STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019881	A. BUILDING: _____ B. WING _____	C 02/25/2025

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N 000	Initial Comments On 02/18/2025, Surveyor conducted one (1) complaint investigation and standard survey at LakeHouse Cedarburg. Additional information was gathered through 02/25/2025. As a result of the survey, nine (9) deficiencies identified, 1 complaint unsubstantiated. Census: 29	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 out of 2 employees (Caregiver B) reviewed had a complete caregiver background check done upon hire. Findings include: The facility is licensed to provide services for up to 65 residents who may be advanced aged,	N 219		

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

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N 219	Continued From page 1 physically disabled and/or irreversible dementia/Alzheimer's. The census at time of survey was 29. According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete criminal background check (CBC), at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID); 2) A response from the Department of Justice (DOJ); 3) A "Response to Caregiver Background Check" letter from the Department of Health Service, also referred to as the Integrated Background Information System (IBIS). On 02/18/2025, Surveyors requested employee file and caregiver background check for Caregiver B. Executive Director (ED) A provided Surveyor with employee file. Caregiver B had a hire date of 10/21/2022. Caregiver B's record was reviewed, and Surveyor could not locate a BID, DOJ or IBIS in Caregiver B's record. On 02/18/2025 at 12:05 PM. Surveyor interviewed ED A. ED A stated Caregiver B was hired by the previous company and acknowledged s/he could not locate Caregiver B's BID, DOJ or IBIS. The provider did not ensure 1 out of 2 employees reviewed had a complete caregiver background check done.	N 219		

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N 230	Continued From page 2	N 230		
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 1 of 2 employees obtained orientation training which shall include 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. Findings include: On 02/18/2025, Surveyors reviewed employee records and identified the following: The record for Caregiver C, hired 08/06/2024, did	N 230		

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	0019881	A. BUILDING: _____ B. WING _____	C 02/25/2025

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N 230	Continued From page 3 not contain evidence of orientation topics which included documentation of orientation in 1) assessed needs and individual services 2) emergency and disaster plan and evacuation procedures prevention 3) policy and procedures 4) recognizing and responding to resident changes of condition. On 02/18/2025 at approximately 12:05 PM, Surveyor interviewed Executive Director (ED) A. ED A stated s/he observed Caregiver C had not completed his/her orientation training that had been scheduled. ED A acknowledged s/he messaged Caregiver C and was waiting to hear back from him/her. ED A confirmed Caregiver C had been working in the facility since s/he was hired. ED A stated s/he was unaware prior to this survey that Caregiver C had not completed all the required training. On 02/19/2025 at 9:47 AM, Surveyor received an email from ED A. ED A did not provide any additional information on Caregiver C. The provider did not ensure employees obtained orientation training before performing any job duties. Cross reference DHS 83.21 All Employee Training	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	N 243		

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N 243	Continued From page 4 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. 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:	N 243		

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N 243	Continued From page 5 Based on record review and interview, the provider did not ensure 1 of 2 employees reviewed obtained all training as required within 90 days after starting employment. Caregiver C did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment. Caregiver C did not have training in required client groups within 90 days after starting employment. Findings include: On 02/18/2025, Surveyor conducted a review of employees to verify compliance with all employee training requirements. Surveyor requested training records from Executive Director (ED) A for Caregiver C. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for Caregiver C, hired 08/06/2025, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 02/18/2025 at 12:05 PM, Surveyor interviewed ED A. ED A confirmed the provider did not have evidence Caregiver C completed or met an exemption for challenging behaviors training. Client Group The facility is licensed to provide services for up to 65 residents who may be advanced aged,	N 243		

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N 243	Continued From page 6 physically disabled and/or irreversible dementia/Alzheimer's. The record for Caregiver C, hired 08/06/2024, did not contain evidence of training or evidence of meeting an exemption for client group training. On 02/18/2025, at 12:05 PM, Surveyor interviewed ED A. ED A confirmed the provider did not have evidence Caregiver C completed or met an exemption for client group training specific to advanced age, physically disabled and/or irreversible dementia/Alzheimer's. Cross reference DHS 83.19 Orientation	N 243		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance	N 310		

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N 310	Continued From page 7 fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have an Admission Agreement for 15 of 29 residents providing information regarding services and accommodations available including charges for services. Findings include: The facility is licensed to provide services for up to 65 residents who may be advanced aged, physically disabled and/or irreversible dementia/Alzheimer's. The census at time of survey was 29. On 02/18/2025 at 12:05 PM, Surveyor requested Resident 1 and Resident 2's record from Executive Director (ED) A. Surveyor requested copies of admission agreements for Resident 1 and Resident 2. Resident 1 was admitted under the previous licensee on 09/30/2022, Resident 2 was admitted under the current licensee on 01/31/2025. Surveyor interviewed ED A, and ED	N 310		

