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PRAIRIE PLACE CBRF	749 E OSHKOSH ST RIPON, WI 54971

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N 000	Initial Comments On 09/12/2023, Surveyor conducted a complaint investigation, 2 verifications visits, and standard survey at Prairie Place CBRF. Six deficiencies were identified. All violations from SOD XZ9Z11, dated 02/14/2023 and SOD E88412, dated 09/15/2021 were substantially corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 18	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 ensure documentation was	N 220		

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

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N 220	Continued From page 1 obtained from a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse indicating 1 of 3 employees (Caregiver E) were screened for clinically apparent communicable disease including tuberculosis (TB). Findings include: On 09/01/2023, Surveyor reviewed employee records and identified the following: Caregiver E had a hire date of 05/24/2023. Caregiver E's record did not contain documentation to show Caregiver E was screened for clinically apparent communicable disease including TB within 90 days of starting employment. On 09/01/2023 at 1:39 PM, Surveyor conducted an exit conference and shared findings with Administrator A and Licensee B. Administrator A stated s/he wanted to check with Caregiver E to see if s/he had documentation of a TB test and communicable disease screen at home. Surveyor informed Administrator A evidence of a TB test and communicable screen for Caregiver E would need to be submitted no later than 09/05/2023. As of 09/06/2023, Surveyor did not receive documentation that Caregiver E was screened for clinically apparent communicable disease including TB within 90 days of starting employment.	N 220		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s	N 381		

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needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure an assessment was completed for 3 of 3 residents reviewed when there was a change in needs.

Resident 1 was not re-assessed when s/he continued to experience falls, began utilizing an assistive device, and had ongoing behaviors.

Resident 2 was not re-assessed when s/he continued to experience repeat falls.

Resident 3 was not re-assessed when s/he continued to have behaviors.

Findings include:

Example 1-Resident 1

Resident 1 was admitted to the provider on 06/25/2020 with diagnoses including type 2 diabetes, left side paralysis, and hypercholesteremia. Resident 1 is their own legal decision maker.

Resident 1's progress notes dated

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N 381	Continued From page 3 03/01/2023-09/01/2023 documented: "03/11/2023: At 11:15 AM, resident was found on [his/her] floor laying on [his/her] left side in front of [his/her] recliner. [S/he] told staff [s/he] was transferring to [his/her] recliner. 03/22/2023: 7:35 PM, staff walked by resident's room. Staff saw resident laying on floor. Resident was laying on bedroom floor. Resident was laying on resident's back between wheelchair and recliner. Staff asked resident if head was hit during fall. Resident stated head was not hit and told staff reason fall happened was trying to self-transfer from wheelchair to recliner. 05/22/2023: Housekeeper found resident on the floor and notified staff. Resident tried to self-transfer to [his/her] chair and ended up on the floor between [his/her] chair and [his/her] scooter. 05/22/2023: Writer was helping coworker transfer resident from [his/her] bed to wheelchair after [his/her] fall when [s/he] began to touch writer. Resident was grabbing inner thigh and attempted to grab chest. 05/31/2023: Staff heard yelling went to go see where it was coming from, and staff found resident on bedroom floor. Resident had injury to left side of [his/her] face it was bleeding. 06/23/2023: When doing rounds, resident was wet and needed to be changed. When changing [him/her] [s/he] punched staff in the face. 07/21/2023: Resident has refused toileting and changing all night. One of the times, staff went in by resident, [s/he] tried to punch staff in the face. 07/26/2023: At 11:00 PM, staff found resident laying on the floor in front of [his/her] recliner on [his/her] left side with [his/her] wheelchair right in front of [him/her]. When asked what happened, [s/he] stated "they said they would come back and they never did, I've been sitting in my wheelchair, and I couldn't get my call light." So	N 381		

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resident was trying to transfer from [his/her] wheelchair to [his/her] recliner. Staff found [his/her] call light under [his/her] blanket and sheet in [his/her] bed to where it was not accessible.
07/27/2023: Staff went to check and change resident at 4:00 AM rounds and resident was swearing at staff member and pinched staff in the arm. Two staff had to boost resident up in [his/her recliner and resident was trying to hit both staff members.
08/28/2023: Staff went to resident after hearing them yell for help. Staff found resident on the floor stuck between the bathroom and bedroom doorway. Resident left arm was stuck between the doorway and their scooter."

Resident 1's progress notes documented 6 falls and 4 incidents of behaviors such as physical aggression and refusing cares.

Resident 1's fall risk assessment dated 04/20/2023 documented Resident 1 had a score of 18/29. The assessment noted, "Total score of 10 or greater indicates that the resident is at high risk for potential falls. Prevention measures should be implemented and documented on the ISP."

