STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016509	A. BUILDING: _____ B. WING _____	R-C 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN WINDS LLC	N3767 AIRPORT RD CAMBRIDGE, WI 53523

(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 02/16/2026, with information gathered through 02/19/2026, Surveyor conducted a verification visit and complaint investigation at Autumn Winds LLC. Ten deficiencies were identified. Eight of 10 deficiencies were repeat violations (see Statement of Deficiency (SOD) FFKZ12, SOD FFKZ13, SOD UTJG11, SOD M5QP11 and SOD M5QP12. Complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Community-Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. This had the potential to affect 5 of 5 residents who resided at the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ13, dated 01/14/2025. Findings include: The provider received a regular license on	N 196		

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

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N 196	Continued From page 1 03/01/2018, as a class CNA (nonambulatory) CBRF able to serve up to 10 residents within the client groups advanced aged, developmentally disabled, traumatic brain injury, irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled. On 02/16/2026, with information gathered through 02/19/2026, Surveyor conducted a verification visit and complaint investigation at Autumn Winds LLC. Ten deficiencies, including this one, were identified. Complaint was substantiated. N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0229 83.18(2) Employee Records Available Upon Request N0352 83.32(3)(h) Rights of Residents: Receive Medication. This deficiency is being cited for a fourth time. See SOD FFKZ12, dated 07/25/2024; SOD FFKZ13, dated 01/14/2025; and SOD M5QP12, dated 09/24/2025. N0388 83.35(3)(c) Implement, Follow The Individual Service Plan. This is a repeat deficiency. See SOD M5QP11, dated 03/31/2025. N0396 83.36(1)(a) Adequate Staff To Meet Resident Needs. This is a repeat deficiency. See SOD FFKZ13, dated 01/14/2025. N0404 83.37(1)(e) Medication Regimen, Administration Review. This is a repeat deficiency. See SOD M5QP12, dated 09/24/2025. N0431 83.38(1)(g) Health Monitoring. This deficiency is being cited for a third time. See SOD M5QP11, dated 03/31/2025, and SOD M5QP12, dated 09/24/2025. N0490 83.44(2)(b) Toilet and Bathing Area N0525 83.47(2)(d) Fire Drills. This deficiency is being cited for a third time. See SOD UTJG11,	N 196		

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N 196	Continued From page 2 dated 05/25/2021, and SOD M5QP12, dated 09/24/2025. N0526 83.47(2)(e) Other Evacuation Drills. This is a repeat deficiency. See SOD M5QP12, dated 09/24/2025. Review of facility records documented three previous survey events identifying noncompliance, as follows: -SOD M5QP12 - 09/24/2025 On 09/22/2025, with information gathered through 09/24/2025, Surveyor conducted a standard licensure survey and a verification visit at Autumn Winds LLC. Eight deficiencies were identified. N0220 83.17(2)(a) Employees Screened For Communicable Disease N0310 83.29(2) Admission Agreement Include Services, Charges N0352 83.32(3)(h) Rights of Residents: Receive Medication N0404 83.37(1)(e) Medication Regimen, Administration Review N0431 83.38(1)(g) Health Monitoring N0499 83.45(3) Toxic Substances N0525 83.47(2)(d) Fire Drills N0526 83.47(2)(e) Other Evacuation Drills SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Autumn Winds LLC: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall develop and implement corrective measures to ensure all	N 196		

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N 196	Continued From page 3 residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. The licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency (SOD) M5QP12. WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) for Resident 1 and Resident 3 with a copy of SOD M5QP12 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the department, to verify compliance with Order #1. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. The documentation required by Order #1 will be available to department representatives upon request. WITHIN 45 DAYS of receipt of this notice, the licensee will provide training to all managers and resident care staff on the corrective actions taken to resolve each deficient practice identified in SOD M5QP12. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. -SOD M5QP11 - 03/31/2025 On 03/16/2025, with information gathered through 03/31/2025, Surveyor conducted a complaint investigation at Autumn Winds LLC. Four deficiencies were identified. N0205 83.14(2)(j) Not Permit A Condition of Substantial Risk	N 196		

