STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	INITIAL COMMENTS On 05/26/2026, with information gathered through 05/27/2026, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation and a verification visit of statement of deficiency (SOD) 0UES11 at Joy Home Care located at 1908 N Chapman Drive in Waukesha, WI. Four citations of noncompliance were issued, including 2 repeat citations. The complaint was unsubstantiated. Census: 3 Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{M 000}		
{M 346}	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 2 was evaluated annually for evacuation time, using the department's form. This requirement is being cited for a second time. See Statement of Deficiency (SOD) 0UES11, issued on 03/12/2026.	{M 346}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 346}	Continued From page 1 The findings include: On 05/26/2026 at approximately 9:15 A.M., Surveyor observed Resident 2 seated in a wheelchair located in the living room near the front door. Resident 2 said s/he utilized the wheelchair for all mobility. On 05/26/2026, Surveyor reviewed Resident 2's record, as provided by Caregiver B. Caregiver B told Surveyor Resident 2's record was complete. Resident 2 was admitted to the facility on 04/26/2024. Resident 2's evacuation assessment was dated 04/27/2024, with documentation included under "Evaluator's Remarks:" including, "04/26/2025, cooperated timely. No changes." Resident 2's record did not include an annual evacuation evaluation was completed and documented for Resident 2 as of 05/26/2026. On 05/26/2026 at 9:45 A.M., Caregiver B utilized his/her phone to contact Licensee A who was not available at the facility. Surveyor conducted an interview with Licensee A. Licensee A stated Resident 2's record contained the most current documentation and s/he was not aware of this requirement. Licensee A said s/he was going to correct this noncompliance.	{M 346}		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following:	M 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 410	Continued From page 2	M 410		

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not ensure Resident 1's individual service plan (ISP) contained a description of the services provided to Resident 1 based on need by the facility and by outside agencies.

The findings include:

On 05/26/2026 at 9:15 A.M., Surveyor observed Resident 1 assisted to the kitchen dining room table in his/her wheelchair by a home care agency caregiver. Surveyor observed a cushion/pillow located between Resident 1's left side and the left arm of the wheelchair.

On 05/26/2026 at approximately 9:30 A.M., Surveyor observed Resident 1 seated at the facility's kitchen table across from Surveyor. Surveyor observed Resident 1's head leaning to his/her left side with head hanging down and eyes closed. Surveyor observed Caregiver B gently put his/her hand on Resident 1's left cheek, lift Resident 1's head, and stated Resident 1's name. Surveyor observed Resident 1 was slow to respond to Caregiver B's interaction.

On 05/26/2026 at approximately 10:15 A.M., Surveyor observed Caregiver B and Caregiver C utilize a mechanical Hoyer lift to transfer Resident 1 from his//her wheelchair to Resident 1's bed. Surveyor observed Resident 1 had knee-high type socks on both of Resident 1's feet and legs, cushion/repositioning devices located in Resident 1's wheelchair, and cushion devices applied to both feet of Resident 1's wheelchair. Surveyor observed a body length pillow located on a chair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 410	Continued From page 3	M 410		

near Resident 1's bed. Caregiver B said the body length pillow was used to reposition Resident 1 to Resident 1's left side, as this was the only side Resident 1 would allow to be positioned when in bed. Caregiver C demonstrated how both of Resident 1's feet were to be "floated" above the mattress with rolled blankets related to Resident 1's right heel skin breakdown.

On 05/26/2026 at approximately 11:07 A.M., Caregiver B told Surveyor Resident 1 had visits from a home care agency 3 times a week to provide wound care to Resident 1's right heel skin breakdown, Resident 1 required the use of a mechanical Hoyer lift for all transfers, Resident 1 required socks to both feet every day, and Resident 1 required all food to be pureed and fed to Resident 1 by a caregiver. Caregiver B told Surveyor Resident 1 was not able to independently reposition self in bed and/or chair. Caregiver B said Resident 1 was provided with daily bed baths instead of a shower or standard bath. Caregiver B said Resident 1 was transferred out of bed in the morning, assisted with breakfast, and transferred back to bed for a nap and to prevent further skin breakdown. Caregiver B said Resident 1 was transferred out of bed for lunch and/or supper when Resident 1 agreed to be transferred.
Caregiver B told Surveyor Resident 1 sometimes yelled and "thrashed around."

