STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020571	A. BUILDING: _____ B. WING _____	C 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMENSIONS LIVING BEAVER DAM	626 MONROE ST BEAVER DAM, WI 53916

(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 From 05/19/2026 to 05/20/2026, Surveyor conducted 2 complaint investigations and a standard survey at Dimensions Living Beaver Dam, a CBRF in Beaver Dam. Eleven deficiencies were identified. One deficiency was a repeat deficiency - See Statement of Deficiency (SOD) 46JQ11, dated 11/12/2025. Two of 2 complaints were substantiated. Census: 11	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 death of a resident as a result of an incident was reported to the department within 3 working days. The provider did not send a report to the department when Resident 2 died from choking at the facility. Findings include: From 05/19/2026 to 05/20/2026, Surveyor conducted 2 complaint investigations alleging the provider did not provide prompt care to a	N 156		

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

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N 156	Continued From page 1	N 156		

resident.

On 05/19/2026 at 6:00 a.m., Surveyor reviewed an emergency medical services (EMS) report, obtained by Surveyor. The report, dated 04/14/2026, documented that EMS responded to the provider's facility for Resident 2, who had reportedly choked on grilled cheese. The report documented that EMS personnel suctioned to create an opening for intubation, provided compressions and transferred Resident 2 to the hospital with the primary impression listed as asphyxia and hypoxemia.

On 05/19/2026 at 8:02 a.m., Surveyor interviewed Resident 1. Resident 1 stated s/he was in the dining room when Resident 2 began choking. Resident 1 stated s/he witnessed EMS personnel suction food from Resident 2 upon arrival.

On 05/19/2026 at approximately 3:00 p.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 02/12/2025 with diagnosis of developmental disability and legal blindness. Resident 2's progress notes, dated 04/14/2026, documented that Resident 2 choked during mealtime, was transferred to the hospital via EMS, and per hospital nurse report, was having food cleared from his/her lungs while intubated and ventilated. A progress note, dated 04/15/2026, documented Resident 2 as deceased.

On 05/20/2026 at 1:30 p.m., Surveyor interviewed Administrator G. Administrator G stated s/he was aware of the 04/14/2026 incident but was not physically at the building due to training s/he was at on 04/14/2026 through 04/16/2026. Administrator G stated s/he did not complete a self-report to the department following Resident

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N 156	Continued From page 2 2's death because s/he thought Administrator J was completing the report given Administrator G was at training. Administrator G stated s/he shouldn't have assumed Administrator J completed the report.	N 156		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, record review and interview, Administrator J did not supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances and physical plant. Findings include: From 05/19/2026 to 05/20/2026, Surveyor conducted 2 complaint investigations alleging the provider did not provide prompt care to a resident and a standard survey. On 05/19/2026 at 7:00 a.m., Surveyor reviewed department records. Department records	N 214		

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N 214	Continued From page 3	N 214		

identified Administrator J as the administrator of the facility.

On 05/19/2026 at approximately 7:50 a.m., Surveyor interviewed Caregiver I. Caregiver I stated management was not frequently at the facility. Caregiver I stated reordering medications, getting new prescriptions and arranging transportation for appointments often fell to caregivers. Caregiver I stated Administrator G was the facility's new administrator but rarely at the facility because s/he had to be at an affiliated facility. Caregiver I wasn't sure who Administrator J was.

On 05/19/2026 at 8:45 a.m., Surveyor interviewed Caregiver H. Caregiver H stated administration had been at the facility approximately 2 times per week, but after a situation at an affiliated facility administration had been present much less. Caregiver H stated s/he hadn't seen administration "in a minute."

On 05/19/2026 at approximately 9:05 a.m., RN B arrived from an affiliated facility to assist Surveyor with the survey process. Administrator A, who was also from an affiliated facility, arrived shortly after and worked with Surveyor through the survey process.

On 05/19/2026 at approximately 1:00 p.m., Surveyor reviewed concern with Administrator A and RN B that the facility did not appear to have administrative oversight daily. Administrator A acknowledged Surveyor's concern and confirmed Administrator G had been spending much of his/her time at an affiliated facility. Administrator A and RN B stated they identified areas that needed attention within facility operations and would be addressing the concerns.

