STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017655	A. BUILDING: _____ B. WING _____	C 11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAPHA HOUSE	**7835 W FIEBRANTZ AVE MILWAUKEE, WI 53222**

(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
M 000	INITIAL COMMENTS On 11/12/2025, Surveyors conducted a standard survey and 2 complaint investigation at Rapha House. As a result, 9 deficiencies were identified, and 2 complaints were substantiated. Census: 2	M 000		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider permitted the existence and continuation of conditions in the home placing the health, safety, and welfare of 2 of 2 residents (Resident 1 and Resident 2) at substantial risk of harm. The provider did not ensure the home was properly staffed when Resident 1 and Resident 2 utilized a mechanical lift for all transfers. Findings include: This facility was licensed on 08/12/2020 to provide services to 3 non-ambulatory residents with a diagnosis of advanced aged, physically disabled, and emotionally disturbed/mental illness. On 10/29/2025 the Department received 2 complaints alleging concerns regarding resident transfers.	M 230		

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

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M 230	Continued From page 1 Observations On 11/12/2025, at 9:25 AM, Surveyors entered the facility to conduct a standard survey. Caregiver C was the only caregiver present when Surveyors began the survey. Caregiver C contacted Compliance Officer B who arrived at the facility at approximately 10:40 AM. Record Review On 11/12/2025, at 10:20 AM, Surveyors reviewed resident records and identified the following: Resident 1 was admitted on 01/04/2025 with diagnoses including myoneural disorder and inherited spinal muscular atrophy. Resident 1's individual service plan (ISP), dated 07/07/2025, indicated Resident 1 utilized a wheelchair for ambulation and required the use of a mechanical lift for transfers. Resident 1's ISP indicated s/he attended college on weekdays with a caregiver from the facility. Resident 2 was admitted on 01/25/2024, with diagnoses including multiple sclerosis. Resident 2's individual service plan (ISP), dated 07/21/2025. The indicated Resident 2 utilized a wheelchair for ambulation and required the use of a mechanical lift for transfers. Surveyors reviewed staff schedules for September 2025 to November 2025 and identified the following: 09/03/2025 - 09/06/2025 - 1 caregiver scheduled 7AM-3PM, 1 caregiver scheduled 8AM-8PM, 1 caregiver scheduled 3PM-11PM, 1 caregiver 11PM-7AM	M 230		

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M 230	Continued From page 2 09/09/2025 - 09/13/2025 - 1 caregiver scheduled 7AM-3PM, 1 caregiver scheduled 8AM-8PM, 1 caregiver scheduled 3PM-11PM, 1 caregiver 11PM-7AM 09/17/2025 - 09/20/2025 - 1 caregiver scheduled 7AM-3PM, 1 caregiver scheduled 8AM-8PM, 1 caregiver scheduled 3PM-11PM, 1 caregiver 11PM-7AM 09/30/2025 - 10/04/2025 - 1 caregiver scheduled 7AM-3PM, 1 caregiver scheduled 8AM-8PM, 1 caregiver scheduled 3PM-11PM, 1 caregiver 11PM-7AM 10/14/2025 - 10/18/2025 - 1 caregiver scheduled 7AM-3PM, 1 caregiver scheduled 8AM-8PM, 1 caregiver scheduled 3PM-11PM, 1 caregiver 11PM-7AM 10/21/2025 - 11/01/2025 - 1 caregiver scheduled 7AM-3PM, 1 caregiver scheduled 8AM-8PM, 1 caregiver scheduled 3PM-11PM, 1 caregiver 11PM-7AM 11/11/2025 - 11/12/2025 - 1 caregiver scheduled 7AM-3PM, 1 caregiver scheduled 8AM-8PM, 1 caregiver scheduled 3PM-11PM, 1 caregiver 11PM-7AM On 11/12/2025, at 12:45 PM, Surveyors interviewed Resident 2. Resident 2 reported s/he requires the use of a mechanical lift for transfers. Surveyors inquired how many caregivers are utilized for transfers. Resident 2 reported caregivers utilize 2 staff members for transfers. Resident 2 reported when Resident 1 is at school, only 1 caregiver is present until s/he returns from school with the second scheduled caregiver.	M 230		

