STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018788	A. BUILDING: _____ B. WING _____	R 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONNECTED FAMILY HOME CARE	336 RICHARD STREET 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 07/16/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Connected Family Home Care, an adult family home (AFH) located in Waukesha, WI. As a result of the survey, 9 deficiencies were identified. Six deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) 3LFH11, dated 10/30/2024. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
M 235	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult family home shall comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 2 service providers reviewed completed universal precautions training in accordance with the U.S. Occupational Safety and Health Administration (OSHA) standard.	M 235		

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

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M 235	Continued From page 1 Caregiver D, hired 03/15/2023 and whose tasks involved potential exposure to residents' blood, did not complete training in universal precautions. Findings include: Wis. Admin Code § DHS 88.04(2)(h) directs that "all service providers comply with universal precautions in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens." This OSHA standard requires an employer to provide training in the prevention of blood-borne infections when a worker is assigned tasks where they might be exposed to blood. The standard specifies that this training should be given to all workers who may come in contact with blood and should be provided annually. On 07/16/2025, at approximately 9:50 a.m., Surveyor arrived onsite and observed Caregiver F working alone. Caregiver F confirmed that staff worked alone throughout their shifts and typically worked in 12-hour shift increments. Caregiver F confirmed that Residents 2 and 3 sometimes needed staff assistance with personal care tasks. Caregiver F confirmed that Resident 1, who had diabetes, required staff to conduct a finger prick blood test in order to test his/her blood sugar four times daily prior to administering his/her insulin. On 07/16/2025, Surveyor conducted a review of 2 service providers to verify compliance with initial training requirements. Surveyor requested training records from Manager B for Caregiver D. The record for Caregiver D, hired 03/15/2023, did not contain any evidence of training completed in universal precautions.	M 235		

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M 235	Continued From page 2 At approximately 10:55 a.m., Surveyor interviewed Manager B, who is an instructor through the Department's approved Community-Based Residential Facility (CBRF) training entity. Manager B confirmed that staff work shifts alone. Manager B confirmed that Caregiver D did not complete training in universal precautions. Manager B reported that s/he didn't have time to train Caregiver D but that s/he intended to get his/her training done.	M 235		
{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 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 1 of 2 service providers reviewed, Caregiver D, completed training in first aid as part of his/her 15 hours of training approved by the licensing agency within 6 months after starting to provide care. This is a repeat deficiency. See Statement of Deficiency (SOD) 3LFH11, dated 10/30/2024. Findings include:	{M 244}		

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{M 244}	Continued From page 3 On 07/16/2025, at approximately 9:50 a.m., Surveyor arrived onsite and observed Caregiver F working alone. Caregiver F confirmed that staff worked alone throughout their shifts and typically worked in 12-hour shift increments. Caregiver F confirmed that Residents 2 and 3 sometimes needed staff assistance with personal care tasks. On 07/16/2025, Surveyor conducted a review of 2 service providers to verify compliance with initial training requirements. Surveyor requested training records from Manager B for Caregiver D. The record for Caregiver D, hired 03/15/2023, did not contain any evidence of training completed in first aid. At approximately 10:55 a.m., Surveyor interviewed Manager B, who is an instructor through the Department's approved Community-Based Residential Facility (CBRF) training entity. Manager B confirmed that staff work shifts alone. Manager B confirmed that Caregiver D did not complete training in first aid. Manager B reported that s/he didn't have time to train Caregiver D but that s/he intended to get his/her training done.	{M 244}		
{M 262}	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard	{M 262}		

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{M 262}	Continued From page 4 surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure any of the following for Resident 2, who utilized a manual wheelchair for ambulation: that the exits from the home were ramped to grade with a hard surfaced pathway and handrails; that interior doors serving his/her bedroom, the sole resident bathroom, and an entryway leading to 1 of the 2 home exits had openings of at least 32 inches; and that the sole resident bathroom had enough space to provide a turning radius for his/her wheelchair. This is a repeat deficiency. See Statement of Deficiency (SOD) 3LFH11, dated 10/30/2024. Findings include: The provider is licensed to serve up to 4 ambulatory individuals in the client groups of developmentally disabled, advanced aged, and physically disabled. On 07/16/2025, Surveyor reviewed Department	{M 262}		

