STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020277	A. BUILDING: _____ B. WING _____	C 02/25/2026

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(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 02/19/2026 with information gathered through 02/25/2026, Surveyors conducted a standard and complaint investigation, at Atlas Assisted Living II, a Community-Based Residential Facility (CBRF) in Brown Deer, WI. Fifteen deficiencies were identified. Complaint substantiated. Census: 13	N 000		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees (Caregiver B, Caregiver C and Caregiver D) reviewed obtained all orientation training. Caregiver B, Caregiver C and Caregiver D did not have the following orientation training: information regarding assessed needs and individual services	N 230		

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

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N 230	Continued From page 1 for each resident for whom the employee is responsible, and emergency and disaster plan and evacuation procedures. Findings include: On 02/25/2026, Surveyor reviewed caregiver records and identified the following: Caregiver B -Caregiver B was hired on 02/01/2024. -Caregiver B's record did not contain evidence of orientation training in information regarding assessed needs and individual services for each resident for whom the employee is responsible, and emergency and disaster plan and evacuation procedures. Caregiver C -Caregiver C was hired on 02/24/2024. -Caregiver C's record did not contain evidence of orientation training in information regarding assessed needs and individual services for each resident for whom the employee is responsible, and emergency and disaster plan and evacuation procedures. Caregiver D -Caregiver D was hired on 10/22/2025. -Caregiver D's record did not contain evidence of orientation training in information regarding assessed needs and individual services for each resident for whom the employee is responsible, and emergency and disaster plan and evacuation procedures. On 02/25/2026, at approximately 12:36 PM,	N 230		

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N 230	Continued From page 2 Surveyor interviewed Administrator A. Administrator A confirmed Caregiver B, Caregiver C and Caregiver D did not receive the above-mentioned orientation training. Administrator A reported s/he was not aware of this requirement.	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group.	N 243		

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N 243	Continued From page 3 Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees reviewed (Caregiver B, Caregiver C and Caregiver D) obtained all training as required within 90 days after starting employment. Caregiver B, Caregiver C and Caregiver D did not have training in responding to challenging behaviors within 90 days after starting employment. Findings include: The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to service up to 15 residents in client groups of terminally ill, developmentally disabled, traumatic brain injury, physically disabled, irreversible dementia/Alzheimer's advanced aged and emotionally disturbed/mental illness. On 02/25/2026, Surveyors reviewed caregiver records and identified the following:	N 243		

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N 243	Continued From page 4 Caregiver B -Caregiver B was hired on 02/01/2024. -Caregiver B's record did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. Caregiver C -Caregiver C was hired on 02/24/2024. -Caregiver C's record did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. Caregiver D -Caregiver D was hired on 10/22/2025. -Caregiver D's record did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 02/25/2026, at approximately 12:36 PM, Surveyors interviewed Administrator A. Administrator A confirmed Caregiver B's, Caregiver C's and Caregiver D's records did not contain evidence that they completed or met an exemption for challenging behaviors training. Administrator A reported if training documentation is not in caregiver records, then the above-mentioned training was not completed.	N 243		
N 308	83.29(1)(b) Written information on services, charges Services and charges. Written information regarding services and charges. Before or at the time of admission, the CBRF shall provide written information regarding services available and the charges for those services to each resident,	N 308		

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N 308	Continued From page 5	N 308		

including persons admitted for respite care, or the resident ' s legal representative,. This information shall include any charges for services not covered by the daily or monthly rate, any entrance fees, assessment fees and security deposit.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not provide written information regarding services available and the charges for those services to 4 of 4 residents (Resident 1, Resident 2, Resident 3 and Resident 4).

Findings include:

On 02/19/2026 through 02/25/2026, Surveyors reviewed resident records and identified the following:

Resident
- Resident 1 was admitted on 06/04/2024 and his/her record did not contain evidence of written information regarding charges for services.