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N 214	Continued From page 4 On 05/20/2026 at 1:30 p.m., Surveyor interviewed Administrator G. Administrator G confirmed s/he had not been at the facility often because s/he was instructed by corporate to spend his/her time at an affiliated facility. Administrator G explained that s/he started with the provider on 03/23/2026, was in administrator training for 3 weeks and upon completion of his/her training, learned of a situation at an affiliated facility that required his/her presence at the affiliated facility. Administrator G stated s/he had been at the facility Surveyor was at approximately 3 times in the past 3 weeks. Administrator G stated s/he determined which facility s/he should be at based on the direction from Administrator J, who was the administrator on record with the department. Throughout the survey process, Administrator J did not participate in the survey.	N 214		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.	N 220		

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N 220	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 caregivers reviewed had documentation indicating they had been screened for clinically apparent communicable disease including tuberculosis within 90 days before the start of employment or when the provider's change of ownership became effective. The provider did not have documentation of communicable disease screens, including tuberculosis, for Caregiver D, Caregiver E and Caregiver F. Findings include: On 05/19/2026 at approximately 1:30 p.m., Surveyor reviewed employee records with Administrator A. Records documented the following: - Caregiver D was hired on 02/10/2026. Caregiver D's record did not include documentation of a communicable disease screen, including tuberculosis test. - Caregiver E was employed by the provider's facility prior to a change of ownership effective 11/24/2025. Caregiver E's record did not include documentation of a communicable disease screen, including tuberculosis test. - Caregiver F was employed by the provider's facility prior to a change of ownership effective 11/24/2025. Caregiver F's record did not include documentation of a communicable disease screen, including tuberculosis test. As Surveyor reviewed employee records with Administrator A, Administrator A acknowledged	N 220		

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N 220	Continued From page 6 the provider should have a communicable disease screen on file for Caregiver D as s/he was hired during the provider's current license. Administrator A stated the provider should also have a communicable disease screen on file for Caregiver E and Caregiver F because the provider's RN completed communicable disease screens on all caregivers at the time of the change of ownership. Administrator A stated s/he would follow up with Surveyor regarding documentation. On 05/19/2026 at 1:30 p.m., Surveyor spoke with Administrator G, who started at the facility 03/23/2026. Administrator G stated s/he was unable to locate documentation of communicable disease screens, including tuberculosis tests, for the 3 caregivers reviewed.	N 220		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed received prompt and adequate treatment appropriate to his/her needs. Resident 2 did not receive the Heimlich maneuver when s/he was choking. Resident 2 passed away following the choking incident.	N 353		

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N 353	Continued From page 7 Findings include: From 05/19/2026 to 05/20/2026, Surveyor conducted 2 complaint investigations alleging the provider did not provide prompt care to a resident. On 05/19/2026 at 6:00 a.m., Surveyor reviewed an emergency medical services (EMS) report, obtained by Surveyor. The report, dated 04/14/2026, documented the following: - Primary Impression: Asphyxia and hypoxemia - EMS was dispatched to the facility for Resident 2 who was choking on grilled cheese. - On arrival, Resident 2 was lying on the floor, unresponsive with compressions being performed by law enforcement. - Staff reported Resident 2 was eating grilled cheese when s/he began coughing and became unresponsive. Staff reported they moved him/her to the floor and began CPR. - Crews worked to identify the blockage within Resident 2's airway, suctioning to create an opening for intubation. Compressions continued; once an advanced airway was placed, Resident 2 was moved to a compression device and transferred to the hospital. On 05/19/2026 at 8:02 a.m., Surveyor interviewed Resident 1. Resident 1 stated s/he was in the dining room when Resident 2 began choking. Resident 1 stated when Resident 2 began choking staff responded by rubbing and patting Resident 2's back. Resident 1 stated caregivers reported they could not do the Heimlich maneuver on residents but moved Resident 2 to the ground once s/he stopped responding and started doing compressions. Resident 1 stated s/he witnessed emergency medical technicians	N 353		

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suction food from Resident 2 upon arrival.

On 05/19/2026 at 8:45 a.m., Surveyor interviewed Caregiver H and asked what s/he would do in the event a resident was choking. Caregiver H stated s/he would immediately call 911, but that s/he had been told caregivers could not do the Heimlich maneuver. Caregiver H stated since Resident 2's choking incident the facility had obtained a Lifevac suction machine but had not received training.

