STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015632	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY COURT ASSISTED LIVING I	2230 14TH ST SOUTH WISCONSIN RAPIDS, WI 54494

(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 06/21/2024, Surveyor conducted a complaint, self-report, and abbreviated survey at Cranberry Court Assisted Living I. The complaint was substantiated. Nine deficiencies were identified. Two of the 9 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) TZ2H11, dated 01/03/2019; and SOD 6MII11, dated 06/05/2023. Census: 19	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in	N 239		

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

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N 239	Continued From page 1 medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 4 employees obtained all department approved training as required. Caregiver E did not have training in fire safety within 90 days after starting employment. Findings include: On 06/21/2024, Surveyor conducted a review of 4 employees to verify compliance with department approved training requirements. Surveyor requested training records from Business manager (BM) D for Caregiver E, Caregiver F, Caregiver G, and Caregiver H. The record for Caregiver E, hired 08/29/2022, did not contain evidence of training, or evidence of meeting an exemption for, fire safety. On 06/21/2024, at approximately 2:30 p.m., Surveyor interviewed BM D. BM D confirmed the provider did not have evidence Caregiver E completed or met an exemption for fire safety training. On 06/21/2024, Surveyor verified Caregiver E was not on the Community-Based Care and Treatment training registry for fire safety. On 06/21/2024 at approximately 4:30 p.m.,	N 239		

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N 239	Continued From page 2 Surveyor conducted an interview with Director of Operations (DO) B, Wellness Director C, and BM D, with Administrator A attending by phone. Surveyor reviewed exemptions for required training with the management team. Caregiver E was currently enrolled in a nursing program and was exempt from all other department approved training but s/he did not have an exemption for fire safety training. DO B told Surveyor s/he would get Caregiver E enrolled in fire safety training next week.	N 239		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not develop a comprehensive individual service plan (ISP) that identified the mobility needs for 1 of 1 resident reviewed that required the use of a Hoyer lift (mechanical lift).	N 386		

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N 386	Continued From page 3 Resident 1's ISP did not specify methods for delivering needed care and who was responsible for delivering the care related to Resident 1's mobility. This is a repeat deficiency. See Statement of Deficiency 6MII11, dated 06/05/2023. Findings include: On 06/21/2024 at 10:15 a.m., Surveyor observed Resident 1's room. There was a Hoyer lift in his/her room. On 06/21/2024, Surveyor reviewed Resident 1's ISP. The ISP's last review date of 03/11/2024, indicated the following goal: "Resident assistive device needs will be met per resident choice and as indicated on the individual service plan. Date Initiated: 12/08/2023." The "Interventions/Tasks" read: "Hospital bed, walker, wheelchair, hoyer [sic] lift, bed against wall. Date initiated: 12/08/2023. Revision on: 03/11/2024." The ISP did not indicate Resident 1's mobility status. The ISP indicated s/he had an assistive device of a walker and a Hoyer mechanical lift. It did not include the method of delivering the care of these assistive devices or who was responsible for delivering the care. On 06/21/2024 at approximately 4:15 p.m., Surveyor interviewed Director of Operations B, Wellness Director C, Business Manager D, and Administrator A, who was on the phone. Surveyor asked if staff operated the Hoyer lift with 1 or 2 staff members. Administrator A told Surveyor they do not specify in the resident's ISP	N 386		

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N 386	Continued From page 4 if they need 1 or 2 staff to operate a Hoyer lift. Resident 1's ISP was not comprehensive as it did not include his/her mobility status, methods for delivering care related to his/her mobility status, and who was responsible for delivering the care related to his/her mobility status. His/her ISP indicated Resident 1 had a walker and also a Hoyer mechanical lift. The ISP did not specify how staff were to use these devices or when they should use these devices.	N 386		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not implement Resident 5's individual service plan (ISP). Resident 5 did not receive continuous oxygen as required in his/her ISP. Findings include: On 06/21/2024 at approximately 11:40 a.m., Surveyor interviewed Registered Nurse (RN) K and Licensed Practical Nurse (LPN) L. RN K and LPN L worked for hospice and provided services for Resident 5. RN K and LPN L told Surveyor the last 4 times they were in the facility, Resident 5's oxygen tank was empty. Surveyor observed Resident 5 with RN K. Resident 5 was seated at the dining room table having lunch. S/he had an oxygen tank behind his/her wheelchair with a nasal cannula in. RN K told Surveyor the tank	N 388		

