STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012325	A. BUILDING: _____ B. WING _____	R-C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRU GROUP HOME INC BROWN DEER MANOI	8238 N 44TH ST BROWN DEER, WI 53209

(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 08/01/2023, Surveyor completed a verification visit and a complaint investigation at CRU Group Home Inc. Brown Deer Manor. As a result, 7 deficiencies were identified. Six of the 7 deficiencies were repeat violations. See Statement of Deficiency (SOD) H4X911, dated 04/22/2021, and SOD KJ5Z11, dated 01/25/2023. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 7	{N 000}		
{N 355}	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents had the opportunity to serve themselves food and beverage on their own for 1 of 1 resident. Resident 1 was not allowed to obtain her/his own snack or drink. Resident 1 was not allowed in the kitchen or in the refrigerator. This is a repeat deficiency. See Statement of Deficiency KJ5Z11, dated 01/25/2023. Findings include:	{N 355}		

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

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{N 355}	Continued From page 1 On 07/26/2023, at 10:23 AM, Surveyor observed a sign on the kitchen cabinet which stated, "Stop No Residents Allowed In the Kitchen Cabinet or Refrigerator." On 01/04/2023, at 11:15 AM, Surveyor interviewed Caregiver E. Caregiver E confirmed staff did not allow residents into the kitchen of the home. Caregiver E reported s/he had worked for the company since May 2022 and residents were not allowed since s/he started. Caregiver E stated s/he believed residents were not allowed in the kitchen because they might hurt themselves if they were near the stove, and believed they were not allowed in the refrigerator because they may take something that did not belong to them. On 07/26/2023, at 10:25, Surveyor interviewed Resident 3. Resident 3 confirmed s/he had to ask staff for a snack or something to drink. Staff would tell him/her the residents were not allowed in the kitchen Resident 3 stated, "Drives me crazy. A [Resident 3's age] has to ask for Kool-Aid." On 08/01/2023, at 9:00 AM, Surveyor interviewed Operations Manager (OM) B. OM B reported the sign was removed after the last survey and s/he was not aware it was put up again. OM B stated, "They took it down ...I don't know why it's up. I'll have to ask [House Manager D]."	{N 355}		
{N 406}	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued,	{N 406}		

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{N 406}	Continued From page 2	{N 406}		

the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure every prescription medication was stored as specified by the manufacturer for 2 of 2 residents. Resident 1 and Resident 3 required insulin and their in-use insulin pens were not disposed of after the expiration date.

This is a repeat deficiency. See Statement of Deficiency KJ5Z11, dated 01/25/2023.

Findings include:

On 07/26/10:00 AM, Surveyor observed the medication cabinet. There were 2 containers with open, in-use insulin pens past the expiration date. Resident 1's Humalog insulin pen contained an

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{N 406}	Continued From page 3 expiration date of 07/13/2023. Resident 3's Novolog insulin pen contained an expiration date of 07/21/2023. "...Insulin is available from the drug manufacturers in two basic packages-vials and pens. General insulin storage requirements are as follows...5. Check Storage guideline specific to the insulin formulation. This is usually in the product package insert...The following tables address specific expiration or beyond-use dating guidelines that apply to insulin products...Insulin storage for Pens...Novolog insulin pen: label expiration date 28 days when seal is punctured... Humalog insulin pen: label expiration date 28 days when seal is punctured..." (DQA Publication-01904, Insulin Storage Guide, 06/2023) On 07/26/2023, at 10:45 AM, Surveyor interviewed Caregiver E regarding the in-use insulin pens. Caregiver E reported when s/he opened a new insulin pen, s/he wrote the date s/he opened it and the expiration date on the pen. Caregiver E confirmed Resident 1 and Resident 3's in-use insulin pens were past the written expiration date. Caregiver E did not know why the pens were not discarded and would discard the expired pens. On 08/01/2023, at 10:00 AM, Surveyor interviewed Operations Manager (OM) B. OM B confirmed the insulin pens were to be discarded after expiration date. OM B reported s/he did not know why staff did not discard the pens. Surveyor inquired if audits were completed of the residents' medications. OM B reported the nursing staff conducted medication audits, "about once a week." OM B reported s/he would follow up with the staff.	{N 406}		