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N 196	Continued From page 4 N0388 83.35(3)(c) Implement, Follow The Individual Service Plan N0416 83.37(2)(e) Other Administration Given or Delegated by RN. This is a repeat deficiency. See SOD UTJG11, dated 05/25/2021 N0431 83.38(1)(g) Health Monitoring -SOD FFKZ13 - 01/14/2025 On 01/06/2025, with information gathered through 01/14/2025, Surveyor conducted 2 verification visits and a complaint investigation at Autumn Winds Inc. Seventeen deficiencies were identified. N0156 DHS 83.12(1)(b) Death Reporting Related to Accident Or Injury N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication. This is a repeat deficiency. See SOD FFKZ12, dated 07/25/2024. N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023. N0391 DHS 83.35(3)(f) Staff Access to Assessment And ISP N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs N0406 DHS 83.37(1)(g) Disposition of Medications. This is a repeat deficiency. See SOD FFKZ12, dated 07/25/2024. N0415 DHS 83.37(2)(d) Documentation of Medication Administration. This is a repeat deficiency. See SOD FFKZ12, dated 07/25/2024. N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023, and SOD	N 196		

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N 196	Continued From page 5 FFKZ12, dated 07/25/2024. N0420 DHS 83.37(3)(d) Medication Storage: Refrigeration. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023. N0432 DHS 83.38(1)(h) Medication Administration. This is a repeat deficiency. See SOD FFKZ12, dated 07/25/2024. N0450 DHS 83.41(2)(c) Nutrition: Menus N0452 DHS 83.41(3)(b) Food Safety. This is a repeat deficiency. See SOD FFKZ12, dated 07/25/2024. N0489 DHS 83.44(2)(a) Rooms Clean and Free From Odors N0499 DHS 83.45(3) Toxic Substances. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023, and SOD FFKZ12, dated 07/25/2024. SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Autumn Winds LLC: CONSULTANT REQUIRED 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure the provision of services to meet residents' physical and mental health needs. The licensee will correct identified deficiencies in consultation with a registered nurse (RN), not currently affiliated with the licensee, at the licensee's expense. The RN will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 83, Wis. Stat. ch. 50) and knowledge of the client groups served by Autumn Winds LLC.	N 196		

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N 196	Continued From page 6 Consultation will include the development (or revision) of written procedures and staff training (as appropriate) to address: Assessment and Service Plan -All required written resident assessments will be retained in resident records, in accordance with Wis. Admin. Code § DHS 83.35(1)(d). -All staff responsible for assisting in resident assessment will be trained on assessment procedures. - The timely development, completion, and revision of individualized services plans. The ISP review process shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or legal representative shall sign the ISP acknowledging their involvement in, understanding of, and agreement with the ISP. - All staff responsible for providing services to residents will review the resident's individualized service plan and will provide services in accordance with the plan. Medication Management and Administration -Including how the facility will: (a) document medication orders, medication administration, and missed/refused doses. (b) administer medications to ensure residents receive medications at the intervals and dosages prescribed. (c) prevent medication errors. (d) respond to medication errors if they occur. (e) monitor for adverse side effects.	N 196		

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N 196	Continued From page 7 (f) ensure medications are securely stored. (g) monitor for adverse side effects. (h) discontinue and dispose of medications; and (i) document and maintain proof of use record for schedule II drugs. Refer to: https://www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm The licensee will provide the RN with a copy of the Statement of Deficiency (SOD) FFKZ13, along with this Notice and Order letter prior to providing consultation services. Additionally: - All managers and resident care staff (as appropriate) will receive in-service training regarding the facility's written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - Consultation activities, including dates of consultation, will be documented, signed and dated by the consultant. - A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request. -SOD FFKZ12 - dated 07/25/2024 On 07/22/2024, with information gathered through 07/25/2024, Surveyor conducted a verification visit at Autumn Winds LLC. Nine deficiencies	N 196		

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N 196	Continued From page 8 were identified. N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0406 DHS 83.37(1)(g) Disposition of Medications N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0417 DHS 83.37(3)(a) Medication Storage: Original Containers. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023. N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023. N0425 DHS 83.38(1)(a) Personal Care N0432 DHS 83.38(1)(h) Medication Administration N0452 DHS 83.41(3)(b) Food Safety N0499 DHS 83.45(3) Toxic Substances. This is a repeat deficiency. See SOD FFKZ11, dated 11/16/2023. SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Autumn Winds llc: Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall ensure each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by the practitioner. The resident has the right to refuse medication unless the medication is court ordered. WITHIN 45 DAYS of receipt of this notice, the licensee will develop and implement corrective measures to address each medication	N 196		