On 05/19/2026 at 8:55 a.m., Surveyor interviewed Caregiver I and asked what s/he would do in the event a resident was choking. Caregiver I stated s/he would attempt to scoop food from the resident's mouth and call 911. Caregiver I stated s/he thought caregivers could do Heimlich maneuver if needed.

On 05/19/2026 at approximately 3:00 p.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 02/12/2025 with diagnosis of developmental disability and legal blindness. Resident 2's progress notes included the following:

- 04/14/2026: Received call form team lead at 5:34 p.m. Resident choked during mealtime in dining area. EMS contacted at 5:30 p.m., arrived and administered CPR at 5:34 p.m. Resident transferred to hospital. Power of Attorney notified at 6:02. Message left for case manager and physician.
- 04/14/2026: Spoke to emergency room nurse at 6:27 p.m. Resident has a pulse. Still clearing food from lungs. Currently intubated and on ventilation. May transfer to another hospital for bronchoscopy.
- 04/15/2026: Documented as deceased at 3:30

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N 353	Continued From page 9 p.m. On 05/19/2026 at approximately 1:00 p.m., Surveyor interviewed Administrator A regarding Resident 2's choking incident and resulting death. Administrator A stated in the event of a resident choking, the expectation would be for staff to do the Heimlich maneuver, as well as use the Lifevac device if available and caregivers are trained to do so. On 05/20/2026 at 1:30 p.m., Surveyor interviewed Administrator G. Administrator G stated s/he was aware of the 04/14/2026 incident, but was not physically at the building due to a training s/he was at on 04/14/2026 through 04/16/2026. Administrator G stated staff did not do the Heimlich maneuver when Resident 2 was choking because they had been told by previous administration not to do so. Administrator G stated the expectation would be for staff to perform the Heimlich maneuver in the event of choking. Administrator G stated a Lifevac machine had since been purchased for the facility and that follow up training needed to occur.	N 353		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 resident individual service plans (ISP) were followed as written. Resident 4's vitals were not taken weekly as indicated in his/her ISP.	N 388		

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N 388	Continued From page 10 Findings include: On 05/19/2026 at approximately 12:00 p.m., Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider's facility on 07/15/2025 with diagnosis of Alzheimer's disease. Resident 4's ISP, last revised 03/06/2026, indicated Resident 4's vitals should be taken weekly. Resident 4's record, dated 04/01/2026 to 05/19/2026, did not include documentation of weekly vitals. "Vital signs measure your body ' s basic functions. The measurements check your general physical health. They ' re the first step of any medical exam or evaluation. Vital signs are important because they give a healthcare provider clues about any underlying conditions that affect your health or show your progress toward recovery. There are four main vital signs: Body temperature. Blood pressure. Pulse (heart rate). Respiratory rate (breathing rate). (Source: Cleveland Clinic website, Vital Signs, March 15, 2023, https://my.clevelandclinic.org/health/articles/10881-vital-signs (retrieval date, June 16, 2026).) On 05/19/2026 at approximately 1:00 p.m., Surveyor reviewed concern with Administrator A that Resident 4's vitals were not documented as taken weekly. Administrator A reviewed Resident 4's record and confirmed s/he was unable to locate documentation of weekly vitals. Administrator A stated the vitals were not listed on the task list to take weekly.	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes	N 389		

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N 389	Continued From page 11 Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 individual service plans (ISP) were signed by the resident or resident's legal representative acknowledging their involvement in, understanding of and agreement with the individual service plan. Resident 4 and Resident 1's ISPs were not signed by the resident and/or legal representative. This is a repeat deficiency. See Statement of Deficiency (SOD) 46JQ11, dated 11/12/2025. Findings include: On 05/19/2026 at approximately 12:00 p.m., Surveyor reviewed resident records, provided by Administrator A. The following concerns were identified: - Resident 4 was admitted to the provider's facility	N 389		

