STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018595	A. BUILDING: _____ B. WING _____	11/10/2025

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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
M 000	INITIAL COMMENTS On 11/03/2025, with information gathered through 11/10/2025, Surveyors conducted a standard licensure survey at Housing Matters. Twelve deficiencies were identified. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department, within 24 hours, a significant change in status for 1 of 1 resident. Resident 2 experienced a medical emergency, was placed on a Chapter 51 hold (involuntary commitment), and the provider did not notify the Department. Findings include: On 11/03/2025, Surveyors reviewed Resident 2's record.	M 134		

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

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M 134	Continued From page 1 Resident 2 moved into the home on 05/02/2025 with diagnoses including traumatic brain injury and autism. Resident 2's "Statement of Emergency Detention by Law Enforcement Officer," dated 08/08/2025, documented: "Walking on roadside, punching [him/herself] in the head screaming [s/he] wanted to kill [him/herself]. When asked about a plan [s/he] stated [s/he] wanted to slit [his/her] own throat. ... Chapter was approved at approximately 5:41 PM (08/07/2025)." Resident 2's inpatient discharge paperwork documented: Admit Date: 08/07/2025 Discharge Date: 08/12/2025 Reason for Admit: Suicidal Ideations On 11/10/2025 at 4:00 PM, Surveyors interviewed Licensee A. Surveyors discussed the requirements of reporting a significant change in status of a resident and the reporting requirements. Licensee A stated s/he understood and was provided with guidelines on when to report adult family home concerns to the department. Cross Reference: M0424 DHS 88.06(3)(f) Review of ISP	M 134		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety,	M 246		

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M 246	Continued From page 2	M 246		

welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received.

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure that staff received at least 8 hours of continuing education training related to health, safety, welfare, resident rights and treatment of residents during 2024.

Caregiver G did not receive resident rights training in 2024.

Findings include:

The provider was licensed, 07/12/2021, to provide cares for up to 4 residents in the client groups traumatic brain injury, physically disabled, advanced aged, irreversible dementia/Alzheimer's, developmentally disabled and emotionally disturbed/mental illness.

On 11/03/2025, Surveyor reviewed Caregiver G's records.

Caregiver G was hired 06/12/2023.
Caregiver G's 2024 continuing education did not contain training in resident rights.

On 11/03/2025, at approximately 10:30 AM, Surveyors interviewed Licensee A. Licensee A stated that s/he would ensure that staff received required training each year.

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M 276	Continued From page 3	M 276		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home's physical environment was safe, well maintained, and appropriate to provide a homelike environment to residents. Findings include: On 11/03/2025, at approximately 9:30 AM, Surveyors and Licensee A toured the home and observed: Resident Bathroom: -The ceiling, above the shower, displayed a black substance that had the appearance of a mold-like substance. -Sink vanity surface was pealing. -Sink bowl had what appeared to be a soap-like buildup throughout. -As Surveyors attempted to temp the water at the sink, the sink filled up with water to the point that Surveyors stopped waiting for the water to become warm, so the sink would not overflow. -Surveyors pulled out a vanity drawer and was unable to push the drawer back in. Surveyors requested assistance from Licensee A who also was unable to push the drawer back in. The	M 276		

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M 276	Continued From page 4	M 276		

drawers handle was not securely fastened.
-Approximate 12 inch by 12 inch hole in the ceiling where the ceiling fan had been placed. Licensee A stated the fan had become inoperable and the replacement fan did not fit, so s/he was still in the process of repairing the fan.
-Tub had a thick layer of what appeared to be a soap-like substance.
-Toilet was missing the protective cap for the bolts that hold the toilet to the floor. There was a buildup of a dust-like substance and hair around the toilet base. Flooring around the toilet and baseboards had the appearance of a dust-like substance.
-Clear shower curtain displayed a white splattered pattern that had the appearance of 'hard' water buildup.

Common Area:
-Couch vinyl was torn exposing the interior frame.
-Carpeting in the stairwell to the basement displayed significant breakdown of the carpeting due to foot traffic and brown and black splattered patterns which appeared to be due to spillage.