Surveyor reviewed Resident 1's outpatient evaluation, consultation, treatment document: 04/04/2023: "You wanted to talk to [him/her] about [his/her] behaviors. Yelling at staff when trying to do [his/her] cares or toilet [him/her] at night. Many times [s/he] refuses HS cares, HS meds and toileting on rounds."

On 09/01/2023 at 8:58 AM, Surveyor observed Resident 1's bedroom. Observed by the left side of the bed, was a pole, from the floor to the

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ceiling. Surveyor asked Administrator A if Resident 1 used the device. Administrator A stated that at times, Resident 1 understood to grab the bar to aid in getting to a standing position or aid in sitting.

Resident 1's individual service plan (ISP) dated 04/25/2023 documented:
"Physical Disabilities, Mobility/Transfer, Alarms & Fall Risk: One assist with transfers, to transfer resident safely. Keep free from falls/harms. Staff assist of one at all times. Staff will ensure call light is in resident's reach.
Behavior Interventions, verbally abusive, aggressive/combative: N/A."

The ISP did not address the use of the pole device. The ISP did not include new interventions to address the ongoing fall risk and behaviors.

The record did not contain an assessment after Resident 1 had documented ongoing falls, behaviors, and the use of an assistive device.

Example 2-Resident 2

Resident 2 was admitted on 04/08/2023 with a diagnosis of Alzheimer's. Resident 2 had an activated healthcare power of attorney that made decisions on his/her behalf.

Resident 2's progress notes dated 05/24/2023-08/29/2023:
"05/24/2023: Resident was sitting in wheelchair watching TV in the community room. Staff found resident on the floor.
05/31/2023: 2 staff heard a thump from the laundry room. Staff found resident on the floor. Staff is not sure what happened.
06/03/2023: Resident tried to stand but ended up

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falling.
06/13/2023: Staff found resident on floor in another resident's room on the floor laying on [his/her] back.
06/23/2023: At 2:15 AM, resident was found on the floor laying on [his/her] back in [his/her] room .....At 5:20 AM, resident was found on the floor laying on [his/her] back in the common area. Red area on the right side of [his/her] back .....6:44 AM, 3 staff found resident on the floor in the common area.
06/30/2023: Staff heard resident's alarm going off. Went to resident's room and found [Resident 2] on the floor in front of [his/her] recliner chair.
07/04/2023: Writer walked past common area looking for resident, since [his/her] chair alarm was going off. Found resident sitting up against the recliner.
07/10/2023: Staff went looking for resident since [his/her] alarm was going off. Resident was in [his/her] bedroom sitting on the floor in front of [his/her] recliner.
07/13/2023: Staff heard resident's bed alarm going off after coming out of another resident's room. Staff found resident in [his/her] room laying on the crash mat on [his/her] back. Resident had BM all over form playing in it.
07/21/2023: Resident has been up all night. Continued all night to try and stand, go in other resident's room, set door alarms off from trying to leave the facility. Scratch both CBRF and RCAC staff when trying to boost [him/her] in [his/her] wheelchair.
07/25/2023: Staff heard resident's alarm going off. Resident was found in [his/her] room on the floor.
07/27/2023: Resident chair alarm was going off. Writer witnessed [him/her] stand from wheelchair and lose balance due to wheelchair not being locked. When writer approached resident [s/he]

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laid flat on [his/her] back.
07/29/2023: Resident was found on the floor in the common area.
08/03/2023: Staff went into resident's room to get [him/her] lunch, staff found resident laying on [his/her] bathroom floor. Staff observed pad alarm on resident's wheelchair, but alarm had not gone off.
08/11/2023: Staff was mopping floor when staff heard a loud noise coming from resident's room. Staff walked in resident room and saw resident on the floor by [his/her] dresser. Staff noticed that the alarm was not on [his/her] bed but on wheelchair.
08/12/2023: Staff went to check on resident and saw resident laying on floor by end of bed on resident's back.
08/17/2023: Another resident came and notified staff that [s/he] saw someone on the floor. Writer and coworkers went to check it out. Found resident laying on the floor, [his/her] head pointed to the bathroom. We saw [his/her] chair alarm was still under [him/her].
08/23/2023: Staff heard resident's seat alarm going off, so staff went to check on them. Staff found resident on the floor in front of their recliner."

Resident 2's progress notes documented 20 falls from May 2023-August 2023.

Resident 2's fall risk assessment dated 04/04/2023 documented Resident 2 as a score of 16/29. The assessment noted, "Total score of 10 or greater indicates that the resident is at high risk for potential falls. Prevention measures should be implemented and documented on the ISP."

