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	0018566	A. BUILDING: _____ B. WING _____	C 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEIGHTS 2	306 EAST HAVEN WATERTOWN, WI 53094

(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 06/20/2025, with information obtained through 06/26/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a standard licensing survey and 2 complaint investigations at Concord Heights 2, an adult family home (AFH) located in Watertown, WI. As a result of the survey, 9 deficiencies were identified. Both complaints were substantiated. Census: 4	M 000		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that each required smoke detector was tested monthly to ensure that it was operating. There was no evidence that smoke detectors located in the home's 4 bedrooms were checked from January 2024 through April 2025 (a 16-month period).	M 336		

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

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M 336	Continued From page 1 Findings include: The provider is licensed to serve up to 4 adults in the client groups of physically disabled, alcohol/drug dependent, emotionally disturbed/mental illness, developmentally disabled, and traumatic brain injury. On 06/25/2025, at approximately 9:45 a.m., Surveyor toured the home and observed 4 different resident bedrooms. On 06/20/2025, Surveyor reviewed "Monthly Check" documents from the provider, dated January 2024 through April 2025, which included a section in each monthly check where the provider's staff documented conducting checks of the home's smoke detectors. The various smoke detector locations of the home were delineated on individual lines of the document. Surveyor observed that specific dates of the checks were documented for smoke detectors located in the hallways and common areas, however, a line was written through each of the bedroom smoke detector checks. There were no annotations on the documents indicating that any of the bedroom smoke detectors were checked from January 2024 through April 2025 (16 months total). At approximately 3:01 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) A. In reviewing the monthly check documents, Coordinator A acknowledged Surveyor's concern that there was no evidence that staff checked the bedroom smoke detectors given the line through each bedroom check entry. Coordinator A reported that the written line through each bedroom entry seemed to indicate that staff thought the check was not applicable.	M 336		

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M 344	Continued From page 2	M 344		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 2 residents reviewed were evaluated using the Department's form to determine whether they were able to evacuate the home without help within 2 minutes. Resident 1 did not have an evacuation assessment completed. Resident 2's evacuation assessment was approximately 50% completed, with half of the pages not included as part of the assessment. Findings include: Example 1 - Resident 1 On 06/20/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 04/23/2025 with diagnoses including Down syndrome and autism spectrum disorder. There was no evidence of an evacuation assessment having been completed.	M 344		

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M 344	Continued From page 3 At approximately 1:15 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) A. After Surveyor shared the concern that there was no evacuation assessment in Resident 1's record, Coordinator A was observed to look through Resident 1's record. After a couple of minutes, Coordinator A confirmed s/he was unable to find an evacuation assessment for Resident 1. Example 2 - Resident 2 On 06/20/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/31/2024 with diagnoses including autism spectrum disorder, epilepsy, and anxiety. An evacuation assessment dated 08/01/2024 was located in Resident 2's record, however of the 5 total pages of the Department's assessment form, only pages 1, 3, and 5 were included. Pages 2 and 4, which contained 4 assessment sections (approximately 50% of the assessment) were missing. At approximately 1:15 p.m., Surveyor interviewed Coordinator A. Coordinator A confirmed Surveyor's concern that only approximately half of Resident 2's evacuation assessment was completed.	M 344		
M 428	88.07(1)(b) AUTONOMY AND CHOICES The licensee shall encourage a resident's autonomy, respect a resident's need for physical and emotional privacy and take a resident's preferences, choices and status as an adult into consideration while providing care, supervision and	M 428		

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M 428	Continued From page 4 training. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assist in encouraging Resident 1's autonomy when not maintaining his/her communication tablet to be charged, which s/he utilized to participate in therapy and educational activities at school. One of Resident 1's school staff members made Lead Caregiver C aware on 05/01/2025 of the need for Resident 1 to have his/her communication tablet charged each night. Guardian F also requested that Lead Caregiver C inform the provider's other staff of this need the same day. Despite this, on at least 3 occasions afterwards - 05/07/2025, 05/16/2025, and 05/19/2025 - school staff noted ongoing concerns about his/her tablet not being charged. Interview with Caregiver H, Coordinator A, and Guardian F identified that the provider's staff had still been unaware of the need until near the end of May 2025. Lead Caregiver C reported to Director of Operations G on 05/19/2025 that s/he had been unaware of the need despite the earlier communication to him/her from school staff on 05/01/2025. While Lead Caregiver C reported to Director of Operations G on 05/19/2025 that for that past week staff had charged Resident 1's tablet each night, a communication note from Resident 1's school staff that very day indicated that Resident 1's device had not been charged. Findings include: On 06/20/2025, Surveyor conducted a complaint investigation into allegations of a resident's electronic device not being adequately maintained by staff.	M 428		