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N 389	Continued From page 12 on 07/15/2025 with diagnosis of Alzheimer's. Resident 4's face sheet did not identify that s/he had an activated Health Care Power of Attorney or legal guardian. Resident 4's ISP, last revised 03/06/2026, was not signed by him/her or an identified legal representative. - Resident 1 was admitted to the provider's facility on 03/27/2025 with diagnoses including Alzheimer's disease and congestive heart failure. Resident 1's face sheet did not identify that s/he had an activated Health Care Power of Attorney or legal guardian. Resident 1's ISP was not signed by him/her or an identified legal representative. On 05/19/2026 at approximately 1:00 p.m., Surveyor reviewed concern with Administrator A and RN B that 2 of 3 ISPs reviewed were not signed and dated by the resident and/or an identified legal representative to indicate agreement with the plan. Administrator A reviewed resident records and confirmed Surveyor's observation. Administrator A stated s/he was unable to locate signed ISPs for Resident 4 or Resident 1.	N 389		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident.	N 431		

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N 431	Continued From page 13 Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed had their health monitored, with arrangements made for his/her physical health and changes documented in the resident's record. Resident 4 did not have arrangements made to address his/her lower extremities, which were observed red, weeping and edematous. Resident 4's record did not document the monitoring of Resident 4's lower extremities, which were observed red, weeping and edematous. Findings include: From 05/19/2026 to 05/20/2026, Surveyor conducted 2 complaint investigations alleging care concerns. On 05/19/2026 at approximately 8:55 a.m., Surveyor interviewed Caregiver F. Caregiver F	N 431		

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stated Resident 4 has had raw and weepy legs. Caregiver F stated Resident 4 had been to the emergency room "a million times" and caregivers were unsure what to do for the legs.

On 05/19/2026 at approximately 12:00 p.m., Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider's facility with Alzheimer's disease. Resident 4's record included the following documentation related to skin integrity:

- 03/06/2026: Skin assessment - No concerns.
- 03/28/2026: Progress Notes - Red, swollen, hot to touch lower extremities.
- 03/28/2026: After Visit Summary - Prescribed Cephalexin x 7 days, compression socks and encouraged to elevate legs.
- 05/01/2026: Skin assessment - No concerns.
- 05/08/2026: Skin assessment - Bilateral lower extremities are red, inflamed and have open areas. Nurse and Power of Attorney notified.
- 05/13/2026: Contacted physician regarding lower extremities.

Resident 4's Medication Administration Record (MAR), dated 05/01/2026 to 05/14/2026, documented caregivers were applying Aquaphor ointment to Resident 4's bilateral lower extremities for dryness and Hydrocortisone 2.5% ointment to Resident 4's left calf for dermatitis every morning.

On 05/19/2026 at approximately 1:00 p.m., Surveyor interviewed Administrator A and RN B regarding Resident 4's lower extremities. Surveyor shared caregiver's frustration with the care of Resident 4's lower extremities and observation that concerns were noted on 03/28/2026 with no documented follow up and

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N 431	Continued From page 15 again on 05/13/2026 with no documented follow up. Administrator A and RN B reviewed Resident 4's record and were unable to locate documentation of any follow up for Resident 4's legs after 05/13/2026. Administrator A stated the RN who would have followed up on 05/13/2026 was no longer with the facility. On 05/19/2026 at 1:30 p.m., Surveyor and RN B observed Resident 4's lower extremities together. Resident 4's bilateral lower extremities were observed red, with some weeping on the right lower extremity. RN B reported edema. After observing Resident 4's lower extremities, RN B informed Surveyor that s/he would follow up to address Resident 4's lower extremity concerns.	N 431		
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, interview and record review, the provider did not provide medication administration services adequate to meet 3 of 4 residents reviewed.	N 432		

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N 432	Continued From page 16 Resident 1 did not receive 7 of his/her medications as prescribed due to lack of availability. Resident 4 did not receive 1 of his/her medications as prescribed due to lack of availability. Resident 3 received insulin after it's "beyond use" date. Findings include: On 05/19/2026, Surveyor made observations, reviewed records and completed interviews as part of complaint investigations and a standard survey. The following medication administration concerns were identified: Example 1 - Resident 1: On 05/19/2026 at 8:02 a.m., Surveyor interviewed Resident 1. Resident 1 stated the provider had a history of running out of his/her pain medications and nebulizer medications. On 05/19/2026 at approximately 8:55 a.m., Surveyor interviewed Caregiver I. Caregiver I stated medication availability had been an issue at the facility. Caregiver I stated having scripts renewed fell to caregivers to complete. On 05/19/2026 at approximately 12:00 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 03/27/2025 with diagnoses included Alzheimer's disease and congestive heart failure. Resident 1's medication administration record (MAR), dated 04/01/2026 to 05/19/2026, and corresponding progress notes documented the following occurrences of medications being unavailable for	N 432		