Kitchen:
-Stainless steel dishwasher, microwave and toaster oven had what appeared to be water-like streaks down the front.
-Oven interior displayed a significant amount of black, brown, golden substances that appeared to be food spillage.
-Freezer interior, at the bottom along the vent, was held together with tape
-Dishwasher interior - sections of the rubber protective covering on the racks appeared to have rusted away. The interior displayed what appeared to be food spillage when the dishwasher was empty.

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M 276	Continued From page 5 Licensee A stated s/he would address the concerns immediately with staff.	M 276		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider's service agreement did not include the necessary elements required within the service agreement for 3 of 3 resident record (Resident 1, Resident 2, and Resident 3) reviewed. Findings include: On 11/03/2025, Surveyor reviewed Resident 1's and Resident 2's record. Resident 1 moved into the home 07/18/2025. Resident 1's service agreement, signed 07/18/2025 by Resident 1, did not document: - Resident's name - Charges for room and board and services and any other applicable expenses - The source and method of payment	M 384		

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M 384	Continued From page 6 - Date the agreement went into effect. The service agreement was not signed by the provider. Resident 2 moved into the home 05/02/2025. Resident 2's service agreement, signed by Resident 1, did not document: - Resident's name - Charges for room and board and services and any other applicable expenses - Date the agreement went into effect. - Date Resident 1 signed the agreement. The service agreement was not signed by the provider. Resident 3 moved into the home 03/18/2022 and was represented by Guardian F. Resident 3's admission agreement did not contain Guardian F's signature. On 11/03/2025, at approximately 10:00 AM, Surveyor interviewed Licensee A. Licensee A stated s/he would review resident records to ensure completeness.	M 384		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the	M 404		

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M 404	Continued From page 7	M 404		

provider did not ensure 1 of 1 resident's (Resident 1) individual service plan (ISPs) was developed in coordination with the pre-admission assessment.

Findings include:

On 11/03/2025, Surveyors reviewed Resident 1's record.

Resident 1 moved into the home, 07/18/2025, with diagnoses including diabetes, cognitive impairment, alcoholic hepatitis with ascites (liver damage), and anemia (iron deficiency).

Resident 1's managed care organization (MCO) referral packet contained an assessment that documented:
Grooming, Bathing, Dressing, Mobility, Transferring, Cognition: Needs Assistance - Formal/Natural Supports/Needs to Find Helper.
Does the member need assistance with incontinence cares, toileting, mobility, transfers or repositioning at night? Yes

Resident 1's ISP, dated 07/24/2025, documented:
Oral Care - No assistance required with oral needs.
Bathing - Independent and requires no assistance.
Dressing - Independently can dress and undress as well as choose proper attire.
Chronic Illnesses - Not applicable
Short Term Illnesses - Not applicable
Physical Disabilities - Not applicable
Capacity for self-direction - Not completed
Supervision - Not completed
Mobility and Transferring - Has issues with his/her vision. Confirm that there are no trip hazards or unnecessary obstacles.

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M 404	Continued From page 8 On 11/10/2025 at 4:00 PM, Surveyors interviewed Licensee A. Surveyors and Licensee A discussed the importance of individualized service plans and ensuring the identified concerns by a MCO were identified in the resident's ISP.	M 404		
M 406	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Individual Service Plan (ISP) for 1 out of 3 records (Resident 3) reviewed were developed together with the placing agency, the guardian and the provider. Findings include: On 11/03/2025, Surveyors reviewed Resident 3's record. Resident 3 moved into the home on 03/19/2022 and was represented by managed care organization (MCO) Case Manager (CM) E and Guardian F.	M 406		

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M 406	Continued From page 9 Resident 3's record contained an ISP, dated 07/24/2025 and 08/05/2025, which were not signed by CM E and Guardian F. On 11/03/2025, at approximately 10:00 AM, Surveyors interviewed Licensee A. Surveyors asked for clarification on the provider's process to review a resident's ISP and obtain signatures. Licensee A stated s/he had the MCO managed care plan, but after discussion, determined that was not an ISP. Licensee A stated s/he would coordinate with the MCO CM's and resident representatives to ensure a resident's care team reviewed the ISP. On 11/05/2025 at 9:16 AM, Licensee A emailed Surveyor a signature page for the MCO member centered plans, dated 03/01/2025 to 08/30/2025, with signatures dated 02/10/2025.	M 406		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's	M 424		