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M 428	Continued From page 5 On 06/20/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 04/23/2025 with diagnoses including Down syndrome and autism spectrum disorder. Resident 1 was documented as having a legal guardian. Resident 1's individual service plan (ISP), dated 05/28/2025 documented that s/he used a communication device but didn't include any information as to how staff utilized or assisted Resident 1 in utilizing it, nor did it include any other information about his/her communication needs or abilities. Under the "Capacity for Self-Direction" heading of the ISP, a box was checked indicating that Resident 1 required assistance to make his/her needs known. On 06/20/2025, Surveyor reviewed Resident 1's communication log book which contained communication notes from Resident 1's school staff regarding Resident 1 as well as summaries of daily activities in which s/he participated. In reviewing the communication log book, Surveyor observed the following notes: - 05/06/2025: "Please plug in talker." - 05/19/2025: "[Augmentative and Alternative Communication] device not charged again." At approximately 2:25 p.m., Surveyor interviewed Caregiver H. Caregiver H confirmed that s/he was aware of Resident 1 having a tablet that was used for his/her schooling and that when school had been in session, staff had to charge the tablet each night. Caregiver H reported that for an initial period after Resident 1 was admitted, staff were not charging the tablet due to not being aware of it.	M 428		

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M 428	Continued From page 6 At approximately 2:33 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) A regarding Resident 1's communication tablet. Coordinator A reported that it was a device Resident 1 used at school. Coordinator A reported that when Resident 1 pressed certain pictures, the tablet would verbalize corresponding words or sentences. Coordinator A reported that the tablet was used only at school but that the provider's staff were responsible for charging it each night. At approximately 2:51 p.m., Surveyor interviewed Coordinator A again. Coordinator A reported being aware of concerns raised by Resident 1's guardian during Resident 1's initial 30-day care plan meeting regarding staff not charging Resident 1's communication tablet. Coordinator A reported s/he believed staff were not consistently charging it at that point because during the care plan meeting the participants asked the staff member working at the time about the device and s/he had replied being unaware of it. On 06/25/2025, at approximately 8:55 a.m., Surveyor interviewed the legal guardian for Resident 1, Guardian F. Guardian F reported that staff from Resident 1's school brought to his/her attention concerns regarding staff not charging Resident 1's communication tablet. Guardian F reported that upon hearing the allegations, s/he reached out and spoke with Caregiver I who reported s/he didn't even know Resident 1 had a communication tablet. Guardian F reported that sometime after, a care meeting occurred during which staff were introduced to Resident 1's communication tablet as well as the expectation that they would charge it. At approximately 11:56 a.m., Surveyor	M 428		

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interviewed Case Manager J. Case Manager J confirmed awareness of Resident 1 having a communication tablet which s/he used at times to help communicate his/her needs. Case Manager J reported that Resident 1 could be hard to understand at times due to his/her speech impairments.

On 06/25/2025, Surveyor reviewed e-mail correspondence between the provider's staff, Resident 1's school representatives, Persons K and L, and Guardian F as well as notes from Guardian F. In the correspondence and notes, Surveyor observed the following:

- E-mail from Person K to Guardian F and Lead Caregiver C on 05/01/2025 at 1:39 p.m.: "Hi [Lead Caregiver C]! I believe you are the direct contact for the group home...if you could also make sure [his/her] communication device is charged overnight so it comes to school fully charged, we'd appreciate it..." A couple of hours later, at 3:35 p.m., Guardian F replied to both Lead Caregiver C and Person K, "[Lead Caregiver C] - If you could please share this with the other staff in the home that would be great."

- Note from Guardian F on 05/07/2025: "[Person K] had texted that...[Resident 1]'s communication device has not been coming to school charged. I called the group home and spoke with Caregiver I about these concerns. [Caregiver I] noted that [s/he] did not know these items were in [Resident 1]'s backpack. [Caregiver I] stated that [s/he] would write a note in the house communication log book to make everyone aware..."

