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SILENCE NO MORE HOME LLC	1666 TERRY DALE DRIVE W BEND, WI 53090

(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 08/05/2025 with information gathered through 08/11/2025, Surveyors conducted a complaint investigation at Silence No More Home LLC, an Adult Family Home (AFH) in West Bend, WI. Nine deficiencies identified. Complaint substantiated. Census: 3	M 000		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or activities of the adult family home,	M 114		

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

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M 114	Continued From page 1 the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees (Administrator A, Caregiver B and Caregiver C) reviewed had a completed background check at the time of hire. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete Caregiver Background Check, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check" letter from the Department of Health Service, also referred to as the Integrated Background Information System (IBIS). On 08/05/2025 at approximately 9:05 AM, Surveyors requested complete background check information for Administrator A, Caregiver B and	M 114		

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M 114	Continued From page 2 Caregiver C from Administrator A. Administrator A provided Surveyors with employee files for Administrator A and Caregiver B. Administrator A stated Caregiver C's employee file was located at his/her other location. -Administrator A: Hire date unknown, Administrator A has worked here since home licensed 07/29/2024. -BID form - Blank -No DOJ report -No IBIS letter -Caregiver B: Date of Hire - 05/01/2025 -BID form dated 05/05/2025 - completed -No DOJ report -No IBIS letter -Caregiver C: Date of Hire - 06/03/2024 -No BID form -No DOJ report -No IBIS letter On 08/05/2025 at approximately 12:00 PM, Surveyors interviewed Administrator A. Administrator A stated s/he would need to look for the background information requested. Administrator A acknowledged s/he would provide the information to Surveyors. As of 5:00 PM on 08/11/2025, no additional background information was received.	M 114		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring	M 134		

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hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental.

This Rule is not met as evidenced by:
Based on record review and interview, the licensee did not report to the Department of a significant change in a resident status for 1 of 1 resident. On 07/13/2025, Resident 1 left the facility and had gotten lost. Resident 1 was found at a home approximately a mile away from the group home. Law enforcement was contacted by the homeowners to assist with Resident 1. Resident 1 was placed on a Chapter 51 and taken to the local hospital for medical clearance and then conveyed to a mental health institute. This incident was not reported to the Department.

Findings include:

Resident 1 was admitted to the facility on 05/04/2025 with diagnoses of anxiety unspecified, bipolar disorder, and schizoaffective disorder.

On 08/05/2025 at 9:00 AM, Surveyors interviewed Administrator A. Administrator A stated Resident 1 would like to go outside and walk around the yard but staff would keep an eye on him/her. Administrator A stated Resident 1 would pack up all of his/her things and go outside with them and try to leave the facility. Administrator A stated Resident 1 needed 24/7 supervision due to his/her behaviors. Administrator A stated Resident 1 would yell out at staff and residents in

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the home, refuse to take his/her medications and call law enforcement on the landline often. Administrator A stated on 07/12/2025, Resident 1 left the home and was found by law enforcement at someone's home because Caregiver B did not know s/he was gone from the home. Caregiver B stated s/he thought Resident 1 was in his/her room. Administrator A stated Resident 1 has not been back since 07/12/2025 because s/he was admitted to a mental health institution. Administrator A stated s/he did not report this information to the Department.

On 08/05/2025 at 04:30 PM, Surveyor reviewed Department records and did not see evidence of a self-report regarding Resident 1.

On 08/06/2025 at approximately 9:30 AM, Surveyor reviewed Resident 1's record and identified the following information:
-Resident 1's Individual Service Plan (ISP) which had no date or signatures. Resident 1's ISP indicated Resident 1 was independent with ambulation and needed 24/7 supervision from staff at the home.
-Resident 1's incident report dated 07/12/2025 stated [Resident 1] continued to display behavioral issues (reference the behavior tracking submitted from 7/12/2025). Around 7:30 PM [Resident 1] with law enforcement arrived at the home with [Resident 1's] belongings in hand and stated "[S/he] had been wandering the neighborhood and that [Resident 1] ended up at the residence of an unstated person/location". [Caregiver B] then proceeded to ask questions, during this time nothing was answered however [s/he] went on to state [Resident 1] had been gone since approximately 4:00 PM, [Caregiver B] knowingly informed [him/her] that was impossible and how did [s/he] come up or was sure of the