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N 310	Continued From page 8 A confirmed residents that resided prior to the change of owner, did not have updated admission agreements. ED A acknowledged 15 residents, identified on the resident roster, resided under the prior owner. ED A stated s/he completed new admission agreements with residents that have admitted since s/he started. ED A stated s/he started 02/06/2024, but acknowledged the license was issued on 06/26/2024. ED A stated s/he will work on completing new admission agreements for the residents with admission agreements from prior licensee.	N 310		
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 a living environment that was safe, clean, comfortable and homelike for residents. Findings include: On 02/18/2025 at approximately 8:45 AM, Surveyors entered with Executive Director (ED) A. ED A stated s/he would have Maintenance Director (MD) D tour Surveyors. Surveyor observed the following: -Resident 3 - toilet dirty -Resident 4 - bedroom carpet stained/dirty, eggs	N 481		

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	0019881	A. BUILDING: _____ B. WING _____	C 02/25/2025

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N 481	Continued From page 9	N 481		

on carpet
-Resident 5 - toilet with substance resembling BM on toilet and towel hanging next to toilet; no shower curtain
-Resident 6 - bedroom carpet stained, bed sheets stained, and toilet seat cracked through
-Resident 7 - bedroom carpet stained/dirty
-Resident 8 - toilet dirty
-Kitchen - Ceiling dirty, vent dirty, wall in area of sink peeling
-Several empty rooms with stained carpet, missing PTAC (packaged terminal air conditioner) unit, walls scuffed
-Sewer smell - hallway outside of marketing office had a strong odor of sewer
Surveyor toured 7 resident rooms and 6 of 7 resident rooms had concerns identified.

On 02/18/2025 at approximately 9:30 AM, Surveyor interviewed MD D. MD D stated the belly of the sewer line needs to be jetted out. MD D stated the ground is frozen and s/he needs to wait to have the sewer line jetted. MD D acknowledged the smell and confirmed s/he had not contacted a plumber, and that s/he will when it warms up. MD D acknowledged Surveyor concerns with the environment. MD D stated staff are supposed to fill out maintenance requests when they observe something in need of repair. MD D stated s/he checks the log daily. Surveyor observed MD D telling a housekeeper to clean toilets that need to be cleaned during our tour. MD D confirmed rooms are cleaned weekly, but if they need to be cleaned more frequently the caregivers need to tell MD D or the housekeeper.

On 02/18/2025 at 12:05 PM, Surveyor interviewed ED A. ED A stated s/he will look into concerns with the environment and the sewer smell. ED A stated s/he had a list of rooms s/he

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 481	Continued From page 10 shows to prospective residents/families. ED A stated rooms would be updated prior to new resident moving in. On 02/19/2025 at 9:47 AM, Surveyor received email from ED A. ED A stated, "Sewage smell in hallway. Writer discussed with corporate facilities director. We will be scheduling a plumber to assess and quote." The provider did not ensure they provided a living environment that was safe, clean, comfortable and homelike.	N 481		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the	N 525		

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	0019881	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE CEDARBURG	W56 N225 MCKINLEY BLVD CEDARBURG, WI 53012

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N 525	Continued From page 11	N 525		

provider did not ensure quarterly fire drill reports documented a total evacuation time for 2 of 2 quarters, in calendar years 2024. The provider did not document resident evacuation times during quarterly fire drills.

Findings include:

The facility is licensed to provide services for up to 65 residents who may be advanced aged, physically disabled and/or irreversible dementia/Alzheimer's.

On 02/18/2025, at approximately 11:00 AM, Surveyor reviewed the facility's safety records and identified the following:

The fire drill records reported fire drills were conducted on the following dates and times:

07/31/2024, First Shift Fire Drill
12/13/2024, 5:00 AM

The records did not include total evacuation time.

On 02/18/2025, at 11:30 AM, Surveyor interviewed Maintenance Director (MD) D. MD D reported s/he was responsible for completing fire drills and maintaining the records. MD D reported s/he did not document resident evacuation time, only staff that were involved in the fire drill. MD D stated s/he did not know that was a requirement.

On 02/18/2025, at approximately 12:05 PM, Surveyor interviewed Executive Director (ED) A. Surveyor inquired how the facility was completing fire drills. ED A reported MD D was responsible for the fire drills and confirmed s/he would work with MD D to ensure resident evacuation times are included in the report.

