STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017574	A. BUILDING: _____ B. WING _____	R-C 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT CARE	**9035 N 97TH ST MILWAUKEE, WI 53224**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 09/18/2024, Surveyor completed a standard survey, verification visit, and complaint investigation at Bright Care. Eleven deficiencies were identified. One of the eleven deficiencies was a repeat violation (see Statement of Deficiency (SOD) FQ9911, dated 04/30/2021, SOD FQ9912, dated 12/22/2021, SOD FQ9913, dated 08/30/2022, and SOD FQ9914 dated 04/12/2023). One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 23	{N 000}		
N 191	83.13(3)(d) Posting activity schedule. The CBRF shall post all of the following: Activity schedule as required under s. DHS 83.38(1)(c). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure an activity schedule was posted in the facility. Findings include: On 07/30/2024, at 9:00 AM, Surveyor toured the facility and did not observe an activity schedule posted. On 07/31/2024, at 10:48 AM, Surveyor interviewed Director of Operations A. Director of Operations A confirmed an activity schedule was not posted in the facility. S/He reported after Activity Coordinator Y resigned in 2022, there had not been a formal activity schedule posted or	N 191		

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

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N 191	Continued From page 1 followed by the facility. Cross Reference: DHS N0427 83.38(1)(c) - Leisure Time Activities	N 191		
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 and its operation did not comply with all laws governing the Community-Based Residential Facility (CBRF). This had the potential to negatively affect 23 of 23 residents. As a result of this survey, a total of 11 deficiencies were identified. One of 11 deficiencies is being cited for a fifth time (see Statement of Deficiency (SOD) FQ9911, dated 04/30/2021, SOD FQ9912, dated 12/22/2021, SOD FQ9913, dated 08/30/2022, and SOD FQ9914, dated 04/12/2023). Findings include: The facility was licensed as a community based residential facility (CBRF) class CNA non-ambulatory, serving up to 28 residents, in the client groups irreversible dementia/Alzheimer's, physically disabled, advanced age, emotionally disturbed/mental illness, and developmentally disabled. On 07/30/2024, with information gathered through	N 196		

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N 196	Continued From page 2 09/18/2024, Surveyor conducted a standard survey, verification visit, and a complaint investigation. One deficiency was a repeat citation, and 10 new deficiencies were identified. 83.13(3)(d) - Posting Activity Schedule 83.14(2)(a) - Licensee Ensures Facility Complies With Laws 83.25 - Continuing Education - Repeat 83.38(1)(c) - Leisure Time Activities 83.43(1) - Environment Safe, Clean, And Comfortable 83.47(2)(d) - Fire Drills 83.47(2)(e) - Other Evacuation Drills 83.47(3) - Fire Inspection 83.47(4)(a) - Fire Extinguishers: Type and Inspection 83.48(1)(b) - Smoke And Heat Detectors Per Nfpa 72 83.55(1)(a) - One Toilet, Sink, And Bath Or Shower On 06/26/2023, the Department issued a Notice and Order Letter with SOD FQ9914, dated 04/12/2023. The letter stated, ". . . AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements . . . " Special orders included: "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 ... 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall ensure the administrator and resident care staff receive	N 196		

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N 196	Continued From page 3 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. WITHIN 45 DAYS of receipt of this notice, continuing education requirements must be met for the administrator and all resident care staff, as appropriate, for calendar year 2022. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, standard precautions, client group related training, medications, resident rights, prevention and reporting of abuse, neglect and misappropriation, fire safety and emergency procedures including first aid. Training will be documented in employee files and include the date/duration of training, the name of the instructor, and an outline of course content. 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for each resident with a copy of Statement of Deficiency FQ9914 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request. On 07/30/2024 and 07/31/2024, Surveyor conducted an onsite verification visit of SOD FQ9914, a complaint investigation, and a standard survey. Surveyor conducted interviews with administration, caregivers, and residents,	N 196		