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time. [S/he] went on to state [s/he] was sure because [s/he] was at someone home and only provided that [Resident 1] was going to be a chapter 13 and declined to provide anything else. The events prior to placed [Resident 1] in the house between the time of 5:13 PM and 6:00 PM. Between this time frame [Resident 1] first continued to use the house phone to call another member of staff and [Caregiver B] was informed via text by that member. Following that [Resident 1] became more upset that [his/her] phone privileges were temporarily removed. [S/he] was also placed in the house around 6:00 PM because during this time as another resident was leaving the house [s/he] was ranting out of [his/her] bedroom window at [him/her] and [his/her] ride.
Following [his/her] rant [Resident 1] was not seen leaving out of [his/her] bedroom nor was there an alert to either door being opened. Things calmed down as they do at times following multiple rants, especially considering [s/he] was upset with staff, [his/her] roommate was gone, and [s/he] had no telephone to keep [him/her] going on a rampage, especially after being up all day and night. Therefore [Caregiver B] was under the impression [s/he] had tired [him/herself] and took a nap. This assumption was even communicated to another staff that [s/he] was in [his/her] room, this was roughly around 7:00 PM. Approximately around 7:15 PM the other resident came back and during our exchange of communication I proceeded to knock on [Resident 1's] room door twice to check on [him/her] and give [him/her] night medication. After [Caregiver B] knock [s/he] didn't respond, [Caregiver B] knocked again still no response, [Caregiver B] then checked [his/her] door and it was locked as it always is .... Again [Caregiver B] said oh [s/he] is knocked out, [other resident] made a lite(sp) joke saying that's good

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M 134	Continued From page 6 [s/he] was up all night. Seeing [s/he] has until 9 to take [his/her] medication the issue wasn't forced. Nor did [Caregiver B] enter [his/her] room seeing nothing was out of the norm and this has caused an issue in the past however under different circumstances that [Caregiver B] felt entertaining was necessary. (reference incident report May 24 2025). Back to the beginning at roughly 7:30 is when it was evident that [Resident 1] eloped per the non uniformed member of law enforcement. While [Resident 1] will go in and out the door multiple times, [s/he] has never just snuck off. [S/he] is either going to sit out or check the mailbox. However at certain times of night has been a concern to the point research has been done in regards to what was in and out of range regarding door locks to prevent her nighttime in and outs when [s/he] is having an episode. Which has been an issue (reference June 12 incident report). In conclusion [Caregiver B] felt that [Resident 1] thought this through. [Caregiver B] would say [s/he] left the back door open enough after coming in to not set off the alert. [S/he] was also fully aware that staff was washing bedding for the other resident because [s/he] also ranted about that as well. [Caregiver B] almost certain this is where [s/he] took the opportunity to leave the house. Considering [s/he] did go to [his/her] room following the laundry rant and [Caregiver B] vaguely recall [him/her] looking at [him/her] watch and asking the time, then changing up and asking the day and saying [s/he] missed [his/her] day and needed to wash after [Caregiver B] let [other resident] know [Caregiver B] had started the dryer. [Resident 1] is also very well with watching time with laundry, [s/he] does it with washing [his/her] own. This would be the greatest opportunity [s/he] could possibly have. The door	M 134		

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alert is also loud and can't be muted nor volume adjusted by any one besides the owner.

On 08/11/2025, Surveyor reviewed police report. Police reported dated 07/12/2025 at 6:33 PM stated the following:
-"On Saturday, July 13, 2025, at approximately 6:33 PM, Deputies responded to 6837 Eastwood Trail, in the Town of Trenton, Washington County, as [Resident 1] had attempted to walk to West Bend, leaving [his/her] residence approximately three hours earlier, and had gotten lost. [Resident 1] was on this property and was refusing to leave, rambling and talking to [him/herself]. [Resident 1] was agitated and tangential. [Resident 1] repeatedly refused to return to the group home and had taken the group home's landline phone, placing them in danger in the event of an emergency. Numerous attempts to get [Resident 1] to leave this location and this property were futile and [Resident 1] refused to return to the group home, neglecting [his/her] basic needs for shelter. [Resident 1] was placed on a Chapter 51, as [s/he] was a danger to [him/herself] via act/omission (refusing shelter, refusing conveyance despite being lost, entering other people's property without consent and refusing to leave), and had placed other residents at the group home in danger by removing their means to obtain emergency services. [Resident 1] has a diagnosis of Schizophrenia and Bipolar Disorder and refuses to take medications. [Resident 1] actively vocalized paranoid delusions including the placement of a probe into [his/her] anus by "Brenda" to track [him/her], [his/her] involvement in a murder of a "Remi," and that nuclear war would start as it was in the ground if [s/he] returned to [his/her] residence. [Resident 1] further demonstrated impulsivity and poor decision making. [Resident 1] was transported to