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{N 406}	Continued From page 4 On 08/01/2023, at 12:30 PM, Surveyor interviewed Registered Nurse (RN) N regarding the insulin pens. RN N reported s/he completed weekly checks on blood sugar monitoring and if any diabetic supplies were needed. RN N reported s/he was in process of implementing a new system for medication oversight. RN N reported the house managers would be included in the audit process.	{N 406}		
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 staff interview, the provider did not ensure each person administering medications to residents, initialed the medication administration record to identify the name, dosage, date, and time each medication administered for 1 of 1 resident. Resident 3's medication administration record (MAR) for June 2023 and July 2023 were missing staff initials from multiple administration dates for	N 415		

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N 415	Continued From page 5 Resident 3's prescribed medication. Findings include: On 08/01/2023, at 8:00 AM, Surveyor reviewed Resident 3's record and identified the following: Resident 3 was admitted on 01/13/2022. Resident 3's individual service plan, dated 06/24/2023, identified Resident 3 required staff administration of medications. Resident 3's MARs for June 2023 and July 2023, indicated the following: Aspirin 81 milligrams (mg) daily- missed documentation on 06/01/2023, 06/02/2023, 06/05/2023, 06/16/2023, 06/19/2023, 06/22/2023, 06/24/2023, 06/29/2022, 07/05/2023, 07/07/2023, 07/19/2023, 07/20/2023, 07/22/2023, and 07/26/2023. Total of 14 missed documentation doses. Atorvastatin 20 mg daily- missed documentation on 06/01/2023, 06/11/2023, 06/13/2023, 06/14/2023, 06/15/2023, 06/16/2023, 06/21/2023, 06/29/2023, 07/12/2023, 07/17/2023, 07/19/2023, 07/20/2023, and 07/25/2023. Total of 13 missed documentation doses. Clopidogrel 75 mg daily- missed documentation on 06/01/2023, 06/02/2023, 06/05/2023, 06/16/2023, 06/19/2023, 06/22/2023, 06/24/2023, 06/29/2023, 07/05/2023, 07/07/2023, 07/19/2023, 07/20/2023, 07/22/2023, and 07/26/2023. Total of 14 missed documentation doses. Lisinopril 40 mg daily- missed documentation on 06/01/2023, 06/02/2023, 06/05/2023, 06/16/2023, 06/19/2023, 06/22/2023, 06/24/2023, 06/29/2023,	N 415		

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N 415	Continued From page 6 07/05/2023, 07/07/2023, 07/19/2023, 07/20/2023, 07/22/2023, and 07/26/2023. Total of 14 missed documentation doses. Novolog flex pen sliding scale insulin 3 times per day: 8:00 AM dose- missed documentation on 06/01/2023, 06/05/2023, 06/14/2023, 06/16/2023, 06/19/2023, 06/22/2023, 06/24/2023, 06/29/2023, 07/04/2023, 07/07/2023, 07/08/2023, 07/19/2023, 07/20/2023, 07/22/2023, and 07/26/2023. Noon dose- missed documentation on 06/14/2023, 06/18/2023, 07/09/2023, 07/18/2023, 07/19/2023, 07/20/2023, 07/21/2023, and 07/25/2023. 4:00 PM dose- missed documentation on 06/01/2023, 06/05/2023, 06/14/2023, 06/16/2023, 06/19/2023, 06/22/2023, 06/24/2023, 06/29/2023, 07/11/2023, 07/12/2023, 07/14/2023, 07/16/2023, 07/17/2023, 07/18/2023, 07/19/2023, 07/20/2023, 07/21/2023, and 07/25/2023. Total of 41 missed documentation doses. Oxybutynin extended release 10 mg daily- missed documentation on 06/01/2023, 06/02/2023, 06/05/2023, 06/14/2023, 06/16/2023, 06/19/2023, 06/22/2023, 06/24/2023, 06/29/2023, 07/02/2023, 07/05/2023, 07/07/2023, 07/19/2023, 07/20/2023, and 07/22/2023. Total of 15 missed documentation doses. Vitamin D2 50,000 units, weekly on Tuesday- missed documentation on 06/05/2023. Gabapentin 100 mg twice daily: 8:00 AM dose- missed documentation on 06/01/2023, 06/02/2023, 06/05/2023, 06/14/2023, 06/16/2023, 06/19/2023, 06/22/2023, 06/24/2023, 06/29/2023, 07/05/2023, 07/07/2023, 07/19/2023, 07/20/2023, 07/22/2023, and 07/26/2023.	N 415		

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8:00 PM dose- missed documentation on 06/01/2023, 06/11/2023, 06/13/2023, 06/14/2023, 06/15/2023, 06/16/2023, 06/21/2023, 06/29/2023, 07/12/2023, 07/17/2023, 07/19/2023, 07/20/2023, and 07/25/2023.
Total of 28 missed documentation doses.