On 05/26/2026, Surveyor reviewed Resident 1's record, as provided by Caregiver B.
Resident 1 was admitted to the facility on 08/15/2025, as documented on a list of resident dates of admission from Caregiver B. Resident 1's diagnoses included schizophrenia, bipolar disorder, seizures, congestive heart failure, peripheral vascular disease, hypertension,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 410	Continued From page 4 venous insufficiency, and paraplegia. Resident 1's most recent individual service plan [ISP], signed 02/10/2026, included, "Medication: Totally assisted by staff [caregivers]" and "Behaviors: None." Resident 1's ISP did not address any prescribed "scheduled" or "as needed" psychotropic medications. Resident 1's ISP included, "totally assisted by staff" or "assisted by staff" regarding Resident 1's activities of daily living/care needs. Resident 1's ISP did not address the use of a mechanical lift to transfer Resident 1, the use of repositioning devices, socks, and plan to alleviate pressure and skin breakdown, pureed food, and Resident 1's need for home care agency services related to current need for wound care. On 05/26/2026 at 12:52 P.M., Caregiver B utilized his/her phone to contact Licensee A who was not available at the facility. Surveyor conducted an interview with Licensee A and discussed Resident 1's current ISP. Licensee A said s/he was responsible for developing and updating resident ISPs. Licensee A said s/he developed Resident 1's ISP but did not understand ISPs required a description of the services provided, including services provided by outside agencies.	M 410		
{M 462}	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician.	{M 462}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 462}	Continued From page 5 This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 2's insulin medication was securely stored. This requirement is being cited for a second time. See Statement of Deficiency (SOD) 0UES11, issued on 03/12/2026. The findings include: On 05/26/2026 at 9:00 A.M., Caregiver B told Surveyor Resident 2 was the only current resident prescribed to receive insulin injections daily. Caregiver B told Surveyor the caregivers were responsible for administering Resident 2's insulin injection every morning. On 05/26/2026 at approximately 9:15 A.M., Surveyor observed Resident 2 seated in a wheelchair located in the living room near the front door. Resident 2 said s/he utilized the wheelchair for all mobility. Surveyor observed Resident 2 was capable of propelling his/her wheelchair independently within the facility. On 05/26/2026 at 10:07 A.M., Caregiver B and Surveyor observed a box labled with Resident 2's name and containing 2 full Lantus Solostar insulin pre-filled, injectable pens and a single, pre-filled Lantus Solostar insulin pen stored within a clear, open shelf of the door within the facility's refrigerator located in the kitchen. Surveyor observed the refrigerator door was not secured or locked. Caregiver B told Surveyor all of Resident 2's insulin available at the facility was stored	{M 462}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 462}	Continued From page 6 within the facility's refrigerator as observed. Photos 1 and 2. On 05/26/2026 at 10:37 A.M., Surveyor observed Resident D, a resident visiting from Licensee A's other licensed facility, ambulating freely within the kitchen and living room area without constant supervision by Caregiver B and/or Caregiver C, and Prospective Resident E and his/her family member touring the facility and not always supervised by Caregiver B and/or Caregiver C during their visit. On 05/26/2026 at 12:52 P.M., Caregiver B utilized his/her phone to contact Licensee A who was not available at the facility. Surveyor conducted an interview with Licensee A and discussed Resident 2's insulin not securely stored, a repeat citation of noncompliance. Licensee A told Surveyor s/he would correct this noncompliance.	{M 462}		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on observation, interview, and record	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 7	M 582		

review, the provider did not ensure Resident 1 received an "as needed" psychotropic medication, clonazepam, as prescribed.