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N 196	Continued From page 4 and conducted record review (continuing education). On 07/30/2024, at approximately 3:00 PM, Surveyor requested evidence of special order 2 from Director of Operations A. Director of Operations A reported s/he needed to request the information from Licensee F. Licensee F did not have evidence the facility complied with special order 2. Director of Operations A reported the facility had complied with special order 2, but s/he could not locate or obtain evidence. On 09/18/2024, at 2:00 PM, Surveyor interviewed Director of Operations A. Director of Operations A confirmed Licensee F did not comply with the Notice and Order Letter. Director of Operations A reported copies of the SOD and letter were sent to the required persons but could not provide documented evidence.	N 196		
{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, 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:	{N 277}		

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{N 277}	Continued From page 5 Based on record review and interview, the provider did not ensure 4 of 4 staff received at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Administrator G, Daily Operations Manager (DOM) N, Caregiver U, and Caregiver V did not meet the minimum requirements for calendar year 2023. This is a repeat deficiency. See Statement of Deficiency (SOD) FQ9911, dated 04/30/2021; SOD FQ9912, dated 12/22/2021; SOD FQ9913, dated 08/30/2022; and SOD FQ9914, dated 04/12/2023. Findings include: On 07/30/2024, at 2:19 PM, Surveyor reviewed employee records. The following was identified: 1. Administrator G was hired on 05/01/2019. Administrator G had 9.5 hours of continuing education in the calendar year 2023. S/He did not have continuing education in the following topics for the calendar year 2023: fire safety and emergency procedures, including first aid. 2. DOM N was hired on 05/01/2019. DOM N had 9.5 hours of continuing education in the calendar year 2023. S/He did not have continuing education in the following topics for the calendar year 2023: fire safety and emergency procedures, including first aid. 3. Caregiver U was hired on 10/21/2021. Caregiver U did not have continuing education in the calendar year 2023. 4. Caregiver V was hired on 07/08/2021. Caregiver V had 5 hours of continuing education	{N 277}		

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{N 277}	Continued From page 6 in the calendar year 2023. S/He did not have continuing education in the following topics for the calendar year 2023: client group related training; resident rights; prevention and reporting of abuse, neglect, and misappropriation; and fire safety and emergency procedures, including first aid. On 07/30/2024, at approximately 12:30 PM, Surveyor interviewed Director of Operations A and Administrator G. Director of Operations A reported s/he was trying to find a training platform to make sure all staff had the required trainings. S/He was aware required training had not been completed for staff and s/he was working on compliance with the codes. Administrator G reported s/he was responsible for making sure staff received their required trainings. Administrator G completed some trainings for staff at their staff meetings, but reported all required trainings for staff were not completed. On 09/18/2024, at 2:00 PM, Surveyor interviewed Director of Operations A. Director of Operations A and Administrator G were responsible for overseeing training for all staff at the facility. They were waiting on Licensee F to give financial approval to complete required training courses with all staff. S/He was aware of the special orders from the Department, which required continued education training to be completed for all staff. Director of Operations A had worked through a payment schedule and had started working on having all staff complete required trainings.	{N 277}		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the	N 427		

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N 427	Continued From page 7 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on interview and observation, the provider did not ensure a daily activity program was provided to meet the interests and capabilities of the residents. The provider did not provide activities. This had the potential to affect 24 of 24 residents. Findings include: The facility was licensed as a community based residential facility (CBRF) class CNA non-ambulatory, serving up to 28 residents, in the client groups irreversible dementia/Alzheimer's, physically disabled, advanced age, emotionally disturbed/mental illness, and developmentally disabled. On 07/30/2024, at 9:18 AM, Surveyor interviewed Resident 8 and her/his Licensed Professional Counselor (LPC) W. Resident 8 reported s/he enjoyed activities such as sewing and playing cards. S/He also wanted to exercise and gain better movement and mobility in her/his knees. The facility did not have an area in which	N 427		

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residents could exercise or have exercise equipment. The provider did not provide opportunities for the residents to do activities. The provider had a communal television (tv) for the residents, and it was the one activity they provided. LPC W reported s/he had been working with Resident 8 for approximately 1 year at the facility and had not observed residents doing activities other than watching tv.