On 09/01/2023 at 8:45 AM, Surveyor observed

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Resident 2's bedroom. Observed a quarter rail attached to Resident 2's bed. Observed a fall mat folded up against a table and not stored out of the way.

Resident 2's ISP dated 04/11/2023 documented: "Physical Disabilities, Mobility/Transfer, Alarms & Fall Risk: Transfers independently, To transfer resident safely and keep free from harm/falls, Independent with transfers, staff will assist per resident request."

Resident 2's ISP did not address the use of a fall mat, chair alarm, bed alarm, and quarter rail to mitigate Resident 2's fall risk.

The record did not contain an assessment after Resident 2 had a change in needs requiring the use of a fall mat, chair alarm, bed alarm, and a quarter rail when increased falls occurred.

Example 3-Resident 3

Resident 3 was admitted on 12/29/2021 with diagnoses including Parkinson's, type 2 diabetes, and dementia. Resident 3 had an activated healthcare power of attorney that made decisions on his/her behalf.

On 09/01/2023 at 8:56 AM, Surveyor observed Resident 3's bedroom. Surveyor observed paper and contents of an unused brief shredded all over Resident 3's floor.

On 09/01/2023 at 9:25 AM, Surveyor interviewed Caregiver C. Caregiver C stated Resident 3's bedroom always looked like how the Surveyor observed. Caregiver C stated Resident 3 liked to take anything s/he could find in his/her room and rip it up. Caregiver C stated staff would clean

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Resident 3's room and hours later, paper or other things that can be ripped up would be observed all over Resident 3's floor. Caregiver C stated Resident 3 did not like when staff came into his/her room and would blame staff about the mess s/he caused.

Resident 3's ISP dated 10/19/2022 documented: "Behavior Interventions, verbally abusive, aggressive/combative: N/A."

The ISP did not address Resident 3's behavior of ripping paper and other items to the point his/her room was no longer homelike.

The record did not contain an assessment related to Resident 3's behavior of ripping paper and other items to the point his/her room was no longer homelike.

On 09/01/2023 at 1:39 PM, Surveyor conducted an exit conference and shared findings with Administrator A and Licensee B. Administrator A stated Resident 1's pole device was installed by hospice and they assessed him/her. Administrator A stated s/he could not provide evidence an assessment existed for Resident 1's pole device. Administrator A stated Resident 2 continues to self-transfer without requesting staff assistance. Administrator A confirmed the provider is using a fall mat, chair alarm, bed alarm, and a quarter rail as fall prevention measures. Administrator A noted s/he did not have an updated assessment besides the one completed at admission for Resident 2. Administrator A acknowledged Resident 3's behavior is a concern, and the staff are trying to clean it as much as possible. Administrator A acknowledged s/he did not realize assessments were required when there was a change in

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N 381	Continued From page 10 resident needs. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 381		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there were sufficient number of employees on a 24-hour basis to meet the needs of all residents. Findings include: On 04/04/2023, the department received a complaint that alleged concerns related to staffing. On 09/01/2023, Surveyor conducted a complaint investigation and identified the following: The provider is licensed to care for up to 20 residents in the client groups of advanced age and irreversible dementia/Alzheimer's. On 09/01/2023, Surveyor reviewed the resident roster. There were 18 residents. At 8:15 AM, Administrator A identified Resident 8, Resident 9, and Resident 10 as requiring 2 staff to assist with cares. A review of the provider's employee schedule	N 396		

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dated June, July, and August 2023 documented:
June 3rd shift (NOC): The schedule documented 17 of 30 days where only 1 caregiver was working. The following dates only 1 caregiver was scheduled on the NOC shift: 06/02/2023, 06/03/2023, 06/04/2023, 06/08/2023, 06/09/2023, 06/10/2023, 06/11/2023, 06/15/2023, 06/16/2023, 06/17/2023, 06/18/2023, 06/22/2023, 06/23/2023, 06/24/2023, 06/25/2023, 06/29/2023, 06/30/2023.

July NOC: The schedule documented 20 of 30 days where only 1 caregiver was working. The following dates only 1 caregiver was scheduled on the NOC shift: 07/01/2023, 07/02/2023, 07/04/2023, 07/05/2023, 07/06/2023, 07/07/2023, 07/08/2023, 07/09/2023, 07/13/2023, 07/14/2023, 07/15/2023, 07/16/2023, 07/20/2023, 07/21/2023, 07/22/2023, 07/23/2023, 07/27/2023, 07/28/2023, 07/29/2023, 07/30/2023.