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M 424	Continued From page 10 guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not update 1 of 1 resident's individual service plan (ISP) regarding his/her behaviors. Resident 2 suffered from suicidal ideations and his/her triggers and calming influences were not included in his/her ISP Findings include: On 11/03/2025, Surveyors reviewed Resident 2's record. Resident 2 moved into the home 05/02/2025 with diagnoses including traumatic brain injury and autism. Resident 2's "Outpatient Clinical Services Crisis Intervention Safety Plan," dated 07/21/2025, documented: "Presented to the emergency department following statements made to [Parent D] regarding thoughts of suicide. [Parent D] notified [Resident 2's] group home who subsequently dropped [Resident 2] off at the emergency department. [Resident 2] was initially voluntary for inpatient admission but eloped the emergency department and was later found by hospital security. Law enforcement was contacted, and [Resident 2] is indicating [s/he] is no longer voluntary for inpatient admission but interested in returning to [his/her] placement and outpatient mental health treatment. [Resident 2] reports frustration yesterday when [s/he] was attempting to help another group home resident. [S/he]	M 424		

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states this resident asked him/her] to leave the room resulting in [Resident 2] feeling dismissed. When this occurred [s/he] had thoughts about wanting to end [his/her] life and identified a plan to slit [his/her] neck with a knife. [S/he] has also had plans including jumping off a cliff or bridge and jumping in front of a moving vehicle. [Resident 2] states despite thoughts and plan [s/he] does not have intent to act on these thoughts ... also does not have the means to act on these reported plans due to placement within a group home setting staffed 24/7 with ability to mitigate for safety proofing and supervision of client.
Writer is able to speak to [Licensee A] at the placement to discuss safety proofing and mitigating patient's access to sharps within the placement. Client/family encouraged to contact crisis for additional support or mental health needs to assist client and family as needed. High pitch loud noises are indicated as a trigger to client. [Resident 2] will limit exposure to this trigger to assist in management of [his/her] mental health. Client indicates music as a coping strategy and benefit to [him/her]. [S/he] states [s/he] enjoys rapping and playing guitar in addition to listening to music."

Resident 2's "Statement of Emergency Detention by Law Enforcement Officer," dated 08/07/2025, documented:
"At approximately 3:53 PM ... well-being check complaint located at Watertown Road/Sierra Drive (approximately ½ mile from provider's home) ... complainant called to report that a [fe/male] was walking down the street and punching themselves in the face ... so hard that snot and spit were coming out. ... arrived on scene and made contact with the subject at the

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M 424	Continued From page 12 intersection of Watertown Road and Pitzka Court (approximately ¾ mile from provider's home) ... subject yelled "I want to die." ... Make statements about not wanting to be 'here' anymore and about not wanting to live." Resident 2's "Care Plan," dated 07/24/2025, documented: "Supervision - (left blank)" "Capacity for Self-Direction - (left blank)" "Wandering Risk - Shows no signs of wandering/elopement risk." "Suicidal Tendencies - Receiving supervision and assistance in all areas of preventing and redirecting suicidal thoughts and behaviors." The care plan did not identify Resident 2's triggers or signs/symptoms staff should be monitoring that represented suicidal ideations. The care plan did not provide guidance on how to redirect Resident 2 when s/he experienced suicidal ideations. On 11/10/2025 at 4:00 PM, Surveyors interviewed Licensee A. Surveyors reviewed Resident 2's ISP with Licensee A. Licensee A stated s/he understood that Resident 2's ISP required more individualization and s/he would review all resident ISPs to ensure this was completed.	M 424		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his	M 462		

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M 462	Continued From page 13 or her physician. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure that 1 of 3 residents received the correct dosage of medication at the correct time and followed physician guidelines. Resident 2's medication container had 2 Lithium Carbonate capsules and a Trazadone tablet that had not been administered lying on the bottom. Resident 2's medication container held 4 bottles of Fluticasone, one was dispensed 02/25/2025, one was dispensed 05/30/2025, one was dispensed 09/30/2025 and one was dispensed 10/28/2025. Each bottle contained 120 actuations and based on the prescription would be a 30-day supply. Findings include: On 11/03/2025, at approximately 9:10 AM, Surveyors and Licensee A observed Resident 2's medications. Surveyors observed 2 Lithium Carbonate capsules and a Trazadone tablet on the bottom of the container that held Resident 2's medications. Licensee A stated s/he was not aware of the medication being on hold and would discuss the concern with staff. Surveyors observed 4 bottles of Fluticasone, one was dispensed 02/25/2025, one was dispensed 05/30/2025, one was dispensed 09/30/2025 and one was dispensed 10/28/2025. The prescription read "Use 2 sprays in each nostril in the morning." Each bottle contained 120 actuations	M 462		

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and based on the prescription would be a 30-day supply.

