STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015157	A. BUILDING: _____ B. WING _____	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEHAVEN	512 ALAN DRIVE MOUNT HOREB, WI 53572

(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 11/17/2025, Surveyors conducted a standard licensure survey at Inglehaven. Nine deficiencies were identified. Five of 9 deficiencies were repeat violations (See Statement of Deficiency (SOD) VLFJ11, SOD VLFJ13 and SOD L76811). Census: 12	N 000		
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 in the intervals prescribed by a practitioner for 1 of 1 resident. This is a repeat deficiency. See Statement of Deficiency (SOD) L76811, dated 10/06/2022. Resident 4's Novolog (insulin) was not administered as prescribed. Findings Include: On 11/17/2025, at approximately 11:00 AM, Surveyor and Care Coordinator B observed Resident 4's Novolog FlexPens in the med cart. Care Coordinator B commented that Resident 4	N 352		

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

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N 352	Continued From page 1 was on sliding scale insulin. On 11/17/2025, Surveyors reviewed Resident 4's record. Resident 4 was admitted to the facility, 04/10/2025, with diagnosis including diabetes. Resident 4's Medication Administration Records (MARs), dated 10/01/2025 to 11/17/2025, documented: Novolog FlexPen U (unit) -100 Insulin (insulin aspart [rapid-acting]) 100 unit/ml (milliliter) (3 ml). -Check blood sugar 4 times daily. Start Date: 04/10/2025. Scheduled at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. -Inject 10 Units subcutaneously three times daily with meals for Type 2 Diabetes Mellitus. Starty Date: 06/12/2025. Scheduled at 8:00 AM, 12:00 PM, and 4:00 PM. -Inject subcutaneously three times daily with meals per sliding scale if BS (blood sugar) < (less than) 150=0U (Units); 151-200=1U; 201-250=2U; 251-300=4U; 301-350=6U; > (greater than) 351=Updated NP (nurse practitioner)/MD (medical doctor). Start Date: 06/12/2025. Scheduled at 8:00 AM, 12:00 PM, and 4:00 PM. Surveyors noted the MARs did not document how many units of sliding scale insulin were administered at 8:00 AM, 12:00 PM and 5:00 PM. Care Coordinator B provided Surveyors with a sheet of paper that had the date of the month, the BS level and how many units of insulin that had been administered, handwritten on it. The document stated: 10/02 12:00 PM 144 BS - 11 Units administered - Should have administered 10 Units	N 352		

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N 352	Continued From page 2 10/11 8:00 AM 175 BS - 10 Units administered - Should have been 11 Units 10/13 12:00 PM 200 BS - 12 Units administered - Should have been 11 Units 11/04 8:00 AM 147 BS - 11 Units administered - Should have been 10 Units 11/09 5:00 PM 151 BS - 10 Units administered - Should have been 11 Units 11/12 5:00 PM 138 BS - 11 Units administered - Should have been 10 Units 11/14 5:00 PM 157 BS - 10 Units administered - Should have been 11 Units Along with the BS level and how many units of insulin were administered for 8:00 PM, each day. On 11/17/2025, at approximately 3:45 PM, Surveyors interviewed Care Coordinator B. Surveyors asked for clarification as to why Resident 4 received sliding scale insulin at 8:00 PM, when the MARs did not document that order. Care Coordinator B stated s/he could not explain but the MAR displayed that the insulin was to be administered 4 times a day. Surveyors reviewed the MARs with Care Coordinator B and stated the MARs documented that the BS levels were to be checked 4 times a day, but the sliding scale insulin was to be administered 3 times a day with meals. Surveyors requested Resident 4's physician order for the Novolog FlexPen. On 11/17/2025, Surveyors reviewed Resident 4's Novolog FlexPen physician order, provided by Care Coordinator B, which documented: Novolog FlexPen U -100 Insulin (insulin aspart u-100) 100 unit/ml (3ML). Subcutaneous. Three times a day. 8:00 AM, 12:00 PM and 5:00 PM. On 11/17/2025, at approximately 4:00 PM, Surveyors discussed above concern with Administrator A and Care Coordinator B. Care	N 352		

