STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 000	Initial Comments On 10/01/2024, Surveyor concluded an abbreviated survey and 2 complaint investigations at Maranatha House Potomoc. Six deficiencies were identified. One complaint was substantiated. One complaint was unsubstantiated. Census: 8	N 000		
N 306	83.28(7) Advanced directives. Advanced directives. At the time of admission, the CBRF shall determine if the resident has executed an advanced directive. An advanced directive describes, in writing, the choices about treatments the resident may or may not want and about how health care decisions should be made for the resident if the resident becomes incapacitated and cannot express their wishes. A copy of the document shall be maintained in the resident record as required under s. HFS 83.42(1)(s). A CBRF may not require an advanced directive as a condition of admission or as a condition of receiving any health care service. An advanced directive may be a living will, power of attorney for health care, or a do-not-resuscitate order under chs. 154 or 155, Stats., or other authority as recognized by the courts of this state. This Rule is not met as evidenced by: Based on record review and interview, at the time of 2 of 2 resident admissions, the provider did not accurately document or maintain a record of Resident 1 and Resident 2's executed, advanced directive naming Guardian D as Resident 1's	N 306		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 306	Continued From page 1 legal decision maker for health care and Activated Health Care Power of Attorney J (AHCPOA) J as Resident 2's legal decision maker for health care. Findings include: On 09/24/2024 at 11:45 a.m., Surveyor reviewed resident records. The following was identified: Resident 1 Resident 1 was admitted to the facility on 06/26/2024. Resident 1's diagnoses included autism spectrum disorder, cerebral infarction (heart attack), chronic kidney disease stage 2, chronic pain, depression, alcohol abuse, and cognitive communication disorder. Resident 1 had a guardian. Surveyor was unable to locate guardianship paperwork for Resident 1. On 09/25/2024 at 12:01 p.m., Managed Care Organization (MCO) Care Manager (CM) D faxed Resident 1's guardianship paperwork to Surveyor. Guardian D was appointed on 03/28/2022. Resident 2 Resident 2 was admitted to the facility on 03/16/2021. Resident 2's diagnoses included irreversible dementia, amputation, malnutrition, fracture/joint disorders/scoliosis, seizure disorder, glaucoma, and blindness, one eye, low vision, in the other eye. Resident 2 had an activated health care power of attorney. Surveyor was unable to locate activated health care power of attorney paperwork for Resident 2.	N 306		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 306	Continued From page 2 On 09/24/2024 at 3:24 p.m., Surveyor received Resident 1's MCO record from Health Information Manager (HIM) L. The following was identified: On 07/21/2024, Resident 2's Managed Care Organizations Member Care Plan read, "Legal Decision Maker for Health Care: DPOA-HC Activated. [Guardian J]." On 08/22/2024, Resident 2's Managed Care Organization (MCO) Care Manager (CM) K documented in semiannual/annual case note, under advanced directive/legal decision maker, "[Resident 2] has a court appointed Guardian of Person [family], [Guardian J]." On 09/01/2024, Resident 2's MCO's care plan, under member input/response to plan documented, "[Resident 2] is agreeable to his/her plan of care. [Guardian J] is agreeable to [Resident 2's] plan of care. I give permission for my care team to share information about me assessment/care plan with: [Guardian J]; Relationship: [Guardian]." On 09/25/2024, Resident 2's Managed Care Organizations, Long Term Care Audit read, "[Guardian J] is also Resident 2's family member." Interviews On 09/24/2024 at 9:25 a.m., Surveyor interviewed Caregiver C who confirmed Resident 1 and Resident 2 had legal healthcare power of attorneys and/or guardians. On 09/24/2024 at 10:05 a.m., Surveyor interviewed Lead Supervisor (LS) B, who stated, "[Guardian D] is [Resident 1's] guardian. I do not	N 306		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 306	Continued From page 3 know if I have the document on file." On 09/24/2024 at 4:30 p.m., Surveyor interviewed LS B, who confirmed, "We do not have legal guardianship paperwork in [Resident 1's] file. [MCO CM D] never gave them to us. S/He's been on leave for four months. We don't have [Resident 2's] legal paperwork either. It's not in either of their files." On 09/25/2024 at 4:30 p.m., Surveyor interviewed MCO CM D, who confirmed, Resident 1's guardianship was activated before s/he moved in. On 09/27/2024 at 3:45 p.m., Surveyor interviewed AHCPOA J, who confirmed who confirmed, Resident 2's AHCPOA before s/he moved in.	N 306		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including,	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 383	Continued From page 4 choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Based observation and interview, the provider did not complete an assessment for the use of a bed bar device placed on 2 of 2 resident beds (Resident 1 and Resident 2). The provider did not identify the reason for the use, assess for risk and safety of the device. Findings include: Maranatha House Potomac is a class CNA (non-ambulatory) facility that can serve up to eight residents with primary diagnoses that include but are not limited to advanced age, irreversible dementia/Alzheimer's, developmentally disabled, emotionally disturbed/mental illness, traumatic brain injury and/or physically disabled. On 09/24/2024 at 11:45 a.m., Surveyor reviewed resident records. The following was identified: Resident 1 Resident 1 was admitted to the facility on	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 383	Continued From page 5 06/26/2024. Resident 1's diagnoses included autism spectrum disorder, cerebral infarction (heart attack), chronic kidney disease stage 2, chronic pain, depression, alcohol abuse and cognitive communication disorder. Resident 1 had a guardian. On 09/24/2024 at 1:45 p.m., Surveyor observed Resident 1's room and noted