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M 134	Continued From page 8 Froedtert - West Bend for medical clearance and will then be conveyed to Winnebago Mental Health Institute."	M 134		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees reviewed were screened for clinically apparent communicable disease, including tuberculosis (TB), within 90 days before the start of employment and that documentation of the test was available to the department. Findings include: On 08/05/2025 at approximately 9:05 AM, Surveyor requested the records for Administrator A, Caregiver B and Caregiver C from Administrator A. Administrator A's record did not have a date of	M 232		

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M 232	Continued From page 9 hire, but Administrator A stated s/he had worked at the facility since licensed on 07/29/2024. Administrator A had a completed communicable disease form signed by Administrator A. The form was not dated and was not signed by a registered nurse (RN). Administrator A's record did not have documentation a TB test. Caregiver B was hired on 05/01/2025. Caregiver B's record had TB test results dated 05/09/2025. Caregiver B had a completed communicable disease form signed by Caregiver B. The form was not dated and was not signed by a RN. Caregiver C was hired on 06/03/2024. Caregiver C's record had TB test results dated 09/24/20023, completed over 8 months prior to the date of hire. Caregiver B did not have a screening for clinically apparent communicable disease. As of 5:00 PM on 08/11/2025, no additional communicable disease/TB information was received. The provider did not have documentation of a communicable disease screen, including TB test, for Administrator A and Caregiver C, and communicable disease screen for Caregiver B.	M 232		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months	M 244		

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after starting to provide care. This training shall include training in fire safety and first aid.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that 2 of 2 employees reviewed received training in the resident rights with his/her initial training.

Findings include:

The provider is licensed to provide services for up to 4 residents who may have a developmental disability, physical disability, terminal illness, traumatic brain injury, Alzheimer's/dementia, emotionally disturbed/mental illness, correctional clients, pregnant women/counseling, alcohol/drug dependent and/or be advanced aged.

On 08/05/2025, Surveyors requested Administrator A and Caregiver C's employee record from Administrator A.

Administrator A's record did not have a date of hire, but Administrator A confirmed s/he had worked at the facility since being licensed 07/29/2024. Administrator A's record reflected CBRF training for first aid and choking, medication administration, standard precautions and fire safety.

Caregiver C was hired on 06/03/2024. Caregiver C's record reflected CBRF training for first aid and choking, medication administration, standard precautions and fire safety.

On 08/05/2025 at approximately 12:00 PM,

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M 244	Continued From page 11 Surveyors interviewed Administrator A. Administrator A stated s/he will look for the information and send it to Surveyors. On 08/06/2025 at 8:15 AM, Surveyors received an email from Administrator A. Administrator A provided the CBRF registry for Administrator A and Caregiver C. On 08/06/2025 at 8:31 AM, Surveyors replied to Administrator A and asked, "Was there any other training for you and the employees we requested info for? On 8/06/2025 at 8:59 AM, Surveyors received an email from Administrator A which stated, "Currently, that is the extent of our training. However, if there is further training that we need or that you recommend, we can take care of it." The provider did not ensure that 2 of 2 employees reviewed received training in resident rights with his/her 15 hours of initial training within 6 months after starting.	M 244		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes.	M 344		

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M 344	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents reviewed were evaluated within 3 days of admission for evacuation time, using the Department's form. Findings include: On 08/05/2025, Surveyors requested Resident 2's resident records from Administrator A. Resident 2 was admitted to the facility on 07/11/2025. Resident 2 did not have an evacuation assessment. Administrator A stated Resident 2 was a direct referral from his case manager. The case manager informed Administrator A that Resident 2 was placed as an emergency respite and will remain in that status until all of his/her paperwork is finalized, at which point s/he will become a full-time member with MyChoice. Administrator A acknowledged s/he did not complete the evacuation assessment for Resident 2. The provider did not ensure the fire safety evacuation plan was completed within 3 days of admission.	M 344		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a	M 380		