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M 230	Continued From page 3 Resident 2 reported if only 1 caregiver is present, the caregiver would call another caregiver to the facility to complete the transfer. On 11/12/2025, at 1:17 PM, Surveyors Interviewed Compliance Officer B and Caregiver C. Compliance Officer B confirmed 1 staff member accompanied Resident 1 to school on weekdays. Compliance Officer B reported they complete 2 person transfers with the mechanical lift for safety purposes. When Surveyors inquired about only 1 staff being present in the home when they entered the facility, Compliance Officer B reported s/he was "not that far away." Caregiver C reported s/he would wait until another staff showed up because s/he did not feel comfortable utilizing a mechanical lift independently.	M 230		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 (Caregiver D and	M 232		

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M 232	Continued From page 4 Caregiver E) employees reviewed were screened for clinically apparent communicable disease, including tuberculosis (TB), within 90 days before the start of employment. Caregiver D did not have a completed communicable disease screening prior to performing cares. Caregiver E did not have a TB test completed prior to performing cares. Findings include: On 11/12/2025, at 12:30 PM, Surveyors reviewed staff records and identified the following: Caregiver D was hired 11/03/2025. Caregiver D's record contained a TB test dated 11/03/2025. Caregiver D's record contained a communicable disease screening form. The form was not dated or signed by Caregiver D or a qualified medical professional. Caregiver E was hired on 09/22/2025. Caregiver E's record contained a communicable disease screening dated 09/22/2025. Caregiver E's record had TB test results dated 09/25/2025, completed 3 days after date of hire. Surveyors reviewed Caregiver E's staff schedule and identified the following: 09/22/2025 7:30 AM - 3:00 PM 09/23/2025 7:30 AM - 3:00 PM 09/24/2025 11:00 PM - 7:00 AM Caregiver E was the only scheduled caregiver on 09/24/2025 from 11:00 PM - 7:00 AM. On 11/12/2025, at 1:17 PM, Surveyors interviewed Compliance Officer B and Caregiver C. Compliance Officer B reported the facility	M 232		

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M 232	Continued From page 5 registered nurse (RN) completed the communicable disease screening for staff members. Compliance Officer B reported caregivers do not work in the facility until TB results are obtained. Compliance Officer B did not offer an explanation for Caregiver D's communicable disease screening not being completed prior to providing cares. Compliance Officer B reported Caregiver E did not work the floor until the results of her/his TB test were obtained. Surveyors inquired who trained Caregiver E during third shift 09/24/2025. Compliance Officer B did not offer any further information regarding Caregiver E's training.	M 232		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 service provider (Caregiver F) received 8 hours of annual training for 2 of 3 years reviewed. Caregiver F did not receive annual training in 2023 or 2024. Findings include:	M 246		

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M 246	Continued From page 6 On 11/12/2025, at 12:30 PM, Surveyors reviewed Caregiver F's record. Caregiver F was hired on 05/12/2021. Caregiver F's record did not contain any evidence of annual training for 2023 or 2024. On 11/12/2025, at 1:17 PM, Surveyors interviewed Compliance Officer B and Caregiver C. Compliance Officer B reported Caregiver F was a rehire in February 2025. Surveyors inquired when Caregiver F's termination date was prior to her/his rehire date. Compliance Officer B reported Caregiver F was never terminated and continued to work as needed at the facility while working in a different state. Compliance Officer B reported Caregiver F began working more consistent hours at the facility in February of 2025. Compliance Officer B did not provide any evidence of required training for Caregiver F for 2023 or 2024.	M 246		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at	M 262		

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M 262	Continued From page 7	M 262		

all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility 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 ensure 2 of 2 exits from the home were ramped to grade. Resident 1 and Resident 2 required the use of a wheelchair to assist with mobility. The front and rear exits contained ramps which did not meet the length for the raised landing for safe use.

Findings include:

This facility was licensed on 08/12/2020 to provide services to 3 non-ambulatory residents with a diagnosis of advanced aged, physically disabled, and emotionally disturbed/mental illness.

On 11/12/2025, at 9:45 AM, Surveyors toured the facility and observed the following:

The front door identified as an emergency exit. There was a ramp from the front porch to the side of the house. The landing of the front exit ramp was approximately a 24-inch rise. The ramp extended approximately 177 inches (14.75 feet), approximately 1.25 feet short of the required length for a 24-inch-tall rise. This slope of the front ramp is greater than a 1 inch of rise to 12 inches (1 foot) of run (1:12) ratio. The safe length according to minimum standards of a rise to run ratio of 1:8, the ramp should be 192 inches long.

