cart and observed Resident 4's blister card of PRN acetaminophen, with a dispensed date of 05/05/2023, and a plastic bag of bisacodyl suppositories, with a discard date of 11/2023. On 01/13/2025, Surveyor reviewed December 2024 and January 2025 Medication Administration Records (MARs), dated 12/01/2024 to 01/06/2025, which did not document that Resident 4 was prescribed these medications. An article published by the FDA (Food and Drug Administration), dated 03/1/2016, titled, "Don't Be Tempted to Use Expired Medications," documented: " ...The expiration date can be found printed on the label or stamped onto the bottle or carton, sometimes following 'EXP.' It is important to know and stick to the expiration date on your medicine. Using expired medical products is risky and possibly harmful to your health. ... Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength..." On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated the medications should have been disposed of and would ensure this occurred.	{N 406}		
{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	{N 415}		

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{N 415}	Continued From page 26	{N 415}		

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 within the Medication Administration Record (MAR) for 2 of 2 resident reviewed.

This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ12, dated 07/25/2024.

Caregiver D administered medications but did not document the administration in the resident's MAR.
Resident 1's MAR documented medication had been administered when they remained in the blister card.

Findings include:

Example 1: Caregiver D

On 01/06/2025, at approximately 10:20 AM, Surveyor arrived at the facility and was greeted by Caregiver D. Caregiver D stated s/he was the only staff member scheduled.

On 01/06/2025, at approximately 10:35 AM,

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{N 415}	Continued From page 27 Surveyor reviewed the med cart and determined the morning medications for 01/06/2025 had been administered to the 5 residents who resided in the facility. Surveyor reviewed the resident MARs which did not document that the morning medications had been administered. On 01/06/2025, at approximately 11:00 AM, Surveyor interviewed Caregiver D. Caregiver D explained that s/he passed the medications but s/he did not document the administration in the resident MARs; Administrator A was responsible for that. Example 2: Resident 1 On 01/06/2025, at approximately 10:30 AM, Surveyor observed Resident 1's blister cards of Triamt/Hctz, Donepezil, Vitamin D3, Levothyroxine, and Escitalopram which displayed the medication had not been given on 12/26/2024 and 01/05/2025. On 01/06/2025, Surveyor reviewed Resident 1's December 2024 and January 2025 MARs, dated 12/01/2024 to 01/06/2025, which documented: Triamterene - Take 1 tablet by mouth every morning Donepezil - Take 1 tablet by mouth every morning Vitamin D3 - Take 1 tablet by mouth every morning Levothyroxine - Take 1 tablet by mouth daily before breakfast Escitalopram - Take 1 tablet by mouth every morning The MARs documented that the medications had been administered. On 01/14/2025 at 9:00 AM, Surveyor interviewed	{N 415}		

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{N 415}	Continued From page 28 Administrator A. Administrator A confirmed that medications are dispensed in correlation with the date on the blister card with the date of the month. Administrator A did not have a response as to why Resident 1 did not receive his/her medications on 12/26/2024 and 01/05/2025. Administrator A did not know why s/he would document a medication had been administered if it had not been.	{N 415}		
{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, not all medications administered by the provider were securely stored. The medication cabinet was unlocked with the keys in the locking device during the survey process. This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ11, dated 11/16/2023, and SOD FFKZ12, dated 07/25/2024. Findings include: The provider is licensed to care for 10 residents in the following client groups: advanced aged, irreversible dementia/Alzheimer's disease, physically disabled, developmentally disabled, traumatic brain injury, and terminally ill. On 01/06/2025, at approximately 10:20 AM, Surveyor arrived at the facility and while standing in the entry way, observed the med cart, which was stored in the office, with keys hanging in the	{N 419}		

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{N 419}	Continued From page 29 locking mechanism. Staff were not in the office. On 01/06/2025, at approximately 10:30 AM, Surveyor and Caregiver D walked into the office and Caregiver D stated Surveyor could review the medications in the med cart and left the office. Surveyor left the facility at approximately 1:30 PM and the keys remained in the unlocked med cart, in the unlocked office. On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated the med cart should be locked at all times.	{N 419}		
N 420	83.37(3)(d) Medication storage: refrigeration Refrigeration. Medications stored in a common refrigerator shall be properly labeled and stored in a locked box. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications stored in the common refrigerator were stored in a locked box. This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ11, dated 11/16/2023. Resident 2's blister cards of Florajen (probiotic) were stored unsecured in the common refrigerator. Findings include: On 01/06/2025, at approximately 10:30 AM, Surveyor observed the refrigerator in the kitchen. Stored on the shelf in the door of the refrigerator, next to the medication lock box, were 2 blister	N 420		

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N 420	Continued From page 30 cards of Resident 2's Florajen. On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated s/he understood that refrigerated medications needed to stored securely.	N 420		
{N 432}	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident received prescribed medications in the proper dosage and administration times and prior to expiration dates. This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ12, dated 07/25/2024. Resident 2's bottle of Ketotifen Fumarate Ophthalmic Solution (eye drop) and Olopatadine Hydrochloride Ophthalmic Solution 0.1% (eye drops) were administered after their expiration date when opened.	{N 432}		