Resident 2
- Resident 2 was admitted on 06/20/2024 and his/her record did not contain evidence of written information regarding charges for services.

Resident 3
- Resident 3 was admitted on 10/02/2025 and his/her record did not contain evidence of written information regarding charges for services.

Resident 4
-Resident 4 was admitted on 02/04/2026 and his/her record did not contain evidence of written information regarding charges for services.

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N 308	Continued From page 6 On 02/19/2026, at approximately 2:19 PM, Surveyor interviewed Administrator A. Administrator A confirmed Resident 1's and Resident 2's records did not contain evidence of written information regarding charges for services. Administrator A reported s/he was not aware of the requirement to ensure resident records contain written information regarding services available and charges for those services. On 02/25/2026, at approximately 12:35 PM, Surveyors interviewed Administrator A. Administrator A confirmed Resident 3's and Resident 4's records did not contain evidence of written information regarding charges for services. Administrator A reported s/he was not aware of the requirement to ensure resident records contain written information regarding services available and charges for those services.	N 308		
N 343	83.32(2)(a) Explanation of rights, grievance procedure. Explanation of resident rights, grievance procedure, and house rules. Before the admission agreement is signed by the resident or the resident ' s legal representative or at the time of admission, the CBRF shall provide a copy of and explain resident rights, the grievance procedure under s. HFS 83.33 and the house rules to the person being admitted, the person ' s legal representative, and family members of the person. The resident or the resident ' s legal representative shall be asked to sign a statement to acknowledge the receipt of an explanation of resident rights. The CBRF shall document the date and to whom the information was provided.	N 343		

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N 343	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a signed statement acknowledging the provider explained resident rights, grievance procedure and house rules to 4 of 4 residents (Resident 1, Resident 2, Resident 3 and Resident 4) reviewed. Findings include: On 02/19/2026 through 02/25/2026, Surveyors reviewed resident records and identified the following: Resident 1 -Resident 1 was admitted on 06/04/2024. Resident 1 had a guardian. Surveyor was unable to locate documentation indicating resident rights, grievance procedures and house rules were explained to or signed by Resident 1's guardian upon admission. Resident 2 -Resident 2 was admitted on 06/20/2024. Resident 2 was his/her own decision maker. Surveyor was unable to locate documentation indicating resident rights, grievance procedures and house rules were explained to or signed by Resident 2 upon admission. Resident 3 -Resident 3 was admitted on 10/02/2025. Resident 3 had an activated healthcare power of attorney. Surveyor was unable to locate documentation indicating resident rights, grievance procedures and house rules were explained to or signed by Resident 3's activated healthcare power of attorney upon admission. Resident 4	N 343		

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N 343	Continued From page 8 -Resident 4 was admitted on 02/04/2026. Resident 4 was his/her own decision maker. Surveyor was unable to locate documentation indicating resident rights, grievance procedures and house rules were explained to or signed by Resident 4 upon admission. On 02/19/2026, at approximately 2:19 PM, Surveyor interviewed Administrator A. Administrator A confirmed Resident 1's and Resident 2's records did not include a signed statement acknowledging the receipt of an explanation of resident rights, grievance procedure and house rules. Administrator A reported s/he was not aware of this requirement. On 02/25/2026, at approximately 12:35 PM, Surveyors interviewed Administrator A. Administrator A confirmed Resident 3's and Resident 4's records did not include a signed statement acknowledging the receipt of an explanation of resident rights, grievance procedure and house rules. Administrator A reported s/he was not aware of this requirement.	N 343		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities.	N 358		

