STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LARSON HOUSE SOUTH	550 RIVER RD COLUMBUS, WI 53925

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 07/21/2026, Surveyor conducted a complaint investigation and standard survey at Larson House South, a CBRF in Columbus. Seven deficiencies were identified. The complaint was substantiated. Census: 23	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on observation and interview, the provider did not submit a written report to the department within 3 working days when law enforcement personnel were called to the facility as a result of an incident that jeopardized the health, safety, or welfare of residents or employees. The provider did not submit a report to the department when law enforcement was called to the provider's facility due to the behavior of Resident 1's Power of Attorney for Health Care (POAHC).	N 164		

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

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N 164	Continued From page 1 Findings include: On 07/21/2026 at 7:00 a.m., Surveyor reviewed the department's self-report records for the facility. Records did not include a self-report related to law enforcement presence at the facility in 2026. On 07/21/2026 at 10:40 a.m., Surveyor reviewed Resident 1's record. Resident 1 resided at the provider's facility from 06/30/2025 to 01/03/2026. Resident 1's progress notes included the following: - 12/25/2025 5:15 p.m. While assisting Resident 1 to the bathroom, there was a knock on the door by local law enforcement. After Resident 1 was done with the bathroom, Resident 1's POAHC invited local law enforcement into Resident 1's room. - 12/25/20206 8:30 p.m. Administrator A received multiple calls from facility today regarding concerns with Resident 1's POAHC and PRN pain medication. During conversation, Resident 1's POAHC became very verbally aggressive with staff as well ad dusting profanity at staff in front of other residents. Staff were instructed to call law enforcement if behavior continued. On 07/21/2026 at approximately 11:00 a.m., Surveyor asked Administrator A if the 12/25/2026 law enforcement presence at the facility was reported to the department. Administrator A stated s/he would check his/her records. On 07/21/2026 at approximately 2:15 p.m., Surveyor interviewed Administrator A and RN B. Administrator A stated s/he was unable to locate a self-report. RN B provided Surveyor with an email from the provider's regional director, dated	N 164		

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N 164	Continued From page 2 07/21/2026, that stated, "The facility did not complete a self-report regarding the involvement of law enforcement with an intoxicated family member because the incident did not involve suspected abuse, neglect, exploitation, mistreatment, or injury to a resident. Staff contacted law enforcement as a proactive measure to prevent potential escalation and to ensure the safety of a resident, family member, staff and others present."	N 164		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 5 residents reviewed receiving their medications as prescribed. Resident 1 admitted to the provider's facility on 06/30/2026 with an order for Buprenorphine patch weekly but did not receive the Buprenorphine patch until 07/11/2026. Resident 4 did not receive his/her Latanoprost .005% eye drops on 9 dates in February 2026. Findings include: On 07/21/2026, Surveyor conducted a complaint investigation alleging medication administration concerns at the facility. Surveyor identified the	N 352		

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N 352	Continued From page 3 following concerns: Example 1 - Resident 1's Buprenorphine Patch: On 07/21/2026 at 10:40 a.m., Surveyor reviewed Resident 1's record. Resident 1 resided at the provider's facility from 06/30/2025 to 01/03/2026. Resident 1's diagnoses included dementia. Resident 1's admission physician orders, dated 06/30/2026, included Buprenorphine 10 mcg/HR weekly patch - Apply 1 patch weekly. Resident 1's medication administration record (MAR), dated 06/30/2026 to 07/31/2026, indicated Resident 1 received his/her first Buprenorphine 10 mcg/HR patch at the provider's facility on 07/11/2026. Resident 1's progress notes included the following documentation: - 07/10/2026 12:45 p.m. Power of Attorney for Health Care (POAHC) called to check on resident and stated s/he got a pain patch once weekly. Writer advised the medication was not in the facility's system to give. Writer contacted primary care physician who will send order to pharmacy and facility for Buprenorphine 10 mcg. - 07/10/2026 2:00 p.m. Received order for Buprenorphine 10 mcg/HR weekly. On 07/21/2026 at 12:16 p.m., Surveyor interviewed Administrator A regarding the Buprenorphine patch. Administrator A stated the facility was unaware the patch was ordered until Resident 1's POAHC called on 07/10/2026. Administrator A stated the provider was going off Resident 1's MAR, completed by pharmacy, which only listed medications the pharmacy had supplied. Surveyor shared observation that the provider had received Resident 1's admission orders, allowing the provider to identify the discrepancy between the orders and the MAR. Administrator A stated the missing patches	N 352		

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N 352	Continued From page 4	N 352		

should have been caught by the provider while reviewing orders. Administrator A stated s/he was unsure if Resident 1 was admitted wearing a patch.