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N 432	Continued From page 17 administration: - Diltiazem 120 mg (Start Date: 03/28/2025) - Take 1 tablet daily: Unavailable 04/21/2026 through 04/30/2026. *Progress notes, dated 04/21/2026 and 04/24/2026 stated waiting for delivery. Progress note, dated 04/23/2026, stated a new script was needed. - Donepezil Hcl 10 mg (Start Date: 03/27/2025) - Take 1 tablet daily: Unavailable 04/21/2026 through 04/30/2026. *Progress note, dated 04/21/2026, stated medication not available and RN notified. Progress note, dated 04/29/2026, documented medication not in cart and medication re-ordered. - Hydrocodone-Acetaminophen 5-352 mg (Start Date: 04/21/2026 / End Date: 04/24/2026) - Take 1 tablet 3 times daily and 1 tablet ever 6 hours as needed: Unavailable for 04/23/2026 evening dose. "Other/See Progress Note" was documented for 04/22/2026 p.m., 04/23/2026 p.m. and 04/24/2026 a.m. *Progress notes did not provide details. - Iprat-Albuterol .5-3 mg/3 ml (Start Date: 09/27/2025) - Inhale contents of 1 vial via nebulizer 4 times daily: Unavailable 04/13/2026 at 4:00 p.m. and 8:00 p.m., 04/21/2026 8:00 p.m., 04/22/2026 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 pm. The MAR documented "Other/See Progress Note" for 04/13/2026 12:00 p.m. and 05/09/2026 8:00 a.m. dose through 05/12/2026 8:00 p.m. dose. *Progress notes, dated 04/13/2026 (x2), 04/21/2026 and 04/22/2026 (x2) stated waiting on delivery. Progress notes did not provide details 05/09/2026 through 05/12/2026. - Budesonide .5 mg/2ml (Start Date: 09/27/2025) - Inhale contents of 1 vial via nebulizer 2 times daily: Unavailable 05/16/2026 3:00 p.m. dose,	N 432		

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05/17/2026 7:00 a.m. and 3:00 p.m. dose, and 05/18/2026 7:00 a.m. and 3:00 p.m. dose.
*Progress notes, dated 04/11/2026, 04/12/2026 (x2), 04/13/2026 (x2) and 04/29/2026 stated waiting on delivery.
- Vitamin D2 1.25 mg (Start Date: 08/25/2025) - Take 1 capsule every week: Unavailable all 3 weeks of May.
- Famotidine 20 mg (Start Date: 03/16/2026) - Take 1 tablet daily: Unavailable 04/16/2026 through 04/19/2026.
*Progress note, dated 04/21/2026, stated waiting for delivery. Progress note, dated 05/17/2026, stated medication was not in cart and pharmacy was contacted.

Example 2 - Resident 4's Lovastatin:

On 05/19/2026 at approximately 12:00 p.m., Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider's facility on 02/12/2025 and discharged on 04/14/2026. Resident 4's MAR, dated 03/01/2026 to 04/14/2026 documented his/her Lovastatin 40 mg (Start Date: 09/26/2025) - Take1 tablet daily was documented as unavailable for administration on 05/02/2026, 05/05/2026, 05/07/2026, 05/08/2026 and 05/13/2026. Resident 4's progress notes did not provide further details regarding the unavailability of the medication.