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N 358	Continued From page 9 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents were safeguarded from environmental hazards for 13 of 13 residents. The facility fire panel was not in working condition. Findings include: The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to service up to 15 residents in client groups of terminally ill, developmentally disabled, traumatic brain injury, physically disabled, irreversible dementia/Alzheimer's advanced aged and emotionally disturbed/mental illness. On 02/19/2026, Surveyor requested annual fire inspections for 2024 and 2025 and identified the following: -North Shore Fire Department Notice of Violations and Order to Correct, dated 05/01/2024, documented the following: "Inspection Type: Periodic. Location: First Floor. Category/Nature: Fire Alarm and Detection Systems/Fire alarm system to be fully functional and maintained. Abate by 05/01/2025. Remarks: [This facility] is on fire watch. Fire alarm system to be updated/replaced." -North Shore Fire Department Notice of Violations and Order to Correct, dated 06/11/2025, documented the following: "Inspection Type: Periodic; Re-inspection. Location: First Floor. Category/Nature: Fire Alarm and Detection Systems/Fire alarm system to be fully functional and maintained. Unabated - Violation uncorrected."	N 358		

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N 358	Continued From page 10 The facility fire panel was not in working condition. On 02/25/2026, Surveyors requested fire watch documentation and identified the following: -Facility has been conducting continuous fire watch from 2024 to present. On 02/25/2026, at approximately 2:29 PM, Surveyors interviewed Administrator A. Administrator A confirmed the fire panel was not in working condition. Administrator A reported the fire panel was not working at the time of change of ownership on 05/01/2024. Administrator A reported North Shore Fire Department has facility on fire watch. Administrator A reported the facility has been conducting continuous fire watch from 2024 to present. Administrator A reported that facility did not have a plan in place to get the fire panel fixed and would continue doing the fire watch. Administrator A reported that there was not a plan for a long-term solution.	N 358		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the	N 387		

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N 387	Continued From page 11 development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident and/or the resident's legal representative, as appropriate, were involved in developing the individual service plan (ISP) and signed the plan acknowledging their involvement in, understanding of, and agreement with the plan for 1 of 2 residents (Resident 1). Findings include: On 02/19/2026, Surveyor reviewed Resident 1's record and identified the following: Resident 1 -Resident 1 was admitted on 06/04/2024. -Resident 1 had a guardian. -Resident 1's ISP, dated 10/28/2025, was not signed by his/her guardian. On 02/19/2026, at approximately 12:48 PM, Surveyor interviewed Acting Administrator (AA) E. AA E confirmed Resident 1's ISP, dated 10/28/2025, was not signed or dated by his/her guardian. AA E reported s/he did not follow up with Resident 1's guardian to obtain his/her signature. AA E reported s/he forgot to have Resident 1's guardian sign Resident 1's ISP.	N 387		

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N 389	Continued From page 12	N 389		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 2 residents (Resident 1's and Resident 2's) Individual Service Plans (ISPs) were updated when there was a change in condition. Resident 1's ISP was not updated to reflect Resident 1's need of hospice care, utilization of wheelchair for ambulation and assistance needed with toileting. Resident 2's ISP was not updated to reflect Resident 2's utilization of wheelchair for ambulation, assistance needed with toileting and housekeeping. Findings include: On 02/19/2026, at approximately 9:30 AM, Surveyor observed Resident 1 and Resident 2	N 389		

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N 389	Continued From page 13 utilizing a wheelchair for mobility throughout this facility. On 02/19/2026, Surveyor reviewed Resident 1's and Resident 2's records and identified the following: Resident 1 -Resident 1 was admitted on 06/04/2024. Resident 1 had diagnoses including: anemia, thrombocytopenia, type 2 diabetes, schizophrenia, anxiety disorder, epilepsy, hypertension, congestive heart failure, peripheral vascular disease, constipation and edema. -Resident 1's Member Centered Plan (from the Managed Care Organization (MCO), dated 10/20/2025, indicated the following: "[Resident 1] receives hospice care at [this facility]. Toileting: Level of Assistance: Needs Assistance. Durable Medical Equipment (DME): Grab bars. Urinary Incontinence: Yes. Incontinence Supplies: Yes. Comments: Due to cognitive and physical impairments, [Resident 1] needs cues/help to change incontinence products, cues to complete peri cares and help rearranging clothing afterwards. [Resident 1] has daily urinary incontinence." -Resident 1's ISP, dated 10/28/2025, documented the following: "Toileting. Current Status: Independent with toileting. Frequency of service and service performed: Toileting - Independent. Goals/Outcome: Maintain proper hygiene and independence with toileting. Service provider responsibilities: To encourage [Resident 1] independence with toileting needs. Physical Disabilities - Ambulation. Current Status: Not Applicable."	N 389		