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N 525	Continued From page 12 On 02/19/2025 at 9:47 AM, ED A emailed Surveyor and stated - "Writer is creating a form that we will use moving forward to identify evacuation times/responses. This will be uploaded to our tels system with each drill." The provider did not document resident evacuation times during quarterly fire drills.	N 525		
N 534	83.48(1)(a) Smoke detection system. Except as provided under sub. (2), the CBRF shall have an interconnected smoke detection system pursuant to s. 50.035(2) Stats., and shall have an interconnected heat detection system to protect the entire CBRF so that if any detector is activated, an alarm audible throughout the building will be triggered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the smoke and heat detectors were maintained in accordance with NFPA 72 National Fire Alarm Code. FINDINGS INCLUDE: On 02/18/2025 at 11:00 AM, Surveyor requested the smoke and heat detector testing from Maintenance Director (MD) D. MD D provided J.F. Ahern Fire Inspection Initiating and Supervisory Device Tests and Inspections dated 01/23/2025. The report reflected the following: Kitchen Exit by Sink - Pull - Fail Kitchen Wash Area - Heat - Fail Surveyor reviewed the Fire Alarm Inspection Semi-Annual report dated 01/23/2025. The	N 534		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 534	Continued From page 13	N 534		

Equipment Summary reflected:
Fire Alarm Control Panel - Fail - 1
Heat Detect - Restorable Spot - Fail - 1
SH Manual Alarm - Release - Fail - 1

The Deficiency Details:
FA06 - Fire Alarm Control Panel
Did batteries pass charger test, discharge test and load voltage test? No
Deficiency Authority - NFPA 72 Section: Table 14.4.2.2 5c - Operation of battery charger shall be checked in accordance with charger test for the specific type of battery.

FA08 - Heat Detect - Restorable Spot
Did all devices pass visual inspection? No
Tech Note: "Same heat in kitchen from july [sic]"
Deficiency Authority - NFPA 72 Section: 14.3.4
The visual inspection shall be made to ensure there are no changes that affect equipment performance.

FA09 - SH Manual Alarm - Release
Did all devices pass visual inspection? No
Tech Note: "Same pull in kitchen from July not replaced"
Deficiency Authority NFPA 72 Section:14.3.4
The visual inspection shall be made to ensure that there are no changes that affect equipment performance.

This report was signed by MD D on 01/23/2025.

On 02/18/2025 at 11:11 AM, Surveyor interviewed Executive Director (ED) A. ED A stated s/he would talk with MD D to ensure that everything is functional.

On 02/19/2025 at 9:47 AM, Surveyor received an email from ED A stating: "Repairs with Ahern on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 534	Continued From page 14 inspections- I have attached a quote for the repairs to the deficiencies they found. This is being signed off on for Ahern to repair. This is the response I received via email for timeframe of completion:" "I will check on the parts and get a better timeframe. We can take care of this in the next week or so if material is available." The quote was dated 10/01/2024 referencing "Fire Protection System Deficiency Repair Proposal." The proposal stated, "Ahern will replace the pull station in the kitchen exit by sink, heat detector in the kitchen was area, and fire alarm panel batteries that failed during the annual fire alarm inspection." The provider did not ensure the smoke and heat detectors were maintained in accordance with NFPA 72 National Fire Alarm Code. Cross Reference: DHS 83.48(8)(b) Sprinkler System Installation and Maintenance DHS 83.59(7)(a) Emergency Egress Lighting Provided	N 534		
N 558	83.48(8)(b) Sprinkler system installation and maintenance Installation and maintenance. 1. All sprinkler systems shall be installed by a state licensed sprinkler contractor. All sprinkler systems shall be maintained, inspected and tested at least annually or at intervals determined by the requirements in NFPA 25. 2. In facilities with sprinklers, sprinkler heads shall be placed at the top of each linen or trash chute and in the rooms where the chutes terminates. 3. The sprinkler system flow alarm shall be connected to the CBRF ' s fire alarm system.	N 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019881	A. BUILDING: _____ B. WING _____	C 02/25/2025