Example 3 - Resident 3's Insulin:

On 05/19/2026 at 9:20 a.m., Surveyor reviewed the medication cart with Caregiver I. Surveyor observed Resident 3's Insulin Glargine pen had been opened 04/01/2026. Surveyor voiced concern that Resident 3's insulin pen should have been disposed due to the date of opening. Caregiver I acknowledged Surveyor's concern

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N 432	Continued From page 19 and stated s/he had noticed a new insulin pen was needed on 05/15/2026 and told 2nd shift to order a new one. Caregiver I stated s/he followed up today and noticed a new insulin pen had not been ordered, but continued to be used, so s/he worked with the RN to have the issue addressed. On 05/19/2026 at approximately 12:30 p.m., Surveyor reviewed Resident 3's MAR, dated 05/01/2026 to 05/19/2026, which indicated Insulin Glargine was administered to Resident 3 nightly from 05/01/2026 to 05/18/2026. Guidelines identify in-use/punctured seal Lantus as being "beyond use" after 28 days (DQA Publication- 01904, Insulin Storage Guide, 06/2023, p. 3). *Insulin glargine is generic for Lantus. On 05/19/2026 at approximately 1:00 p.m., Surveyor reviewed concern that insulin was used beyond 28 days and that medications were not administered due to lack of availability with Administrator A and RN B. Administrator A acknowledged Surveyor's concern and stated the concerns should have been addressed by an RN who was no longer with the company for a reason. Administrator A stated the provider was interviewing a nurse to fill the vacated position.	N 432		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent	N 488		

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N 488	Continued From page 20 tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 dryers had vent tubing made of rigid material. Two of 2 dryers had semi-rigid venting. Findings include: On 05/19/2026 at approximately 8:00 a.m., Surveyor toured the provider's laundry rooms and observed 2 of 2 dryers had semi-rigid venting. "Flexible vents can twist, allowing lint to build up and catch on fire if it comes in contact with a sufficient amount of heat. If a fire starts beneath the dryer when the motor overheats, then the drafts from the dryer can pull the fire up into the duct, allowing a house fire to develop." ("Clothes Dryer Fires in Residential Buildings (2008-2010)", Topical Fire Report Series, Volume 13, Issue 7, August 2012, Page 7). On 05/19/2026 at 10:26 a.m., Surveyor reviewed concern with Maintenance C that 2 of 2 dryer vents were semi-rigid. Maintenance C reviewed Surveyor's pictures of the dryer vents, which showed rigid venting at the top of the dryer (visible when just looking at the dryer), but semi-rigid venting lower to the ground where the vents connected to the dryers. Maintenance C stated s/he had just changed out dryer vents at another location and would do the same at this facility.	N 488		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that	N 499		

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N 499	Continued From page 21 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 all toxic substances were stored in a secured area. The provider had toxic substances accessible to residents in 3 areas of the facility. Findings include: The provider is licensed to serve up to 20 residents with diagnoses including advanced age and irreversible dementia/Alzheimer's. On 05/19/2026 at approximately 8:00 a.m., Surveyor toured the provider's facility and observed the following concerns: - An unlocked laundry room contained Windo-Clean+ Professional Strength Cleaner (Label: Harmful if swallowed or absorbed through skin) and Bissell Multi-Surface cleaner (Label: In case of eye contact, flush thoroughly with water. If irritation persists, consult physician. KEEP OUT OF REACH OF CHILDREN). - An unlocked furnace room contained 4 1-gallon containers of paint. - Another unlocked laundry room contained Windo-Clean+ Professional Strength Cleaner (Label: Harmful if swallowed or absorbed through skin). On 05/19/2026 at 10:26 a.m., Surveyor reviewed concern with Maintenance C that toxic chemicals were left unsecured in laundry rooms and a furnace room. Maintenance C shook his/her head	N 499		

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N 499	Continued From page 22 and stated s/he was always on staff to keep laundry and furnace rooms locked, but that s/he couldn't be there all the time to oversee this. Surveyor and Maintenance C then observed the unlocked rooms together and observed the furnace room had tape keeping the lock in an unlocked position.	N 499		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 laundry rooms, which were located on the same floor as resident bedrooms, had self-closing doors. Findings include: On 05/19/2026 at approximately 8:00 a.m., Surveyor toured the provider's facility and observed 2 laundry rooms, neither of which had doors that were self-closing. On 05/19/2026 at approximately 10:26 a.m., Surveyor observed the laundry room doors with	N 640		

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N 640	Continued From page 23 Maintenance C. Maintenance C confirmed Surveyor's observation that doors were not self-closing and stated s/he would need to install hinges.	N 640		