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N 388	Continued From page 5 was completely empty. S/he removed the tank from the regulator and went to retrieve a new oxygen tank. On 06/21/2024, Surveyor reviewed Resident 5's ISP, with a review date of 03/29/2024. The ISP indicated the following: Resident 5 diagnoses including dementia, congestive heart failure, chronic obstructive pulmonary disease, and shortness of breath. His/her oxygen therapy was initiated on 10/12/2022, with the following goals: "The resident will receive Oxygen [sic] equipment from desired source and have continued, uninterrupted support of equipment through review date. The resident will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern. The resident will have no complications related to SOB (shortness of breath) through review date." The following interventions and tasks were listed: "Oxygen at 3-5L/m (liters per minute) via nasal cannula continuous... Oxygen therapy routinely per MD (medical doctor) direction... Monitor for changes in skin color and SOB... Oxygen ordered through: [name] Hospice... Oxygen Management: continuous oxygen at 3 - 5L/m via nasal cannula." The provider did not ensure Resident 5 received oxygen continuously.	N 388		
N 396	83.36(1)(a) Adequate staff to meet resident needs.	N 396		

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N 396	Continued From page 6 The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not provide employees in sufficient numbers, on a 24-hour basis, to meet the needs of all residents. Resident 1 required the use of a mechanical lift, also known as a Hoyer lift, for transfers. Employees were trained to use the Hoyer lift with 2 staff. The provider did not ensure there were 2 staff members present on a 24-hour basis. Findings include: The provider is licensed as a Class C non-ambulatory (CNA) facility to care for up to 20 residents in the client groups of: advanced age, developmentally disabled, irreversible dementia/Alzheimer's disease, physically disabled, terminally ill, and emotionally disturbed/mental illness. On the day of survey, 06/21/2024, there were 19 residents. On 06/21/2024, Surveyor reviewed the employee schedule, which indicated there was 1 caregiver per shift and at times a 2nd caregiver from 7:00 a.m. - 9:00 a.m. and from 7:00 p.m. - 9:00 p.m. On 06/21/2024 at 10:15 a.m., Surveyor observed Resident 1's room. There was a Hoyer lift in his/her room. On 06/21/2024 at approximately 10:55 a.m., Surveyor interviewed Caregiver I. Caregiver I told Surveyor the staffing pattern was 1 person	N 396		

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N 396	Continued From page 7	N 396		

per shift and "sometimes" a caregiver from 7:00 a.m. - 9:00 a.m. and from 7:00 p.m. - 9:00 p.m. Surveyor asked Caregiver I if any of the residents required the assistance of 2 staff members. Caregiver I told Surveyor Resident 1 required the use of a Hoyer lift for transfers. Caregiver I told Surveyor, "Per policy" you are supposed to have 2 staff to operate the Hoyer lift.

On 06/21/2024 at approximately 12:05 p.m., Surveyor interviewed Business Manager (BM) D. BM D told Surveyor there was 1 caregiver per shift other than the "short shift." Surveyor clarified the short shift were the 7:00 a.m. - 9:00 a.m. and 7:00 p.m. - 9:00 p.m. timeframes. Surveyor reviewed the employee schedule with BM D and s/he verified there was no staff on the schedule for the short shift that day.

On 06/21/2024 at 12:45 p.m., Wellness Director (WD) C provided Surveyor with the transfer status for each resident. Resident 1 was identified as requiring the use of a Hoyer lift. Resident 3, Resident 8, Resident 9, and Resident 10 were identified as requiring the use of a mechanical E-Z Stand lift. Surveyor requested the provider's policy and procedure on operating the mechanical lifts.

On 06/21/2024, Surveyor reviewed Resident 1's individual service plan (ISP). His/her ISP (last review date 03/11/2024) indicated the following goal: "Resident assistive device needs will be met per resident choice and as indicated on the individual service plan. Date Initiated: 12/08/2023." The "Interventions/Tasks" read: "Hospital bed, walker, wheelchair, hoyer [sic] lift, bed against wall. Date initiated: 12/08/2023.