On 07/30/2024, at approximately 9:30 AM, Surveyor observed residents gathered in the living room watching tv. Surveyor did not observe an activity schedule posted within the facility. At 10:57 AM, Surveyor interviewed Resident 8 and Resident 9, who were sitting in the living room watching tv. Surveyor informed Resident 8 and Resident 9 of the activity room and the games which were inside cabinets. Resident 8 reported s/he was aware of the activity room but would not go in there to do an activity. Resident 8 reported there was an employee who used to play bingo and other activities with residents, but the last time s/he did s/he got fired. Resident 8 expressed hesitation to go into the activities room to engage in games due to her/his fear of the activity coordinator getting fired. Surveyor encouraged Resident 8 and Resident 9 to go to the activities room and play games; they did. Director of Operations A observed Resident 8 and Resident 9 in the activities room and requested Caregiver X help them with doing some activities. Caregiver X played games with Resident 8 and Resident 9.

On 07/31/2024, at approximately 9:30 AM, Surveyor observed residents gathered in the living room watching tv. For approximately 5 hours, during the on-site visit, Surveyor did not observe staff engage the residents with an activity.

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N 427	Continued From page 9 On 07/31/2024, at 10:48 AM, Surveyor interviewed Director of Operations A. Director of Operations A confirmed the requirement a daily activity schedule was needed to meet the interests and capabilities of the residents. Director of Operations A reported the facility did not have an activity schedule or calendar. S/He looked into a subscription to an activity calendar website, which helped create a schedule, but Licensee F had not moved forward with it. From 2021-2022, the facility had an activities coordinator, but s/he was not replaced when s/he resigned. Director of Operations A reported s/he had found Caregiver X sitting in the library when Surveyor was speaking with Resident 8 and Resident 9 in the activities room. Director of Operations A asked Caregiver X to engage in activities with the residents. The caregivers had downtime they could have used to engage the residents in activities. Director of Operations A was working on creating an admission form which would screen incoming residents for their interests and abilities to participate in group activities. On 09/18/2024, at 2:00 PM, Surveyor interviewed Director of Operations A and s/he reported the following: Prior to Surveyor's on-site visit on 07/30/2024, there had been nothing formal in place for activities for the residents, or a calendar of activities/events. S/He was in the process of developing an interest survey for residents, as well as seeking an employee to fill a part-time position facilitating activities for residents. The National Institute of Aging stated: "Engaging in social and productive activities you enjoy, such as taking an art class, joining a hiking	N 427		

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club, or becoming a volunteer in your community, may help to maintain your well-being and independence as you age. An active lifestyle is more than just getting your daily steps in. It includes doing activities that are meaningful to you and benefit your mind, spirit, and body. Research has shown that older adults with an active lifestyle:

- Are less likely to develop certain diseases. Participating in hobbies and other social activities may lower risk for developing some health problems, including dementia, heart disease, stroke, and some types of cancer.

- Have a longer lifespan. Studies looking at people's outlooks and how long they live show that happiness, life satisfaction, and a sense of purpose are all linked to living longer. Doing things that you enjoy may help cultivate those positive feelings.

- Are happier and less depressed. Studies suggest that older adults who participate in activities they find meaningful, such as volunteering in their communities or being physically active, say they feel happier and healthier.

- Are better prepared to cope. When people feel happier and healthier, they are more likely to be resilient, which is our ability to bounce back and recover from difficult situations. Positive emotions, optimism, physical and mental health, and a sense of purpose are all associated with resilience.

- May be able to improve their thinking abilities. Research suggests that participating in certain activities, such as those that are mentally

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N 427	Continued From page 11 stimulating or involve physical activity, may have a positive effect on memory - and the more variety the better. Other studies are providing new information about ways that creative activities, such as music or dance, can help older adults with memory problems or dementia." (Source: National Institute of Aging, Participating in Activities You Enjoy as You Age, https://www.nia.nih.gov/health/healthy-aging/participating-activities-you-enjoy-you-age (retrieval date: September 11, 2024).) Cross Reference: DHS N0191 83.13(3)(d) - Posting Activity Schedule	N 427		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 24 of 24 residents were provided a living environment that was safe, clean, comfortable, and homelike. The windows in the common spaces throughout the facility were broken, missing cranks, and contained dust, dirt, debris, and dead bugs. The hallway light fixtures were missing covers/sconces, were burnt out, and filled with dead bugs. Several areas of the hallway ceiling had staining from current and past leaks.	N 481		

