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N 000	Initial Comments On 03/26/2025, Surveyor conducted a standard survey and complaint investigation at An Innovative Care South Winds. As a result, 15 deficiencies were identified. One of the deficiencies was a repeat citation. The complaint was unsubstantiated. Census: 20	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis (TB), within 90 days before the start of employment for 5 of 6 caregivers reviewed (Caregiver D, Caregiver E, Caregiver F, Caregiver H, and Caregiver I). Caregiver E,	N 220		

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N 220	Continued From page 1 Caregiver F, and Caregiver I were not screened for communicable disease including TB. Caregiver D and Caregiver H was not screened for communicable disease. This is a repeat deficiency. See Statement of Deficiency (SOD) 47KH11, dated 06/08/2022. Findings include: On 03/26/2025, at 11:00 AM, Surveyor reviewed staff files and identified the following: Caregiver E was hired on 07/18/2024. Caregiver E's record did not contain evidence Caregiver E was screened for communicable disease including TB. Caregiver F was hired on 10/18/2024. Caregiver F's record did not contain evidence Caregiver F was screened for communicable disease including TB. Caregiver I was hired on 12/16/2024. Caregiver I's record did not contain evidence Caregiver I was screened for communicable disease including TB. Caregiver D was hired on 09/16/2022. Caregiver D's record contained the results of a TB test on 06/16/2022. Caregiver D's record did not contain evidence Caregiver D was screened for communicable disease. Caregiver H was hired on 10/17/2023. Caregiver H's record contained the results of a TB test on 10/18/2023. Caregiver H's record did not contain evidence Caregiver H was screened for communicable disease.	N 220		

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N 220	Continued From page 2 On 03/26/2025, at 2:00 PM, Surveyor interviewed Manager A. Manager A reported s/he was aware staff needed to be screened for TB but was not aware of communicable disease screening. Manager A reported Nurse C was responsible for ensuring staff were screened for TB.	N 220		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the	N 239		

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N 239	Continued From page 3 provider did not ensure 2 of 4 employees (Caregiver E and Caregiver F) obtained all department approved training as required. Caregiver E and Caregiver F did not have training in fire safety within 90 days after starting employment. Caregiver E did not have training in first aid and choking within 90 days after starting employment. Caregiver E, who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these duties. Caregiver E, who had responsibilities for medication administration, did not have training in medication administration and management prior to assuming these duties. Findings include: On 03/26/2025, at 11:00 AM, Surveyor conducted a review of 4 employees to verify compliance with department approved training requirements. Fire Safety Caregiver E was hired on 07/18/2024. Caregiver E's record did not contain evidence of training or evidence of meeting an exemption for fire safety. Caregiver F was hired on 10/18/2024. Caregiver F's record did not contain evidence of training or evidence of meeting an exemption for fire safety. On 03/26/2025, Surveyor verified Caregiver E and Caregiver F were not on the	N 239		

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N 239	Continued From page 4 Community-Based Care and Treatment training registry for fire safety. First Aid and Choking Caregiver E was hired on 07/18/2024. Caregiver E's record did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 03/26/2025, Surveyor verified Caregiver E was not on the Community-Based Care and Treatment training registry for first aid and choking. Standard Precautions Caregiver E was hired on 07/18/2024. Caregiver E's record did not contain evidence of training or evidence of meeting an exemption for standard precautions. Caregiver E did not receive training standard precautions before assuming job responsibilities. On 03/26/2025, Surveyor verified Caregiver E was not on the Community-Based Care and Treatment training registry for standard precautions. Medication Administration Caregiver E was hired on 07/18/2024. Caregiver E's record did not contain evidence of training or evidence of meeting an exemption for medication administration. On 03/26/2025, Surveyor verified Caregiver E was not on the Community-Based Care and Treatment training registry for medication administration.	N 239		