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N 396	Continued From page 8 Revision on: 03/11/2024." On 06/21/2024 at approximately 4:00 p.m., WD C provided Surveyor with their policy on mechanical lifts. The policy read: "Section: Wellness Subject: Mechanical Lift Policy: It is the policy of this community to transfer residents safely with the use of a mechanical lift. Procedure: 1) Each resident that is no longer able to transfer with staff assist, shall be assessed by therapy for the most appropriate means of transfer, which may include a mechanical lift. 2) Once type of lift has been determined and delivered to community with appropriate sling, staff to use lift to transfer resident as needed. 3) Staff to be trained on mechanical lifts as needed. 4) Resident's ISP shall be updated with transfer method to be used." On 06/21/2024 at approximately 4:05 p.m., Surveyor interviewed WD C and Director of Operations (DO) B and explained Surveyor requested the policies specific to the Hoyer lift and E-Z stand lifts. WD C said s/he reached out to Clinical Market Leader J and this is the policy that they have. Surveyor asked how staff knew how to use the Hoyer lift and E-Z stand.. Administrator A said they do skills check off sheets after they complete their training. WD C checks off their skill sheet, which includes the use of mechanical lifts. On 06/21/2024 at approximately 4:15 p.m., Surveyor interviewed DO B, WD C, BM D, and Administrator A, who was on the phone.	N 396		

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N 396	Continued From page 9 Surveyor explained the regulation that if a resident required 2 staff to meet their needs, then 2 staff need to be available on a 24-hour basis. Administrator A told Surveyor they do not specify in the resident's ISP if they need 1 or 2 staff. Surveyor asked how staff were supposed to use the Hoyer lift. Administrator A told Surveyor it was not recommended for staff to use the Hoyer lift alone and it was "best practice" to have 2 staff members use the Hoyer lift. Surveyor asked WD C if staff were ever trained on how to operate the Hoyer lift with only 1 person. WD C told Surveyor staff were "never" trained to do a Hoyer lift alone. The provider trained staff to operate a Hoyer lift with 2 staff. They did not train staff to operate a Hoyer lift alone. Resident 1 required assistance with a Hoyer lift. The provider did not ensure there were 2 staff members present on a 24-hour basis to meet the needs of Resident 1. Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individual Service Plan	N 396		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve	N 397		

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N 397	Continued From page 10 the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a qualified resident care staff was present when Caregiver E worked alone in the facility. Caregiver E was not a qualified resident care staff as s/he did not complete all required training. Findings include: The provider is licensed as a Class C non-ambulatory (CNA) facility to care for up to 20 residents in the client groups of: advanced age, developmentally disabled, irreversible dementia/Alzheimer's disease, physically disabled, terminally ill, and emotionally disturbed/mental illness. On the day of survey, 06/21/2024, there were 19 residents. Wis. Admin. Code § DHS 83.02(42) reads: "Qualified resident care staff means an employee who has successfully completed all of the applicable training and orientation under subch. IV."	N 397		

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N 397	Continued From page 11 On 06/21/2024, Surveyor reviewed a sample of 4 employees for their required training. Caregiver E did not complete the Department approved fire safety training. On 006/21/2024, Surveyor reviewed the employee schedule from 05/01/2024 - 06/21/2024. Caregiver E was identified as working alone in the facility from 11:00 p.m. - 7:00 a.m. on the following dates: 05/23/2024 05/28/2024 05/30/2024 06/04/2024 06/06/2024 06/08/2024 06/09/2024 06/13/2024 06/18/2024 06/20/2024 On 06/21/2024 at approximately 4:30 p.m., Surveyor conducted an interview with Director of Operations (DO) B, Wellness Director C, Business Manager D, and Administrator A, who was on the phone. DO B told Surveyor Caregiver E worked casual hours as s/he was enrolled in a nursing program. S/he said s/he would get Caregiver E enrolled into fire safety training next week. Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individual Service Plan	N 397		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents	N 426		