On 11/03/2025, Surveyors reviewed Resident 2's record.

Resident 2 moved into the home 05/02/2025.

Resident 2's pharmacy delivery report documented that a bottle of Fluticasone was delivered on 05/30/2025, 09/30/2025 and 10/30/2025.

Resident 2's MAR, dated 10/13/2025 to 11/03/2025, documented:
Fluticasone Propionate 50 MCG (microgram)/actuation spray - Use 2 sprays in each nostril in the morning. Scheduled at 8:00 AM. Start Date: 05/30/2025.
The MAR documented that the medication had been administered as prescribed.

"Each bottle contains a net fill weight of 16 g (grams) and will provide 120 actuations. Each actuation delivers 50 mcg (micrograms) of fluticasone propionate in 100 mg (milligram) of formulation through the nasal adapter. The correct amount of medication in each spray cannot be assured after 120 sprays even though the bottle is not completely empty." (Source: National Institute of Health website, Fluticasone Propionate, 12/2022, https://dailymed.nlm.nih.gov/dailymed/fda (retrieval date - November 09, 2025).)

Based on 120 actuations per bottle which equaled a 30 day supply (4 actuations per day - 4 x 30 = 120), the bottle delivered 05/30/2025 would have been empty approximately 06/30/2025, leaving no medication available until the next bottle was

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M 462	Continued From page 15 delivered 09/30/2025. On 11/10/2025 at 4:00 PM, Surveyors interviewed Licensee A. Licensee A stated s/he would be re-educating staff on proper medication administration.	M 462		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not keep a record of all prescription medications controlled, dispensed or administered by the licensee showing the date and time the resident took the medication and errors and omissions for 1 of 2 residents reviewed. Resident 2's Medication Administration Records (MARs) did not document accurate medication administration of his/her Aripiprazole and Lithium Carbonate. Findings include: On 11/03/2025, Surveyor reviewed Resident 2's	M 466		

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M 466	Continued From page 16	M 466		

record.

Resident 2 moved into the home 05/02/2025.

Resident 2's MAR, dated 10/13/2025 to 11/03/2025, documented:
Aripiprazole 10 MG (milligram) tablet - Take 1 tablet by mouth in the morning. Scheduled at 8:00 AM. Start Date: 08/25/2025.
The MAR documented administration on 10/13, 10/16, 10/21, 10/22, 10/24, 10/27, 10/28, 10/30, 10/31, 11/01 and then a line had been drawn through the administration.
Another MAR documented administration on 10/17, 10/18, and 10/19.

Lithium Carbonate 150 MG capsule - Take 3 capsules (450 MG) by mouth 2 times a day. Scheduled at 8:00 AM and 8:00 PM. Start Date: 08/25/2025.
The MAR documented administration at 8:00 AM on 10/13, 10/16, 10/21, 10/22, 10/24, 10/27, 10/28, 10/30, 10/31, 11/01 and then a line had been drawn through the administration.
Another MAR documented administration on 10/17, 10/18, and 10/19.

On 11/03/2025, at approximately 9:00 AM, Surveyors and Licensee A observed Resident 2's medications in the med closet. Resident 2's 8:00 AM blister bubbles contained a 10 MG tablet of Aripiprazole and 3 capsules of Lithium Carbonate. Licensee A stated that s/he took responsibility for the poor documentation of Resident 2's Aripiprazole and Lithium Carbonate and would ensure that staff were given clear MARs to work from.