- E-mail from Person L to Guardian F dated 05/16/2025 at 8:05 a.m. that outlined concerns of Resident 1 not receiving his/her needed

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M 428	Continued From page 8 assistance and stating, "[Resident 1] has an [augmentative and alternative communication] (talker) device that [s/he] needs to have access to at school, especially first hour, since that is when [s/he] has speech therapy. It is really important that it be charged overnight." - E-mail from Lead Caregiver C to Director of Operations B dated 05/19/2025 at 11:49 p.m.: "...As far as [his/her] communication device, we were not aware of it having to be charged until a little over a week ago. It has been plugged in every night since we were told." Surveyor noted that despite the e-mail above from Lead Caregiver C on 05/19/2025 in which s/he reported not being aware of Resident 1's communication tablet needing to be charged until "a little over a week ago," Lead Caregiver C would have been aware of this need as early as 05/01/2025 when Person K e-mailed him/her directly to request that the tablet be charged every night and when Guardian F e-mailed him/her directly that same day to request that that information be shared with the provider's other staff (as documented above). Surveyor also noted that despite Lead Caregiver C reporting via his/her 05/19/2025 e-mail that staff charged Resident 1's communication tablet every night that week, a note from Resident 1's school staff on 05/19/2025 documented that the tablet was not charged that very day (as documented above).	M 428		
M 434	88.07(1)(e) Supervision The licensee shall arrange for a service provider to be present in the home when the licensee is gone	M 434		

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M 434	Continued From page 9	M 434		

overnight or when the licensee's absence prevents the resident from receiving the services, training or supervision specified in the resident's individual service plan under s. HSS 88.06(3).

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that a service provider was present in the home when 4 residents were present for approximately 1 hour on 05/05/2025 from 10:30 - 11:30 p.m. Two of 2 residents reviewed were identified as requiring 24-hour supervision by staff. Actions were taken to remedy the situation that night only after Resident 3 discovered the home was not staffed and called his/her guardian, Guardian F, at 10:55 p.m. Guardian F reported that Resident 3 was very upset and had high anxiety during the phone call upon discovering that there was no staff in the home.

Findings include:

On 06/20/2025, Surveyor conducted a complaint investigation into allegations of inadequate nighttime supervision by staff.

On 06/20/2025, Surveyor reviewed Department records for the provider. The provider's home is a duplex-style home with each side being maintained as separately-licensed adult family homes, known as 304 and 306 East Haven, respectively.

On 06/20/2025, Surveyor reviewed a self-report that was submitted by the provider on

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M 434	Continued From page 10 05/13/2025. The report detailed the following: "On 5/5/25 [Caregiver D] was scheduled to work at 306 East Haven from 1400-2200. [S/he] was advised that an Uber would pick [him/her] up after [his/her] shift at 2200 to transport [him/her] back to [city]. Per [his/her] statement [s/he] was informed that a caregiver was scheduled to come in at 2200. [His/her] Uber arrived and after waiting a bit [Caregiver D] notified caregiver [Caregiver E] who was working next door at 304 East Haven [s/he] was leaving and the keys were on the table. [Resident 3] a resident discovered that there was no caregiver and called [his/her] guardian [Guardian F]. [Guardian F] called [Director of Operations G] the Program Manager who contacted [Caregiver E] who was working at 304 East Haven to check on the clients at 306 and have [Resident 3], since [s/he] was awake come over to 304. [Director of Operations G] contacted [Caregiver D] who had the Uber turn around and return [him/her] to 306. "...Per [Caregiver D]'s time card [s/he] left about 2228 and returned at 2330. [S/he] retrieved [Resident 3] from 304 East Haven and rounded on the remaining 3 residents who were asleep. No resident suffered any injury or harm." Accompanying the self-report were investigation documents which outlined staff statements received and records that were reviewed as part of the provider's own investigation into the above incident. Additional details from the investigation included that Caregiver D "believed that the third staff [sic] was just late and would be there shortly...[S/he] stated [s/he] did ask [Caregiver E] to check on the residents at 306," and that Caregiver E "said [s/he] was really busy with the clients at [his/her] house and was not able to check on the clients at 306." The investigation	M 434		

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also detailed that while the house was unattended Resident 3 was the only resident who was awake while Residents 1, 2, and 4 slept throughout the incident, and that "while we acknowledge that [Resident 3] suffered emotional distress, no client suffered significant harm by the lack of a caregiver at the residence." The investigation also identified that a delayed schedule change, which staff were not made aware of, was what ultimately led to an overnight (NOC) shift staff member not having come in at 10:00 p.m. that evening. The investigation detailed that as a result of the incident, Caregiver D received a written warning and staff received training related to the provider's central scheduling policy.