Potassium chloride 20 milliequivalents (meq) daily- missed documentation on 6/01/2023, 06/02/2023, 06/05/2023, 06/14/2023, 06/16/2023, 06/19/2023, 06/22/2023, 06/24/2023, 06/29/2023, 07/02/2023, 07/05/2023, 07/07/2023, 07/19/2023, 07/20/2023, 07/22/2023, and 07/26/2023.
Total of 16 missed documentation doses.

Sertraline 25 mg daily- missed documentation on 06/01/2023, 06/02/2023, 06/05/2023, 06/10/2023, 06/14/2023, 06/16/2023, 06/18/2023, 06/19/2023, 06/22/2023, 06/23/2023, 06/29/2023, 07/05/2023, 07/07/2023, 07/19/2023, 07/20/2023, 07/22/2023, 07/23/2023, and 07/26/2023.
Total of 18 missed documentation doses.

Acetaminophen 1000 mg twice daily:
8:00 AM dose- missed documentation on 06/01/2023, 06/02/2023, 06/05/2023, 06/16/2023, 06/19/2023, 06/22/2023, 06/24/2023, 06/29/2023, 07/07/2023, 07/19/2023, 07/20/2023, 07/22/2023, and 07/26/2023.
8:00 PM dose- missed documentation on 06/01/2023, 06/11/2023, 06/13/2023, 06/14/2023, 06/15/2023, 06/16/2023, 06/29/2023, 07/12/2023, 07/17/2023, 07/19/2023, 07/20/2023, and 07/25/2023.
Total of 25 missed documentation doses.

Glimepiride 2 mg daily- missed documentation on 06/01/2023, 06/02/2023, 06/05/2023, 06/16/2023, 06/19/2023, 06/22/2023, 06/24/2023, 06/29/2023, 07/05/2023, 07/07/2023, 07/19/2023, 07/20/2023,

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N 415	Continued From page 8 07/22/2023, 07/26/2023. Total of 14 missed documentation doses. Lantus Solostar pen- twice daily 8:00 AM dose- 06/01/2023, and 06/05/2023. 8:00 PM dose- 06/01/2023, 06/11/2023, 06/13/2023, 06/14/2023 and 06/15/2023. Total of 7 missed documentation doses. On 08/01/2023, at 12:30 PM, Surveyor interviewed Registered Nurse (RN) N. RN N reported some staff had difficulty with completing documentation since the implementation of the electronic medication record keeping system. RN N reported s/he was working on implementing new safeguards regarding medication administration and documentation. RN N reported the new medication documentation system alerted house managers if the prescribed medication was not initialed by staff at the time of administration.	N 415		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 medication cabinet was locked and the key was available only to personnel who passed medications. This is a repeat deficiency. See Statement of Deficiency H4X911, dated 04/22/2021. Findings include:	N 419		

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N 419	Continued From page 9 On 07/26/2023, at 10:00 AM, Surveyor observed residents' medications were stored in a cabinet located in the kitchen. The cabinet was equipped with a key locking mechanism, which was not engaged. Surveyor opened the door and observed 7 bins of medications. The cabinet contained medications for all 7 residents in the home. Medications included: acetaminophen 325 milligrams (mg), acetaminophen extended release 650 mg, Advair, alendronate 35 mg, allopurinol 100 mg, amlodipine 5 mg, atorvastatin 20 mg, atorvastatin 40 mg, aspirin chew 81 mg, aspirin 325 mg, buspirone 3 mg, calcium 600 mg, carvedilol 12.5 mg, Cerovite Senior, clopidogrel 75 mg, doxazosin 2 mg, escitalopram 20 mg, folic acid 1 mg, gabapentin 300 mg, Latuda 80 mg, lisinopril 10 mg, lisinopril 20 mg, lisinopril 40 mg, levetiracetam 500 mg, melatonin 3 mg, meloxicam 7.5 mg, meloxicam 15 mg, metoprolol tartrate 50 mg, metformin 500 mg, mirtazapine 30 mg, omeprazole 20 mg, oxcarbazepine 300 mg, pantoprazole 40 mg, pravastatin 20 mg, pregabalin 50 mg, quetiapine 25 mg, Rexulti 3 mg, risperidone 3 mg, Robafen cough syrup, senna-s 8.6-50 mg, sertraline 100 mg, Siltussin cough syrup, vitamin B12 1000 micrograms (mcg), vitamin C 500 mg, vitamin D3 2000 international units, and vitamin D3 25 mcg. While at the facility, Surveyor observed 2 residents and a visitor moving freely throughout the facility, including where the medication cabinet was located. On 07/26/2023, at 9:55 AM, Surveyor interviewed Caregiver E regarding the medication cabinet. Caregiver E reported s/he did not administer morning medications to the residents, the night	N 419		

