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 11/07/2025

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 11/06/2025, with information obtained through 11/07/2025, 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, 4 deficiencies were identified. Three deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) 3LFH12, dated 07/16/2025, and 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 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure that the home and its operation complied with Wis. Stat ch. 88 and with all other laws governing the home and its operation. Findings include: Example 1 - Repeated noncompliance since the provider's initial licensure on 03/02/2022	M 216		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018788	A. BUILDING: _____ B. WING _____	R 11/07/2025

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 216	Continued From page 1 On 11/06/2025, with information obtained through 11/07/2025, Surveyor conducted a verification visit for Statement of Deficiency (SOD) 3LFH12, dated 07/16/2025. Four deficiencies were identified, which included the following 3 repeat deficiencies: M0262 DHS 88.05(2)(a) Difficulty Walking This requirement is being cited for a third time. See SOD 3LFH12, dated 07/16/2025, and SOD 3LFH11, dated 10/30/2024. M0424 DHS 88.06(3)(f) Review of ISP This requirement is being cited for the second time. See SOD 3LFH12, dated 07/16/2025. M0448 DHS 88.07(2)(b)5 Monitoring Health This requirement is being cited for a third time. See SOD 3LFH12, dated 07/16/2025, and SOD 3LFH11, dated 10/30/2024. Example 2 - Special order noncompliance On 11/06/2025, Surveyor reviewed Department records for the provider. The associated Notice and Order letter for SOD 3LFH12, issued 08/14/2025, detailed the following special orders: "WITHIN 14 DAYS of receipt of this notice, the licensee shall hold a care conference for Resident 2, with their legal representative, and case manager (if any), for the purpose of discussing the resident's mobility needs and the resident's access to the home and within the home. "WITHIN 45 DAYS of receipt of this notice, if compliance with Wis. Admin. Code § DHS 88.05(2)(a) and 88.05(2)(d) is not achieved, the licensee shall establish a relocation plan	M 216		

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 11/07/2025

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 216	Continued From page 2	M 216		

addressing the discharge of any resident who 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."

Through both observation and interview with Resident 2 and Manager B during the verification visit on 11/06/2025, Surveyor identified that Resident 2 continued to reside with the provider since the issuance of SOD 3LFH12 on 08/14/2025. Interview with both Manager B and Resident 2 identified that Resident 2 continued to use a manual wheelchair for mobility within and around the home. Observation of the home's interior doorways (including that of the bathroom and Resident 2's room) and exits identified that all the home's doorways, exits, and bathroom remained structurally unchanged since the previous survey.

On 11/06/2025, at approximately 12:00 p.m., Surveyor interviewed Manager B. Manager B confirmed awareness of the special orders that were associated with SOD 3LFH12. Manager B reported s/he had spoken with Resident 2's case manager about moving. Surveyor requested all evidence of Manager B's compliance with the special orders to be sent by 4:00 p.m. that day.

On 11/7/2025, Surveyor reviewed the records sent by Manager B. One record included an e-mail from Manager B to Care Manager G, who was identified by Manager B as being Resident 2's case manager. The e-mail, dated 08/29/2025, documented, "...The situation regarding [Resident 2]'s living arrangements is currently uncertain. [S/he] has expressed a desire to relocate to a new home, so it may be beneficial to reach out to [him/her] to discuss this possibility. If

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 11/07/2025

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 216	Continued From page 3	M 216		

improvements are not observed, there is a chance [s/he] may receive a 30-day notice." Below that were paragraphs outlining concerns Manager B had regarding Resident 2's behaviors. There was no evidence of mention regarding Resident 2's mobility concerns and related needs.

A second series of e-mails forwarded by Manager B documented correspondence between Licensee A and Resident 2's managed care organization that occurred during April 2025 (before Surveyor even conducted the previous revisit on 07/16/2025).

In an e-mail from Manager B to Surveyor at 2:51 p.m., Manager B reported, "I had some email correspondences with [Care Manager G], [Resident 2]'s new care manager. [S/he] sends encrypted messages and the ones we had in August were automatically deleted after a certain time frame. I did however send what I had."

From the records Manager B provided, there was no evidence that a care conference took place within 14 days of the issuance of SOD 3LFH12 with Resident 2 and his/her case manager to specifically discuss Resident 2's mobility needs and access to the home and within the home (as outlined in the special orders). There was also no evidence that a relocation plan was established within 45 days of the issuance of SOD 3LFH12 to address Resident 2's discharge.