The findings include:

On 05/26/2026 at approximately 9:30 A.M., Surveyor observed Resident 1 seated at the facility's kitchen table across from Surveyor. Surveyor observed Resident 1's head leaning to his/her left side with head hanging down and eyes closed. Surveyor observed Caregiver B gently put his/her hand on Resident 1's left cheek, lift Resident 1's head, and stated Resident 1's name. Surveyor observed Resident 1 was slow to respond to Caregiver B's interaction.

On 05/26/2026, Surveyor reviewed Resident 1's record, as provided by Caregiver B.
Resident 1 was admitted to the facility on 08/15/2025, as documented on a list of resident dates of admission from Caregiver B. Resident 1's diagnoses included schizophrenia, bipolar disorder, and seizures.
Resident 1's most recent individual service plan [ISP], signed 02/10/2026, included, "Medication: Totally assisted by staff [caregivers]" and "Behaviors: None." Resident 1's ISP did not address any prescribed "scheduled" or "as needed" psychotropic medications.

On 5/26/2026 at 11:26 A.M., Surveyor observed Caregiver B remove a blister pack card of clonazepam 0.5 mg including a pharmacy label including Resident 1's name and "Take 1 tablet by mouth three times daily as needed for anxiety/agitation" from the medication closet. Caregiver B said this blister pack card was the only remaining card for Resident 1 at the facility. Caregiver B said s/he needed to order more from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 8	M 582		

the pharmacy. The blister pack card included, "Card 3 of 3." The pharmacy label included a quantity of 90 tablets were "filled: 03/01/2026." Surveyor observed 4 tablets remaining within the blister pack card, unopened, indicating 86 tablets had been dispensed from the blister pack cards. Caregiver B told Surveyor all of the 86 tablets dispensed had been administered to Resident 1. Photo 3.
Caregiver B showed Surveyor Resident 1's scheduled clonazepam 1 mg tablets were packed in individual envelope packets for the specific date and time the medication was to be administered, not in a blister pack card.

On 05/26/2026, Surveyor reviewed Resident 1's current practitioner's orders, as provided by Caregiver B, included, "Clonazepam 1 mg [milligram] tabs [tablets]. Take 1 tablet by mouth three times daily [scheduled]" to be administered at "8:00 A.M., 4:00 P.M., and 8:00 P.M." The prescription was dated "01/12/2026."
Resident 1's current practitioner's orders included, "Clonazepam .05 mg tabs. Take 1 tablet by mouth three times daily, as needed [PRN] for anxiety/agitation." This prescription was dated 10/27/2025.
Surveyor reviewed Resident 1's medication administration record [MAR] for March 2026, including documentation of administration of Resident 1's prescribed scheduled and "as needed" clonazepam. Resident 1's March 2026 MAR included Resident 1 received three scheduled doses of clonazepam every day between 03/01/2026 and 03/31/2026. Resident 1's March 2026 MAR included caregivers documented their initials within one box for each date regarding administration of Resident 1's "as needed" clonazepam: 03/04/2026; 03/14/2026; 03/15/2026; 03/16/2026; 03/17/2026; 03/24/2026;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 9 03/25/2026; 03/26/2026, 03/29/2026; and 03/31/2026. Caregiver B told Surveyor caregivers documented their initials within the box for each date, as reviewed, that up to 3 doses of PRN clonazepam was administered to Resident 1 on each individual date. Surveyor observed the back of all the pages of Resident 1's March, April, and May 2026 MARs, including the "as needed" MAR, did not include any caregiver documentation. Caregiver B said s/he did not realize the back of the MAR could be utilized to document individual doses of "as needed" medication administration including the reason for administration and Resident 1's response to the medication. Resident 1's April 2026 MAR included Resident 1 received three scheduled doses of clonazepam every day between 04/01/2026 and 04/30/2026. Resident 1's April 2026 MAR included caregiver initials within one box for each date regarding administration of Resident 1's "as needed" clonazepam: 04/02/2026; 04/04/2026; 04/05/2026; and 04/10/2026 through 04/29/2026. Caregiver B told Surveyor Resident 1 was hospitalized between 04/05/2026 and 04/10/2026. Resident 1's May 2026 MAR included Resident 1 received three scheduled doses of clonazepam every day between 05/01/2026 and the 8:00 A.M. dose on 05/26/2026. Resident 1's May 2026 MAR included caregiver initials within one box for each date regarding administration of Resident 1's "as needed" clonazepam on each date between 05/01/2026 and approximately 12:00 P.M. on 05/26/2026. Caregiver B told Surveyor Resident 1's practitioner said to administer Resident 1's scheduled and "as needed" clonazepam 3 times a day for both dosages. During this discussion, Caregiver B was not able to accurately state the meaning or purpose of Resident 1's "as needed"	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 10	M 582		