Resident 1's bed contained a bed bar device. The device was very loose from the bed and was very wobbly and unstable (Photo 1). Resident 2 Resident 2 was admitted to the facility on 03/16/2021. Resident 2's diagnoses included irreversible dementia, amputation, malnutrition, fracture/joint disorders/scoliosis, seizure disorder, glaucoma, and blindness, one eye, low vision, in the other eye. Resident 2 had an activated health care power of attorney. Resident 2's record contained an incident report dated 06/01/2024. The incident report stated, "[Resident 2] stated s/he rolled over in her/his bed as s/he was falling to sleep and fell on the floor and hit his/her head." Under prevention information, Resident 2's fall report read, "Will need to inquire about a bed bar restraint -- will need to seek approval from state; a fall prevention plan will also be developed to minimize this type of fall in the future [sic]." On 09/24/2024 at approximately 9:45 a.m., Surveyor interviewed Caregiver C, who stated Resident 2 was at risk of falling. Resident 2 fell out of bed recently and hit his head and went to the hospital to get staples. The provider was waiting for a hospital bed from Activated Health	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 383	Continued From page 6 Care Power of Attorney (AHCPOA) J. Resident 2 had the rail on his/her bed for a couple of months because of that fall. On 09/24/2024 at 11:40 a.m., Surveyor observed Resident 2's room and noted Resident 2's bed contained a bed bar device. The device was very loose from the bed and was very wobbly and unstable (Photo 1). On 09/24/2024 at 11:45 a.m., Surveyor interviewed Lead Supervisor (LS) B about the device on Resident 2's bed. LS B stated s/he was not aware there was a device on the bed any longer. On 09/24/2024 at approximately 12:00 p.m., Surveyor asked Licensee A for the assessment for Resident 2's bed bar device. Licensee A stated, "We do not use the bed bar anymore. [AHCPOA B] brought it in for him/her to use." On 09/24/2024 at 1:50 p.m., Surveyor interviewed Resident 1, who stated s/he had the device for about three months. Surveyor asked Resident 1 what it was used for. Resident 1 stated, "I use it to keep me in bed and to pull myself up. I wasn't falling out of bed. They just didn't want me too." On 09/24/2024 at 2:00 p.m., Surveyor interviewed LS B, who confirmed s/he was unable to locate bed bar assessments for Resident 2 in his/her file. On 09/27/2024 at 3:50 p.m., Surveyor interviewed AHCPOA J, who stated s/he brought the bed bar device to the facility to keep [Resident 2] safe, but s/he ripped it up. AHCPOA J stated, "The facility bought another one. They have had the bed bar for about a year."	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 383	Continued From page 7 On 09/27/2024 at 3:55 p.m., Surveyor interviewed AHCPOA J, who confirmed, "[Resident 2] was never assessed by a physical therapist for a bed bar device. This is just a thing that you slide up in between the mattress type of bed bar." On 10/01/2024, Surveyor interviewed Nurse M confirmed, "The bed bar is helping as much is it can for [Resident 2] ...We did not get a reassessment on [Resident 2] after his/her fall and to use the bed bar... I believe the family is trying to get a hospital bed to keep him/her safe."	N 383		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure 1 of 1 resident reviewed (Resident 1) received all prescribed medications in the dosages and at intervals prescribed by a practitioner. Between September 9, 2024, and September 22, 2024, Resident 1 missed 5 of 42	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 415	Continued From page 8 doses of codeine 300 milligram (mg) tablets. Findings Include: On 08/23/2024, the Department received a complaint indicating a resident was not receiving medication in accordance with physician's orders. On 09/24/2024 at approximately 11:15 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 06/26/2024. The provider managed and administered all Resident 1's medication. Resident 1's medical record contained orders for codeine 300 milligram (mg) tablet, three times a day. The order indicated, "APAP (acetaminophen)/ Codeine #3 (300/30 mg) tab (tablet). Take 2 tablets by mouth four times daily for pain. *PT (patient) may refuse if pain doesn't warrant med. Staff may withhold if PT sleeping or sedated* [sic] (Max (maximum) of acetaminophen 3000 mg/24hr (hour))." On 09/24/2024 at approximately 11:25 a.m., Surveyor reviewed Resident 1's September 9, 2024, to September 22, 2024, electronic Medication Administration Record (MAR), and identified the following: Codeine 300 mg tablet was not initialed as given at 8:00 a.m. on 09/13/2024. Resident 1 missed one of fourteen 8:00 a.m. doses. Codeine 300 mg tablet was not initialed as given at 2:00 p.m. on 09/10/2024 and 9/21/2024. Resident 1 missed two of fourteen 2:00 p.m. doses. Codeine 300 mg tablet was not initialed as given	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 415	Continued From page 9 at 8:00 p.m. on 09/17/2024 and 9/21/2024. Resident 1 missed two of fourteen 8:00 p.m. doses. On 09/24/2024 at 2:40 p.m., Surveyor interviewed Lead Supervisor (LS) B about medication times not initialed. LS B confirmed, "That's a medication error, if it's not signed or noted." On 09/24/2024 at 2:45 p.m., Surveyor interviewed Caregiver C, who confirmed when a box is left empty on the MAR, the medication was either not given or not signed out. S/He stated LS B and Nurse (RN) M audited the medications. On 09/24/2024 at 2:50 p.m., Surveyor interviewed Co-Licensee A, who confirmed, "The caregivers should have documented in those empty spots." Co-Licensee A confirmed s/he or one of the other licensees audit the MARs. Co-Licensee A stated, "I don't know what happened. That's a medication error. We have some training to do." On 10/01/2024 at 2:05 p.m., Surveyor interviewed RN M, who confirmed Co-Licensee H monitored the MARs. RN M stated, "I only discuss medication errors at the monthly staff meetings."	N 415		
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	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 525	Continued From page 10	N 525		