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N 426	Continued From page 12 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 provide supervision adequate to meet the needs of all residents. Staff did not respond appropriately to a door alarm, which resulted in Resident 12 eloping from the facility. Findings include: On 03/11/2024, the Department received a self-report from the provider which indicated Resident 12 eloped from the facility on the morning of 03/01/2024. The report read as follows: "At approximately 0710 on 03/01/2024, staff [Caregiver Q, Caregiver R, Caregiver F] were unable to locate resident [Resident 12] in community. Staff observed right front door, near resident's room, was not secured. Staff began a search of the property and notified [Wellness Director C]. At 0718, [Police Officer (PO) T] with the Wisconsin Rapids Police Department contacted the community and spoke with [Business Manager (BM) U]. [PO T] stated non emergent call was placed at 0647 that [Resident	N 426		

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N 426	Continued From page 13	N 426		

12] had been found in the Lincoln High School parking lot, a block away from community ... [Resident 12] was transported to [Name] ED (emergency department) by [PO T]."

The police report read: "On March 1, 2024, at approximately 6:45 a.m., I [PO T], responded to Lincoln High School, 1801 16th Street South, in the City of Wisconsin Rapids, County of Wood, for a report of a welfare check. Upon arrival I made contact with [Resident 12] ... [Resident 12] stated [s/he] left [his/her] house on [name] because [s/he] was scared that someone was inside of [his/her] residence ... I asked [Resident 12] if [s/he] needed medical attention. [S/he] stated [s/he] did not want an ambulance. I asked [him/her] if [s/he] wanted to go to [hospital]. [S/he] stated yes. Please note that [Resident 12] was walking around outside of Lincoln High School for approximately one hour ..."

The police report indicated Resident 12 was walking around the high school for approximately 1 hour. PO T received a call at 6:45 a.m. If Resident 12 was walking around the school for approximately an hour that would have placed Resident 12 at the school at approximately 5:45 a.m. The provider did not recognize Resident 12 was missing until 7:10 a.m. This would have been approximately 1.5 hours since Resident 12 eloped. Lincoln High School was located approximately 1 block from the provider. Lincoln High School is located near State Highway 54, which is a divided 4 lane highway. According to https://www.wunderground.com/history/daily/us/wi/wisconsin-rapids/KCWA/date/2024-3-1, (Retrieved on 06/24/2024), on 03/01/2024 at approximately 6:00 a.m., it was 30 ° Fahrenheit outside.

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N 426	Continued From page 14 On 06/21/2024, Surveyor reviewed Resident 12's record. Resident 12 was admitted to the facility on 02/23/2024 with multiple diagnoses, including dementia with mild anxiety and adult failure to thrive. Resident 12 resided at the facility for 1 week prior to his/her elopement. On 06/21/2024, Surveyor reviewed the provider's investigation into Resident 12's elopement, which included the following email from Director of Operations (DO) B to the staff. The email, dated 03/01/2024, read: "This morning, a resident eloped while under our care. I want to issue some serious reminders to you all so that we can ensure the safety of our residents. 1. ALL door alarms are to be investigated immediately. Alarms should never be disengaged unless all residents are accounted for. 2. The specific individual who eloped is now on 15 minutes safety checks indefinitely. You MUST lay eyes on this resident and record [his/her] location at the time of each check. 3. All staff is expected to test the door alarms at the beginning of every shift (7am, 3pm, 11pm). You MUST call [WD C] at [number] and inform [him/her] the test was completed and that the alarms are in working order. 4. We will be scheduling elopement drills on every shift next week. If you have any questions or think you might need more training in an elopement situation, please reach out to me." On 06/21/2024 at approximately 3:20 p.m., Surveyor interviewed WD C about Resident 12's elopement. WD C told Surveyor Caregiver F	N 426		