The rear door was located off the kitchen which

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M 262	Continued From page 8 was identified as an emergency exit. The landing of the rear exit ramp was approximately a 24-inch rise. The ramp extended approximately 157 inches (13 feet), approximately 2 feet short of the required length for a 24-inch-tall rise. The slope of the rear ramp is greater than a 1:8 ratio. The ramp should have been at least 192 inches long. On 11/12/2025, at 1:17 PM, Surveyors Interviewed Compliance Officer B and Caregiver C. Compliance Officer B reported s/he was not aware of code requirements for exit ramps. Compliance Officer B reported s/he would inform Licensee A of ramp deficiency. 2010 Americans with Disabilities Act (ADA) Standards for Accessible Design states,"...405 Ramps. 405.1 General. Ramps on accessible routes shall comply with 405...405.2 Ramp runs shall have a running slope not steeper than 1:12. Exception: In existing sites, buildings and facilities, ramps shall be permitted to have running slopes steeper than 1:12 complying with Table 405.2 where such slopes are necessary due to space limitations...Slope (A slope steeper > than 1:8 is prohibited.)..." (Source: 2010 ADA Standards for Accessible Design website, Chapter 4: Accessible Routes, September 2010, https://www.ada.gov/law-and-regs/design-standards/2010-stds/#303-changes-in-level (retrieval date - November 25, 2025).)	M 262		
M 338	88.05(4)(c)1 EXITING FROM THE FIRST FLOOR Exiting from the first floor. The first floor of the home shall have at least 2 means of exiting which provides unobstructed access to the	M 338		

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M 338	Continued From page 9 outside. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 2 exits provided unobstructed access to the outside. The path to the rear exit, located at the top of a stairway leading to the basement, identified as an emergency exit, was blocked with buckets, a broom, and a mop. Findings include: This facility was licensed on 08/12/2020 to provide services to 3 non-ambulatory residents with a diagnosis of advanced aged, physically disabled, and emotionally disturbed/mental illness. On 11/12/2025, at 9:45 AM, Surveyors toured and observed two buckets, a mop bucket, and a broom/dustpan by the rear exit door. Surveyors measured the pathway between opened rear exit door and measured the clear opening. The clear opening from the door to the doorframe to was approximately 22 inches wide. On 11/12/2025, at 1:17 PM, Surveyors interviewed Compliance Officer B and Caregiver C. Compliance Officer B acknowledged placement of cleaning supplies at the rear entrance obstructed the rear emergency exit. Compliance Officer B reported items would no longer be stored in the path to the rear exit door.	M 338		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated	M 346		

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M 346	Continued From page 10 annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete an annual evacuation assessment review for 1 of 2 residents reviewed who lived in the facility beyond one year. Resident 2 did not have an evacuation assessment completed in 2025. Findings include: On 11/12/2025, at 10:20 AM, Surveyors reviewed Resident 2's record. Resident 2 was admitted on 01/25/2024, with diagnoses including multiple sclerosis. Resident 2's record contained a Resident Evacuation Assessment, dated 01/26/2024. Resident 2's record did not contain an annual evacuation assessment review for 2025. On 11/12/2025, at 1:17 PM, Surveyors interviewed Compliance Officer B and Caregiver C. Compliance Officer B reported s/he was unaware of the code requirement. Compliance Officer B reported s/he would ensure evacuation assessments were reviewed yearly.	M 346		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the	M 420		

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M 420	Continued From page 11 plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a statement of agreement with the Individual Service Plan (ISP) was dated and signed by all persons involved in developing the plan for 2 of 2 residents (Resident 1 and Resident 2). Resident 1's July 2025 ISP was not signed by Resident 1. Resident 2's ISP was not signed by all parties involved in July of 2025. Findings include: On 11/12/2025, at 10:20 AM, Surveyors reviewed resident records and identified the following: Resident 1 was admitted on 01/04/2025 . Resident 1 was her/his own person. Resident 1 had a Managed Care Organization (MCO). Resident 1's ISP, dated 07/07/2025, was not signed by Resident 1 or Licensee A. Licensee A's name was typed on the ISP signature page with no signature. Resident 2 was admitted on 01/25/2024. Resident 2 was her/his own person. Resident 2 had an MCO. Resident 2's record contained an ISP, dated 07/21/2025. The ISP was not signed by Resident 2 or Licensee A. Licensee A's name was typed on the ISP signature page with no signature. On 11/12/025, at 1:17 PM, Surveyors interviewed Compliance Officer B and Caregiver C. Compliance Officer B confirmed the code requirement. Compliance Officer B reported the	M 420		