On 06/20/2025, Surveyor reviewed the current individual service plans (ISPs) for 2 residents - Residents 1 and 2. Both were identified as requiring 24-hour staff supervision.

On 06/20/2025, at approximately 2:51 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) A regarding the above incident. Coordinator A reported that s/he only heard about the incident from Guardian F but otherwise didn't have knowledge about the specific details it entailed.

On 06/25/2025, at approximately 8:55 a.m., Surveyor interviewed Guardian F regarding the above incident. Guardian F confirmed that s/he received a phone call from Resident 3 at 10:55 p.m. on 05/05/2025 and that Resident 3 was very upset with high anxiety. Guardian F reported that Resident 3 told him/her that no staff were in the house as s/he was walking through the common areas but that the other residents were still sleeping in their rooms. Guardian F reported that s/he verbally instructed Resident 3 in getting

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M 434	Continued From page 12 through the duplex to the other side to talk to staff in the other home. Guardian F reported that s/he then spoke with that staff member, Caregiver E, and instructed him/her to check on the residents at 306 since there were no staff there. Guardian F reported that it was unclear from his/her conversation with Caregiver E if s/he had known whether the home (the side s/he was not working) was not staffed. Guardian F then verbally instructed Resident 3 through finding a list of emergency numbers which included contact information for Director of Operations G. Guardian F reported that s/he then called Director of Operations G but initially wasn't able to get in contact with him/her until s/he called back approximately 5 minutes later. Guardian F reported s/he called Caregiver E to confirm that s/he was still continuing to monitor both homes. Guardian F reported that s/he received a call shortly after midnight to confirm that the same staff who initially left returned to the home.	M 434		
M 510	88.09(1)(d)11 RESIDENT FUNDS Records maintained by the licensee of the resident's finances, including written authorization from the resident of resident's guardian to control the resident's funds. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a written authorization from Resident 2's legal guardian for staff to control his/her funds was maintained. Findings include: On 06/20/2025, Surveyor reviewed Resident 2's	M 510		

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M 510	Continued From page 13 record. Resident 2 was admitted to the provider on 07/31/2024 with diagnoses including autism spectrum disorder, anxiety, and epilepsy. Resident 2 was documented as having 2 guardians. There was no evidence of a written authorization from either of Resident 2's guardians authorizing the provider's staff to control his/her funds. At approximately 1:50 p.m., while reviewed Resident 2's record, Surveyor observed a pencil pouch-style bag in his/her binder which contained two dollar bills and several coins. While observing the bag, Surveyor interviewed Coordinator of Administrative Services (Coordinator) A. Coordinator A confirmed that staff maintained Resident 2's record (which contained the bag of money) as well as a debit card belonging to him/her which they used to make purchases for him/her. During the interview, Coordinator A showed Surveyor a ledger that was maintained documenting staff's purchases using Resident 2's debit card as well as receipts for those purchases. When asked if there was a record showing the authorization by Resident 2's guardians for staff to control his/her funds, Coordinator A reported s/he wasn't sure if such a record existed for Resident 2 and that s/he was unfamiliar with what it would be.	M 510		
M 552	88.10(3)(c) Confidentiality Confidentiality. To have his or her records kept confidential as described in s. HSS 88.09(1)(b). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that information that was	M 552		