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N 481	Continued From page 12 Findings include: On 07/30/2024, Surveyor toured the facility and observed the following: Front Entry - The front entry/lobby area contained 6 windows, which looked out to the courtyard. Two of 6 windows contained a film which covered the screen and obstructed the outside view. One of 6 windows were missing the cranks to open the window. Six of 6 windows had dust, dirt, debris, webs, and dead bugs inside the sill. Activity Room - The activity room contained 8 windows, which looked out to the courtyard and 7 windows, opposite the courtyard windows. One of 15 windows contained a film which covered the screen and obstructed the outside view. Seven of 15 windows had broken or missing cranks to open the windows. Eight of 15 windows had dust, dirt, and debris covering the screen. Dining Room - The dining room contained 8 windows, which looked out to the courtyard. Three of 8 windows contained a film which covered the screen and obstructed the outside view. Four of 8 windows were missing the cranks to open the window. Six of 8 windows had dust, dirt, debris, webs, and dead bugs inside the sill and on the screens. One window had cracked glass and had an active spider web inside on the ledge. Between the hallway and dining room was a floor transition strip, which separated the carpeted hallway from the tiled dining room. The transition strip was approximately 30 feet in length. The dining floor along the entire length of the transition strip was covered in dust and debris and was sticky. There	N 481		

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were 2 sticky fly ribbons hanging from the ceiling, directly above the dining room tables. The fly ribbons had multiple bugs stuck to them. There were 4 paper signs posted within the dining room which stated, "no cell phones."

Living Room -
The living room contained 8 windows, which looked out to the courtyard and 8 windows, opposite the courtyard windows. Four of 16 windows were missing the cranks to open the windows. Five of 16 windows had dust, dirt, debris, webs, and dead bugs inside the sill and on the screens. One heating register was missing the cover, which exposed the heating element inside. Two heating resisters had pieces of the cover falling off or broken.

Library -
The library had 2 chairs and the cushions on the chairs were covered with hospital style blankets. A 2-drawer nightstand was stacked on top of a small shelving unit. Stacked behind the nightstand was a dresser which had pillows on top. The opening to the library was blocked by the stacked furniture and did not allow the space required for a wheelchair or walker to enter the room.

Hallways -
The hallways throughout the facility had 2 feet by 2 feet tiled ceilings. Several areas of the ceiling were brownish and stained. The northeast hallway had a garbage bin filled with a brownish liquid. Above the garbage bin, the ceiling tile was moved aside which exposed the area above the ceiling. Underneath the garbage bin was approximately a 4-foot by 4-foot area of the carpet stained and wet. There was an active leak from that area of the roof. Surveyor observed the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 481	Continued From page 14 dripping liquid throughout the on-site visit. On 07/31/2024, Surveyor returned to the facility and observed the leak was still active. There were 2 other areas within the hallways of the facility where the ceiling was stained and bulging. Resident 10's Room - Resident 10's room contained a can of Hot Shot ant, roach, and spider spray on the floor nearby her/his bed and refrigerator. The inside of the mini refrigerator had black spots, staining, and insects on the bottom shelf and door. There were 6 packets of butter on the bottom shelf which were covered in black spots, consistent with mold and insects. Three packets of butter were on the floor outside of the refrigerator. On 09/18/2024, at 2:00 PM, Surveyor interviewed Director of Operations A and s/he reported the facility had been without a consistent housekeeper for a long period of time. A part-time housekeeper had been hired, following Surveyor's on-site visit. Quotes were obtained to fix the cracked window. Replacement window screens were located and were in the process of being replaced. The sticky fly ribbons in the kitchen were removed, and a pest control company provided treatment for flies around the facility. Maintenance Manager Z was working on wall repairs, ceiling tile repairs, and other minor repairs to clean up the facility. The library was used as a storage area by staff when they did not want to put items in the garage but was cleared out and was available for residents' use. The lighting in the hallways was in the process of being replaced with new fixtures.	N 481		
N 525	83.47(2)(d) Fire drills.	N 525		