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M 380	Continued From page 13 registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents had been screened for communicable diseases, including tuberculosis, within 90 days before and up to 7 days after admission. Findings include: On 07/23/2025, Surveyor requested Resident 1 and Resident 2's resident records from Administrator A. Resident 1 was admitted to the facility on 05/04/2025. Resident 1 did not have evidence s/he had been screened for communicable disease including tuberculosis. Resident 2 was admitted to the facility on 07/11/2025 for respite. Resident 2 did not have evidence s/he had been screened for communicable disease including tuberculosis, when s/he resided in the home more than 7 days. The provider did not ensure residents were screened for communicable diseases within 90 days before and up to 7 days after admission for 2 of 2 residents residing in the home for more than 7 days.	M 380		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE	M 384		

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M 384	Continued From page 14 An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a service agreement for 3 of 3 residents reviewed. Findings include: On 08/05/2025, Surveyors requested Resident 1, Resident 2 and Resident 3's records from Administrator A. Resident 1 was admitted to the facility on 05/04/2025. Resident 1 did not have a service agreement completed. Resident 1's service agreement was signed by Administrator A, however there was no signatures by the resident or guardian, and no date Administrator A signed the service agreement. Resident 2 was admitted to the facility on 07/11/2025, under respite. Resident 1 did not have an admission agreement completed when his/her respite exceeded 14 days. Resident 3 was admitted to the facility on	M 384		

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M 384	Continued From page 15 08/04/2025. Resident 3 did not have an admission agreement completed prior to admission or at time of admission. On 08/05/2025 at 11:04 AM, Administrator A stated "[Resident 2] was a direct referral from [his/her] case manager. [S/he] informed [Administrator A] that [s/he] was placed as an emergency respite and will remain in that status until all of [his/her] paperwork is finalized." Administrator A stated Resident 3 was a recent admit. On 08/06/2025 at 11:51 AM, Surveyors received an email from Administrator A. Administrator A stated Resident 1's guardian "expressed discomfort with signing it and indicated that [s/he] would have [his/her] lawyer review it." Administrator A provided a copy of the service agreement. The service agreement clarified respite as "Respite care for those seeking temporary placement for up to 14 days. Administrator A did not have evidence a service agreement was completed when Resident 2 resided in the facility over 14 days. Administrator A acknowledged Resident 3 was a new admit and s/he had not completed a service agreement for Resident 3. As of 08/11/2025, 5:00 PM, no additional documentation was received. The provider did not have a service agreement completed for 3 of 3 residents.	M 384		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed	M 412		

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M 412	Continued From page 16 need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's Individual Service Plan (ISP) contained a description of services the licensee would provide for 1 of 1 resident. Resident 1 eloped from the facility, had manic behaviors and needed 24/7 supervision. Law enforcement came to facility multiple times to assist Resident 1. Resident 1's ISP did not identify strategies the licensee and caregivers would provide Resident 1 to prevent these behaviors. Findings include: On 08/05/2025 at approximately 9:35 AM, Surveyors interviewed Administrator A. Administrator A stated Resident 1 was currently at a mental health institution because of his/her behaviors. Administrator A stated Resident 1 was found by law enforcement on 07/12/2025 about a mile away from the facility. Administrator A stated Caregiver B did not know Resident 1 was not in his/her room until law enforcement showed up to the facility dropping of Resident 1's belongings s/he had with them when they eloped from the facility. Administrator A stated Resident 1 was would yell a lot at the other residents and staff at the home and s/he would go outside and walk around the yard. Administrator A stated law enforcement has been to the facility a few time because of Resident 1's behaviors and s/he would bother other residents and/or neighbors in	M 412		

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the community. Administrator A stated it would be typical for Resident 1 to stay up all night.