August NOC: The schedule documented 26 of 31 days where only 1 caregiver was working. The following dates only 1 caregiver was scheduled on the NOC shift: 08/01/2023, 08/03/2023, 08/04/2023, 08/05/2023, 08/06/2023, 08/10/2023-08/16/2023, 08/18/2023-08/31/2023.

On 09/01/2023, Surveyor reviewed resident records and identified the following:

Example 1-Resident 8

Resident 8 was admitted on 05/11/2023 with diagnosis including urge incontinence. Resident 8 had an activated healthcare power of attorney that makes decisions on his/her behalf.

Resident 8's pre-admission assessment dated 05/01/2023 documented:
"Describe Resident's Strengths, Abilities, and

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N 396	Continued From page 12 Capacity for Self Care-Needs full assist with cares. Situations of Conditions Which Could put the resident at risk of harm or injury-Not able to bare weight." Resident 8's individual service plan (ISP) dated 05/11/2023 documented: "Toileting/Incontinence: Staff assist of 2 to get on the toilet with the full body lift. Incontinent of bowel and bladder. To be sure residents' elimination needs are met daily. 2 staff members assist [him/her] to the toilet with the full body lift before and after all meals and when [s/he] calls for help 2. 2 staff members need to change [him/her] at night as [s/he] isn't able to assist with turning and repositioning. Physical Disabilities, Mobility/Transfer, Alarms & Fall Risk: 2 staff with the full body lift for all transfers. To transfer resident safely and keep free from harm/falls. 2 staff members to assist with all transfers with the full body lift." Example 2-Resident 9 Resident 9 admitted on 01/25/2021 with diagnoses including muscle weakness, major depressive disorder, UTI, and anxiety. Resident 9 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 9's ISP dated 01/03/2023 documented: "Toileting/incontinence needs assistance with toileting. [S/he] needs to be transferred by 2 staff with the full body lift. All elimination needs will be met. Staff will assist resident with toileting every 2 hours and PRN. It takes 2 staff to change [him/her] in bed as [s/he] cannot assist with repositioning. [S/he] will not use [him/her] call light when [s/he] has to go to the bathroom. [S/he]	N 396		

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yells for staff to come in.
Physical Disabilities, Mobility/Transfer, Alarms & Fall Risk: Staff assist of two with transfers with the full body lift. To transfer resident safely and keep from falls/harm. Staff assist of 2 with transfers with full body lift."

Example 3-Resident 10

Resident 10 was admitted on 12/18/2019 with diagnosis including memory impairment, hearing loss, and CKD stage 3. Resident 10 had an activated healthcare power of attorney that made decisions on his/her behalf.

Resident 10's ISP dated 10/18/2022 documented: "Toileting/Incontinence: 2 assist needed for toileting and changing him. All elimination needs will be met. Staff will assist with toileting and changing of under garments several times through out the day. Due to [him/her] being afraid [s/he] is grabby and very hard to change so it will take 2 staff to change [him/her] in bed.
Physical Disabilities, Mobility/Transfer, Alarms & Fall Risk: 2 assist needed for transfers as [s/he] is a hoyer lift. To transfer resident safely and keep free from harm and falls. 2 assist with all transfers as [s/he] is a full body lift."

On 09/01/2023 at 9:10 AM, Surveyor interviewed Administrator A regarding the staffing concerns mentioned in the complaint. Administrator A stated the provider usually had 3-4 caregivers working 1st shift, 2-3 caregiver working 2nd shift, and 1-2 caregivers working 3rd shift. Surveyor asked if residents on the 3rd shift required the assistance from 2 staff. Administrator A again noted Resident 8, Resident 9, and Resident 10 as requiring 2 staff to assist with cares. Administrator A stated if only 1 caregiver was

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scheduled in the CBRF, another staff member from the RCAC would come over during the 2-hour rounds to assist with cares. Administrator A denied CBRF staff leaving their position to assist RCAC staff. Administrator A noted the provider utilized agency staff some days to ensure enough staff were working to meet the needs of the residents. Administrator A confirmed the provider's schedule was up to date and if a staff member called off or had the day off, a line through their name would be indicated or "off" by their name.

On 09/01/2023 at 9:25 AM, Surveyor interviewed Caregiver C. Caregiver C stated there was always at least 1 person on the CBRF side. Caregiver C noted if assistance was needed on the 3rd shift, a staff member from the RCAC may come over to assist with cares. Caregiver C confirmed the provider used agency staff at times. Caregiver C noted an agency staff was on shift today. Caregiver C stated many of the 3rd shift staff gave their 2-week notice lately, so that shift was harder to fill with consistent staff.