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N 352	Continued From page 3 Coordinator B stated s/he would follow up with Resident 4's primary care physician to determine the accurate medication administration requirement for Resident 4's Novolog. Care Coordinator B stated staff would be re-educated on how to determine how many additional units of insulin were to be given based on the resident's BS level.	N 352		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not assess 2 of 2 residents (Resident 1 and Resident 2) when there was a change of condition regarding the use of bedrails. Findings include: On 11/17/2025, at approximately 9:50 AM, Surveyor toured the facility and observed 2 half-length side bedrails on Resident 1's and Resident	N 381		

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N 381	Continued From page 4 2's hospital style bed. Example 1: Resident 1 On 11/17/2025, Surveyor reviewed Resident 1's record. Resident 1 moved into the facility, 02/14/2023, with diagnoses including dementia and Parkinson's disease. Resident 1's unsigned "Individual Service Plan (ISP)," dated 06/19/2024, documented: "Safety: I will need to be monitored to prevent falling in my new environment. Assistance with locomotion to prevent falling or injury. I use walker/cane and need safety reminders to use durable medical equipment safely." "Maximum assist for point of rescue level of care assistance needed." "Implement exercise program that targets strength, gait and balance." "Elopement Risk." Resident 1's "Level of Care Assessment," dated 02/14/2023, documented: "Communication: Dependent: Resident is totally disoriented and is unable to make good decisions. Resident must be on frequent daily checks and is in constant need of redirection." "Ambulation/Physical Abilities: Limited Assistance: Staff must frequently supervise and instruct resident for ambulation and/or transfers with an assistive device. Resident also needs one person to reposition them while in bed every 2 hours or as needed." Resident 1's record did not contain a bedrail assessment or any indication that Resident 1 utilized bedrails.	N 381		

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N 381	Continued From page 5 Example 2: Resident 2 On 11/17/2025, Surveyor reviewed Resident 2's record. Resident 2 moved into the facility, 06/05/2025, with diagnoses including weakness, chronic fatigue, and dizziness. Resident 2's unsigned "Individual Service Plan (ISP)," dated 09/18/2025, documented: "Resident is to be repositioned every 2 hours due to being a HIGH risk for skin breakdown." "Requires a 1 to 2 persons to get into and out of [his/her] bed safely." Resident 2's record did not contain a bedrail assessment or any indication Resident 2 utilized bedrails. On 11/17/2025, Surveyors reviewed the provider's "5.09 Side Rails" policy provided by Care Coordinator B, which documented: "When Inglehaven is aware a resident is utilizing side rails (a medical device) on a bed, Inglehaven will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistently with the manufacturer's directions. ... When side rails are in use, an RN (registered nurse) must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. If the side rail is acting as a restraint, appropriate action should be taken." On 11/17/2025, at approximately 4:00 PM, Surveyors discussed above concern with	N 381		

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N 381	Continued From page 6 Administrator A and Care Coordinator B. Care Coordinator B stated that s/he had been under the impression that when hospice orders a hospital bed for a resident, hospice was responsible for bedrail assessment. Administrator A explained to Care Coordinator B that when residents utilized bedrails, an assessment had to be completed. Care Coordinator B stated s/he would ensure the assessments were completed. According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment...3. Use of bed rails should be based on patient's assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patients' assessed needs...The care plan should: include educating the patient about possible bed rail danger to	N 381		

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N 381	Continued From page 7 enable the patient to make an informed decision; and address options for reducing the risks of the rail use..." (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 07/18/2024)).	N 381		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 4 of 4 Individual Service Plans (ISP) were reviewed when the resident experienced a change of condition. This is a repeat deficiency. See Statement of Deficiency (SOD) L76811, dated 10/06/2022. Resident 1's ISP did not identify that s/he required	N 389		

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sit-by assist for meals.