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{M 262}	Continued From page 5 records for the provider, which included previous SOD 3LFH11. The onsite visit from that survey was conducted by Surveyor on 10/29/2024 (with information obtained through 10/30/2024). The SOD was issued on 01/03/2025. A period of correction extension was granted on 01/27/2025 with a revised correction date of 04/03/2025. On 07/16/2025, at approximately 9:50 a.m., Surveyor interviewed Caregiver F about residents' needs and abilities. Caregiver F reported that Resident 2 used to use a 4-wheeled walker (with a platform seat that s/he could sit on) for ambulation but for at least the last couple of months Resident 2 utilized a manual wheelchair for ambulation. While touring the home at approximately 10:02 a.m., Surveyor observed the home's 2 exits, which included the front door (Photos 1 and 2) and back door to the patio (Photos 3 and 4). The front door was elevated approximately 8" from a landing. The landing required use of an additional step to get to the level of the cement walkway, and was elevated approximately 1' off the ground with no surrounding handrails. The cement walkway, which led from the landing, connected to the home's driveway but was elevated approximately 6" from the level of the driveway, which required residents to step off the walkway onto the driveway. Regarding the back patio exit, the door to the patio was elevated approximately 8" from a landing. The landing was raised approximately 6" off the surrounding brick level of the patio, with no surrounding handrails, and required use of an additional step to get to the cement patio itself. The brick section of the patio, surrounding both the left and right sides of the landing, was raised approximately 4" from the cement patio itself.	{M 262}		

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{M 262}	Continued From page 6 After this, Surveyor observed the home's interior doorways. The width of Resident 2's doorway opening was measured by Surveyor as approximately 29.5" (Photo 5). The width of the sole resident bathroom doorway opening was measured by Surveyor as approximately 27.5" (Photo 6). An entryway separated the home's kitchen from a landing that led to the back door (where the patio exit was located). The width of that entryway was measured by Surveyor as approximately 28.5" (Photo 7). In observing the resident bathroom, Surveyor observed that the bathroom was an approximate rectangular shape, with the resident shower to the left (immediately past the door swing area), a vanity to the immediate right upon entering the bathroom doorway, and the resident toilet immediately past the vanity on the right. The width of the bathroom doorway of approximately 27.5", as detailed above, was the maintained accessible width throghout the bathroom (Photo 6). Surveyor observed that at this width, there was not enough space for a manual wheelchair to turn. On 07/16/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/09/2022. Surveyor reviewed Resident 2's current individual service plan (ISP), which was most recently signed as reviewed on 11/04/2024. Under the "Mobility and Transferring" section, the following was documented: "unable to walk. uses a walk chair for mobility." Under the "Physical Disabilities" section, the following was documented: "unable to walk, needs assistance from staff." At approximately 12:14 p.m., Surveyor	{M 262}		

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{M 262}	Continued From page 7 interviewed Manager B. Manager B reported that since Surveyor's last onsite visit on 10/29/2024, during which Resident 2's mobility concerns in the context of the home's accessibility was discussed, him/her and Licensee A were attempting to move Resident 2 to another home that Licensee A owned. Manager B reported that for that to happen they had to move a resident from that other home to this home but that they had concerns that the resident's behaviors would make him/her not fit well with the other residents of the home. Manager B reported that they were working with that resident's care team to improve his/her behavior management. Surveyor noted that an approximate 8.5 month period had passed since the home's accessibility concerns for Resident 2 were last discussed with Manager B and Licensee A (on 10/29/2024) and the current survey.	{M 262}		
{M 290}	88.05(3)(e)2.b INSPECTIONS-GAS FURNACE A gas furnace shall be inspected and serviced every 3 years by a heating contractor or local utility company. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the gas furnace was inspected and serviced every 3 years by a heating contractor or local utility company. This is a repeat deficiency. See Statement of Deficiency 3LFH11, dated 10/30/2024. Findings include: On 07/16/2025, at approximately 10:35 a.m.,	{M 290}		

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{M 290}	Continued From page 8 Surveyor requested the home's most recent furnace inspection report from Manager B. Surveyor then reviewed the records provided, which included 2 chimney inspections. No furnace inspection record was observed. Manager B reported that these were the only records s/he had and that s/he had no other records of the provider's furnace having been inspected.	{M 290}		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure that individual service plan (ISP) for 2 of 3 residents reviewed was reviewed at least once every 6 months by the licensee, the resident or the resident's guardian,	M 424		