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N 389	Continued From page 14 Resident 1's ISP did not reflect Resident 1's need of hospice care, utilization of wheelchair for ambulation and assistance needed with toileting. Resident 2 -Resident 2 was admitted on 06/20/2024. Resident 2 had diagnoses including: psychoactive substance abuse, major depressive disorder, hypertension and pain in hip. -Resident 2's Member Centered Plan (from the MCO), dated 09/01/2025, indicated the following: " Mobility (In the Home). Level of Assistance: Needs Assistance. DME: Wheelchair or Scooter. Comments: [Resident 2] needs assistance from [this facility] staff due to physical limitations. [Resident 2] uses a wheelchair. Mobility (Outside the Home). Level of Assistance: Needs Assistance. DME: Wheelchair or Scooter. Comments: [Resident 2] needs assistance from [this facility] staff due to physical limitations. [Resident 2] uses a wheelchair. Toileting. Level of Assistance: Needs Assistance. DME: Grab Bars; Commode or Other Adaptive Equipment. Urinary Incontinence: Yes. Incontinence Supplies: Yes. Comments: [Resident 2] needs assistance from [this facility] staff due to physical limitations. [Resident 2] uses raised toilet seat and grab bars. Laundry/Chores. Level of Assistance: Needs Assistance. Comments: [Resident 2] needs assistance from [this facility] staff due to physical limitations." -Resident 2's ISP, dated 10/25/2025, documented the following: "Toileting. Current Status: [Resident 2] requires staff to monitor and document bowel movements. Independent with toileting. Frequency of service and service performed: Bowel Movement Monitoring - As needed every day. Toileting - Independent.	N 389		

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	0020277	A. BUILDING: _____ B. WING _____	C 02/25/2026

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N 389	Continued From page 15 Goals/Outcome: To have regular bowel movements. Maintain proper hygiene and independence with toileting. Physical Disabilities - Ambulation. Current Status: Not Applicable. Housekeeping Skills. Current Status: [Resident 2] has a key to lock [his/her] door. [Resident 2] chooses to keep key to [his/her] door in designated locked area in office. [Resident 2] door lock is disabled due to (describe reason door lock has been disabled). Frequency of service and service performed: Lock on [Resident 2's] door. As needed every day. Goals/Outcome: [Resident 2's] room has a lock on the door to enhance [Resident 2's] privacy." Resident 2's ISP did not reflect Resident 2's utilization of wheelchair for ambulation, assistance needed with toileting and housekeeping. On 02/19/2026, at approximately 1:17 PM, Surveyor interviewed Administrator A. Administrator A confirmed the most recent ISP for Resident 1 was 10/28/2025 and for Resident 2 was 10/25/2025. Administrator A reported s/he was responsible for ISP updates. Administrator A confirmed Resident 1 and Resident 2 utilized a wheelchair for mobility. Administrator A confirmed Resident 1's and Resident 2's ISPs were not updated to reflect the above-mentioned service needs.	N 389		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm.	N 394		