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N 239	Continued From page 5 On 03/26/2025, at 2:00 PM, Surveyor interviewed Manager A. Manager A confirmed the code requirement. Manager A confirmed Caregiver E was required to have standard precaution training and medication administration training due to the job responsiblilities. Manager A reported Caregiver E and Caregiver F went to class. Manager A reported Caregiver E had a certificate from the trainer. Surveyor relayed both Caregiver E and Caregiver F were not on the registry, and Surveyor was unable to find Trainer G's name on the registry as an instructor. Manager A showed Surveyor Trainer G's transcript for the train the trainer classes. Surveyor again relayed Trainer G was not on the registry as an approved trainer. Manager A acknowledged Surveyor's concerns.	N 239		
N 284	83.26(2) Orientation, continuing education documented Employee orientation and hours of continuing education shall be documented in the employee ' s file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure training hours were documented for 4 of 6 caregivers (Caregiver D, Caregiver E, Caregiver G, and Caregiver H). Caregiver E's record did not contain dates of orientation training occurred. Caregiver D's, Caregiver H's, and Caregiver J's record did not contain the dates and hours of continuing education training. Findings include: On 03/26/2025, at 11:00 AM, Surveyor reviewed	N 284		

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N 284	Continued From page 6	N 284		

staff files and identified the following:

Caregiver E was hired on 07/18/2024. Caregiver E's record contained a list of the following trainings Caregiver E received: job responsibilities, abuse, neglect, prevention and reporting, resident needs and client group, emergency plans, policy and procedures, responding to resident's conditions and changes in conditions, resident rights training, basic client needs, evacuation route, and infection control. The documentation did not include on what date Caregiver received the trainings.

Caregiver D was hired on 09/16/2022. Caregiver D's record did not contain evidence of continuing education hours or dates the continuing education was received.

Caregiver H was hired on 10/17/2023. Caregiver H's record did not contain evidence of continuing education hours or dates the continuing education was received.

Caregiver J was hired on 09/16/2022. Caregiver J's record did not contain evidence of continuing education hours or dates the continuing education was received.

Surveyor reviewed a binder of trainings. The trainings in the binder were infection control, Alzheimer's disease verses aging, administering medications, resident rights/HIPPA, abuse/neglect/misappropriation, fire safety, emergency planning, first aid/choking, procedures indwelling catheter/nebulizers/tube feedings, understanding diabetes, general policies and procedures, shower/tub/partial baths, grooming, mental illness with emphasis on anxiety, understanding death and dying, wound care for

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N 284	Continued From page 7 assisted living, activities in the community based residential facility, falls prevention and employee safety. On 03/26/2025, at 2:00 PM, Surveyor interviewed Manager A. Manager A reported staff were responsible for ensuring they review the continuing education binder and complete an exam. Manager A reported there was no instructor for the classes, and management does not keep track of when the staff complete the trainings. Manager A reported s/he was unaware of the code requirements.	N 284		
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 record review and interview, the provider did not ensure each resident received updated Individual Service Plans (ISPs) annually for 1 of 1 resident (Resident 9). Resident 9's ISP was not updated in 2022, 2023, and 2024.	N 389		

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N 389	Continued From page 8 Findings include: On 03/26/2025, at 12:30 PM, Surveyor reviewed Resident 9's record. Resident 9 was admitted on 10/29/2021 with diagnoses including chronic obstructive pulmonary disease, anxiety, major depressive disorder, alcohol abuse, cocaine abuse, viral hepatitis C, rheumatoid arthritis, and psychoactive substance abuse. Resident 9's record contained an ISP, dated 11/02/2021. Resident 9's ISP was due to be updated in 11/2022, 11/2023, and 11/2024. Resident 9's record did not contain any evidence of an updated ISP. On 03/26/2025, at 2:00 PM, Surveyor interviewed Manager A. Manager A reported Nurse C ensures resident ISPs were completed and updated. Manager A reported s/he was unsure if Resident 9's ISP was updated and if the updates were in Nurse C's office.	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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not evaluate each resident's mental or physical capability to respond to a fire alarm at least annually for 2 of 2 residents (Resident 8 and Resident 9). Resident 8 was not evaluated in 2024. Resident 9 was not evaluated in 2022, 2023, and 2024.	N 394		