Example 2 - Resident 4's Eye Drops:

On 07/21/2026 at 12:55 p.m., Surveyor interviewed Resident 4. Resident 4 expressed concern that a few months back a caregiver had accidentally taken Resident 4's eye drops home on 2 separate occasions. Resident 4 stated the caregiver wouldn't drive back to return the eye drops, so s/he had to go without eye drops for several days. Resident 4 stated s/he resolved the situation by reaching out to his/her doctor and requesting permission to administer the eye drops him/herself.

On 07/21/2026 at 1:05 p.m., Surveyor interviewed Caregiver C. Caregiver C stated s/he recalled a time when Resident 4's eye drops were unavailable but couldn't recall the date.

On 07/21/2026 at approximately 1:30 p.m., Surveyor interviewed Administrator A and asked if there was a time Resident 4 had gone without his/her eye drops because the eye drops were at a caregiver's home. Administrator A stated s/he wasn't aware but would have been in his/her regional position at that time. Administrator A stated s/he would investigate it.

On 07/21/2026 at approximately 1:45 p.m., Surveyor reviewed Resident 4's MAR, dated 02/01/2026 to 03/01/2026, which listed Latanoprost .005% eye drops 1 time daily. The MAR documented the eye drops as administered 02/01/2026 through 02/15/2026, 02/17/2026 through 02/19/2026 and on 02/26/2026. The MAR

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N 352	Continued From page 5 documented the medication as "not in cart" on 02/20/2026 through 02/23/2026, "other" on 02/24/2026 with no notation and "not in cart" 02/25/2026 through 02/28/2026. Administrator A stated the medication was attempted to fill on 02/20/2026 and 02/22/2026; however, a notation stated the drops weren't due for a fill. Administrator A stated s/he was unsure why the eye drops were due for a refill prior to being eligible and was unable to confirm why the eye drops were unavailable for administration 9 days in February.	N 352		
N 425	83.38(1)(a) Personal care. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure personal care services provided by staff were adequate to meet resident needs.	N 425		

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N 425	Continued From page 6 Resident 2 did not receive catheter cares appropriate to his/her needs. Findings include: On 07/21/2026 at 8:00 a.m., Surveyor observed Resident 2 in his/her bed with the head of the bed raised. Surveyor observed Resident 2's catheter bag attached to a bedrail at the head of the bed, resulting in the catheter bag being higher than the tubing. Surveyor observed a sign above Resident 2's bed instructing caregivers where to clip Resident 2's catheter bag to ensure proper drainage. On 07/21/2026 at 10:30 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 11/15/2021. Resident 2's individual service plan (ISP), dated 11/21/2025, documented that caregivers were to assist Resident 2 with personal cares, including transfers, dressing, incontinence cares and positioning. On 07/21/2026 at 1:30 p.m., Surveyor observed Caregiver C escort Resident 2 to activities in his/her wheelchair. Surveyor observed Resident 2's catheter bag exposed with the tubing dragging on the ground. On 07/21/2026 at 1:36 p.m., Surveyor observed Resident 2 playing Bingo in the common area with his/her catheter bag exposed and tubing resting on the ground. On 07/21/2026 at approximately 2:00 p.m., Surveyor reviewed catheter care concerns with Administrator A and RN B. Administrator A stated s/he would order a bag to hold Resident 2's catheter bag and ensure the bag was off the	N 425		

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N 425	Continued From page 7 ground. RN B stated s/he would complete education with caregivers.	N 425		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure medication administration services were provided to meet the needs of 3 of 5 residents reviewed. Resident 1 did not receive his/her bisacdoyl suppository on 2 occasions when s/he was constipated. Resident 1 did not receive his/her PRN Morphine when exhibiting pain. Resident 2 did not receive hydrocortisone cream to his/her hemorrhoids. Resident 3 received expired Refresh Liquigel 1 eye drops from 07/13/2026 through 07/20/2026. Findings include: On 07/21/2026, Surveyor conducted a complaint investigation alleging medication administration	N 432		

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concerns at the provider's facility. The following concerns with medication administration were identified:

Example 1 - Resident 1's Bisacodyl Suppository:

On 07/21/2026 at 10:40 a.m., Surveyor reviewed Resident 1's record. Resident 1 resided at the provider's facility from 06/30/2025 to 01/03/2026. Resident 1's diagnoses included dementia. Resident 1's progress notes documented the following:
- 12/12/2025 12:45 a.m. Staff reordered resident's suppository because s/he was impacted a great amount. Staff was having a hard time helping resident, so staff called coworker over. Staff assisted resident to his/her side to try to help pass bowel movement but was only able to get out a small amount. Still very much impacted. Wanted to administer suppository but needed to reorder it. Gave prune juice.
- 12/12/2025 5:45 a.m. Resident screaming in pain because of extra large bowel movement. It took multiple caregivers to help relieve the pain and pass the bowel movement.