On 09/01/2023 at 10:15 AM, Surveyor interviewed Family Member G. Family Member G reported it appeared the facility was always understaffed. Family Member G reported s/he visits almost daily and when s/he visits, Resident 11 is always missing small daily cares completed such as not having his/her glasses, hearing aids, and grooming tasks. Family Member G noted there were a few good staff members, but due to high turnover, new faces were always present, and it was hard to build relationships with staff.

On 09/01/2023 at 1:39 PM, Surveyor conducted an exit conference and shared findings with Administrator A and Licensee B. Administrator A

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N 396	Continued From page 15 confirmed Resident 8, Resident 9, and Resident 10 all required 2 staff to assist with cares. Surveyor noted after reviewing the CBRF's staff schedule, only 1 caregiver was scheduled during the NOC shift for over half the month, during the months of June, July, and August 2023. Licensee B confirmed the staff schedule was accurate and for years, the facility had operated with only 1 caregiver on the 3rd shift and assistance from RCAC staff when needed.	N 396		
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 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.	N 406		

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This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure 5 of 5 resident medications were disposed of after 30 days of the expiration date.

Findings include:

On 09/01/2023 at 9:45 AM, Surveyor toured the provider's medication cart with Caregiver C. Surveyor observed the following:

-Resident 1 had 36 tabs of Lorazepam 1 mg to be taken as needed and an expiration date of 03/02/2023.
-Resident 1 had 22 tabs of Stool Softener 100 mg to be taken as needed and an expiration date of 11/18/2022.
-Resident 4 had 26 tabs of Loperamide 2 mg to be taken as needed and an expiration date of 05/26/2023.
-Resident 5 had 23 tabs of Benzonatate 200 mg to be taken as needed and an expiration date of 05/16/2023.
-Resident 6 had 55 tabs of Cyclobenzaprine 5 mg to be taken as needed and an expiration date of 06/24/2023.
-Resident 7 had 8 tabs of Senna Plus 8.6-50 mg to be taken as needed and an expiration date of 05/04/2023.

A review of the provider's medication storage inspection dated 04/27/2023 documented 6 outdated PRN medications were found.

On 09/01/2023 at 1:39 PM, Surveyor conducted an exit conference and shared findings with Administrator A and Licensee B. Administrator A stated staff were supposed to review the medication cart for any expired medications.

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N 406	Continued From page 17 Administrator A stated s/he was surprised by the number of expired medication cards since the pharmacy had just completed their review. Surveyor noted most of the expired medications were from the month following the pharmacy's review in April.	N 406		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the environment was safe, clean, and comfortable. Findings include: On 09/01/2023, Surveyor toured the facility and observed the following: Resident 1's room had a heat register attached to the wall that was damaged. The heat register's cover was missing leaving the elements inside open to the environment and wires exposed. Resident 1's bedroom and bathroom walls had black streaks along the bottom. The black streak marks caused damage to the drywall. Resident 1's bathroom door was damaged with holes at the bottom of the door. Resident 3's room had paper and dirt debris all	N 481		

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N 481	Continued From page 18 over the carpet. On 09/01/2023 at 1:39 PM, Surveyor conducted an exit conference and shared findings with Administrator A and Licensee B. Administrator A stated Resident 1's room was damaged due to him/her receiving a new electric wheelchair and s/he was still learning how to use it. Administrator A noted Resident 3's room was always messy, and staff continue to clean on a daily basis. Administrator A noted Resident 3 will rip paper, depends, or anything in his/her room.	N 481		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic substances were secured. Findings include: The facility provides care up to 20 residents in the following client groups: irreversible dementia/Alzheimer's and advanced age. On 09/01/2023 at 8:39 AM, Surveyor toured the facility and observed the laundry room door unlocked and propped open. The laundry room had a gallon of bleach and Shout cleaning spray in the sink. Inside a storage room next to the laundry room contained the following unsecured chemicals: 4 bottles of Shout cleaning spray, 3 bottles of Soft Scrub Cleaner, a spray bottle of	N 499		

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N 499	Continued From page 19 weed killer. In Resident 2's bathroom, Surveyor observed a bottle of Spray N Wash. On 09/01/2023 at 1:39 PM, Surveyor conducted an exit conference and shared findings with Administrator A and Licensee B. Administrator A stated the laundry room cannot be locked, so the provider was in the process of adding a lock to the door. Administrator A noted the storage room should have been locked so memory care residents did not have access and s/he did not know why Resident 2's room had cleaning compounds in the bathroom as this could be a hazard for Resident 2.	N 499		