Resident 2's ISP did not document that s/he utilized a commode and s/he required assistance to communicate via telephone. The ISP did not provide monitoring guidelines for staff to ensure s/he was receiving adequate oxygen.

Resident 4's ISP was not updated when s/he started to utilize a urinal and had a change in orders regarding the wearing of suspension offloading boots.

Resident 6's ISP did not provide monitoring guidelines for staff to ensure s/he was receiving adequate oxygen.

Findings include:

The provider is licensed to care for a maximum of 16 residents from client groups Irreversible Dementia/Alzheimer's, Physically Disabled and Advanced Aged.

Example 1: Resident 1

On 11/17/2025, at approximately 11:30 AM, Surveyors observed residents starting to gather in the dining room for the noon meal. Surveyors observed Caregiver C independently bringing residents that required assistance into the dining area while Caregiver D completed housekeeping tasks.
At approximately 11:55 AM, staff delivered the noon meal and Caregiver C proceeded to plate the food for the residents. Resident 1 was observed sitting at the dining room table.
At approximately 12:05 PM, Resident 1's food was plated and placed in front of him/her. Resident 1 appeared to be the only resident that

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required 'sit-by' assist during meals. Resident 1 did not attempt to eat the food that was placed in front of him/her.
Caregiver C continued to respond to questions/requests residents had, for instance an additional drink. Caregiver C ensured each resident's dessert was also plated and placed in front of them.
At approximately 12:18 PM, Caregiver C sat down next to Resident 1 and proceeded to feed him/her. Resident was unable to pick up and hold his/her glass. Caregiver C placed a straw in the cup and lifted the cup up to Resident 1's mouth and placed the straw in his/her mouth which Resident 1 accepted.. Surveyors observed Carergiver D plate him/herself a plate of food and stand in the kitchenette area and consume his/her food.
At approximately 12:25 PM, Caregiver C was observed in the kitchenette area cleaning up the dishes.
Surveyors noted that between 12:18 PM and 12:25 PM, Caregiver C had gotten up at least two times to assist other residents and to retrieve a drink for Resident 1.

On 11/17/2025, at approximately 1:00 PM, Surveyor interviewed Caregiver C. Surveyor asked for clarification on who was responsible to assist residents during meals. Caregiver C stated Caregiver D was new and would not probably assist Resident 1 with feeding.
Caregiver C stated s/he had independently gotten all residents ready for the noon meal and ensured all residents were present for the meal.
Caregiver C confirmed Resident 1 did not receive assistance until s/he had assisted all other residents and that s/he had to get up to assist other residents during Resident 1's meal.

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N 389	Continued From page 10 On 11/17/2025, Surveyors reviewed Resident 1's record. Resident 1 moved into the facility 02/14/2023. Resident 1's ISP, unsigned, dated 06/19/2024, documented: Supervision, limited, assistance with eating. Nutrition: I will eat mechanical soft meals. I will eat in the dining room or room. My fluids are thin. Independent after set up. I don't use special utensils or devices. I am at risk for swallowing problems and will need monitoring for choking/aspiration hazard. Surveyor noted the ISP should have been updated annually in 06/2025. On 11/17/2025, at approximately 4:00 PM, Surveyors discussed above concern with Administrator A and Care Coordinator B. Surveyors asked for clarification on how long a resident should have to wait to receive assistance if they were 'sit-by' assists during meals. Administrator A stated that based on the observation, Resident 1's dignity was not respected and the provider's process for providing sit-by assist during meals would need to be reviewed. On 11/17/2025, at approximately 4:50 PM, when Surveyors were exiting the facility, they observed Resident 1 being fed his/her evening meal by a family member. Example 2: Resident 2 On 11/17/2025, at approximately 10:05 AM, Surveyors observed Resident 2 in his/her bedroom. While Surveyors communicated with	N 389		

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Resident 2, they observed a commode in his/her bathroom. Resident 2 explained that s/he did not utilize his/her bathroom because s/he utilized the commode. While Surveyors were visiting with Resident 2, Resident 2's landline telephone began to ring. Surveyors asked if s/he would like to answer his/her telephone. Resident 2 proceeded to look at Surveyor and after about 30 seconds stated s/he wanted to answer the phone. Surveyors assisted Resident 2 by handing his/her phone to him/her. Resident 2 appeared not to know how to operate the telephone. Surveyor noted the telephone displayed "16 New Messages" and "42 Missed Calls." Surveyor observed an oxygen concentrator in Resident 2's room which displayed the flow meter ball resting between the markings for 3 liters (L) and 2.5 L.