Cross Reference:
M0262 DHS 88.05(2)(a) Difficulty Walking
M0424 DHS 88.06(3)(f) Review of ISP
M0448 DHS 88.07(2)(b)5 Monitoring Health

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 11/07/2025

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 262}	Continued From page 4	{M 262}		
{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 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	{M 262}		

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 11/07/2025

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 262}	Continued From page 5 Deficiency (SOD) 3LFH12, dated 07/16/2025, and 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 11/06/2025, Surveyor reviewed the resident roster, provided by Manager B. Surveyor observed Resident 2's name on the roster, who had been with the provider since his/her admission on 07/09/2022. Of note, from Surveyor's review of the previous SODs in which this deficiency was cited, the subject of both previous citations for Wis. Admin. Code § DHS 88.05(2)(a) was Resident 2, who was identified in both previous SODs (SOD 3LFH12 and SOD 3LFH11) as requiring either a walker and/or manual wheelchair for mobility. At approximately 9:35 a.m., Surveyor interviewed Manager B about Resident 2's mobility. Manager B reported that Resident 2 had not been using his/her 4-wheeled walker at all since approximately last winter and had been exclusively using his/her manual wheelchair for all mobility within and outside of the home. Manager B confirmed that Resident 2's wheelchair could not fit in the sole resident restroom. Manager B reported that in order to access the toilet or shower, Resident 2 stood out of his/her wheelchair in the bathroom doorway and relied on the bathroom structures for support as s/he ambulated to either the toilet or shower. Manager B reported that since Surveyor's last onsite visit on 07/16/2025, during which Resident 2's mobility concerns in the context of the home's	{M 262}		

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 11/07/2025

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 262}	Continued From page 6	{M 262}		

accessibility were 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 then an issue arose when Resident 2 experienced a mental health crisis around mid-September where s/he was out of the home for approximately 2 weeks receiving treatment. Surveyor noted that an approximate 12-month period had passed since the home's accessibility concerns for Resident 2 were first discussed with Manager B and Licensee A (on 10/29/2024 and as documented in SOD 3LFH11) and the current survey.

While touring the home between approximately 10:33 a.m. - 11:58 a.m. Surveyor observed the home's interior doorways. The width of Resident 2's doorway opening was measured by Surveyor as approximately 29.5" (Photo 1). The width of the sole resident bathroom doorway opening was measured by Surveyor as approximately 27.5" (Photo 2). 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 3).

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

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 11/07/2025

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 262}	Continued From page 7 27.5", as detailed above, was the maintained accessible width throughout the bathroom. Surveyor observed that at this width, there was not enough space for a manual wheelchair to turn. As part of the same tour, Surveyor observed the home's 2 exits, which included the front door (Photos 4, 5, and 6) and back door to the patio (Photos 7, 8, and 9). 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. On 11/06/2025, 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 07/30/2025. 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."	{M 262}		

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 11/07/2025

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 262}	Continued From page 8 At approximately 11:50 a.m., Surveyor interviewed Resident 2, who was seated in a chair in the kitchen. Resident 2 confirmed that his/her wheelchair, which s/he used to get around the home, didn't fit in the bathroom. Resident 2 reported s/he had left his/her wheelchair outside earlier that morning. When Surveyor asked how Resident 2 was going to get up and around from the chair, Resident 2 reported s/he could crawl on the floor to get out to the patio. Resident 2 reported s/he typically crawled on the floor to get in and out from the back patio area where s/he often went outside. At approximately 12:00 p.m., Surveyor interviewed Manager B. Manager B reported that Resident 2 often went outside and remained outside for long periods of time. Manager B reported that Resident 2 smoked out on the back patio and typically crawled on the floor to get outside in order to smoke. Manager B reported that Resident 2 refused staff assistance for getting in or out from the back patio. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities	{M 262}		
{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	{M 424}		

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 11/07/2025

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 424}	Continued From page 9	{M 424}		

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 record review and interview, the provider did not ensure that the individual service plan (ISP) for 1 of 2 residents reviewed, Resident 2, was updated to include information regarding the change in his/her mental health needs.

This is a repeat deficiency. See Statement of Deficiency (SOD) 3LFH12, dated 07/16/2025.

Findings include:

On 11/06/2025, Surveyor reviewed Department records for the provider. Within the Department files was e-mail correspondence between Surveyor, Licensee A, and Manager B. One of the e-mails, sent by Licensee A on 09/08/2025 documented the following: "...I would like to inform all parties that [Resident 2] was apprehended by the authorities today and has been taken to the [local county mental health facility]. This action was prompted by [his/her] recent refusal to comply with a court order..."

On 11/06/2025, at approximately 9:35 a.m., Surveyor interviewed Manager B. Manager B reported that Resident 2 experienced a mental health crisis around mid-September which

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 11/07/2025

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 424}	Continued From page 10	{M 424}		

caused him to be at a mental health facility for approximately 2 weeks.