Resident 1's hospice record, obtained by surveyor, included a 12/26/2026 7:18 a.m. note that stated a caregiver reported Resident 1 had not had a substantial bowel movement in several days. The caregiver had reported Resident 1 was on the toilet calling out in pain due to constipation. Resident 1 was given PRN milk of magnesia and miralax earlier in the morning without results. Resident 1 had an order for bisacodyl suppositories but there was not a nurse at the provider's facility to administer a suppository, and caregiver was unsure if s/he could administer a suppository.

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N 432	Continued From page 9 Resident 1's MAR, dated 12/01/2026 to 12/31/2026, did not document any administrations of his/her bisacodyl suppository. On 07/21/2026 at 12:18 p.m., Surveyor interviewed Administrator A and RN B regarding Resident 1 receiving suppositories. Administrator A stated bisacdoyl suppositories were reordered on 12/12/2025. Administrator A stated the prior delivery of bisacodyl suppositories was 07/26/2025 and s/he was unable to confirm if that supply was depleted or why bisacodyl suppositories were unavailable for administration on 12/12/2025. Administrator A stated the caregiver working on 12/26/2026 was delegated to administer suppositories and would have been able to do so. Example 2 - Resident 1's Pain Management: Resident 1's hospice record, obtained by surveyor, documented the following concerns with Resident 1's pain management: - 12/21/2025 11:30 a.m. Resident has been in pain, reported 10/10 pain. Resident reported pain "everywhere." PRN had not been administered. Hospice RN provided education to caregiver that if Resident 1 was having breakthrough pain 30-60 minutes after scheduled dose of Morphine, s/he could receive a PRN dose and that can be given every 4 hours as needed. Hospice RN explained that administration of PRN Morphine is independent of scheduled Morphine. *Per MAR, Morphine PRN administered at 11:37 a.m. after hospice arrival. - 12/23/2025 9:15 a.m. Hospice RN arrived. Caregiver reported resident was having more pain today and cream was applied to back and knees. Walked into room and resident was scrunched in bed. Resident stated s/he was	N 432		

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having pain "all over" and reported it as 10/10. Facility med passer stated the electronic charting program wouldn't allow him/her to give more PRN doses for pain as the computer states max dose. Management stated the narcotic log should be reviewed for PRN administration as well as the computer because the computer doesn't always have administration documentation. *Per MAR, Morphine PRN administered at 9:34 a.m. after hospice arrival.
- 12/24/2025 6:28 p.m. Resident's Power of Attorney for Health Care (POAHC) called reporting that s/he requested PRN Morphine around 4:30 p.m. and as of 6:10 p.m., PRN Morphine had not been administered. 8:15 p.m. Hospice RN arrived to facility and resident reported pain from head to toe, rated at 5/10. Caregiver, who was not the medication passer, reported PRN Morphine was administered; however, POAHC denied this. Caregiver could be mistaken. *Per MAR, Morphine PRN was not administered.
- 12/25/2026 4:59 p.m. POAHC called hospice reporting that PRN Morphine was requested over 2 hours ago. Resident was in extreme pain and couldn't walk. 5:23 p.m. Hospice RN called facility. Med passer reported resident appeared comfortable and denied needing pain medication. Hospice RN called POAHC back and could hear resident agitated in the background, yelling in pain. Hospice RN called facility and asked med passer to administer PRN pain medication. *Per MAR, PRN Morphine administered at 7:08 p.m. (greater than 1 hour after call).
- 12/26/2026 8:25 a.m. Email sent to care team, including director of facility, regarding administration of PRN Morphine. Hospice instructed to complete an assessment 1 hour after scheduled Morphine was administered and every 2 hours. Hospice instructed the