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{N 432}	Continued From page 31 Findings include: On 01/06/2025, at approximately 11:45 AM, Surveyor toured Resident 2's room and observed a bottle of Ketotifen Fumarate Ophthalmic Solution and a bottle of Olopatadine Hydrochloride Ophthalmic Solution 0.1% sitting in a basket on his/her dresser. The eye drops did not contain an open date and did not contain a pharmacy label. On 01/06/2025, at approximately 11:55 AM, Surveyor observed the med cart and did not observe any eye drops for Resident 2. On 01/06/2025, Surveyor reviewed Resident 2's December 2024 and January 2025 Medication Administration Records (MAR), dated 12/01/2024 to 01/06/2025, which documented: "Ketotifen Ophth (Ophthalmic) 0.025%. Instill one drop into both eyes every morning and evening for allergic conjunctivitis. Start Date: 02/01/2023. Scheduled at 8:00 AM and 8:00 PM." The MARs documented that the medication had been administered 12/01/2024 to 01/05/2025. "Olopatadine - Instill one drop in both eyes twice daily as needed." "Zaditen® Eye Drop: The contents and dispenser remain sterile until the original closure is broken. Zaditen multiple dose containers (5 mL [milliliter] plastic bottle) must be discarded 4 weeks after opening." (Source: Novartis, Zaditen Eye Drop, May 2014, https://www.novartis.com/sg-en/sites/novartis_sg/files/Zaditen_Eyedrop-May2014.SINv3-App090920.pdf (retrieval date - January 13, 2025).) "Discard each bottle of Patanol Eye Drops 4 weeks after it has been opened. Write the date	{N 432}		

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{N 432}	Continued From page 32 the bottle was opened on the label to remind you when to discard the bottle." (Source: News Medical Life Sciences website, Patanol - Eye Drops - Olopatadine hydrochloride, October 2023, https://www.news-medical.net/drugs/Patanol.aspx#:~:text=Discard%20each%20bottle%20of%20Patanol,weeks%20after%20opening%20the%20bottle. (retrieval date - January 14, 2025).) On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A was unsure when the bottles had been opened. Administrator A stated s/he would date bottles going forward to ensure they were not administered after expiration.	{N 432}		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation and interview, the provider did not have planned or posted menus readily available to the residents. Findings include: On 12/06/2024, the Department received a concern that a resident had passed away after suffering a choking incident.	N 450		

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N 450	Continued From page 33 On 01/06/2025, at approximately 10:30 AM., Surveyors observed the facility's daily menu board was blank. Surveyors were unable to locate a weekly menu posted anywhere in the facility. On 01/06/2025, at approximately 12:15 PM, Surveyor observed Caregiver D prepare lunch which consisted of macaroni and cheese and corn. Surveyor asked Caregiver D how s/he knew which meal to prepare. Caregiver D stated, "Sometimes [Administrator A] will write the menu on the whiteboard. Today, as you can see, that did not get done." Caregiver D explained that s/he looked through the food that was available and determined what s/he would make for a meal. Surveyor asked if residents knew what was going to be prepared for the evening meal. Caregiver D was unable to answer. On 01/06/2025, at approximately 12:20 PM, Surveyor observed the leftovers in the refrigerator and noted there was a container of macaroni and cheese, undated. On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated there should be a menu posted and staff should not resort to always making residents macaroni and cheese.	N 450		
{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	{N 452}		

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{N 452}	Continued From page 34	{N 452}		

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.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure that food was stored in a safe and sanitary manner. The provider did not implement a system to identify when opened food was to be discarded for the prevention of food borne illnesses.

This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ12, dated 07/25/2024.

Findings include:

The provider is licensed to care for 10 residents in the following client groups: advanced aged, irreversible dementia/Alzheimer's disease, physically disabled, developmentally disabled, traumatic brain injury, and terminally ill.

On 01/06/2025, at approximately 10:30 AM, Surveyor toured the kitchen and observed in the refrigerator the following:

-an opened 9-ounce package of sliced honey

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{N 452}	Continued From page 35	{N 452}		

ham that was not dated. The package appeared to be over filled with air.
-a white bowl of what appeared to be applesauce that was not sealed nor dated.
-an opened bag of shredded lettuce that displayed brownish coloring to the lettuce.
-(2) clear plastic containers of what appeared to be leftovers that were covered with a cellophane film that was not dated.
-A clear plastic container of what appeared to be leftover macaroni and cheese that was not dated.
-A clear plastic container of what appeared to be leftovers that was not dated.
-A plastic baggie with what appeared to be sliced sandwich meat that was not dated.

According to the 2017 FDA (US Food and Drug Administration) Food Code, refrigerated, ready to eat (RTE), Time/Temperature Controlled for Safety (TCS) food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of seven days. The day of preparation shall be counted as Day 1. Refrigerated, RTE/TCS food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed or discarded.