On 11/06/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/09/2022. Diagnosis information was not included with Resident 2's record. Resident 2's ISP, last signed as reviewed on 07/30/2025, did not contain any information regarding Resident 2's mental health and behaviors or related needs in these areas. Resident 2's observation notes, reviewed from 09/01/2025 - 11/06/2025, documented the following in relation to his/her behaviors:

- 09/05/2025 (5:45 p.m.): "[Resident 2] was upset today [s/he] had a couple out burst [sic]...[s/he] spent most of the day in the living room on the phone and in [his/her] room [Resident 2] yelled at me and said [expletive] me because I asked [him/her] to pull up [his/her] pants since other residents were complaining."

- 09/06/2025 (6:30 a.m.): "...[S/he] got upset for no apparent reason and started yelling at [Resident 2] because [s/he] was trying to get out of [his/her] room."

- 09/06/2025 (5:30 p.m.): "...[s/he] had a couple loud out burst [sic], cursing and screaming because [s/he] was upset about some papers [s/he] got in the mail..."

- 09/27/2025 (6:45 a.m.): "...[S/he] was up yelling at 2am i [sic] had to tell [him/her] to be quiet."

- 10/08/2025 (9:30 p.m.): "I was notified by staff that [Resident 2] was cursing loudly and belligerently because [s/he] accused someone of drinking all the coffee. [S/he] said someone broke

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 11/07/2025

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 424}	Continued From page 11 the machine and that [s/he] can yell and curse all [s/he] wants when asked to stop." - 10/09/2025 (6:45 a.m.): "staff heard loud swearing and yelling coming from the kitchen got up to see client was upset about the coffee maker was dripping slow staff assured client [s/he] wasn't aware of the machine [s/he] continued to swear and yell staff asked client to please calm down [s/he]'s disturbing the house [s/he] coninued [sic] and start talking about how much [s/he] pays staff contacted the owner to try to help resolved the situation .... after hanging up [s/he] continued for a while and soon went to room and closed door [s/he] noticed staff ignored [him/her]." At approximately 12:00 p.m., Surveyor interviewed Manager B about Resident 2's mental health needs and behaviors. Manager B reported that Resident 2 had been prescribed an injectable psychotropic medication that was then stopped and replaced with an oral medication by his/her medical provider early in the year. Manager B reported that around the time this happened Resident 2's behaviors intensified - specifically with aggression, being confrontational with staff, and refusing to go to medical appointments. Manager B reported that this was a reportedly known pattern for Resident 2 in the past when s/he had been taken off his/her injectable medication. Manager B clarified that Resident 2's behaviors consisted mostly of yelling and cursing at staff and on occasion name calling the 2 other residents of the home. Manager B reported that Resident 2 wasn't known to be physically aggressive but there were 2 occasions in which s/he attempted to move out of his/her wheelchair towards another person with the seeming intention of intimidating that person. Manager B reported that on one occasion this was directed	{M 424}		

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 11/07/2025

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 424}	Continued From page 12	{M 424}		

towards Resident 1, which stemmed from an incident where Resident 2 "lashed out" verbally at Resident 3 and Resident 1 was attempting to defend him/her. Manager B reported that on the other occasion this was directed towards Caregiver D. When asked how staff manage Resident 2's behaviors, Manager B replied that staff typically gave Resident 2 time and space alone and redirected the other residents to different activities to prevent confrontation between them and Resident 2. Manager B reported that it typically worked for staff to let Resident 2 vent his/her frustrations. Manager B reported that Resident 2's behaviors had noticeable improvement after s/he was started on his/her injectable medication again around the time s/he was at the mental health facility. Manager B acknowledged Surveyor's concern that information regarding Resident 2's behaviors/mental health needs were not documented in his/her ISP.

On 11/06/2025, Surveyor reviewed additional records provided by Manager B. Within the records was an e-mail from Manager B to a representative from Resident 2's managed care organization. The e-mail, dated 08/29/2025, documented the following:

"Yesterday, 7/29/25 approximately 8:30am, there was an incident involving the police being called due to [Resident 2] displaying aggressive behavior towards staff and making derogatory remarks. During this incident, [s/he] became confrontational, approaching a staff member in a threatening manner. The police engaged with [him/her] for approximately 20 minutes, after which [s/he] was able to calm down. In general, [Resident 2]'s behavior has noticeably deteriorated, and it is difficult to connect all of