On 11/17/2025, Surveyors reviewed Resident 2's record.

Resident 2 was admitted to the facility, 06/05/2025, with diagnoses including weakness, chronic fatigue, and dizziness.

Resident 2's hospice oxygen physician order, dated 06/02/2025, documented:
"LPM (liters per minute): 1-4; Frequency: PRN (as needed)"

Resident 2's ISP, unsigned, dated 09/19/2025, documented:
Resident 2 needs assistance with lower body cares such as peri care and maintaining his/her catheter at this time.
Resident 2 will be able to communicate via phone, in person with staff, family, friends and other residents as independently as possible.
Resident 2 will continue on Oxygen as long as needed and facility as well as Hospice will help

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maintain [his/her] oxygen level. Staff will ensure that the resident has oxygen on at all times while in [his/her] room. Staff will also notify Care Coordinator or nurse if resident needs [his/her] oxygen titrated up. Staff will ensure that liter flow is at 3 throughout the day."
Monitor, report and document any changes or as needed in progress notes.

The ISP did not provide guidelines regarding Resident 2's usage of a commode or assistance that may be required to ensure s/he was able to communicate via telephone.
The ISP did not provide guidelines on how staff were to monitor Resident 2's oxygen requirements.

On 11/17/2025, at approximately 3:30 PM, Surveyors interviewed Care Coordinator B. Surveyors asked for clarification on how staff knew what level Resident 2's oxygen concentrator should be set at since his/her ISP stated 3 L, his/her hospice physician order stated 1-4 L, and the oxygen concentrator was currently set at 2.5/3 L. Care Coordinator B stated the provider received guidance from Resident 2's hospice team to determine what his/her oxygen level should be set at. Care Coordinator B could not verify that staff monitored Resident 2's oxygen levels to determine if s/he was receiving too little or too much oxygen. Care Coordinator B stated it was the provider's responsibility to ensure Resident 2's oxygen levels were monitored, and s/he would verify with the hospice care team what parameters Resident 2's oxygen levels should be monitored for.

Example 3: Resident 4

On 11/17/2025, at approximately 12:00 PM,

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Surveyors observed Resident 4 in the dining room for the noon meal. Resident 4 was wearing his/her suspension offloading boots on both feet.

On 11/17/2025, at approximately 2:00 PM, Surveyor observed Resident 4 in his/her bedroom, and s/he was wearing his/her suspension offloading boots on both feet. Surveyor noted there was a urinal sitting on his/her bedside table which appeared to be approximately 50% full.

On 11/17/2025, Surveyors reviewed Resident 4's record.

Resident 4 was admitted to the facility 04/10/2025.

Resident 4's ISP, dated 09/20/2025, did not document that s/he utilized a urinal or guidelines on how staff were to assist Resident 4 regarding toileting. The ISP documented that Resident 4 was to wear his/her suspension offloading boots during hours of sleep.

Resident 4's Medication Administration Records, dated 10/01/2025 to 11/17/2025, documented: "Bilateral Cushion Boots to feel [sic: feet] while in bed for protection. Three Times a Day. Apply heel cushion boots while resident is in bed. Start Date: 04/10/2025."

On 11/17/2025, at approximately 4:00 PM, Surveyors discussed above concern with Administrator A and Care Coordinator B. Care Coordinator B stated that Resident 4's orders for wearing his/her suspension offloading boots had been changed to 'as much as tolerated.' Surveyors requested the physician order that updated when the boots were to be worn. Care

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Coordinator B stated s/he was unable to locate the documentation. Care Coordinator B stated s/he would locate the physician order and update Resident 4's ISP accordingly. Care Coordinator B stated that Resident 4's ISP would be updated to include guidelines regarding the usage and care of his/her urinal.