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N 419	Continued From page 10 shift staff administered the medications. Caregiver E reported residents received medications and breakfast at approximately 7:20 AM. On 08/01/2023, at 10:00 AM, Surveyor interviewed Operations Manager (OM) B regarding the medication cabinet being unlocked. OM B confirmed the medication cabinet was to be locked. OM B reported s/he provided reminders "all the time" for staff to check the cabinet at the start of their shift, throughout the shift and at the end. On 08/01/2023, at 12:30 PM, Surveyor interviewed Registered Nurse (RN) N. RN N reported s/he was requesting locks that automatically locked when staff closed the door.	N 419		
{N 420}	83.37(3)(d) Medication storage: refrigeration Refrigeration. Medications stored in a common refrigerator shall be properly labeled and stored in a locked box. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all medications stored in 1 of 1 common refrigerator, were securely stored. Resident 3's, Resident 5's, and Resident 7's prescription eye drops were in an unlocked bag in the refrigerator. This is being cited for the third time. See Statement of Deficiency (SOD) H4X911, dated 04/22/2021, and SOD KJ5Z11, dated 01/25/2023. Findings include:	{N 420}		

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{N 420}	Continued From page 11 On 07/26/2023, at 9:15 AM, Surveyor observed a black bag stored on the bottom shelf of the common refrigerator. The black bag contained a zipper and locking device, which was not engaged. Surveyor observed 5 bottles of latanoprost eye drops tabled with Resident 3's, Resident 5's, and Resident 7's names. While at the facility, Surveyor observed 2 residents and a visitor moving freely throughout the facility, including where the refrigerator was located. On 07/26/2023, at 10:25 AM, Surveyor interviewed Caregiver E regarding the unlocked medication bag in the common refrigerator. Caregiver E reported s/he was unaware the medication bag was not locked. Caregiver E reported s/he did not administer resident eye drops on her/his shift. On 08/01/2023, at 10:00 AM, Surveyor interviewed Operations Manager (OM) B. OM B confirmed all medications were to be securely stored. OM B reported s/he was not aware of the medication bag in the common refrigerator. OM B reported s/he did not know why the medication bag was not locked. OM B reported s/he provided reminders to staff "all the time" to keep all medications locked up. On 08/01/2023, at 12:30 PM, Surveyor interviewed Registered Nurse (RN) N. RN N reported s/he did not know where the key for the lock was. RN N reported s/he would purchase a new medication bag.	{N 420}		
{N 426}	83.38(1)(b) Supervision.	{N 426}		

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	0012325	A. BUILDING: _____ B. WING _____	R-C 08/01/2023

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{N 426}	Continued From page 12 As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all residents received the supervision identified in their Individual Service Plans (ISPs) for 6 of 7 residents. A former caregiver left residents, who required supervision, unattended. Former Caregiver (FC) O left Residents 1, 3, 4, 5, 6, and 7 unattended on 06/10/2023, from approximately 11:18 PM until 5:15 AM, when House Manager (HM) D arrived. Some residents required 24-hour supervision and cares throughout the night. This is a repeat deficiency. See Statement of Deficiency KJ5Z11, dated 01/25/2023. Findings include: On 06/29/2023, the department received a complaint alleging residents were alone between approximately 11:30 PM and 5:00 AM on 06/10/2023. On 06/13/2023, Operations Manager (OM) B submitted a self-report which identified FC O left	{N 426}		

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{N 426}	Continued From page 13	{N 426}		

the residents before the next shift caregiver arrived. A resident at the facility called the police department. House Manager (HM) D was notified there was no staff at the home. FC O was terminated as a result of his/her actions.

On 07/26//2023, Surveyor reviewed Brown Deer Police Department Incident Report Number 23-006991, dated 06/10/2023, authored by responding Police Officer P. The police report stated, "On 06/09/2023, [FC O] was on-duty as a caregiver at the Brown Deer Manor Group Home when [s/he] left the facility for approximately six hours without being relieved by another caregiver. [FC O] left seven adults who have various physical and cognitive disabilities home alone without any caregivers or responsible adults to care for them. This case will be referred to the Milwaukee County District Attorney's Office for charging considerations."