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N 196	Continued From page 9 administration and medication storage deficiency identified in Statement of Deficiency FFKZ12. All managers, and resident care staff with responsibilities for medication administration and management, will receive in-service training regarding the provider's corrective measures. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. -SOD FFKZ11 - dated 11/16/2023 On 11/07/2023, with information gathered through 11/16/2023, Surveyor conducted a standard licensure survey at Autumn Winds LLC. Twelve deficiencies were identified. N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0394 DHS 83.35(5)(b) Annual Evaluation Of Evacuation Limits N0412 DHS 83.37(2)(a) Self-Administered By Resident N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0417 DHS 83.37(3)(d) Medication Storage: Refrigeration N0420 DHS 83.38(1)(h) Medication Administration N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented N0499 DHS 83.45(3) Toxic Substances N0530 DHS 83.47(3) Fire Inspection N0531 DHS 83.47(4)(a) Fire Extinguishers: Type And Inspection N0640 DHS 83.59\(2)(b) Solid Core Wood Doors	N 196		

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N 196	Continued From page 10 Or Equivalent -SOD UTJG11 - dated 05/25/2021 On 05/19/2021, Surveyor conducted an abbreviated survey at Autumn Winds LLC, a CBRF located in Cambridge. N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0243 DHS 83.21(1)-(3) All Employee Training N0247 DHS 83.22(1)-(4) Task Specific Training N0277 DHS 83.25 Continuing Education N0416 DHS 83.37 Other Administration Given or Delegated by RN N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable N0511 DHS 83.46(3) Public Water Supply or Well Water Test N0525 DHS 83.47(2)(d) Fire Drills N0538 DHS 83.48(3)(a) Fire Detection Systems Inspected Annually On 02/19/2026 at 8:49 AM, Surveyor interviewed Administrator P. Administrator P informed Surveyor that s/he would be forwarding the additional paperwork Surveyor had requested on 02/16/2026 during the onsite survey. Surveyor explained the survey window had closed but would accept the documentation. Surveyor discussed the concerns with Administrator P again that had been identified during the onsite survey. Administrator P stated s/he was working with Licensee A and informed Surveyor that s/he had been more than understanding during the survey process and the provider had areas that needed improvement. Surveyor had emailed Licensee A numerous	N 196		

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N 196	Continued From page 11 times during the onsite survey and did not receive a response. Licensee A emailed Surveyor on 02/16/2026 at 6:57 PM regarding an outstanding fee concern. Surveyor had spoken with Licensee A on 01/08/2026 at 1:39 PM, prior to the onsite survey. Licensee A stated s/he had hired a new administrator and was aware there were areas of concern that needed improvement.	N 196		
N 229	83.18(2) Employee records available upon request Employee records shall be available upon request at the CBRF for review by the department. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure employee records were available for review by the department upon request. Findings include: On 02/16/2026, at approximately 12:30 PM., Surveyor requested a staff roster with hire date and title from Administrator P. Administrator P stated s/he did not have one and would have to reach out to the Assistant Administrator K. Surveyor explained that a staff roster would be reviewed to determine what staff records s/he would review for the verification visit. On 02/19/2026 at 8:49 AM, Administrator P called Surveyor and stated s/he was currently forwarding him/her the documentation that had been requested that s/he was able to locate.	N 229		

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N 229	Continued From page 12 As of 02/19/2026 at 5:00 PM, Surveyor did not a staff roster.	N 229		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not administer medications prescribed by a practitioner for 1 of 1 resident. This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) FFKZ12, dated 07/25/2024, SOD FFKZ13, dated 01/14/2025, and SOD M5QP12, dated 09/24/2025. Resident 3 did not receive his/her scheduled Breo Ellipta (fluticasone furoate and vilanterol inhalation powder) inhaler as prescribed. Findings include: On 01/06/2026, the department received a concern alleging residents did not receive prescribed medication administration. On 02/16/2026, at approximately 11:40 AM, Surveyor and Administrator P observed Resident	{N 352}		