Example 4: Resident 6

On 11/17/2025, at approximately 9:55 AM, Surveyors observed Resident 6 receive his/her medications and determined that Resident 6 utilized an oxygen concentrator.

On 11/17/2025, Surveyors reviewed Resident 6's record.

Resident 6 moved into the facility, 01/15/2024, with diagnoses including acute upper respiration infection and abnormal electrocardiogram.

Resident 6's unsigned ISP, dated 09/25/2025, documented:
"I have to be on continuous oxygen. Staff will ensure that liter flow is at 2-4 throughout the day."

Resident 6's hospice oxygen physician order, dated 10/17/2025, documented:
"O2 (oxygen) at 1-3 L/NC (nasal cannula) or mask as needed for SOB (shortness of breath)."

On 11/17/2025, at approximately 3:30 PM, Surveyors interviewed Care Coordinator B. Surveyors asked for clarification on how staff knew what level Resident 6's oxygen concentrator should be set at since his/her ISP stated 2-4 L and his/her hospice physician order stated 1-3 L. Care Coordinator B stated the provider received guidance from Resident 6's

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hospice team to determine what his/her oxygen level should be set at. Care Coordinator B could not verify that staff monitored Resident 6's oxygen levels to determine if s/he was receiving too little or too much oxygen. Care Coordinator B stated it was the provider's responsibility to ensure Resident 6's oxygen levels were monitored, and s/he would verify with the hospice care team what parameters Resident 6's oxygen levels should be monitored for.

On 11/17/2025, Surveyors reviewed the provider's "6.25 Oxygen" policy, dated 08/01/2025, provided by Care Coordinator B, which documented: "If Inglehaven accepts responsibility for the ordering, refilling, and administration of oxygen, then oxygen shall be managed in the same manner as an ordered medication, including requiring a physician order."

"Oxygen is a medication and should not be adjusted without consultation with a physician or respiratory therapist." (Source: National Library of Medicine (NIH) website, Oxygen Therapy, undated, https://www.ncbi.nlm.nih.gov/books/NBK593208 (retrieval date - November 23, 2025).)

"Always ensure your line of sight is directly level with the ball to get an accurate reading. Observe the ball's movement until it aligns with the prescribed oxygen flow marking. Wait a moment to ensure the ball stabilizes at the new setting. It's important to note that incorrect ball placement can have serious consequences for patient health. Too much oxygen can lead to oxygen toxicity, while too little can result in hypoxemia, both of which can have detrimental effects on the body." (Source: MasVida Health website, Where Should the Ball Be On An Oxygen Concentrator?,

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N 389	Continued From page 16 undated, https://masvidahealth.com/oxygen-concentrators/where-should-the-ball-be-on-an-oxygen-concentrator/#:~:text=Continuous%20Flow%20Concentrators%20and%20Ball,resources%20if%20set%20too%20high. (retrieval date - November 23, 2025).) "If you're using an oximeter at home and your oxygen saturation level is 92% or lower, call your healthcare provider. If it's at 88% or lower, get to the nearest emergency room as soon as possible." (Source: Cleveland Clinic website, Blood Oxygen Level, February 18/2022, https://my.clevelandclinic.org/health/diagnostics (retrieval date - November 23, 2025).)	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN	N 408		