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 fire drills at least quarterly with both employees and residents in 2022 and 2023. The provider did not ensure 7 of 8 required evacuation fire drills were conducted, with at least one annual fire evacuation drill that simulated the conditions during usual sleep hours.

This is a repeat deficiency. See Statement of Deficiency YKVC11 dated 08/19/2021.

Findings include:

On 09/24/2024 at approximately 12:30 p.m., Surveyor reviewed the provider's documentation of fire drills, with at least one annual fire evacuation drill that simulated the conditions during usual sleep hours for 2022 and 2023.

Surveyor observed one documented fire drill dated 02/16/2023 at 10:00 a.m. for 2022 and 2023.

On 09/24/2024 at 12:45 p.m., Surveyor interviewed Lead Supervisor (LS) B, who confirmed s/he was unable to find documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 525	Continued From page 11 of any fire drills conducted in 2022 and 2023.	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 document evacuation drills, such as tornado, flooding or other emergency or disaster, at least semi-annually for 2 of 2 years reviewed (2022 and 2023). This is a repeat deficiency. See Statement of Deficiency YKVC11 dated 08/19/2021. Findings include: On 09/24/2024 at approximately 12:30 p.m., Surveyor reviewed the provider's documentation of evacuation drills, including tornado, flooding or other emergency or disaster for 2022 and 2023. Surveyor observed no documented evidence of other emergency or evacuation drills for 2022 and 2023. On 09/24/2024 at 12:40 p.m., Surveyor interviewed Lead Supervisor (LS) B, who confirmed s/he was unable to find documentation of any other evacuation drills conducted in 2022 and 2023.	N 526		
N 631	83.59(1)(a) Class AS, ANA, CS, CNA 2 grade level exits	N 631		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 631	Continued From page 12 All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Class AS, class ANA, class CS and class CNA CBRFs shall have at least 2 grade level or ramped exits to grade. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the Community Based Residential Facility (CBRF) had at least 2 exits providing unobstructed travel to the outside for 1 of 2 exits. The back ramp exit was obstructed by a pellet grill/smoker. Findings include: Maranatha House Potomac is a class CNA (non-ambulatory) facility that can serve up to eight residents with primary diagnoses that include but are not limited to advanced age, irreversible dementia/Alzheimer's, developmentally disabled, emotionally disturbed/mental illness, traumatic brain injury and/or physically disabled. On 09/24/2024 at approximately 11:55 a.m., Surveyor toured the CBRF. Surveyor observed two ramped exits from the home. On 09/24/2024 at approximately 11:58 a.m., Surveyor observed the back exit obstructed by a pellet grill/smoker that extended approximately 26 inches across the width of the exit ramp (Photo 003). Surveyor toured the CBRF again at 2:20 p.m., and at 4:46 p.m. The grill was still	N 631		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016332	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA HOUSE POTOMAC (THE)	7901 W POTOMAC 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
N 631	Continued From page 13 obstructing the exit ramp (Photo 006 and Photo 007). On 09/24/2024 at approximately 4:45 p.m. Surveyor interviewed Co-Licensee A. Surveyor showed Co-Licensee A the secondary exit. S/He confirmed the exit was obstructed by a pellet grill/smoker. Co-Licensee A attempted to move the grill/smoker and stated it was heavy. Surveyor asked Co-Licensee A what would happen if there was a fire by the other ramped exit and how would the residents safely exit the facility. Co-Licensee A stated s/he understood the importance of keeping all exits cleared in the event residents needed to evacuate the CBRF. Co-Licensee A stated, "I don't know who did that. Obviously, that's not supposed to be there."	N 631		