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N 525	Continued From page 15 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 employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted at least quarterly in 2022, 2023 and 2024. The provider's record did not include fire drills for the calendar years 2022, 2023, and 2024. Findings include: The provider is licensed as a class CNA (non-ambulatory) community based residential facility (CBRF) able to serve up to 28 residents in the following client groups: advanced age, emotionally disturbed/mental illness, physically disabled, and irreversible dementia/Alzheimer's. On 7/30/2024, at approximately 12:30 PM, Surveyor reviewed safety records. The record did not include fire drills conducted in calendar years	N 525		

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N 525	Continued From page 16 2022, 2023, and the first 2 quarters of 2024. On 7/30/2024, at approximately 12:30 PM, Surveyor interviewed Director of Operations A and Administrator G. Director of Operations A reported s/he was aware of the requirement of quarterly fire drills with both employees and residents. Administrator G was responsible for conducting and documenting fire drills. The provider had a policy in which fire drills were to be conducted monthly. Administrator G reported s/he had not completed any fire drills for the calendar years 2022, 2023, and 2024. On 09/18/2024, at 2:00 PM, Surveyor interviewed Director of Operations A. Surveyor inquired why fire drills had not been completed in the past 2.5 years. Director of Operations A stated, "that is insane that wasn't done!" S/He reported s/he spoke with Administrator G, and the provider had started conducting fire drills. Cross Reference: DHS N0526 83.47(2)(e) - Other Evacuation Drills DHS N0530 83.47(3) - Fire Inspection DHS N0531 83.47(4)(a) - Fire Extinguishers: Type and Inspection DHS N0535 83.48(1)(b) - Smoke and Heat Detectors Per Nfpa 72	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the	N 526		

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N 526	Continued From page 17	N 526		

provider did not ensure evacuation drills, such as tornado, flooding, or other emergency or disaster drills were conducted at least semi-annually for the calendar years 2022 and 2023. The providers record did not include drills for the calendar years 2022 and 2023.

Findings include:

The provider is licensed as a class CNA (non-ambulatory) community based residential facility (CBRF) able to serve up to 28 residents in the following client groups: advanced age, emotionally disturbed/mental illness, physically disabled, and irreversible dementia/Alzheimer's.

On 07/30/2024, at approximately 12:30 PM, Surveyor reviewed safety records. The record did not include other evacuation drills conducted in calendar years 2022, 2023, and to date in 2024.

On 7/30/2024, at approximately 12:30 PM, Surveyor interviewed Director of Operations A and Administrator G. Director of Operations A reported s/he was aware of the requirement of semi-annual evacuation drills. Administrator G was responsible for conducting and documenting evacuation drills. Administrator G reported s/he had not completed any evacuation drills for the calendar years 2022, 2023, and to date in 2024.

On 09/18/2024, at 2:00 PM, Surveyor interviewed Director of Operations A. Surveyor inquired why other evacuation drills had not been completed in the past 2.5 years. Director of Operations A stated, "that is insane that wasn't done!" S/He reported s/he spoke with Administrator G, and the facility had started conducting other evacuation drills.

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N 526	Continued From page 18 Cross Reference: DHS N0525 83.47(2)(d) - Fire Drills DHS N0530 83.47(3) - Fire Inspection DHS N0531 83.47(4)(a) - Fire Extinguishers: Type and Inspection DHS N0535 83.48(1)(b) - Smoke and Heat Detectors Per Nfpa 72	N 526		
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 fire inspection for 2 of 2 years (calendar years 2022 and 2023). Findings include: On 07/30/2024, at approximately 12:30 PM, Surveyor reviewed safety records. The record did not include documentation the facility had been inspected by the local fire department or certified fire inspector for the calendar years 2022 and 2023. The last fire inspection the facility had documentation for was on 09/17/2021. On 7/30/2024, at approximately 12:30 PM, Surveyor interviewed Director of Operations A. Director of Operations A reported s/he was aware of the requirement of an annual fire inspection. S/He reported s/he had been unable to get a fire inspection done and did not have an inspection	N 530		