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M 420	Continued From page 12 licensee, case manager, nurse, caregivers, and residents were present during ISP reviews. Compliance Officer B reported the licensee attended ISP reviews via phone. Compliance Officer B reported Resident 1 had the ability to digitally sign documents. Compliance Officer B reported Resident 2 had the ability to sign her/his documents. Compliance officer B confirmed Resident 1's and Resident 2's ISPs were not signed by the residents or the licensee.	M 420		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a resident's individual service plan (ISP) was reviewed every 6 months and with changes for 1 of 2 residents (Resident	M 424		

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M 424	Continued From page 13 1). Resident 1's ISP did not include behaviors or interventions. Findings include: On 11/12/2025, at 10:20 AM, Surveyors reviewed Resident 1's record. Resident 1 was admitted on 01/04/2025. Resident 1's preadmission assessment did not list any behaviors or interventions. Resident 1's ISP, dated 07/07/2025, did not indicate Resident 1 had any behaviors. Surveyors reviewed Resident 1's behavioral incident reports from September 2025 to November 2025 which indicated the following: 09/10/2025 at 4:00 PM - "... The incident involved the resident and the on duty staff. During the resident's transfer from her/his wheelchair to the shower chair, while s/he was completely undressed, the resident urinated on the provider. The staff member was initially unaware that urination had occurred and was informed by the second staff member present. The resident upon realizing that the other staff member witnessed the incident aggressively yelled out 'I didn't know I was peeing.' The resident went on to state that s/he does not have full control over her/his bladder and reported that her/his physician previously told her/him s/he has 'the bladder of a full-term mother carrying multiples.' No physical injuries were reported as a result of the incident." 09/18/2025 at 2:30 PM - "...The incident involved the resident and her/his Managed Care Organization (MCO). During a phone conversation with the MCO, the resident provided inaccurate information regarding her/his school transfers. The resident also instructed staff	M 424		

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	0017655	A. BUILDING: _____ B. WING _____	C 11/12/2025

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RAPHA HOUSE	7835 W FIEBRANTZ AVE MILWAUKEE, WI 53222

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M 424	Continued From page 14	M 424		

members on duty not to speak or intervene during the call. No physical injuries occurred during the incident."

9/26/2025 at 9:45 AM - "...The incident involved the resident and the on duty staff. The resident urinated again on the same caregiver that s/he previously urinated on from September 10th, 2025. The resident exclaimed after the incident, 'See, I told you I don't have control over it.' This type of behavior has not been previously observed during the residents time at the [Adult Family Home] AFH, and the resident has never urinated outside of her/his Depends prior to September 10th or today. No physical injuries were reported as a result of the incident."

10/19/2025 at 1:45 PM - "...The incident involved the resident and the on duty staff. While in the resident's bedroom the resident engaged in conversation with one of the caregivers. During the conversation, the resident stated to the caregiver, 'I noticed that your weekend shift changed. You've been working [7:00 AM-3:00 PM]. I know you used to be scheduled [8:00 AM-8:00 PM]. I'm not trying to scare you, but that's the same thing that happened to the last employee who got fired.' On more than one occasion, the resident has also asked this employee if s/he would be willing to the leave the company, and work for her/him directly, as the resident has expressed interest in transitioning to independent living in the near future. No visible injuries were reported."

11/04/2025 at 12:15 PM "...The incident involved the resident and her/his accompanying staff member while at school. During a normal conversation, the resident confided in the staff member, stating, 'I don't think the company

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thought the hiring process through completely by hiring a [fe/male] caregiver at the [Adult Family Home] AFH.' S/he further expressed that s/he does not feel comfortable with a [fe/male] caregiver and that s/he has previously shared this concern with management and the owner. The resident stated that s/he believes the [fe/male] caregiver should not have been hired and that management should have consulted her/him prior to his/her hiring. NO physical injuries or safety concerns occurred during this interaction."