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N 426	Continued From page 15 worked the night shift when Resident 12 eloped. S/he said the door to the outside was open slightly near Resident 12's room. This indicated Caregiver F disengaged the alarm without checking the door and did not ensure all residents were accounted for. Caregiver F was terminated and reported to the Department. They did re-education with all staff and increased Resident 12's safety checks to every 15 minutes. WD C told Surveyor Resident 12 did not have any further elopements. Resident 12 was on hospice and died on 03/24/2024.	N 426		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not keep all rooms clean and free from odors. Findings include: On 05/14/2024, the Department received a complaint with multiple allegations including: Dirty, soiled laundry was on the resident's floor as clean laundry remained in the laundry baskets not put away. Soiled incontinent briefs were left in garbage's causing odors. Bedding was soiled. On 06/21/2024 at 10:00 a.m., Surveyor entered the facility and noticed an odor of urine as soon as Surveyor entered the foyer. Surveyor met with the management team and then began touring the facility.	N 489		

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N 489	Continued From page 16 At 10:15 a.m., Surveyor observed Resident 1's room. There was soiled clothing in a laundry basket setting on the carpeted floor. (Photo 1). Resident 1's bed was not made and there were linens on the floor at the foot of his/her bed. (Photo 2). On 06/21/2024, Surveyor reviewed Resident 1's individual service plan (ISP), last reviewed 03/11/2024. The ISP read, in part: "Provide housekeeping service weekly and prn (as needed) ... Provide laundry service weekly and prn ... Pick up trash daily ... Daily Bed [sic] Making [sic]." At 10:20 a.m., Surveyor observed Resident 2's room. Resident 2 was present in the room. The room had a very strong odor in it. Resident 2 told Surveyor staff do not clean often enough. The bathroom in Resident 2's room had garbage scattered across the floor. There was a brown mark on the wall near the garbage can that looked like feces smeared on the wall. (Photo 3). The carpet in Resident 2's bedroom was visibly dirty and stained. (Photo 4). On 06/21/2024, Surveyor reviewed Resident 2's ISP, last reviewed 06/18/2024. The ISP read, in part: "Provide housekeeping service weekly and prn ... Provide laundry service weekly and prn ... Pick up trash daily ... Daily Bed Making ... HOUSEKEEPING: Pick up trash and check apartment daily to prevent clutter." At 10:35 a.m., Surveyor observed Resident 3's room. Resident 3 was in his/her room at the time. Surveyor observed Resident 3 had a urinary catheter. In his/her bathroom was a mechanical lift. Resident 3 told Surveyor that staff assisted	N 489		

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N 489	Continued From page 17	N 489		

him/her to the bathroom with the lift. The toilet had a seat riser over it that had feces smeared on the seat. The toilet had dark yellow urine in it. (Photo 5). Resident 3's bed was not made. (Photo 6). Resident 3's wheelchair was visibly dirty. (Photo 7).

On 06/21/2024, Surveyor reviewed Resident 3's ISP, last reviewed 02/26/2024. The ISP read, in part: "The resident requires assistance for toilet use. Resident requires 1:1 assist with EZ stand for transfers to and from the bathroom ... Provide housekeeping service weekly and prn ... Provide laundry service weekly and prn ... Pick up trash daily ... Daily Bed Making ... HOUSEKEEPING: Pick up trash and check apartment daily to prevent clutter."

Resident 3 required assistance from staff to use the toilet and empty his/her catheter into the toilet. Staff left Resident 3's bathroom with urine in the toilet and feces smeared on the seat.

At 10:45 a.m., Surveyor observed Resident 4's room. There was dirty laundry on the floor in his/her bathroom. (Photo 8). His/her bed appeared to have the comforter thrown over the other blankets and sheets. The bed was not made neatly. (Photo 9).

At 11:22 a.m., Surveyor observed Resident 5's room. His/her bed was not made up and did not have linens on it. (Photo 10).

On 06/21/2024, Surveyor reviewed Resident 5's ISP, last reviewed 03/29/2024. The ISP read in part: "HOUSEKEEPING: Pick up trash and check apartment daily to prevent clutter. Daily Bed making."