clonazepam prescription.
Based on the documentation of administration of Resident 1's "as needed" clonazepam between 03/01/2026 and 05/26/2026 there were 86 individual dates documented with administration, which potentially matched the 86 doses dispensed from the 90 tablets issued to the facility within 3 bubble pack cards since 03/01/2026.
Surveyor asked Caregiver B to describe Resident 1's behaviors associated with the administration of Resident 1's "as needed" clonazepam. Caregiver B said Resident 1 was always yelling. Surveyor told Caregiver B s/he did not observe Resident 1 yelling or demonstrating any maladaptive behaviors. Caregiver B changed his/her statement by telling Surveyor Resident 1 sometimes yelled and "thrashed around." Surveyor asked Caregiver B if Resident 1 was able to independently move his/her body. Caregiver B told Surveyor s/he was not able to move his/her body on his/her own and required full assistance from caregivers.

On 05/26/2026, Surveyor reviewed Resident 1's caregiver documentation dated from 04/01/2026 and 05/01/2026 within an individual notebooks labeled with Resident 1's name. The notebooks included documentation of "PRN" (as needed) administration of Resident 1's clonazepam. The notes included an example dated 04/30/2026, "8:00 A.M. [Resident 1's] medications was given to [him/her], including clonazepam 0.5 mg (PRN) which [his/her] doctor instructed that it should be giving [sic] to [him/her]." The notes included an example dated 05/17/2026, "8:00 A.M. [Resident 1's] medications were given to [him/her], including the clonazepam 0.5 mg by the doctor's instruction." There was no documentation of Resident 1 exhibiting behavior associated with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019550	A. BUILDING: _____ B. WING _____	R-C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME CARE	1908 N CHAPMAN DR WAUKESHA, WI 53189

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 582	Continued From page 11 anxiety and/or agitation during this time frame, including behaviors associated with the use of the PRN clonazepam. On 05/26/2026 at 12:52 P.M., Caregiver B utilized his/her phone to contact Licensee A who was not available at the facility. Surveyor conducted an interview with Licensee A and discussed Resident 1's PRN clonazepam administration between March 2026 and May 2026. Licensee A told Surveyor s/he contacted Resident 1's practitioner about Resident 1's clonazepam prescription after a Surveyor conducted a licensing survey in February 2026 and told Licensee A Resident 1 was being administered too much clonazepam. Licensee A told Surveyor the practitioner became upset with Licensee A and said to administer Resident 1's clonazepam as ordered, every day. Licensee A said s/he understood the practitioner's instruction was to administer Resident 1's PRN clonazepam daily in addition to Resident 1's scheduled, 3 times daily doses. Surveyor discussed there was no practitioner's prescription within Resident 1's record instructing Resident 1 to receive additional PRN doses of clonazepam unless "as needed." Surveyor discussed Resident 1's record did not include documentation of Resident 1's behaviors to support the current, approximately daily administration of PRN clonazepam. Surveyor asked Licensee A to describe Resident 1's behaviors requiring PRN clonazepam. Licensee A responded by asking Caregiver B to describe Resident 1's behavior. Caregiver B stated Resident 1 "sometimes yelled and was given the PRN clonazepam." Licensee A told Surveyor s/he would contact Resident 1's practitioner again to gain resolution regarding the administration of PRN clonazepam.	M 582		