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N 394	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident's (Resident 1's) evacuation ability was assessed when they experienced a change in ambulation condition. Resident 1 utilized a walker when his/her assessment was completed, and a new assessment was not completed when s/he had a change in condition and required the use of a wheelchair for mobility. Findings include: On 02/19/2026, at approximately 9:30 AM, Surveyor observed Resident 1 utilizing a wheelchair for mobility throughout this facility. On 02/19/2026, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted on 06/04/2024. -Resident 1's evacuation assessment dated, 02/27/2025, documented the following: "Evaluator's Remarks: [Resident 1] is able to respond to self-starting. With use of a walker and will stay at designated location." The provider did not ensure Resident 1's evacuation ability was assessed when Resident 1 experienced a change in condition. On 02/19/2026, at approximately 2:26 PM, Surveyor interviewed Administrator A. Administrator A confirmed Resident 1's evacuation ability was not assessed when Resident 1 experienced a change in condition. Administrator A confirmed Resident 1 utilized a wheelchair for mobility.	N 394		

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N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was maintained in a safe, clean, comfortable, and homelike environment. The facility needed cleaning and some repairs. This had potential to affect 13 of 13 residents. Doors and door frames throughout facility showed significant scratches, hallway ceiling was bubbling and peeling off and hallway light fixture contained brown substance and standing water. Findings include: The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to service up to 15 residents in client groups of terminally ill, developmentally disabled, traumatic brain injury, physically disabled, irreversible dementia/Alzheimer's advanced aged and emotionally disturbed/mental illness. On 02/19/2026, at approximately 9:46 AM, Surveyor toured the facility with Caregiver B and observed the following: -Doors and door frames throughout facility showed significant scratches.	N 481		

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N 481	Continued From page 18 -Front entrance doors and door frames showed significant scratches. -Exit (labeled # 5) door and door frame showed significant scratches. -Hallway ceiling near exit (labeled # 5) was bubbling and peeling off and hallway light fixture contained brown substance and standing water. Resident 2's room: -Doors and door frames showed significant scratches. -Walls throughout room showed significant signs of scraping and cracking. -Floor vent was not attached to flooring. -Closet sliding doors were off track. On 02/19/2026, at approximately 10:04 AM, Surveyor interviewed Caregiver B. Caregiver B confirmed there were homelike environment issues throughout the facility. Caregiver B reported Administrator A was responsible for the maintenance throughout the facility.	N 481		
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 and interview, the provider did not ensure that all rooms were clean and kept free from odors. Resident 2's room had not been	N 489		

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N 489	Continued From page 19 cleaned, and there was a pungent urine-like odor present. Findings include: On 02/12/2026, the Department received a complaint alleging resident rooms were not being cleaned. On 02/19/2026, at approximately 9:46 AM, Surveyor toured the facility with Caregiver B and observed the following: Resident 2's room: -Had a pungent urine-like odor. -There was a red substance stuck on the floor consistent with candle wax. On 02/19/2026, at approximately 10:04 AM, Surveyor interviewed Caregiver B. Caregiver B confirmed the above-mentioned issues in Resident 2's room. Caregiver B reported Acting Administrator E had deep clean Resident 2's room the day prior.	N 489		
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 1 of 1 toilet areas were clean and in good working order. Resident 2's toilet areas needed to be cleaned and was in need of replacement of missing fixtures.	N 490		

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N 490	Continued From page 20 Findings include: On 02/19/2026, at approximately 9:46 AM, Surveyor toured the facility with Caregiver B and observed the following: Resident 2's toilet areas: -Grab bar was not attached to the wall near side of toilet. -Toilet paper holder was broken, and the toilet paper was not on the holder. -Bathroom toilet was dirty and contained dried feces on the toilet seat. On 02/19/2026, Surveyor reviewed Resident 2's record and identified the following: -Member centered plan indicating they needed toileting assistance due to limitations. -ISP showing inadequate info. On 02/19/2026, at approximately 10:04 AM, Surveyor interviewed Caregiver B. Caregiver B confirmed the above-mentioned issues in Resident 2's toilet areas. Caregiver B reported Administrator A was responsible for the maintenance throughout the facility. CROSS REFERENCE N 481 83.43(1) - Environment Safe, Clean, And Comfortable N 489 83.44(2)(a) - Rooms Clean And Free From Odors	N 490		
N 499	83.45(3) Toxic substances.	N 499		