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N 432	Continued From page 11 assessment to be as follows, "Go to [Resident 1]'s room, lightly touch [him/her] to wake [him/her] up, ask [him/her] if [s/he] is in pain, ask [him/her] to move [his/her] legs and body. If [s/he] is in pain, ask if [s/he] would like medication. If you are unable to wake [Resident 1] stay in [his/her] room attempt to wake again and observe [him/her] with use of the below scale. Observe patient for 5 minutes before scoring them on their five behaviors. Breathing: Normal (1); little labored (1); Noisy labored breathing (2). Negative vocalization: None (0); Occasional moan (1); Loud moaning (2). Facial expression: Smiling (0); Sad (1); Grimacing (2). Body language: Relaxed (0); Tense (1); Rigid (2). Consolability: No need to console (0); Distracted (1); Unable to console (2). Total all scores above: 1-3=Mild pain; 4-6=Moderate pain; 7-10=Severe pain. If [Resident 1] denied having but you are noticing signs of pain as indicated by the above scale, please give a PRN dose of morphine. If there is a pain level of 4 or above, please give a PRN dose of Morphine. A PRN Morphine can be given as soon as 1 hour after the scheduled dose of Morphine. The PRN is listed for every 4 hours, so up to 6 doses can be given in a 24-hour period. If you are unsure or question whether or not to give meds, please call [hospice] number and they can talk through what is being observed and what the next step would be." *Follow up 12/28/2026 hospice note documented the med passer was unable to locate these instructions. Review of Resident 1's record, including MAR, dated 12/01/2026 to 01/03/2026, and ISP, dated 12/23/2025, did not include pain assessment as instructed by hospice. The MAR documented a pain assessment ("Are you having any pain" and "What is resident's pain level") was to be completed at 9:00 a.m., 4:00 p.m., 7:00 p.m. and 10:00 p.m.	N 432		

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N 432	Continued From page 12 On 07/21/2026 at approximately 2:15 p.m., Surveyor interviewed Administrator A and RN B regarding Resident 1's pain management. Administrator A stated Resident 1's pain management was difficult and s/he received many calls regarding the administration of Resident 1's PRN Morphine. Administrator A stated Resident 1's POAHC would state Resident 1 was having pain and request the PRN Morphine when the resident wasn't exhibiting pain. Administrator A stated s/he was unaware a pain assessment had been sent to the provider because it was sent to the director. Administrator A stated s/he had placed the 9:00 a.m., 4:00 p.m., 7:00 p.m. and 10:00 p.m. pain related questions in Resident 1's MAR to assist with PRN Morphine administration. Example 3 - Resident 2's Hydrocortisone Cream: On 07/21/2026 at 8:15 a.m., Surveyor interviewed Resident 2. Resident 2 stated s/he had recently had loose stools and now had a sore bottom. On 07/21/2026 at 10:30 a.m., Surveyor reviewed Resident 2's record, provided by Administrator A. Resident 2 was admitted to the provider's facility on 11/15/2021. Resident 2's record indicated the provider's staff were responsible for medication administration. Resident 2's progress notes included the following: - 07/07/2026 2:00 p.m. Writer was approached by staff on resident's unit. Resident having discomfort while having a bowel movement. Has a hemorrhoid. Writer emailed physician requesting cream for resident. - 07/07/2026 2:30 p.m. Received order for preparation h or equivalent hemorrhoidal cream 1%. Apply thin layer to external hemorrhoids	N 432		

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	0019950	A. BUILDING: _____ B. WING _____	C 07/21/2026

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every 6 hours as needed for hemorrhoidal pain, itching, burning or irritation. Cleanse and dry the area prior to application. Order sent to pharmacy.

On 07/21/2026 at approximately 1:05 p.m., Surveyor interviewed Caregiver C, who was responsible for Resident 2's medication administration on 07/21/2026. Surveyor asked if Resident 2 was prescribed anything for hemorrhoids. Caregiver C replied, "Not that I'm aware of."

On 07/21/2026 at approximately 2:15 p.m., Surveyor interviewed Administrator A and RN B and asked if Resident 2 had received any medication for hemorrhoids. RN B reviewed records and stated hydrocortisone cream was delivered on 07/07/2026 at 4:15 p.m. Surveyor reviewed Resident 2's MAR, dated 07/01/2026 to 07/21/2026, with Administrator A and RN B. The MAR listed hydrocortisone 1% cream - Apply thin layer to rectal area every 6 hours as needed for pain, itching, burning or irritation. The MAR did not document any administrations of the medication. RN B stated Resident 2 would need to ask for the medication. Surveyor shared that Resident 2 had expressed concern with pain to his/her bottom and the current medication passer was unaware of the hydrocortisone order. Administrator A made note of Surveyor's concern.

Example 4 - Resident 3's Eye Drops:

On 07/21/2026 at approximately 1:05 p.m., Surveyor observed the provider's medication cart with Caregiver C. Surveyor observed Refresh Liquigel 1% eye drops for Resident 3 that were labeled "Opened 06/14, Expired 07/12." Surveyor observed this was the only bottle of Liquigel in Resident 3's supply.