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N 530	Continued From page 19 during calendar year 2023. Director of Operations A reported s/he had an inspection done in calendar year 2022 but could not locate documentation. S/He reported there were payment issues between Licensee F and the company which completed the inspections. Director of Operations A reported s/he was working with a different company and getting up to date with inspections. On 09/18/2024, at 2:00 PM, Surveyor interviewed Director of Operations A. S/He reported s/he was unable to locate any documented fire inspections after 2021 for the facility. In 2022, Licensee F attempted to find a certified fire inspector to complete a fire inspection. Licensee F was unable to hire a fire inspector and went without fire inspections for 2022 and 2023. Director of Operations A reported s/he hired a certified fire inspector and was working with her/him to complete a fire inspection and rectify issues found with the sprinkler system. Cross Reference: DHS N0525 83.47(2)(d) - Fire Drills DHS N0526 83.47(2)(e) - Other Evacuation Drills DHS N0531 83.47(4)(a) - Fire Extinguishers: Type and Inspection DHS N0535 83.48(1)(b) - Smoke and Heat Detectors Per Nfpa 72	N 530		
N 531	83.47(4)(a) Fire extinguishers: type and inspection. At least one portable dry chemical fire extinguisher with a minimum 2A, 10-B-C rating shall be provided on each floor of the CBRF. All fire extinguishers shall be maintained in readily usable condition. Inspections of the fire	N 531		

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N 531	Continued From page 20	N 531		

extinguisher shall be done by a qualified professional one year after initial purchase and annually thereafter. Each fire extinguisher shall be provided with a tag documenting the date of inspection.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure 9 of 9 fire extinguishers observed were maintained in readily usable condition and inspected by a qualified professional annually.

Findings include:

On 07/30/2024, at 9:00 AM, Surveyors toured the facility and observed fire extinguishers in the following locations and reviewed the attached tags:

1. Across from room #14 - tagged serviced in January 2023
2. Across from room #23 - tagged serviced in August 2021 (The tag also contained a handwritten note stating, "service required 2022 2023 [sic]," and was punched, "void 1 from mo. (month) punched; systems 6 mos. (months) [sic].")
3. Next to boiler room #2 - tagged serviced in August 2021 (The tag also contained a handwritten note stating, "service required . . . 2022 2023 [sic]," and was punched, "void 1 from mo. punched; systems 6 mos. [sic].")
4. Across from room #33 - tagged serviced in January 2023
5. Inside medication room - tagged serviced in January 2023
6. In kitchen - tagged serviced in August 2021 (The tag also contained a handwritten note stating, "service required . . . 2022 2023 [sic],"

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N 531	Continued From page 21 and was punched, "void 1 from mo. punched; systems 6 mos. [sic].") 7. In kitchen hallway - tagged serviced in January 2022 (The tag also contained a handwritten note stating, "service required 2023.") 8. Across from room #44 - tagged serviced in January 2023 9. Next to the library - tagged serviced in January 2023 On 07/30/2024, at approximately 12:30 PM, Surveyor interviewed Director of Operations A. Surveyor inquired about the handwritten notes on 4 of 9 fire extinguishers. Director of Operations A reported s/he was unaware the handwritten notes were on the tags and did not realize the fire extinguishers in the facility had not been inspected for over a year or more. S/He reported USA Fire was scheduled to come the following week to inspect the fire extinguishers. Director of Operations reported Licensee F had payment issues with the company they utilized for inspections which may have been why the extinguishers had not been inspected annually. On 09/18/2024, at 2:00 PM, Surveyor interviewed Director of Operations A. Director of Operations A reported s/he hired a company to service the fire extinguishers, exit signs, and the smoke/heat detectors. Cross Reference: DHS N0525 83.47(2)(d) - Fire Drills DHS N0526 83.47(2)(e) - Other Evacuation Drills DHS N0530 83.47(3) - Fire Inspection DHS N0535 83.48(1)(b) - Smoke and Heat Detectors Per Nfpa 72	N 531		