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M 424	Continued From page 9 and the placing agency. Findings include: Example 1 - Resident 1 On 07/16/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/26/2024. Resident 1's most recent ISP was dated 12/30/2024 and was signed as last reviewed on that date (approximately 6.5 months prior to the survey). Example 2 - Resident 2 On 07/16/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/09/2022. Resident 2's most recent ISP was dated 11/04/2024 and was signed as last reviewed on that date (approximately 8.5 months prior to the survey). INTERVIEW: On 07/16/2025, at approximately 11:30 a.m., Surveyor interviewed Manager B regarding the ISP reviews for Residents 1 and 2 being out of date. Manager B acknowledged Surveyor's concern and reported s/he had no excuse for the ISPs not having been reviewed every 6 months. Manager B reported s/he had been busy and didn't have time to conduct their most recent reviews.	M 424		
{M 448}	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a	{M 448}		

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{M 448}	Continued From page 10 resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1's health was monitored in relation to his/her diabetes. Resident 1's insulin order included instructions for his/her medical provider to be contacted on occasions when his/her tested blood sugars were above 350. Between 06/01/2025 - 07/16/2025, Resident 1's medical provider was contacted on 0 of 10 occasions when his/her blood sugars were above 350. This is a repeat deficiency. See Statement of Deficiency (SOD) 3LFH11, dated 10/29/2024. Findings include: On 07/16/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/26/2024 with diagnoses including type I diabetes mellitus and Alzheimer's dementia. Resident 1's current prescriptions included insulin lispro 100 units/mL 3x/daily which included instructions for a scheduled dose in addition to a sliding scale dose. Within the sliding scale, the prescription instructions also included, "...Blood sugar, [sic] greater than 350 give 6 units and call [medical doctor (MD)]." Resident 1's current individual service plan (ISP), last signed as reviewed 12/30/2024, documented that Resident 1 required staff assistance for administering his/her insulin, with the specific directive, "Staff turns dial and supervises resident administer own insulin. Staff confirms resident took insulin by checking dial on insulin pen ti [sic] ensure it is at	{M 448}		

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{M 448}	Continued From page 11 0." The ISP also directed for staff to test Resident 1's blood sugars 4x/daily (before meals and at bedtime). Surveyor reviewed Resident 1's medication administration records (MARs) from 06/01/2025 - 07/16/2025, where staff appeared to record Resident 1's blood sugar values. Blood sugar checks in accordance with his/her insulin order for 3x/daily were documented as taking place at 9:00 a.m., 12:30 p.m., and 5:30 p.m. (correlating with his/her meals). Surveyor observed the following 10 occasions in which Resident 1's blood sugar was documented as being above 350: - 06/01/2025 (12:22 p.m.): Blood sugar recorded as 357 - 06/03/2025 (12:44 p.m.): Blood sugar recorded as 438 - 06/04/2025 (1:10 p.m.): Blood sugar recorded as 529 - 06/11/2025 (1:01 p.m.): Blood sugar recorded as 471 - 06/23/2025 (12:17 p.m.): Blood sugar recorded as 390 - 06/26/2025 (5:31 p.m.): Blood sugar recorded as 356 - 06/27/2025 (12:40 p.m.): Blood sugar recorded as 376 - 07/02/2025 (6:32 p.m.): Blood sugar recorded as 439 - 07/07/2025 (12:40 p.m.): Blood sugar recorded as 380 - 07/08/2025 (1:35 p.m.): Blood sugar recorded as 388 At approximately 11:45 a.m., Surveyor requested from Manager B evidence on the above occasions of staff having notified Resident 1's	{M 448}		

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{M 448}	Continued From page 12 medical provider for his/her elevated blood sugar values. Manager B reported that staff could have documented these notifications as observation entries in the provider's electronic record system but s/he didn't think they did. Manager B reported that staff typically called him/her when Resident 1 was experiencing issues with his/her blood sugar levels, including high level values, but confirmed that s/he had not received any calls from staff regarding concerns with Resident 1's blood sugars being above 350. Manager B confirmed s/he was unaware of the above occasions in which Resident 1's blood sugars were above 350. Manager B did not provide any additional records for review.	{M 448}		
{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 that for 1 of 3 residents reviewed, Resident 2, a written order from his/her medical provider, who prescribed his/her medications, specified who by name or position	{M 464}		