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N 394	Continued From page 9 Findings include: On 03/26/2025, at 12:30 PM, Surveyor reviewed resident records and identified the following: Resident 8 was admitted on 05/22/2023. Resident 8's record did not contain evidence Resident 8 was evaluated annually in 2024 for evacuation evaluation assessment. Resident 9 was admitted on 10/29/2021. Resident 9's record contained an evacuation evaluation assessment dated 11/01/2021. Resident 9's record did not contain evidence Resident 9 was evaluated annually in 2022, 2023, and 2024 for evacuation evaluation assessment. On 03/26/2025, at 2:00 PM, Surveyor interviewed Manager A. Manager A reported Nurse C would complete the assessments. Manager A reported s/he was unsure if the evaluations were completed if they were not in the resident's files.	N 394		
N 401	83.37(1)(b) Medication label permanently attached. Medications. Prescription medications shall come from a licensed pharmacy or a physician and shall have a label permanently attached to the outside of the container. Over-the-counter medications maintained in the manufacturer ' s container shall be labeled with the resident ' s name. Over-the-counter medications not maintained in the manufacturer ' s container shall be labeled by a pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 401		

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N 401	Continued From page 10 did not ensure medications were labeled to ensure proper and safe usage for 3 of 3 residents. Findings include: On 03/26/2025, at 10:15 AM, Surveyor observed the medication room. The medications were stored in cabinets. Each resident had their own plastic basket. Surveyor observed the following medications without labels attached: Resident 2 2 albuterol inhalers in a plastic bag. There was no label attached to the inhalers or the bag. Resident 2 Bottle of fluticasone did not have a label attached. Budesonide formoterol dihydrate inhaler did not have a label attached. Resident 7 Budesonide formoterol dihydrate inhaler did not have a label attached. On 03/26/2025, at 2:00 PM, Surveyor interviewed Manager A. Manager A confirmed the code requirement. Manager A reported s/he would talk with staff to ensure the labels were not thrown away.	N 401		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a	N 406		

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N 406	Continued From page 11 physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not establish an effective procedure for proper destruction and disposal of expired medications. Expired medications were observed stored with resident's non-expired medications in 2 of 4 medication carts. Findings include: On 03/26/2025, at 10:15 AM, Surveyor observed the medication room. Surveyor observed the following expired medications: Resident 1 albuterol inhaler, expired 10/02/2024 Resident 3 lactase expired 01/29/2025 Antacid plus calcium expired 01/29/2025	N 406		

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N 406	Continued From page 12 Resident 4 acetaminophen 325 milligrams (mg) expired 01/20/2025 Resident 5 lysine 500mg expired 12/25/2024 Resident 6 albuterol inhaler expired 01/18/2025 On 03/26/2025, at 2:00 PM, Surveyor interviewed Manager A. Manager A confirmed the code requirement. Manager A reported there was a lead caregiver who was responsible for weekly checks to ensure expired medication was removed from the medication cabinets.	N 406		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving.	N 452		

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This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure food was stored and served under sanitary conditions. Two frozen pork butt roasts were thawing at room temperature on the kitchen counter for at least 3 hours.

Findings include:

On 03/26/2025, between 10:40 AM and 1:40 PM, Surveyor observed 2 frozen pork butt roasts on a counter in the kitchen. Surveyor touched the roasts bag and noted parts of the roasts were not frozen.

According to the SERVSAFE 7th Edition Coursebook ©2017 National Restaurant Association Educational Foundation chapter 8, page 3 refers to thawing frozen food and states, "When frozen food is thawed and exposed to the temperature danger zone, pathogens in the food will begin to grow. To reduce this growth, NEVER thaw food at room temperature."

On 03/26/2025, at 2:00 PM, Surveyor interviewed Manager A. When Surveyor inquired about the practices of thawing meat, Manager A reported the meat should be in a pan. Surveyor confirmed in a pan on the counter, Manager A reported yes. Manager A reported the roasts were in the freezer and they were having them for tomorrow, so it was needing to be thawed. When Surveyor inquired if it was common practice to thaw meat on the counter, Manager A stated, "I don't want to answer that but yes."