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M 552	Continued From page 14 maintained as part of Resident 1's record, including information relating to his/her health conditions, service needs, and personal information, was kept confidential. Findings include: On 06/20/2025, at approximately 9:15 a.m., Surveyor arrived to the home to conduct a survey. The home's common areas were observed to have an open-concept style, with the foyer, living area, dining area, and kitchen having no internal walls between them. Surveyor walked to the kitchen area, which was located just past the home's foyer, and observed 2 documents taped to the kitchen counter (Photo 1). Upon observing the documents, Surveyor observed the following: 1. Document 1 (Photo 2): - A heading titled, "*ATTENTION ALL STAFF*" was documented. Underneath, text detailed the location of Resident 1's electronic device and communication log, which indicated to have details regarding his/her behaviors. - Underneath the above text, the following was documented: "*Overnight Shift* [Resident 1] has been diagnosed with aspiration pneumonia. We are required to do hourly checks while [s/he] is sleeping to ensure [s/he] is breathing okay." 2. Document 2 (Photo 3): - A heading titled, "Things to know about [Resident 1]" was documented. The document contained a full page of text regarding information about Resident 1 in the categories of "Recreation", "Hygiene", and "Food/Drink."	M 552		

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M 552	Continued From page 15 - The "Recreation" section contained 6 sentences about activities Resident 1 engaged in and television shows s/he liked. - The "Hygiene" section contained approximately 22 sentences related to his/her care needs. Within this section, Resident 1's challenging behaviors were documented, including behaviors related to toileting and the assistance s/he required by staff to toilet. Information regarding how staff were to manage his/her gender-specific medical care needs as well as his/her behaviors about those needs was also documented. Information about his/her grooming-related abilities and needs as well as feeding-related concerns was also documented. - The "Food/Drink" section contained approximately 6 sentences related to his/her feeding/drinking-related needs and concerns, including how his/her urine color was impacted by impaired hydration. At approximately 1:00 p.m., Surveyor observed someone sitting at the kitchen counter (where the documents about Resident 1 were taped) filling out paperwork. Surveyor then observed Coordinator of Administrative Services (Coordinator) A assisting him/her with the paperwork. Coordinator A later confirmed to Surveyor that that individual was a newly-hired staff member who was completing "new hire paperwork." At approximately 3:01 p.m., Surveyor interviewed Coordinator A regarding the documents about Resident 1 taped to the kitchen counter. Coordinator A reported s/he had been unaware of them and stated that they should have been in Resident 1's binder.	M 552		

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M 570	88.10(3)(I) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe physical environment with residents safeguarded from environmental hazards from which they were likely to be exposed. The faucet water temperature of the back and central resident bathroom sinks reached 149.0° Fahrenheit (F) and 145.6° F, respectively. Findings include: The provider is licensed to serve up to 4 adults in the client groups of physically disabled, alcohol/drug dependent, emotionally disturbed/mental illness, developmentally disabled, and traumatic brain injury. On 06/20/2025, at approximately 10:13 a.m., Surveyor tested the water temperature of the sink in the back resident bathroom, near Resident 3's room, which reached 149.0° F. When testing the	M 570		

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water temperature, Resident 3 approached Surveyor and asked what s/he was doing. When Surveyor explained s/he was testing the water temperature, Resident 3 replied, "It gets really hot. Be careful."

On 06/20/2025, at approximately 10:15 a.m., Surveyor tested the water temperature of the sink in the central resident bathroom, near the laundry room, which reached 145.6° F.

According to the Wisconsin Department of Health Services, "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." Sustained contact with water at or above 140° F can result in second or third-degree burns in approximately 6 seconds (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017).

On 06/20/2025, Surveyor reviewed "Monthly Check" documents from the provider, dated January 2024 through April 2025, which included a section in each monthly check where the provider's staff documented conducting temperature checks of the home's bathroom sinks. Between all the checks, the highest temperature for the bathroom sinks was recorded at 117.6° F.

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M 570	Continued From page 18 At approximately 3:01 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) A. Coordinator A reported that staff (not him/her) typically checked water temperatures monthly. Coordinator A acknowledged Surveyor's concern regarding the hot water temperatures and reported s/he was unaware that the sink temperatures got that high.	M 570		
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 record review and interview, the provider did not ensure that Resident 2 received his/her polyethylene glycol in the dosage prescribed by his/her medical provider. Staff initialed off on administering 81 days-worth of polyethylene glycol powder to Resident 2 on his/her medication administration records (MARs) from 04/01/2025 through 06/20/2025. However, the only container observed onsite was dispensed on 03/07/2025 (approximately 3.5 months prior to the survey), contained 30 doses, and still appeared to be approximately half-full. One of	M 582		