The "Servsafe Coursebook - 7th Edition, documented ready-to-eat TCS food (foods that need time and temperature control for safety) can be stored for only seven days if it is held at 41 degrees Fahrenheit or lower." TCS foods

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{N 452}	Continued From page 36 includes milk and dairy products, eggs, meat (beef, pork, and lamb), poultry, fish, shellfish and crustaceans, baked potatoes, tofu or other soy protein, sprouts and sprout seeds, sliced melons, cut tomatoes, cut leafy greens, untreated garlic-and-oil mixtures, and cooked rice, beans, and vegetables. On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated s/he was aware that food was to be dated when opened, and s/he worked at least six days a week, and would also review the requirement with staff.	{N 452}		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on interview and observation, the provider did not ensure that 3 out of 5 resident rooms (Resident 1, Resident 2, and Resident 4) were clean and free from odor. Findings include: On 01/06/2025, at approximately 10:45 AM, Surveyor observed Resident 4's room. Resident 4's room had a urine like scent emanating throughout. Resident 4's bed had 2 chux pads on top of the bed sheet and the top sheet and blanket were curled up towards the foot of the bed. Surveyor smelled Resident 4's bedding which had a urine like scent. Surveyor bent down and noted the sheet on the mattress had a urine-like odor. As Surveyor pressed down on the mattress, Surveyor heard a crinkle sound.	N 489		

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Surveyor lifted the sheet and observed Resident 4's mattress was wrapped in plastic. The plastic had the appearance of being the plastic which the mattress had been delivered in. Each time Resident 4 moved, the crinkle of the plastic would be able to be heard. Resident 4's garbage can was full to the top with empty containers of Isosource (g-tube feeding product). There were opened containers that were not sealed of Isosource sitting on top of the dresser. The carpeted flooring had what appeared to be garbage remnants throughout the room. Two of Resident 4's pillows were lying on the floor, with the pillow cases only covering half of the pillow.

On 01/06/2025, at approximately 11:40 AM, Surveyor observed Resident 2's room. Resident 2's room had a urine like scent emanating throughout. Resident 2's bed had a chux pad, a plastic sheeting resembling a chux pad, and a clean incontinence product on top of the bed sheet and the top sheet and blanket were curled up towards the foot of the bed, slightly falling off. Surveyor smelled Resident 1's bedding which had a urine like scent.

On 01/06/2025, at approximately 11:45 AM, Surveyor observed Resident 1's room. Resident 1's room had a urine like scent emanating throughout. Resident 1's bed had 2 chux pads on top of the bed sheet and the top sheet and blanket were curled up towards the foot of the bed, slightly falling off. Surveyor smelled Resident 1's bedding which had a urine like scent. Resident 1's garbage can was full to the top with soiled plastic gloves and incontinence products.

On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated staff

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N 489	Continued From page 38 should be ensuring the resident beds are made after breakfast has been served. Administrator A stated s/he was aware of the plastic on Resident 4's bed and s/he would replace it with a waterproof mattress pad.	N 489		
{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 cleaning compounds and toxic substances were stored in a secured area. Surveyor observed cleaning compounds unsecure in the bathroom, laundry room, kitchen area, and resident room. This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ11, dated 11/16/2023, and SOD FFKZ12, dated 07/25/2024. Findings include: The facility is licensed as a Class CNA (non-ambulatory) CBRF (community based residential facility) able to serve up to 10 residents within the client groups of advanced age, terminally ill, physically disabled, developmentally disabled, traumatic brain injury, and irreversible dementia/Alzheimer's. On 01/06/2025, at approximately 10:45 AM, Surveyor conducted a tour of the facility and observed the following unsecured cleaning	{N 499}		

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{N 499}	Continued From page 39 compounds: -Sitting on the kitchen counter: 32 fluid ounce spray bottle of heavy-duty non-acid washroom cleaner -Laundry Room -43 ounce jug of no-splash formula bleach -128 ounce jug of lavender scented multi-purpose cleaner -(2) 21 ounce container of cleanser powder -32 ounce bottle of glass & multi-surface cleaner -32 ounce bottle of bathroom sanitizer -17 ounce spray can of stainless steel cleaner & polish -24 ounce bottle of toilet bowl cleaner -Bathroom -42 ounce bottle of antibacterial floor cleaner -Gallon jug of premium carpet shampoo -11.5 ounce can of almond scented wood cleanser, furniture polish -21 ounce container of cleanser powder -20 ounce spray can of window cleaner -9 ounce spray can of furniture polish -Resident 2's bedroom 19 ounce spray can of disinfectant spray sitting in his/her recliner Surveyor left the facility at approximately 1:30 PM and the On 01/14/2025 at 9:00 AM, Surveyor interviewed Administrator A. Administrator A stated toxic chemicals should be secured and would discuss the concern with staff.	{N 499}		