On 08/06/2025, Surveyor reviewed Resident 1's record and identified the following:
-Resident 1's pre-admission assessment stated Resident 1 had insomnia, member declines meds (psychiatric meds), member believes [s/he] is being battered and upset, [s/he] lives in a system setting.
-Resident 1's Individual Service Plan (ISP) stated Resident 1 has diagnoses of anxiety, bipolar disorder and schizoaffective disorder. Resident 1 needs 24/7 supervision, medication administration and meal preparation.
-Resident 1's progress note dated 05/24/2025 stated :
On May 24th 2025, [Resident 1] could be heard in the early hours of the morning yelling and moving around loudly in [his/her] room. [S/he] yelled about the various topics of [his/her] daily rants of being touched, body pattern waves, having [his/her] body protected, [his/her sibling]. However this particular time [s/he] could be heard yelling telling someone to get back and off of him/her] followed by loud tumbling..[Caregiver B] then proceeded to check on [him/her] and found [him/her] which appeared to be [his/her] talking to the wall. [Caregiver B] asked was [s/he] okay and who was [s/he] talking to and [s/he] stated "I'm talking to God, he's in the palm of my hand, so just get out of [his/her] room." [Caregiver B] shut [his/her] door and just continued to listen. From 6:00 am until 8:00 am nothing was heard. [Resident 1] came out to have coffee and take [his/her] 8:00 am medication, again refusing [his/her] nasal spray but took everything else. [S/he] returned to [his/her] room and could be heard having another conversation appearing to be with one of [his/her] as she states "Con men

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from the Facebook Messenger app" [s/he] often talks to them. After the call [s/he] began yelling again this time about [his/her] relationship and everyone is keeping them apart, how the air needs fumigated due to smoking (it's been explained to [him/her] no one in the house smokes, and that it's coming in through [his/her] window from the outside, possibly from a neighboring house). Loud banging was then heard coming from [his/her] room. [Caregiver B] then went to check in which [s/he] had [his/her] door locked, [Caregiver B] asked about the noise though the door [s/he] stated "Go away and back the freak off". Seconds later there was banging again so [Caregiver B] used the house key to enter to see what was going on. Upon entering [Caregiver B] looked at the walls to see if there was any damage because it sounded like [s/he] was banging on them, no damage was noticed [Caregiver B] then asked [him/her] if [s/he] was throwing something around. [S/he] stated "no no no you are breaking the law back off before I call the police" [Caregiver B] then asked what was the banging and [s/he] said [Caregiver B] was doing this and proceeded to bang on [his/her] dresser with [his/her] fist, and said that's it I'm calling the police because you broke in my room and accused me of throwing things around. [S/he] picked up [his/her] phone and dialed 911. [S/he] remained on the line with the dispatcher going on about the reason for the call and all the various topics of conversation as stated above. Around 9:20 two uniformed of the West Bend Police department arrived. One officer remained outside with [Resident 1] and one came in to take my statement. During this time [s/he] could be heard rambling about with the same various topics of conversation as stated above. After while the officer's got together to speak with each other regarding the incident. During this time [Resident

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M 412	Continued From page 19 1] was over talking and not listening to the police and being irate with them as well. Based off of behavior they consider [him/her] to be having a manic episode and suggested medical treatment which [s/he] declined. Because [s/he] wasn't a threat to [him/herself] or other [s/he] didn't fall into being taken against [his/her] will. Through continuous observation they felt it was necessary and continued to see what could be done. Further steps was initiated which involved calling [Adult Protective Services (APS)]. Again [APS] stated the same thing about what only could be done in legal boundaries. Which was it would have to be voluntary or done by the guardian. The guardian was contacted as well by the West Bend Police department and [APS] but was unavailable to come out. During this whole process [Resident 1] remained to display the same behavior to include going back and forth with the officer. [S/he] had multiple arguments on the phone with [sibling] during this time. The officers requested for a social worker from Washington County to come assess the situation, however within the time of the request and before they could arrive [Resident 1] began to calm down once everyone just let [him/her] be. This is something [Caregiver B] did tell the officer early on that has been effective as part of [him/her] assisting with this behavior. Although the outburst are often and self triggered the more you engage the longer they last. As a result after [s/he] calmed the officers decided to avoid having Social services come out to avoid a reoccurrence of triggering [Resident 1] behavioral episode. For the remainder of the shift [Resident 1] found things to do that kept [him/her] busy. [S/he] had a few more mild outburst but finished the night out at a steady behavior. -Resident 1's progress note dated 06/12/2025 stated:	M 412		