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N 454	Continued From page 14	N 454		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person	N 454		

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AN INNOVATIVE CARE SOUTH WINDS	6305 7TH AVE KENOSHA, WI 53143

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N 454	Continued From page 15 administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain documentation for 3 of 3 resident records (Resident 7, Resident 8, and Resident 9). Resident 7's record did not contain an admission agreement, individual service plan (ISP), preadmission assessment, and results of a fire evacuation assessment. Resident 8's record did not contain an admission agreement, ISP, preadmission assessment, the results of communicable disease screening including tuberculosis (TB), and satisfaction surveys. Resident 9's record did not contain an ISP,	N 454		

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N 454	Continued From page 16 annual assessments for 2022, 2023 and 2024, the results of communicable disease screening including TB, satisfaction surveys for 2022, 2023 and 2024, and psychotropic medication reviews. Findings include: On 03/26/2025, at 12:30 PM, Surveyor reviewed resident records and identified the following: Resident 7 was admitted on 10/24/2024. Resident 7's record did not contain evidence of an admission agreement, individual service plan (ISP), preadmission assessment, and results of a fire evacuation assessment. Resident 8 was admitted on 05/22/2023. Resident 8's record did not contain evidence of an admission agreement, ISP, preadmission assessment, the results of communicable disease screening including tuberculosis (TB), and satisfaction surveys. Resident 9 was admitted on 10/29/2021. Resident 9's record did not contained evidence an ISP, annual assessments for 2022, 2023 and 2024, the results of communicable disease screening including TB, satisfaction surveys for 2022, 2023 and 2024, and psychotropic medication reviews. On 03/26/2025, at 2:00 PM, Surveyor interviewed Manager A. Manager A reported s/he was unsure of where the documentation was. Manager A reported the missing documentation may be in Nurse C's office. Manager A reported Nurse C was out of the office for a personal matter and s/he was unable to get in touch with Nurse C. Surveyor inquired if Manager A was aware all resident documentation was required to be	N 454		

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N 454	Continued From page 17 accessible by staff. Manager A confirmed the code requirement.	N 454		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure 2 of 2 clothes dryers in the laundry room had vent tubing of rigid material, with a fire rating which exceeded the temperature rating of the dryer. The clothes dryers were observed to have the semi-rigid foil type vent tubing. Findings include: On 03/26/2025, at 1:25 PM, Surveyor toured the basement with Maintenance B. Surveyor observed 2 dryers. The vent tubing from the dryers was of a rigid material, which then was connected using a duct splitter. From the duct splitter, there was approximately 4 feet of a semi-rigid foil type vent tubing. On 03/26/2025, at 1:27 PM, Surveyor interviewed Maintenance B. Maintenance B reported s/he was unaware of the code requirement. Surveyor inquired if Maintenance B had documentation which indicated the vent tubing used exceeded the temperature of the dryer or if a waiver had	N 488		

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N 488	Continued From page 18 been filed with the Department. Maintenance B reported s/he would "just change it out." On 03/26/2025, at 5:45 PM, Surveyor reviewed the facility's electronic file with the Department. Surveyor did not review any evidence a waiver was submitted for use of the semi-rigid dryer vent tubing.	N 488		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible materials were not placed within 3 feet of 1 of 1 water heaters. There were plastic covered mattresses stored within 21 inches from the water heater and cardboard boxes within 22 inches from the water heater. Findings include: On 03/26/2025, at 1:25 PM, Surveyor toured the basement with Maintenance B. Surveyor observed 3 mattresses and a boxspring stacked on top of each other. The top mattress was draped in a type of clear plastic, the second mattress had a white zippered mattress covering, the third mattress did not contain a covering and the boxspring did not contain a covering. The third mattress and boxspring were comprised of a cloth covering. The stack of mattresses were 21 inches from the water heater. On the other side of the water heater contained open boxes which contained flooring planks. The boxes were 22 inches from the water heater.	N 507		

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N 507	Continued From page 19 On 03/26/2025, at 1:30 PM, Surveyor interviewed Maintenance B. Maintenance B reported s/he was not aware the code requirement included the water heater. Maintenance B reported the last survey only mentioned the furnaces.	N 507		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure quarterly fire drills were conducted for 2 of 2 years (2023 and 2024). Two drills conducted in 2024 did not contain all the required documentation. A nighttime drill was not documented. Findings include:	N 525		