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N 408	Continued From page 17 psychotropic medication given. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure that 1 of 1 resident's (Resident 3) prescribed PRN (as needed) psychotropic medication (Quetiapine) was documented on the resident's Individualized Service Plan (ISP) or include a rationale for use, nor a detailed description of the behaviors, which indicate the need for administration of PRN psychotropic medication. Findings include: On 11/17/2025, at approximately 11:00 AM, Surveyor and Care Coordinator B observed Resident 3's blister card of PRN Quetiapine in the med cart. The blister card had a dispensed date of 09/30/2025 and 26 of 30 tablets remained. On 11/17/2025, Surveyor reviewed Resident 3's record. Resident 3 moved into the facility, 07/18/2025, with diagnoses including dementia, psychotic disturbance, mood disturbance, and anxiety. Resident 3's "Progress Notes" documented: 09/21/2025 - Per facility nurse behaviors were escalating and that s/he no longer is safe for the facility. Resident 3 was unable to be redirected on many occasions throughout the day. Resident 3 started pushing staff and yelling throughout the halls. Resident 3's agitation was peaking and it was not a good place for him to be at. Power of Attorney was agreeable to this as Resident 3 was not able to understand that s/he needed to calm down. Resident was sent to hospital.	N 408		

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N 408	Continued From page 18 PRN Quetiapine was prescribed. Resident 3's Medication Administration Records (MARs), dated 10/01/2025 to 11/17/2025, documented: "Quetiapine 25 MG (milligrams) - Take 1 tablet by mouth two times daily as needed for severe agitation." Resident 3's MARs did not document that s/he had been administered the PRN Quetiapine 6 times since the blister card was dispensed, 09/30/2025. Resident 3's ISP, unsigned, dated 09/18/2025, documented: "Staff will recognize when [Resident 3] is becoming increasingly confused or agitated while in the facility." "Ensure that resident has the opportunity throughout the day to interact and communicate with peers and staff safely." "Monitor, report and document any changes or as needed in progress notes." Resident 3's ISP did not identify that s/he was on a PRN psychotropic or include a rationale for use, nor a detailed description of the behaviors, which indicate the need for administration of the Quetiapine. On 11/17/2025, at approximately 4:00 PM, Surveyors discussed above concern with Administrator A and Care Coordinator B. Care Coordinator B stated s/he did not have a rationale as to why the 6 doses of PRN Quetiapine were not recorded on the MARs. Care Coordinator B stated s/he would update Resident 3's ISP to include the PRN psychotropic medication and the rationale for administration.	N 408		

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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 tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the clothes dryer in the residential laundry room had vent tubing of rigid material, with a fire rating that exceeds the temperature rating of the dryer. The clothes dryer was observed to have the flexible foil type vent tubing. This is a repeat deficiency. See Statement of Deficiency (SOD) VLFJ11, dated 05/20/2021. Findings include: On 11/17/2025, at approximately 11:50 AM, during a tour of the facility, Surveyor observed a foil accordion style vent tubing from residential clothes dryer to vent duct for two different dryers. The vent was not marked to determine if it met the Underwriters Laboratories (UL) guidelines. "The codes require that dryer vents be made of metal with smooth interior finishes, sections of vent duct be securely supported and firmly sealed together, and the total length of the vent duct not exceed 35 feet (shorter if there are turns or bends). Flexible transition ducts used to connect the dryer to the exhaust system are required to be not longer than 8 feet ... Flexible vents can	N 488		

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N 488	Continued From page 20 twist, allowing lint to build up and catch on fire if it comes in contact with a sufficient amount of heat. ... Only flexible transition ducts that are listed by UL or another approved product safety testing agency should be used." (Source: The US Fire Administration - FEMA website, Clothes Dryer Fires in Residential Buildings (2008-1010), August 2012, https://www.usfa.fema.gov/downloads/pdf/statistics/v13i7.pdf (retrieval date - September 14, 2022).) On 11/17/2025, at approximately 4:00 PM, Surveyors discussed above concern with Administrator A and Care Coordinator B. Administrator A stated maintenance would be contacted immediately to install the proper style dryer vent.	N 488		
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. Findings include: The provider is licensed to care for a maximum of 16 residents from client groups Irreversible Dementia/Alzheimer's, Physically Disabled and Advanced Aged.	N 499		