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N 558	Continued From page 15 This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure the sprinkler system was maintained by the requirements in NFPA 25. Findings include: On 02/18/2025 at 11:00 AM, Surveyor requested from Maintenance Director (MD) D the sprinkler system inspection. MD D provided Surveyor a quarterly sprinkler inspection by J.F. Ahern dated 10/23/2024. Review of the inspection showed Dry Valve and Control Valve failed. The Deficiency Details reflected: 1 - Control Valve Is valve provided with the appropriate identification signs? No Deficiency Authority NFPA 25-2011 Section: 13.3.2.2 "The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position. (2) Sealed, locked, or supervised. (3) Accessible. (4) Provided with appropriate wrenches. (5) Free from external leaks. (6) Provided with appropriate identification. CV00002 - Control Valve Is valve provided with the appropriate identification signs? No Deficiency Authority NFPA 25-2011 Section: 13.3.2.2 "The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position. (2) Sealed, locked, or supervised. (3) Accessible. (4) Provided with appropriate wrenches. (5) Free from external leaks. (6) Provided with appropriate identification. DVR00002 - Dry Valve	N 558		

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N 558	Continued From page 16 Did the Quick Opening Device pass its operational test? No Deficiency Authority NFPA 25-2011 Section: 13.4.4.2.4 "Quick-opening devices, if provided, shall be tested quarterly." SPRKR QUES00002- Sprinkler Questions Hydraulic nameplate (calculated systems only) securely attached to riser and legible? No Deficiency Authority NFPA 25-2011 Section 5.2.6 "The hydraulic nameplate for hydraulically designed systems shall be inspected quarterly to verify that it is attached securely to the sprinkler riser and is legible." SPRKR QUES00002- Sprinkler Questions Alarm devices free from mechanical damage? No Deficiency Authority NFPA 25-2011 Section 5.2.5 "Waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage." On 02/18/2025, Surveyor interviewed Executive Director (ED) A. ED A stated s/he would talk with MD D to ensure that everything is functional. On 02/19/2025 at 9:47 AM, Surveyor received an email from ED A stating: "Repairs with Ahern on inspections- I have attached a quote for the repairs to the deficiencies they found. This is being signed off on for Ahern to repair. This is the response I received via email for timeframe of completion:" "I will check on the parts and get a better timeframe. We can take care of this in the next week or so if material is available." The quote was dated 10/01/2024 referencing "Fire Protection System Deficiency Repair Proposal." The proposal stated, "Ahern will replace the pull station in the kitchen exit by sink, heat detector in	N 558		

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N 558	Continued From page 17 the kitchen was area, and fire alarm panel batteries that failed during the annual fire alarm inspection." This quote did not identify the sprinkler deficiencies. The provider did not ensure the sprinkler system was maintained in accordance with NFPA 25. Cross Reference: DHS 83.48(1)(a) Smoke Detector System DHS 83.59(7)(a) Emergency Egress Lighting Provided	N 558		
N 666	83.59(7)(a) Emergency egress lighting provided All exit passageways and stairways shall be provided with emergency egress lighting with a stand-by power source. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all exit passageways were provided with emergency egress lighting with a stand-by-power source for 1 of 1 emergency egress lighting units near room 2 in common hallway. Findings include: On 02/18/2025 at approximately 11:00 AM, Surveyor toured the facility with Maintenance Director (MD) D. Surveyor tested the egress lighting near room 2 and it did not work. MD D stated s/he had to work on the lighting as s/he had identified issues with the lighting. On 02/18/2025 at 12:05 PM, Surveyor interviewed Executive Director (ED) A. ED A stated s/he would have MD D provide her with the	N 666		

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N 666	Continued From page 18 Emergency Lighting report. On 02/19/2025 at 9:47 AM, Surveyor received an email from ED A. ED A stated, "Emergency lighting inspections attached." Surveyor reviewed the report which identified weekly emergency lighting inspections were completed by MD D. Surveyor observed the inspection report to identify "Some service needed on: 2/01/2025, 1/31/2025, 1/18/2025, 1/11/2025, 1/04/2025, 12/31/2024, 12/21/2024, 12/14/2024, 12/7/2024, 11/30/2024, 11/16/2024, 11/9/2024, 11/2/2024, 10/31/2024, 10/19/2024, 10/12/2024, 10/5/2024, 9/7/2024, 8/31/2024, 8/17/2024, 8/10/2024, 8/3/2024, 7/20/2024, 6/29/2024. Couple need service: 09/30/2024, 9/21/2024, 9/14/2024. Need to schedule service: 7/6/2024, 6/30/2024. Need to check for batteries: 6/22/2024." The report did not identify which emergency egress lighting units were not functioning. There was no evidence to ensure the emergency egress lighting units had been fixed. The provider did not ensure all emergency egress lighting units were in working order. Cross Reference: DHS 83.48(8)(b) Sprinkler System Installation and Maintenance DHS 83.48(1)(a) Smoke Detector System	N 666		