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{M 464}	Continued From page 13 was permitted to administer them. This is a repeat deficiency. See Statement of Deficiency (SOD) 3LFH11, dated 10/30/2024. Findings include: On 07/16/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/09/2022 with diagnoses including cerebral palsy and mild neurocognitive disorder. Resident 2's current individual service plan (ISP), last signed as reviewed 11/04/2024, documented that adult family home staff were responsible for managing Resident 2's medications. Resident 2's electronic record consisted of a medication administration record (MAR) where staff signed off on administering his/her medications. There was no evidence of a medical provider order specifying that adult family home staff were permitted to administer Resident 2's medications. At approximately 11:08 a.m., Surveyor interviewed Manager B. Manager B confirmed that staff stored, managed, and administered Resident 2's medications. Manager B confirmed s/he could not find an order from Resident 2's medical provider specifying that adult family home staff were permitted to administer his/her medications.	{M 464}		
{M 570}	88.10(3)(l) 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	{M 570}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018788	A. BUILDING: _____ B. WING _____	R 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONNECTED FAMILY HOME CARE	336 RICHARD STREET 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 570}	Continued From page 14 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 sole resident bathroom sink reached 138.4° Fahrenheit (F). This is a repeat deficiency. See Statement of Deficiency (SOD) 3LFH11, dated 10/30/2024. Findings include: The provider is licensed to serve up to 4 adults in the client groups of developmentally disabled, advanced aged, and physically disabled. On 07/16/2025, at approximately 10:15 a.m., Surveyor tested the water temperature of the sink in the resident bathroom which reached 138.4° 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	{M 570}		

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{M 570}	Continued From page 15 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 130° F and 140° F can result in second or third-degree burns in approximately 30 seconds and 6 seconds, respectively (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017). At approximately 12:14 p.m., Surveyor discussed the above concern with Manager B. Manager B acknowledged Surveyor's concern regarding the hot water temperature.	{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 1 received his/her insulin in the dosage as prescribed by his/her medical provider on 8 occasions from 06/01/2025 - 07/16/2025.	M 582		

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	0018788	A. BUILDING: _____ B. WING _____	R 07/16/2025

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M 582	Continued From page 16 Findings include: On 07/16/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/26/2024 with diagnoses including type I diabetes mellitus and Alzheimer's dementia. Resident 1's current prescriptions included insulin lispro 100 units/mL 3x/daily which included instructions for a scheduled dose in addition to a sliding scale dose. The order for Resident 1's scheduled insulin dose instructed, "Inject 5 units under the skin 3 (three) times daily before meals. Do not administer if patient does not eat. Still okay to give correctional." The order for Resident 1's sliding scale insulin dose instructed, "Inject 2-6 units under the skin 3 (three) times daily before meals as correctional insulin, whether patient eats or not. Sliding scale: Blood sugar 151-200, give 2 units. Blood sugar 201-250, give 3 units. Blood sugar 251-300, give 4 units. Blood sugar 301-350, give 5 units. Blood sugar, greater than 350 give 6 units and call [medical doctor (MD)]." Surveyor reviewed Resident 1's medication administration records (MARs) from 06/01/2025 - 07/16/2025. In reviewing the MARs, the entry for Resident 1's insulin prompted staff to document how many total units of insulin staff administered (scheduled dose plus sliding scale). Surveyor observed the following 8 discrepancies: - 06/07/2025 (12:18 p.m.): Blood sugar recorded as 150 (within range for 5 units), 7 units administered - 06/12/2025 (12:19 p.m.): Blood sugar recorded as 250 (within range for 8 units), 9 units administered - 06/17/2025 (9:13 a.m.): Blood sugar recorded	M 582		

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M 582	Continued From page 17 as 201 (within range for 8 units), 7 units administered - 06/29/2025 (9:42 a.m.): Blood sugar recorded as 256 (within range for 9 units), 8 units administered - 07/03/2025 (12:28 p.m.): Blood sugar recorded as 262 (within range for 9 units), 8 units administered - 07/09/2025 (2:26 p.m.): Blood sugar recorded as 323 (within range for 10 units), 9 units administered - 07/09/2025 (7:59 p.m.): Blood sugar recorded as 219 (within range for 8 units), 2 units administered (of note, even if staff only documented the sliding scale units administered to Resident 2, 3 sliding scale units should have been administered). - 07/12/2025 (12:22 p.m.): Blood sugar recorded as 294 (within range for 9 units), 8 units administered At approximately 11:45 a.m., Surveyor reviewed Resident 1's insulin administration errors with Manager B. Manager B confirmed s/he had been unaware of any insulin administration errors. Manager B appeared to take notes of Surveyor's concerns and reported s/he would address the concern with staff.	M 582		