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M 470	Continued From page 17	M 470		
M 470	88.07(4)(a) NUTRITION A licensee shall provide each resident with a quantity and variety of foods sufficient to meet the resident's nutritional needs and preferences and to maintain the resident's health. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure each resident received a variety of food that met their individual preferences and maintained resident health. There was a limited amount of food options available that were easily accessible by residents and food items available were expired. Findings include: The provider was licensed, 07/12/2021, to provide cares for up to 4 residents in the client groups traumatic brain injury, physically disabled, advanced aged, irreversible dementia/Alzheimer's, developmentally disabled and emotionally disturbed/mental illness. On 11/03/2025, at approximately 8:45 AM, Surveyors and Licensee A toured the home. -Surveyors observed the refrigerator which contained: Tray of eggs, case of soda, Various condiments, a bowl of a leftover dish that consisted of rice and noodles, celery, and a container of ham slices. -Surveyors observed the freezer which contained frozen bread, 4 family sized Salsbury steak dinners and a box of waffles.	M 470		

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M 470	Continued From page 18 -Surveyors observed the pantry items which consisted of: Can of cream of shrimp soup with a best by date of 08/13/2024 Box of lime jello with a best by date of 09/10/2024 Can of sliced water chestnuts with a best by date of 12/17/2022 Box of cherry jello with a best by date of 09/17/2024 Can of chopped clams with a best by date of 03/23/2025 Can of whole cranberry sauce with a best by date of 03/07/2024 Can of Red Beans and Rice with a best by date of 01/2022 Jar of jalapeno nacho slices with a best by date of 08/2018 (2) multi packs of ramen noodles Surveyors asked Licensee A for clarification on where the food items were purchased and what was available to the residents. Licensee A shower Surveyors his/her grocery list that s/he utilized when s/he went grocery shopping. Surveyors stated the items available in the pantry, which are primarily expired, were not on the grocery list. Licensee A stated that the sister facility next door, which is a certified based residential facility (CBRF), was where the homes' food was primarily stored. Staff at the CBRF would prepare the food and bring it over to the home for the residents. Licensee A stated s/he would purge the available food items to ensure they were not expired and that adequate food was available to the residents.	M 470		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record	M 482		

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M 482	Continued From page 19	M 482		

for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access.

This Rule is not met as evidenced by:
Based on observation, interview and record review, the provider did not ensure records were maintained in a secure location within the home.

The provider's home was independently staffed by Caregiver C, who did not have access to resident records.

Findings include:

The provider was licensed, 07/12/2021, to provide cares for up to 4 residents in the client groups traumatic brain injury, physically disabled, advanced aged, irreversible dementia/Alzheimer's, developmentally disabled and emotionally disturbed/mental illness.

On 11/03/2025, at approximately 8:20 AM, Surveyors arrived at the home to conduct a standard licensure survey. Caregiver C was the only caregiver present. Surveyor requested resident records from Caregiver C. Caregiver C stated s/he was unable to provide Surveyors with any resident records, including full names. Surveyors asked Caregiver C to contact Licensee A or another staff member who could provide assistance. Caregiver C contacted Licensee A via telephone.

On 11/03/2025, at approximately 9:00 AM, Licensee A arrived at the home and explained

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M 482	Continued From page 20 that all the records were stored offsite, and staff did not have access to them. Surveyors requested resident records and Licensee A stated s/he was in the process of converting to an electronic computer system, so some of the documents were not available via paper copy. Licensee A provided resident binders to the Surveyors. Surveyors asked for clarification as to why staff did not have access to basic resident information. Licensee A stated s/he was not aware that resident records needed to be accessible by staff members. Surveyors and Licensee A discussed concern that staff would not be able to provide resident information in the event of an emergency or be able to follow the resident's individual service plan to provide adequate cares for a resident. Caregiver C was responsible for the care of 4 residents at the home, but did not have access to resident information, including their full names, diagnoses or care needs. On 11/10/2025 at 4:00 PM, Surveyors interviewed Licensee A. Surveyors asked if Licensee A had any additional questions regarding staff having access to resident records. Licensee A stated staff having access to the resident records was logical.	M 482		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the	M 550		

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M 550	Continued From page 21 personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses contraband. The resident shall be present for the search. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 4 of 4 residents (Resident 1, Resident 2, Resident 3, and Resident 4) had privacy when they utilized the bathroom. Findings include: On 11/03/2025, at approximately 9:30 AM, Surveyors conducted an onsite tour with Licensee A. Surveyors observed the bathroom door handle did not have locking capabilities from the inside. Surveyors asked Licensee A to show Surveyors how the door locked to ensure residents had privacy. Licensee A examined the door handle and stated s/he did not realize the doorhandle did not have a locking device. Licensee A stated s/he would replace the doorhandle.	M 550		