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N 525	Continued From page 20 On 03/26/2025, at 12:00 PM, Surveyor reviewed facility safety code documentation and identified the following: 2023 Quarter 1 01/12/2023 at 1:39 PM, evacuation time 1 minute, 50 seconds Quarter 2 04/07/2023 at 4:00 PM, evacuation time 2 minutes, 4 seconds Quarter 3 No drill documented Quarter 4 No drill documented 2024 Quarter 1 01/18/2024 at 2:23 PM, evacuation time 2 minutes, 5 seconds Quarter 2 04/07/2024, no time documented, evacuation time 4 minutes, 45 seconds Quarter 3 No drill documented Quarter 4, no time documented, evacuation time 4 minutes, 37 seconds Surveyor was unable to establish compliance with a drill which simulates the conditions of usual sleeping hours. On 03/26/2024, at approximately 12:45 PM, Surveyor interviewed Manager A and Maintenance B. Manager A confirmed the code requirement. Manager A reported s/he thought more drills had been conducted. Manager A inquired to Maintenance B if all the drills had been filed in the binder. Maintenance B reported all drills were filed in the binder and s/he had no other documentation of completed fire drills in her/his office.	N 525		
N 526	83.47(2)(e) Other evacuation drills.	N 526		

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N 526	Continued From page 21 Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster drills were conducted semi-annually for 2 of 2 years. One drill was conducted in 2023, and no drills were conducted in 2024. This is a repeat deficiency. See Statement of Deficiency (SOD) 47KH11, dated 06/08/2022. Findings include: On 03/26/2025, at 12:00 PM, Surveyor reviewed facility safety code documentation. A tornado drill was conducted on 10/12/2023. There was no documentation a second drill was conducted in 2023. The safety files did not contain evidence of other emergency or disaster drills for 2024. On 03/26/2025, at approximately 12:45 PM, Surveyor interviewed Manager A. Manager A confirmed the code requirement. Manager A was unsure why the drills were not completed.	N 526		
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.	N 538		

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N 538	Continued From page 22 This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for an annual fire detection system to be inspected for 1 of 2 years (2023). Findings include: On 03/26/2025, at 12:00 PM, Surveyor reviewed facility safety code documentation. The documentation indicated the fire system had been inspected on 11/22/2022 and 02/01/2024. There was no documentation indicating the fire system had been inspected in 2023. On 03/26/2025, at 2:00 PM, Surveyor interviewed Manager A. Manager A reported the owner relayed through a text message to Manager A the owner relayed due to scheduling conflicts, the fire system inspection was unable to be completed in 2023, and the company had to come out in the beginning of 2024. Surveyor relayed the inspection was to be completed annually, Manager A reported the company did not schedule the inspection until 2024, Surveyor relayed it is the facility's responsibility to ensure compliance with the code requirements.	N 538		
Y3235	50.09(1)(f) Privacy (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (f) Physical and emotional privacy in treatment, living arrangements and in	Y3235		

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Y3235	Continued From page 23 caring for personal needs, including, but not limited to: This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each resident had the right to privacy when electronic monitoring cameras were placed in common areas. This had the potential to effect 20 of 20 residents who resided there. Findings include: On 03/26/2025, at 9:40 AM, Surveyor toured the facility and observed the following: Near the front double doors, there was a black camera with the word "Blink" written on it. The camera was pointed away from the doors and pointed towards a loveseat like couch near the door. Surveyor observed a blue light turn on when Surveyor walked by the camera and down the hallway. Near the kitchen, there was a black camera with the word "Blink" written on it. The camera appeared to be pointed facing the living room/seating room. Surveyor observed residents in the living room watching television, and the	Y3235		

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Y3235	Continued From page 24 blue light on the camera was constant. On 03/26/2025, at 2:35 PM, Surveyor interviewed Manager A. Manager A reported the cameras were placed by the owners after there was an incident of a resident missing a wallet. The owners had to replace the money in the resident's wallet, so they put up cameras. Manager A reported the cameras were only for safety. Manager A reported the owners and Maintenance B had access to the video. Surveyor requested to see the view of the cameras. Maintenance B showed Surveyor the views of the cameras on her/his phone. Surveyor was able to watch the residents in the living room who were watching television. Surveyor turned up the volume on the phone and was able to hear noise from the cameras. When Surveyor relayed concerns about resident privacy, Maintenance B gave an example of what they would use the camera for. In this example, Maintenance B made a hand gesture of a person performing self-pleasure, and who was shielding their eyes. Maintenance B reported if a complaint was lodged regarding that situation, they could go back on the cameras to see if the incident took place. Surveyor questioned if the situation was a common occurrence and if staff were responsible for the supervision of residents, Maintenance B shrugged her/his shoulders.	Y3235		