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{N 352}	Continued From page 13 3's Breo Ellipta inhaler with a handwritten open date of 01/20/2026 and a handwritten discard date of 03/01/2026. The inhaler had 8 of 30 remaining doses. The label stated, "Inhale once daily." Surveyor and Administrator P counted how many days had passed since the inhaler had been opened, 28. Administrator P stated Resident 3 had not received the inhaler as prescribed. Surveyor requested to review Resident 3's record. Administrator P stated s/he would forward Resident 3's medication administration records (MARs) to Surveyor via email. On 02/19/2026, Surveyor reviewed Resident 3's record. Resident 3 moved into the facility 01/23/2025. Resident 3's MARs, dated 01/20/2026 to 02/16/2026, documented: "INHALER: Breo Ellipta - 200-25 Inhale 1 puff daily. Scheduled for 7:00 AM and 9:00 AM. The MAR documented that the medications had been administered as prescribed. "Each inhaler of BREO contains 30 doses, which equals a 30-day supply. That's why your dose counter starts at 30. BREO contains 2 medicines. Inside the inhaler, these 2 medicines are packaged in separate strips that each contain 30 blisters. When you open the inhaler (and hear the click), the contents of 1 blister from each strip combine to form 1 dose of BREO. You may see the quantity "60" mentioned in printouts about your prescription, but your inhaler provides 30 doses. The "60" refers to the number of blisters inside the inhaler and not the number of doses." (Source: Breo website, Breo Ellipta (fluticasone furoate 100 mcg [microgram] and vilanterol 25	{N 352}		

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{N 352}	Continued From page 14 mcg inhalation powder), May 2023, https://www.mybreo.com/#:~:text=Each%20inhaler%20of%20BREO%20contains,that%20each%20contain%2030%20blisters. (retrieval date - June 08, 2025).)	{N 352}		
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 record review and interview, the provider did not follow 1 of 1 resident's Individual Service Plan (ISP) as written. This is a repeat deficiency. See Statement of Deficiency (SOD) M5QP11, dated 03/31/2025. Resident 1 did not receive two bath/showers a week and as needed that was documented on his/her ISP. Findings include: On 01/08/2026, the Department received a complaint alleging residents did not receive individualized care. The facility is licensed as a Class CNA (non-ambulatory) assisted living facility that can provide care and services to 10 residents within the client groups: developmentally disabled, irreversible dementia/Alzheimer's, traumatic brain injury, advanced aged, terminally ill and physically disabled. On 02/16/2026, Surveyor reviewed Resident 1's	N 388		

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N 388	Continued From page 15 record. Resident 1 moved into the facility, 11/28/2022, with diagnoses including cerebral palsy and contractures. Resident 1's "Individual Service Plan," dated 07/24/2025, documented: "Staff to provide shower in evenings and provide as needed around daily programming schedule. Resident utilizes a recliner PVC shower chair. Trained staff will transfer resident into shower chair using Hoyer lift to ensure safety. Will take bath/shower two times a week. On 02/16/2026, at approximately 1:00 PM, Surveyor interviewed Administrator P. Surveyor asked for clarification on how staff documented when a resident received a shower. Administrator P stated staff would document cares completed in a resident's observation notes. Administrator P stated s/he would forward Surveyor Resident 1's observation notes via email. Administrator P explained that s/he was new to the position and was part-time and was still learning the care needs of the residents and how staff completed those cares. Administrator P stated there was an assistant administrator hired to oversee the morning and second shift. During the survey process, Administrator P contacted Assistant Administrator K to seek guidance. On 02/19/2026, Surveyor reviewed Resident 1's observation notes, dated 01/01/2026 through 02/19/2026, which documented: 01/30 - Had a shower. 02/10 - Had a shower.	N 388		

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N 396	Continued From page 16	N 396		
N 396	83.36(1)(a) Adequate staff to meet resident needs. 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 ensure enough employees were provided to meet the 24-hour needs of residents. The provider staffed only 1 caregiver when 2 of 7 residents required assistance from 2 staff members. This is a repeat deficiency. See Statement of Deficiency (SOD) FFKZ13, dated 01/14/2025. Resident 1 was documented as a 2-person assist for emergency evacuations and utilized a Hoyer. Resident 2 was documented as a 2-person assist for emergency evacuations. Findings include: On 02/16/2026, at approximately 11:15 AM, Surveyor arrived at the facility and was greeted by Caregiver Q. Caregiver Q stated s/he was the only staff member currently scheduled. On 02/16/2025, Surveyor reviewed Resident 1's and Resident 2's record. Example 1: Resident 1 Resident 1 moved into the facility 11/28/2022 with diagnoses including intellectual and developmental disabilities and spastic tetraplegia (quadriplegic).	N 396		