11/04/2025 at 2:30 PM "...The resident was at school in between classes during a break and the staff member let the resident know that s/he would need to complete a chair change on her/him. However, during the process, as the staff member's hand was underneath the resident, the resident had a bowel movement, resulting in fecal matter contacting the staff member's hand. Before being informed, the resident asked, 'Is something wrong?' The staff member responded, 'Yes, I have poop on my hand.' The resident then stated, 'The next time s/he poops at school, another caregiver will have to come and do a two-person transfer, so I can be changed on the table.' Prior to the incident, the resident had never taken a bowel movement at school. No physical injuries were reported as a result of the incident."

10/31/2025 at 12:30 PM - "...As staff was preparing the resident for a shower, while in the hoyer lift elevated over the bed, the resident began urinating onto the bed. The resident yelled out, 'Oops I let out a bit of pee. I stopped myself and I'll hold it until I get in the shower.' This is a direct contradiction to the statements made on 9/10/2025 and 9/26/2025 by the resident who previously stated that s/he does not have the

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ability to hold her/his urination and is also unaware of when s/he is urinating. No injuries were incurred during this incident."

11/05/2025 at 11:30PM - "...The resident stated to staff, 'I hope you won't be mad at me, but I told management that you left poop on me over the weekend.' No injuries were incurred during this incident."

11/05/2025 at 8:15 PM - Caregiver observed a discolored fingernail on Resident 1's pinky. Resident 1 reported the injury occurred during a transfer by an employee no longer employed at the facility. Resident 1 reported s/he did not believe it was a "big deal" and did not report the incident when it occurred.

11/10/2025 at 2:00 PM - "... The incident involved the resident and her/his accompanying staff member before leaving the school campus for the day. During a normal conversation, the resident told the same caregiver s/he previously had a conversation with on November 4th, that s/he was, 'surprised that the [fe/male] caregiver was still employed with the AFH, and that s/he hadn't been fired yet.' S/he continued by saying that her/his [parent] was aware of the situation and that s/he would not be happy upon hearing the news either. No physical injuries or safety concerns occurred during this interaction."

On 11/12/2025, at 1:17 PM, Surveyors interviewed Compliance Officer B and Caregiver C. Compliance Officer B confirmed the code requirement. Compliance Officer B reported s/he was responsible for updating resident ISPs. Surveyors inquired why Resident 1's ISP did not contain recent behaviors and interventions. Compliance Officer B reported s/he did not want

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M 424	Continued From page 17 to update Resident 1's ISP because s/he "did not want to blacklist her/him before we knew what was going on". Compliance Officer B confirmed the behaviors should be included in the ISP and s/he would update Resident 1's ISP with behaviors and interventions.	M 424		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident's (Resident 1) prescription medication were securely stored. Resident 1's medications were not securely stored in the kitchen refrigerator. Findings include: On 11/12/025, at 9:45 AM, Surveyors toured the kitchen and observed a plastic box in the refrigerator. The box did not contain a locking mechanism. The box contained Resident 1's gabapentin 250 milligram (mg)/5 milliliter (ml)	M 458		

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M 458	Continued From page 18 solution (Soln), amoxicillin - potassium (POT) clavula, and pulmozyme 1mg/ml Soln. On 11/12/025, at 10:20 AM, Surveyors reviewed Resident 1's record. Resident 1 was admitted on 01/04/2025 with diagnoses including myoneural disorder and inherited spinal muscular atrophy. Resident 1's individual service plan (ISP), dated 07/07/2025, indicated Resident 1 required assistance with medication administration. Resident 1's medication administration record (MAR), dated 10/16/2025 indicated Resident 1 was prescribed medications to include: Gabapentin 250mg/5ml Soln - take 2 ml by mouth 2 times a day as needed for pain (headache) Pulmozyme 1mg/ml Soln - Inhale 2.5ml via nebulizer 2 times a day as needed for illness Amoxicillin - Pot Clavula - 400-57 suspension give 10ml via g tube every 12 hours for 10 days On 11/12/2025, at 1:17 PM, Surveyors interviewed Compliance Officer B and Caregiver C. Compliance Officer B and Caregiver C they were unaware of code requirements for storage of medications in a common refrigerator. Compliance Officer B reported s/he would ensure medications were securely locked in common refrigerator or purchase a separate refrigerator for medications to be stored and locked in.	M 458		