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N 535	Continued From page 22	N 535		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure smoke detectors were tested by community based residential facility (CBRF) personnel according to the manufacturers' recommendation, but not less than once every other month in the calendar years 2022, 2023, and 2024. Findings include: The provider is licensed as a class CNA (non-ambulatory) community based residential facility (CBRF) able to serve up to 28 residents in the following client groups: advanced age, emotionally disturbed/mental illness, physically disabled, and irreversible dementia/Alzheimer's. On 07/30/2024, Surveyor reviewed safety records. The record did not include documentation of smoke detector testing for calendar year 2022, 2023, and 2024. On 07/30/2024, at approximately 12:30 PM, Surveyor interviewed Director of Operations A.	N 535		

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N 535	Continued From page 23 Director of Operations A confirmed smoke detector tests were not conducted at least every other month for calendar years 2022, 2023, and 2024. On 09/18/2024, at 2:00 PM, Surveyor interviewed Director of Operations A. Director of Operations A reported s/he hired a company to service the fire extinguishers, exit signs, and the smoke/heat detectors. S/He reported moving forward, smoke detector tests would be completed monthly. Cross Reference: DHS N0525 83.47(2)(d) - Fire Drills DHS N0526 83.47(2)(e) - Other Evacuation Drills DHS N0530 83.47(3) - Fire Inspection DHS N0531 83.47(4)(a) - Fire Extinguishers: Type and Inspection	N 535		
N 608	83.55(1)(a) One toilet, sink, and bath or shower The CBRF shall provide at least one toilet, one sink and one bath or shower for every 10 residents and other occupants or fraction thereof. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the facility had one bath or shower to every 8 residents. The facility's census was 23, and the facility had a total of 1 shower accessible to all residents. This had the potential to affect 23 of 23 residents. Findings include: On 07/30/2024, at 9:00 AM, Surveyor toured the facility and observed the following: One shower/bath room in the south hallway was	N 608		

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N 608	Continued From page 24 available for all residents within the facility to utilize. The door to the room had 4 screws popped out on the bottom hinge of the door, which pushed the hinge against the door. The door was unable to be secured for privacy. On 07/30/2024, at 10:00 AM, Surveyor interviewed Resident 11. Resident 11's room had a sink and a toilet. The faucet had separate hot and cold action lever handles, which had an automatic shutoff. Surveyor tested the hot water temperature at her/his sink. The hot water handle had to be activated multiple times over a course of approximately 5 minutes before hot water was produced. Surveyor inquired if Resident 11 had an issue with the hot water in her/his room. Resident 11 reported s/he gets hot water from the activities room, adjacent to her/his bedroom. S/He reported s/he did not take a shower/bath, and instead washed her/his face using a washcloth, and a person came once or twice a week to help wash the rest of her/his body down with a washcloth. On 07/31/2024, at approximately 10:50 AM, Surveyor interviewed Director of Operations A. Director of operations A reported the shower/bath room located in the south hallway was the only bath/shower area available to all residents. The facility had 4 double occupancy rooms which had private baths/showers but were only available to the residents who resided in those rooms. Three of the 4 double occupancy rooms were occupied during the survey by single occupants. Director of Operations A reported s/he was unaware of the requirement of 1 shower/bath per 10 residents. The screws on the south hallway shower/bath room were fixed by Maintenance Manager Z, and the door was able to be secured.	N 608		

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N 608	Continued From page 25 On 08/06/2024, at 12:18 PM, Director of Operations A reported the facility had another shower/bath room in the north hallway, which had been utilized as storage. Director of Operations A reported s/he would work on making the second shower/bath room available for use for all residents. On 09/18/2024, at 2:00 PM, Surveyor interviewed Director of Operations A. Director of Operations A reported s/he removed the shelves inside of the north hallway shower/bath room and was working on making it available to the residents. During the survey, Director of Operations A was unaware of the requirement and unaware the facility had a second shower/bath room.	N 608		