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N 499	Continued From page 21 Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic substances were stored in a secure area. Toxic compounds were observed in the unlocked laundry room. This had potential to affect 13 of 13 residents. Findings include: The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to service up to 15 residents in client groups of terminally ill, developmentally disabled, traumatic brain injury, physically disabled, irreversible dementia/Alzheimer's advanced aged and emotionally disturbed/mental illness. On 02/19/2025, at approximately 5:18 PM, Surveyor conducted a tour of the facility with Administrator A and observed the following: Laundry room -(2) 312-ounce (2.43 Gallon) XTRA Calypso Fresh detergent. There were no staff present in the laundry room and residents were able to move around freely to access toxic substances. On 02/19/2026, at approximately 5:18 PM, Surveyor interviewed Administrator A. Administrator A confirmed the above-mentioned toxic compounds were unlocked in the	N 499		

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N 499	Continued From page 22 above-mentioned location. Administrator A stated toxic substances should be always locked.	N 499		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that CBRF (community-based residential facility) personnel tested smoke detectors at least once every other month during 2024 and 2025 to present. Findings include: On 02/19/2026, Surveyor requested smoke detectors tested documentation for 2024, 2025 to present from Administrator A. On 02/19/2026, Surveyor reviewed monthly smoke detector checks logs for 2024 and 2025 to present and identified the following: -Monthly Smoke Detector Checks, Year: 2024 log documented the following: January-December smoke detectors were checked and in working condition. There was a remark documented on	N 535		

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N 535	Continued From page 23 the log stating: "monitored by Cintas." -Monthly Smoke Detector Checks, Year: 2025 log documented the following: January-December smoke detectors were checked and in working condition. -Monthly Smoke Detector Checks, Year: 2026 log documented the following: January-February smoke detectors were checked and in working condition. On 02/19/2026, at approximately 11:17 AM, Surveyor interviewed Administrator A regarding smoke detectors testing. Surveyor asked Administrator A how the smoke detectors testing was being conducted. Administrator A reported if a red light is blinking on the smoke detector staff would call Cintas. Administrator A reported physical testing of the smoke detectors had not occurred, only observations of the lights blinking.	N 535		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for an annual smoke detector system and heat detection system to be inspected for 2 of 2 years (2024 and 2025). Twenty-two of 22 smoke detectors were not inspected in 2024 and 2025. Three of 3 heat	N 538		

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N 538	Continued From page 24 detectors were not inspected in 2024 and 2025. Findings include: On 02/19/2026, Surveyor requested from Administrator A the annual smoke and heat detection system inspection for calendar years (2024 and 2025). On 02/19/2026, at approximately 11:17 AM, Surveyor interviewed Administrator A. Administrator A confirmed the smoke heat detection system were not inspected for calendar years 2024 and 2025. Administrator A reported s/he was not aware of this requirement. CROSS REFERENCE N 358 83.32(3)(n) - Rights Of Residents: Safe Environment N 535 83.48(1)(b) - Smoke And Heat Detectors Per Nfpa 72	N 538		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by:	N 640		

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N 640	Continued From page 25 Based on observation and interview, the provider did not ensure the door to the laundry room, which is located on the same floor as resident bedrooms, was self-closing. Findings include: The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to service up to 15 residents in client groups of terminally ill, developmentally disabled, traumatic brain injury, physically disabled, irreversible dementia/Alzheimer's advanced aged and emotionally disturbed/mental illness. On 02/19/2026, at approximately 5:18 PM while touring the facility with Administrator A, Surveyor observed the laundry room door located on the same floor as resident bedrooms did not have a self-closing mechanism and did not self-close when tested by Surveyor. On 02/19/2026, at approximately 5:18 PM, Surveyor interviewed Administrator A. Administrator A confirmed the laundry room door did not self-close.	N 640		