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N 396	Continued From page 17 Resident 1's "Evacuation Assessment," dated 07/01/2025, documented: "Needs Full Assistance From Two Staff means the resident requires assistance from two persons during most of the evacuation." Resident 1's individualized service plan (ISP), dated 07/24/2025, documented: "Resident requires assist of mechanical lift for all transfers. Trained staff will utilize Hoyer lift for all transfers." Example 2: Resident 2 Resident 9 moved into the facility 08/16/2023 with diagnoses including cerebral infarction (stroke) and disorders of multiple cranial nerves. Resident 9's "Evacuation Assessment," dated 07/01/2025, documented: "Needs Full Assistance From Two Staff means the resident requires assistance from two persons during most of the evacuation." On 02/16/2026, at approximately 12:45 PM, Surveyor interviewed Administrator P. Surveyor asked for clarification on how many staff members were scheduled per shift. Administrator P stated only one staff member is scheduled per shift. Administrator P commented that s/he would discuss the staffing schedule with Licensee A.	N 396		
{N 404}	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident	{N 404}		

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{N 404}	Continued From page 18 ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an onsite review of the CBRF's (Community-Based Residential Facility) medication administration and medication storage system was completed by a physician, pharmacist, or registered nurse since the last survey dated 09/24/2025. This is a repeat deficiency. See Statement of Deficiency (SOD) M5QP12, dated 09/24/2025. Findings include: On 02/16/2026, at approximately 1:00 PM, Surveyor requested the pharmacy onsite medication review that had been completed since the 09/24/2025 survey from Administrator P. Administrator P stated s/he would need to contact Assistant Administrator K as Administrator P was	{N 404}		

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{N 404}	Continued From page 19 new to the company and did not assist in the correction process of the previously cited deficiencies. Administrator P contacted Assistant Administrator K who stated all documentation was in the 'state' binder at the facility. Surveyor noted the documentation in the binder referenced the deficiencies cited on 03/31/2025. On 02/19/2026 at 8:49 AM, Administrator P called Surveyor and stated s/he was currently forwarding him/her the documentation that had been requested that s/he was able to locate. As of 02/19/2026 at 5:00 PM, Surveyor did not receive a pharmacy onsite medication review for 2025.	{N 404}		
{N 431}	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and	{N 431}		

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{N 431}	Continued From page 20 fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident reviewed received appropriate health monitoring to meet his/her needs. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) M5QP11, dated 03/31/2025, and SOD M5QP12, dated 09/24/2025. Resident 1's bowel movements (BMs) were not monitored. Findings Include: On 02/16/2026, Surveyor reviewed Resident 1's record. Resident 1 admitted to the facility, 11/28/2022, with diagnoses including spastic quadriplegic cerebral palsy, paresis of lower extremity and severe intellectual disability. Resident 1 utilized an ostomy bag (an external pouch, worn on the abdomen, to collect body waste (stool or urine) from a surgically created opening called a stoma). Resident 1's individual service plan (ISP), dated 07/24/2025, documented: "Bowel: Does not comprehend or have the ability	{N 431}		

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{N 431}	Continued From page 21	{N 431}		

to use toilet. Resident has a history of constipation. Will have bowel movement within every 3 days. Laxatives prescribed as-needed (PRN) for constipation."

On 02/16/2026, at approximately 1:00 PM, Surveyor interviewed Administrator P and Caregiver Q. Surveyor asked for clarification on how Resident 1's bowel movements were being monitored. Administrator P stated staff should be documenting that information in Resident 1's observation notes. Caregiver Q stated s/he documented in the observation notes but did not necessarily monitor them. Surveyor asked Administrator P how staff were to monitor Resident 1's bowel movements. Administrator P stated s/he was new to the company and was still learning the processes and would follow up with Assistant Administrator K. Administrator P stated s/he would forward Surveyor Resident 1's observation notes. Surveyor asked Administrator P how staff were to monitor Resident 1's BM's when staff are to document Resident 1's BMs but didn't necessarily understand they were to be monitored. Administrator P stated that the BMs should be documented in a manner that staff can easily determine how many days it has been since his/her last BM and if his/her primary physician should be contacted.

On 02/16/2026, at approximately 1:15 PM, Surveyor observed Resident 1's medications in the med cart and did not observe any PRN medications for constipation.