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N 499	Continued From page 21 On 11/17/2025, Surveyor toured the facility and observed the following unsecured cleaning compounds: Resident 2's bedroom: -Gallon jug of isopropyl alcohol Housekeeping room: -(11) bottles of glass and mirror cleaner -(2) bottles of urine remover for stains and odors -(8) bottles of porcelain cleaner - clinging bowl cleaner -(3) tubs that contained 43 pods of dishwasher soap -64 fluid ounce jug of plastic clean and shine -Gallon jug of one-step disinfectant germicidal detergent and deodorant -(10) 8.8 ounce spray cans of air mist - Hawaiian aloha scent -9.7 ounce spray can of everyday clean multisurface cleaner - fresh citrus scent Kitchen cabinet: -32 ounce bottle of stainless steel cleaner and polish -bottle of urine remover for stains and odors -Tub that originally contained 43 pods of dishwasher soap and an unopened tub of 43 pods -(2) hydrogen peroxide wipes Surveyors observed the housekeeping cart not being utilized at approximately 9:50 AM and 2:10 PM, sitting in front of the housekeeping room. The housekeeping cart had a variety of the cleaning compounds listed above stored on it. These areas were accessible to all residents. Residents were observed moving freely throughout the facility.	N 499		

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N 499	Continued From page 22 On 11/17/2025, at approximately 4:00 PM, Surveyors discussed above concern with Administrator A and Care Coordinator B. Care Coordinator B stated the concern would be discussed with staff.	N 499		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct quarterly fire drills (including at least one fire evacuation drill simulating the conditions during usual sleeping hours) with both employees and residents in 2024 and 2025. This is a repeat deficiency. See Statement of	N 525		

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N 525	Continued From page 23 Deficiency (SOD) VLFJ11, dated 05/20/2021, and SOD VLFJ13, dated 04/18/2022. Findings include: The provider is licensed to care for a maximum of 16 residents from client groups Irreversible Dementia/Alzheimer's, Physically Disabled and Advanced Aged. On 11/17/2025, Surveyors requested the facility fire drills for 2024 and 2025 from Care Coordinator B. Care Coordinator B stated s/he had to review his/her records. Administrator A responded to Surveyors request and stated that the documentation could not be located. On 11/17/2025, at approximately 4:00 PM, during the exit interview, Surveyors discussed the completion of the fire drills again with Administrator A and Care Coordinator B. Administrator A stated there was a management change approximately one year ago and some required documentation could not be located.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure evacuation drills, such as tornado, flooding or other emergency or disaster, were completed at least semi-annually in 2024 and 2025.	N 526		

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N 526	Continued From page 24 This is a repeat deficiency. See Statement of Deficiency (SOD) VLFJ11, dated 05/20/2021, SOD VLFJ12, dated 09/09/2021, and SOD VLFJ13, dated 04/18/2022. Findings include: The provider is licensed to care for a maximum of 16 residents from client groups Irreversible Dementia/Alzheimer's, Physically Disabled and Advanced Aged. On 11/17/2025, Surveyors requested the facility other evacuation drills for 2024 and 2025 from Care Coordinator B. Care Coordinator B stated s/he had to review his/her records. Administrator A responded to Surveyors request and stated that the documentation could not be located. On 11/17/2025, at approximately 4:00 PM, during the exit interview, Surveyors discussed the completion of the other evacuation drills again with Administrator A and Care Coordinator B. Administrator A stated there was a management change approximately one year ago and some required documentation could not be located.	N 526		
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	N 640		

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N 640	Continued From page 25 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 the door leading to the laundry room was self-closing, which was located on the same floor as resident bedrooms. Findings include: The provider is licensed to care for a maximum of 16 residents from client groups Irreversible Dementia/Alzheimer's, Physically Disabled and Advanced Aged. On 11/17/2025, at approximately 11:50 AM, Surveyor toured the facility. Surveyor observed the door leading to the laundry room was self-closing but when opened and left to close, did not self-latch to create a solid closure. On 11/17/2025, at approximately 4:00 PM, Surveyors discussed above concern with Administrator A and Care Coordinator B. Administrator A stated s/he would have maintenance repair the door closure.	N 640		