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N 432	Continued From page 14 On 07/21/2026 at approximately 2:15 p.m., Surveyor interviewed Administrator A and RN B. Surveyor shared observation that Resident 2's Refresh Liquigel eye drops were expired and requested Resident 3's MAR, dated 07/01/2026 to 07/21/2026. Surveyor reviewed the MAR, which indicated Resident 2 continued to receive his/her Refresh Liquigel eye drops from 07/13/2026 through 07/20/2026 after they had expired.	N 432		
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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored and served in	N 452		

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N 452	Continued From page 15 sanitary conditions. The provider's ovens were observed with burnt food on the interior surface, a freezer had frozen liquid on the bottom, pudding was stored without a date and food that was stored on the ground. Findings include: On 07/21/2026 at 9:00 a.m., Surveyor toured the provider's memory care unit of the facility. Surveyor observed a kitchen that was used for warming and serving food that was prepared at the affiliated facility next door. Surveyor observed the interior surface of the oven, used to warm food prior to serving, was covered in burnt food, black and white in color. On 07/21/2026 at 9:05 a.m., Surveyor toured the provider's food storage area. Surveyor observed an open box of individually bagged coffee grounds stored on the ground. On 07/21/2026 at 12:58 p.m., Surveyor toured the provider's kitchen in the assisted living unit of the facility. Surveyor observed the freezer's interior surface was covered in frozen liquid that was gray, brown and clear. Surveyor observed the interior surface of the oven, used to warm food prior to serving, was covered in burnt food, black and white in color. Surveyor also observed to 2 large strawberry yogurt containers that were filled with chocolate pudding and butterscotch pudding. Surveyor asked Caregiver C when the puddings were made. Caregiver C stated s/he was unsure and would throw the puddings away. "Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of	N 452		

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N 452	Continued From page 16 death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022). On 07/21/2026 at approximately 2:15 p.m., Surveyor interviewed Administrator A and RN B. Surveyor discussed food safety concerns. Administrator A took note of Surveyor's concern and stated s/he would follow up.	N 452		
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 record review and interview, the provider did not ensure 2 of 4 dryers had vent tubing made of rigid material. The dryers located on the memory care unit of the facility had semi-rigid vents. Findings include: On 07/21/2026 at approximately 9:10 a.m., Surveyor observed the laundry room located in the provider's memory care unit. Surveyor observed 2 of 2 dryer vents were vented with semi-rigid material.	N 488		

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N 488	Continued From page 17 "Flexible vents can twist, allowing lint to build up and catch on fire if it comes in contact with a sufficient amount of heat. If a fire starts beneath the dryer when the motor overheats, then the drafts from the dryer can pull the fire up into the duct, allowing a house fire to develop." ("Clothes Dryer Fires in Residential Buildings (2008-2010)", Topical Fire Report Series, Volume 13, Issue 7, August 2012, Page 7). On 07/21/2026 at 1:16 p.m., Surveyor interviewed Administrator A and RN B. Surveyor discussed concern that 2 of 4 dryers in the facility were vented with semi-rigid material. Administrator A responded, "Are you serious," and explained s/he thought the provider had recently checked the dryer vents in all their buildings.	N 488		
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.	N 525		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure at least 1 fire drill that simulated conditions during usual sleeping hours was conducted annually.

The provider did not conduct a fire drill that simulated sleeping hours from 01/01/2025 to 07/21/2026.

Findings include:

On 07/21/2026 at 8:45 a.m., Surveyor reviewed the provider's environmental documentation, dated 01/01/2025 to 07/21/2026, provided by RN B. Documentation included the following fire drills:
- 01/15/2025 11:30 a.m.
- 02/04/2026 1:15 p.m.
- 06/02/2026 10:30 a.m.

On 07/21/2026 at 1:45 p.m., Surveyor interviewed Administrator A and shared that the environmental binder included only 3 fire drills, none of which simulated nighttime hours, from 01/01/2025 to 06/02/2026. Administrator A stated s/he was certain additional fire drills were completed. Administrator A checked his/her "virtual state binder," which is reportedly electronic records, and was unable to locate additional fire drills.

On 07/21/2026 at 5:49 p.m., Surveyor received an email from Administrator A that stated s/he had located additional fire drills and provided documentation of fire drills completed on the following dates and times:
- 04/16/2025 11:15 a.m.
- 08/25/2025 2:40 p.m.

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N 525	Continued From page 19 - 12/30/2025 10:45 a.m. From 01/01/2025 to 07/21/2026, the provider had not completed a fire drill that simulated sleeping hours.	N 525		