On 02/19/2026, Surveyor reviewed Resident 1's observation notes, dated 01/01/2026 through 02/19/2026, which documented:

01/02/2026 - Extra Small BM

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{N 431}	Continued From page 22 01/04/2026 - Large Loose BM, Small loose BM 01/11/2026 - No BM 01/12/2026 - Had XS (extra small) BM 01/13/2026 - Had XS BM 01/14/2026 - Had XS BM 01/16/2026 - Had XS BM 01/21/2026 - Seemed to be very uncomfortable when coming home from day program. 01/25/2026 - Small BM, Medium BM - 9 days between BMs 02/13/2026 - No BM 02/14/2026 - Soft Large BM - 20 days between BMs 02/16/2026 - No BM 02/17/2026 - No BM 02/18/2026 - Medium BM - 4 days between BMs On 02/19/2026, Surveyor reviewed Resident 1's Medication Administration Records (MARs), dated 01/01/2026 to 02/19/2026, which did not list any physician orders for PRN constipation medications.	{N 431}		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident bathrooms were clean and in good working order. Findings include: On 01/06/2026, the department received a concern alleging the bathrooms were not clean. The provider received a regular license on	N 490		

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N 490	Continued From page 23 03/01/2018, as a class CNA (nonambulatory) CBRF able to serve up to 10 residents within the client groups advanced aged, developmentally disabled, traumatic brain injury, irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled. On 02/16/2026, at approximately 11:30 AM, Surveyors conducted a tour of the facility and observed the following in the shared resident bathroom, which is to the left of the facility entrance: -Shower spray nozzles were sprinkled with a brown-like substance that appeared to be rust. -Bathtub/Shower basin/walls, which were originally white in color, had the appearance of various colors of yellow/brown/orange. Flooring of bathtub/shower and flooring around the bathtub/showers had black residue all along the corners and seams. The shower basins had a soap scum like buildup and drains had resident hair buildup. -Bathroom wall had various drywall patching completed, which did not flow with the texture or color of the wall. -Sprinkler head had a cobweb/dust like substance hanging from it. -Bathroom mirror over the sink had the appearance of leftover residue from a tape. On 02/16/2026, at approximately 12:15 PM, Surveyor discussed his/her observations with Administrator P. Administrator P stated s/he was new to the facility and had been discussing his/her concerns about the condition of the bathroom with Licensee A.	N 490		
{N 525}	83.47(2)(d) Fire drills.	{N 525}		

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{N 525}	Continued From page 24 Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct quarterly fire drills with both employees and residents since the last survey dated 09/24/2025. This deficiency is being cited for a third time. See SOD UTJG11, dated 05/25/2021, and SOD M5QP12, dated 09/24/2025. Findings include: The provider is licensed as a Class CNA (non-ambulatory) CBRF (community based residential facility) able to serve up to 10 residents within the client groups of advanced age, terminally ill, physically disabled, developmentally disabled, traumatic brain injury, and irreversible dementia/Alzheimer's.	{N 525}		

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{N 525}	Continued From page 25 On 02/16/2026, at approximately 12:00 PM, Surveyor requested the fire drills that had been completed since the 09/24/2025 survey from Administrator P. Administrator P stated s/he would need to contact the previous administrator, Administrator K, as Administrator P was new to the company and did not assist in the correction process of the previously cited deficiencies. On 09/22/2025, Surveyor reviewed Resident 1's and Resident 2's evacuation assessments which documented: Resident 1: Needs Full Assistance From Two Staff Resident 2: Needs Limited Assistance From Two Staff On 02/19/2026 at 8:49 AM, Administrator P called Surveyor and stated that Administrator K informed him/her that no fire drills had been completed in 2025.	{N 525}		
{N 526}	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure evacuation drills, such as tornadoes, flooding or other emergency or disaster, were completed since the last survey dated 09/24/2025. This is a repeat deficiency. See Statement of Deficiency (SOD) M5QP12, dated 09/24/2025.	{N 526}		

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{N 526}	Continued From page 26 Findings include: The provider is licensed as a Class CNA (non-ambulatory) CBRF (community based residential facility) able to serve up to 10 residents within the client groups of advanced age, terminally ill, physically disabled, developmentally disabled, traumatic brain injury, and irreversible dementia/Alzheimer's. On 02/16/2026, at approximately 12:00 PM, Surveyor requested the other evacuation drills that had been completed since the 09/24/2025 survey from Administrator P. Administrator P stated s/he would need to contact the previous administrator, Administrator K, as Administrator P was new to the company and did not assist in the correction process of the previously cited deficiencies. On 02/16/2026, Surveyor reviewed Resident 1's and Resident 2's evacuation assessments which documented: Resident 1: Needs Full Assistance From Two Staff Resident 2: Needs Limited Assistance From Two Staff On 02/19/2026 at 8:49 AM, Administrator P called Surveyor and stated that Administrator K informed him/her that no other evacuation drills had been completed in 2025.	{N 526}		