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M 582	Continued From page 19 Resident 2's diagnoses included constipation and s/he was also prescribed a rectal suppository, which was administered once by staff during the review period. Findings include: On 06/20/2025, at approximately 11:05 a.m., Surveyor observed the medication closet with Coordinator of Administrative Services (Coordinator) A. Surveyor observed 1 container of polyethylene glycol powder with a pharmacy label indicating that it was prescribed to Resident 2 (Photos 4 and 5). The manufacturer's label on the container indicated that it contained 510 grams of "Polyethylene Glycol 3350" powder which was enough for "30 Once-Daily Doses." The pharmacy label indicated that the container was dispensed on 03/07/2025 (approximately 105 days prior to the survey) and contained the instructions, "Mix 17 grams (fill cap to line) in 4-8 oz liquid, stir well and drink once daily for constipation." The container appeared to be approximately halfway full. There were no other polyethylene glycol containers observed for Resident 2. On 06/20/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/31/2024 with diagnoses including constipation. Resident 2 was documented as being under legal guardianship and requiring staff assistance to manage and administer his/her medications. One of Resident 2's listed prescriptions included polyethylene glycol 3350 powder with a start date of 08/05/2024 and instructions to, "Mix 17 grams (fill cap to line) in 4-8 oz liquid, stir well and drink once daily for constipation." Resident 2 was also prescribed a glycerin 2 gm suppository with instructions to,	M 582		

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"Insert 1 suppository rectally as needed if no bowel movement for 4 days for constipation."

Surveyor reviewed Resident 2's MARs from 04/01/2025 - 06/20/2025 (81 days). For each of the 81 days within the reviewed MARs, staff signed off on administering Resident 2 his/her polyethylene glycol. Surveyor observed 1 occasion, on 05/03/2025, where staff initialed off on administering Resident 2 a rectal suppository.

At approximately 3:01 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) A. Coordinator A reported s/he was unaware of any issues or concerns with Resident 2's polyethylene glycol administration. Coordinator A confirmed s/he understood Surveyor's concern that Resident 2 did not seem to be receiving her polyethylene glycol powder as prescribed as evidenced by staff documenting having administered 81 days-worth of polyethylene glycol powder from a container dispensed on 03/07/2025 that only contained 30 doses and still appeared to be approximately half-full.

On 06/25/2025, at approximately 10:55 a.m., Surveyor interviewed Pharmacy Support Staff B from the pharmacy that filled Resident 2's prescriptions. Pharmacy Support Staff B reported that 510 grams of Resident 2's polyethylene glycol (equaling 1 container, as observed above from the manufacturer's label) was dispensed on 03/07/2025 (the same bottle observed by Surveyor). Prior to that, Pharmacy Support Staff B reported that 1 container of Resident 2's polyethylene glycol was dispensed on 01/02/2025 (approximately 2 months prior to the most recent dispensing) and prior to that 1 container was dispensed in October of 2024.

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Z 022	50.065(3)(b) COMPLETE BACKGROUND CHECK PROCESS Every 4 years or at any other time within that period that an entity considers appropriate, the entity shall request the information specified in sub. (2) (b) 1. to 5. for all caregivers of the entity. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a complete background check was completed every 4 years for Lead Caregiver C. Findings include: On 06/20/2025, Surveyor conducted a review of staff background checks to ensure compliance with background check requirements. Surveyor requested the most recent background check for Lead Caregiver C from Coordinator of Administrative Services (Coordinator) A. From the records provided for Lead Caregiver C, hired 04/01/2021, Surveyor observed a completed background information disclosure (BID), dated 03/22/2021 as well as a Department of Justice (DOJ) and caregiver background check dated 04/21/2021 - all 3 checks having been approximately 4 years and 2 months from the	Z 022		

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Z 022	Continued From page 22 survey date. At approximately 11:25 a.m., Surveyor interviewed Coordinator A. Coordinator A confirmed that the checks reviewed by Surveyor were the most recent background checks on file for Lead Caregiver C. Coordinator A reported s/he had been in communication with human resources staff during Surveyor's review of the checks, who also confirmed these were the only checks the provider had Lead Caregiver C and reported that Lead Caregiver C needed to fill out a new form to initiate a new background check.	Z 022		