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N 489	Continued From page 18 At 11:26 a.m., Surveyor observed Resident 6's room. His/her bed was not made and there were no linens on the bed. (Photo 11). At 11:30 a.m., Surveyor observed Resident 7's room. His/her bathroom floor appeared to have feces on the floor in front of the toilet. (Photo 12). At 11:43 a.m., Surveyor observed Resident 11's room. His/her bed was not made neatly. It appeared the comforter was thrown over the rest of the bedding as the comforter hung off the foot of the bed onto the floor. The sheets were hanging out the sides of the comforter. (Photo 13). On 06/21/2024 at approximately 11:30 a.m., Surveyor interviewed Certified Nursing Assistant (CNA) P. CNA P provided services to 5 of the residents through hospice. S/he said s/he has been coming into the facility for approximately 3 years. S/he said it was an ongoing problem with dirty laundry on the floor in the residents' rooms and clean laundry remains in laundry basket, not put away. On 06/21/2024 at approximately 4:30 p.m., Surveyor interviewed the management team, which consisted of: Director of Operations B (DO) B, Wellness Director (WD) C, Business Manager (BM) D, and Administrator A was on the phone. Surveyor explained concerns of odor and cleanliness of the facility. Surveyor showed the management team pictures of observations of resident rooms as described above. DO B said they have started doing room checks daily. S/he said WD C and BM D check resident rooms for cleanliness and report any findings to the staff	N 489		

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N 489	Continued From page 19 working. They will then go and re-check the rooms to ensure they have been cleaned. DO B told Surveyor it was a busy day and the room checks did not get done. DO B said this was a new management team and they have started implementing a quality assurance program.	N 489		
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 a fire drill at least quarterly. The provider did not conduct a fire evacuation drill between 10/05/2023 and 05/31/2024. This is a repeat deficiency. See Statement of Deficiency TZ2H11, dated 01/03/2019.	N 525		

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N 525	Continued From page 20 Findings include: On 06/21/2024, Surveyor reviewed the safety binder with fire evacuations drills. The following fire evacuation drills were documented in the binder: 02/28/2023 - This was a night shift simulated fire drill. 05/18/2023 07/26/2023 05/31/2024. On 06/21/2024 at approximately 2:30 p.m., Surveyor interviewed Director of Operations (DO) B and asked if there were any other documented fire evacuation drills. At approximately 3:45 p.m., DO B provided Surveyor with additional information. There was a fire evacuation drill conducted on 10/05/2023. On 03/29/2024, Staff M documented: "Sat down as a group and went over fire drill procedures." There were several staff names listed. There were no resident names listed. On 06/21/2024 at approximately 4:30 p.m., Surveyor interviewed DO B, Wellness Director C, Business Manager D, and Administrator A, who was on the phone. Surveyor explained the documentation on 03/29/2024, did not indicate an actual evacuation took place only a training. The provider did not conduct a fire evacuation drill at least quarterly.	N 525		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water	N 617		

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N 617	Continued From page 21 heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the hot water temperature at fixtures used by residents did not exceed 115 ° Fahrenheit (F). This had the potential to affect all 19 residents. Findings include: The provider is licensed as a Class C non-ambulatory (CNA) facility to care for up to 20 residents in the client groups of: advanced age, developmentally disabled, irreversible dementia/Alzheimer's disease, physically disabled, terminally ill, and emotionally disturbed/mental illness. Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent	N 617		

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N 617	Continued From page 22 disability. (DQA publication P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017). On 06/21/2024 at approximately 11:30 a.m., Surveyor tested the water temperature at the sink in the shower room located across the hall from room 13. The water temperature reached 129 ° F. Certified Nursing Assistant (CNA) P was present in the shower room. CNA P worked for hospice and provided services to 5 residents that resided at the facility. CNA P told Surveyor s/he had problems with the water temperature staying consistent when s/he assisted residents with their showers. On 06/21/2024 at approximately 11:45 a.m., Surveyor tested the water temperature at the sink in the shower room located across the hall from room 3. The water temperature at this faucet reached 117 ° F. Housekeeper N was present in the room. Surveyor asked Housekeeper N if staff monitor the hot water temperatures. Housekeeper N said Maintenance Director (MD) O checked water temperatures. On 06/21/2024 at approximately 4:00 p.m., Surveyor tested the water temperature at the sink in the shower room across from room 13 again with Wellness Director (WD) C present to observe. The water temperature reached 127 ° F. Surveyor explained the water temperature should not exceed 115 ° F. WD C told Surveyor MD O was no longer present at the facility that day, but s/he would pass this information to him/her.	N 617		