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M 412	Continued From page 20 On June 12th 2025, [Resident 1] behaviors has continued and escalated from the previous day. The day started with continuing on about the staff being involved with battering [his/her] body along with the judge, [his/her sibling], and the FBI on body pattern waves and injuries to [his/her] body. Early on in the day [s/he] was in the driveway shouting about various things outside the neighbors house to include walking up to their door and ringing the doorbell multiple times. Staff used multiple angles to try to redirect [him/her] as an attempt to get [him/her] back in. [S/he] stated [s/he] had a right to share [his/her] story with the neighbors. [S/he] did the same thing to the pharmacy driver when [s/he] came to the door, [s/he] followed [him/her] to [his/her] car talking while [s/he] was trying to leave. [S/he] eventually came back in and continued [his/her] rants in the house with yelling, stomping and banging. This continued on for hours. Around 7:30 staff went administrator [Resident 1] evening medications, [s/he] took them with no incident. Maybe 15 minutes later [s/he] stated [his/her] inhaler was on 0 puffs staff informed [his/her] [s/he] just took it and there is medication still in there. [S/he] was showed this and still yelled and said [s/he] is tired of these body pattern waves that [Caregiver B] and everyone else is involved with and that I am working with [Resident 1's sibling] grabbed [his/her] head and ran out the backdoor. Staff again tried to get [Resident 1] back into the house however at this point [s/he] was began walking the neighborhood and going to people door. Staff followed [Resident 1] while calling for police assistance. The police arrived at a residence around the corner on Curtis Dr. after collecting information we all came back to the home. For a while police talked and tried to come up with a solution, Someone from the Crisis Service Unit was called in to observe [his/her] behavior	M 412		

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however again a attempt for medical attention wasn't met under the criteria after evaluation due to this being her normal manic episode behavior. After while the units was getting ready to leave when [s/he] dialed up 911 on [his/her] own this time stating that the cops sent out was also involved. The units came back in the home for a second. The same conversation continued. Again they left.
[Resident 1] continued on with [his/her] behavior for some time. Around midnight [s/he] opted to stay in the house but continued to open the backdoor yelling out. Staff asked [him/her] not to yell out the door and explained to her people are trying to sleep. She stated she can do as she please. Apparently this time a neighbor on Curtis Dr could hear [him/her] yelling outside and called the police. [S/he] did the same thing while the police explained the same thing I did to [him/her]. [S/he] went back and forth with the cops as well to include grabbing on the back of the officer's neck. Again nothing was able to be done they eventually left after letting [him/her] know [s/he] needs to stay in and stop yelling out the door or else [s/he] would be cited. [Resident 1] continued to play with the door through out the night and place calls saying [s/he's] all black and blue, yelling along with stomping. However this is the second time that [s/he] has just ran off and yelled about accusations of [Caregiver B] being involved with the body pattern waves and injuries to [his/her] body. [S/he] states in involved with [his/her] back injury as well.

On 08/06/2025 at approximately 11:51 AM, Administrator A confirmed Resident 1's ISP had not been updated since s/he was admitted and it did not include his/her manic behaviors and incidents involving law enforcement.

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M 464	Continued From page 22	M 464		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written physician order to administer medication was obtained for 3 of 3 residents reviewed. Findings include: On 08/05/2025 at approximately 9::05 AM, Surveyors requested Resident 1, Resident 2 and Resident 3's records from Administrator A. Resident 1 was admitted to the facility on 05/04/2025. Resident 1 did not have a written physician order stating who by name or position is permitted to administer the medication. Resident 2 was admitted to the facility on 07/11/2025, under respite. Resident 2 did not have a written physician order stating who by name or position is permitted to administer the medication.	M 464		

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M 464	Continued From page 23 Resident 3 was admitted to the facility on 08/04/2025. Resident 3 did not have a written physician order stating who by name or position is permitted to administer the medication. On 08/05/2025 at approximately 10:00 AM, Surveyor interviewed Administrator A. Administration A acknowledged they currently administer medications for 3 of 3 residents. Administrator A stated s/he would look for the documentation and send it to Surveyors. As of 08/11/2025, 5:00 PM, no additional documentation was received. The provider did not ensure they had a written physician order stating who by name or position is permitted to administer the medication, prior to dispensing medication.	M 464		