On 07/27/2023, at approximately 12:00 PM, Surveyor reviewed resident records and identified the following:
-Resident 1 was admitted on 11/29/2021. Resident 1's ISP, dated 04/14/2023, identified Resident 1 required 24-hour supervision.
-Resident 3 was admitted on 01/11/2022. Resident 3's ISP, dated 06/24/2023, identified Resident 3 required 24-hour supervision.
-Resident 4 was admitted on 03/27/2009. Resident 4's ISP, dated 04/26/2023, identified Resident 4 required 24-hour supervision and total assistance for all activities of daily living. Resident 4's check and change schedule was identified as daily at 10:00 PM, 2:00 AM, and 6:00 AM and toileting as needed to remain clean and dry.
-Resident 5 was admitted on 09/30/2020. Resident 5's ISP, dated 03/28/2023, identified Resident 5 required 24-hour supervision and total

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{N 426}	Continued From page 14	{N 426}		

assistance for all activities of daily living. Resident 5's check and change schedule was identified as daily at 10:00 PM, 2:00 AM, and 6:00 AM and toileting as needed to remain clean and dry.
-Resident 6 was admitted on 03/05/2019. Resident 6's ISP, dated 04/29/2023, identified Resident 6 required 24-hour supervision.
-Resident 7 was admitted on 09/13/2017. Resident 7's ISP, dated 03/31/2023, identified Resident 7 required "some supervision" but did not specify what some supervision was for. Resident 7 required repositioning and changes daily at 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 AM, 4:00 PM, 6:00 PM, 8:00 PM, and 10:00 PM. Resident 7 had a history of pressure ulcers and positioning every 2 hours was required to prevent further pressure ulcers from developing and promote healing.

On 07/26/2023, at 11:30 AM, Surveyor interviewed HM D. HM D reported Resident 4 and Resident 5 required checks every 2 hours for any incontinence concerns. HM D confirmed the checks were not completed on 06/10/2023 from approximately 11:30 PM until 5:15 AM when HM D arrived. HM D reported when s/he came in that morning, s/he immediately assessed the residents for any health and safety concerns. HM D reported all residents were safe when s/he arrived at the facility on 06/10/2023, at approximately 5:15 AM. HM D confirmed FC O left his/her shift before the next shift arrived and was terminated as a result.

On 08/01/2023, at 10:00 AM, Surveyor interviewed OM B. OM B confirmed FC O left the residents alone on 06/10/2023. OM B reported FCO never called to inform management the 3rd shift caregiver had not arrived. OM B reported FC

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{N 426}	Continued From page 15 O reported s/he left when "a car pulled up" to the driveway. OM B reported the cameras on the outside of the facility indicated there was not car and FC O left at 11:18 PM. OM B confirmed staff were required to be present and awake for all residents in the home. OM B stated, "They need a lot of care in that house. We'd never leave them alone." OM B reported FC O was terminated. OM B reported verbal reminders were provided to the staff. OM B reminded staff to call if a caregiver did not arrive for the next shift.	{N 426}		
{N 639}	83.59(2)(a) One-hand, one-motion door operation All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 3 exterior doors were able to be opened from the inside with a one-hand, one-motion (OHOM) operation without having to turn the locks on the doors to disengage the lock, affecting 7 of 7 residents residing in the facility. This is a repeat deficiency. See Statement of Deficiency KJ5Z11, dated 01/25/2023. Findings include: On 07/26/2023, between 9:20 AM and 9:30 AM, Surveyor observed levered door handles on the west exit (main entrance) and the southeast exit (dining room) of the facility. The levered door handles contained a turn lock button on the handle. Surveyor engaged the lock on the west exit (main	{N 639}		

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{N 639}	Continued From page 16 door) and attempted to open the door by pushing on the handle. The lock did not disengage, and the door did not open. The exit door was not equipped with OHOM latching hardware. Surveyor engaged the lock on the southeast exit (dining room) and attempted to open the door by pushing on the handle. The lock did not disengage, and the door did not open. The exit door was not equipped with OHOM latching hardware. On 07/26/2023, at 9:35 AM, Surveyor interviewed Administrator A. Administrator A confirmed s/he received the SOD KJ5Z11, which identified the OHOM deficiency. Administrator A reported s/he was experiencing staffing issues; however, "most items were corrected."	{N 639}		