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 11/07/2025

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 424}	Continued From page 13 [his/her] actions solely to the impending move. [His/her] conduct appears to be intentional at times, and [s/he] has exhibited bullying behavior towards other residents. It may be considered beneficial for [him/her] to resume [his/her] psych medication injections..." Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities	{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 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 s/he was symptomatic (related to his/her diabetes) and for staff to re-check his/her blood sugar level if s/he experienced signs of hypoglycemia after the administration of his/her insulin. On 18 of 20 occasions that Resident 1 experienced blood sugar levels at or above 400 or below 70, there was no evidence that staff conducted follow up monitoring or assessment of Resident 1 in relation to his/her symptom precautions in order to rule out the need for further blood sugar re-checks or contact with his/her medical provider.	{M 448}		

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 11/07/2025

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 448}	Continued From page 14 This is a repeat deficiency. See Statement of Deficiency (SOD) 3LFH12, dated 07/16/2025, and SOD 3LFH11, dated 10/29/2024. Findings include: On 11/06/2025, 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 was documented as having an activated power of attorney for healthcare. Resident 1's prescriptions included insulin lispro 100 units/mL via pen three times daily with instructions for a scheduled dose in addition to a sliding scale dose. Within the prescription, instructions also included, "...[Blood sugar] 400 or greater give 8U; call [medical doctor] IF having symptoms of nausea/vomiting/abdominal pain. No need to recheck [blood sugar] after correctional unless symptoms of hypoglycemia (dizziness, altered mentation, etc.)." Resident 1 was also prescribed a basaglar 100 unit/mL insulin pen for nightly scheduled insulin administration. Resident 1 also had prescriptions for glutose gel, with instructions to, "Take as directed for 1 dose as needed for blood sugar <50 for diabetes. May repeat in 15 minutes if not resolved," and a glucagon 1 mg emergency kit, with instructions to, "Inject beneath the skin as needed for blood sugar <70, if unable to take glucose orally." Resident 1's current individual service plan (ISP), last signed as reviewed 09/03/2025, 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	{M 448}		

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 11/07/2025

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 448}	Continued From page 15 took insulin by checking dial on insulin pen ti [sic] ensure it is at 0." The ISP also directed for staff to to test Resident 1's blood sugars 4x/day (before meals and at bedtime). There was no information in Resident 1's ISP regarding specific precautions of hyper- or hypoglycemia or how staff were to manage occurrences of such. Surveyor reviewed Resident 1's medication administration records (MARs) from 10/01/2025 - 11/06/2025, where staff appeared to record Resident 1's blood sugar values. Blood sugar checks were documented as taking place at 9:00 a.m., 12:00 p.m., 5:30 p.m., and 9:00 p.m. Surveyor observed the following 20 occasions in which Resident 1's blood sugar was documented as being at or above 400 or below 70: - 10/02/2025 (11:52 a.m.): Blood sugar recorded as 498. Staff documented "no symptoms" in the corresponding notations section. - 10/03/2025 (9:03 p.m.): Blood sugar recorded as 50 with no other notations - 10/04/2025 (5:18 p.m.): Blood sugar recorded as 44 with no other notations - 10/06/2025 (12:54 p.m.): Blood sugar recorded as 400 with no other notations - 10/08/2025 (6:01 p.m.): Blood sugar recorded as 412 with no other notations - 10/13/2025 (12:51 p.m.): Blood sugar recorded as 448 with no other notations - 10/14/2025 (6:10 p.m.): Blood sugar recorded as 36 with no other notations	{M 448}		

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 11/07/2025

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 448}	Continued From page 16 - 10/15/2025 (5:03 p.m.): Blood sugar recorded as 418 with no other notations - 10/17/2025 (10:02 a.m.): Blood sugar recorded as 53 with no other notations - 10/17/2025 (12:20 p.m.): Blood sugar recorded as 407 with no other notations - 10/20/2025 (6:02 p.m.): Blood sugar recorded as 440 with no other notations - 10/22/2025 (9:43 p.m.): Blood sugar recorded as 447 with no other notations - 10/24/2025 (9:56 a.m.): Blood sugar recorded as 532 with no other notations - 10/24/2025 (12:06 p.m.): Blood sugar recorded as 400 with no other notations - 10/27/2025 (2:42 p.m.): Blood sugar recorded as 410 with no other notations - 10/29/2025 (9:02 a.m.): Blood sugar recorded as 67 with no other notations - 10/30/2025 (5:29 p.m.): Blood sugar recorded as 67 with no other notations - 11/02/2025 (5:14 p.m.): Blood sugar recorded as 482 with no other notations - 11/03/2025 (1:10 p.m.): Blood sugar recorded as 581. Staff documented "no symptoms" in the corresponding notations section. - 11/05/2025 (12:34 p.m.): Blood sugar recorded as 421 with no other notations.	{M 448}		

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 11/07/2025

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 448}	Continued From page 17 Resident 1's observation notes documented the following that correlated with the above readings: - 10/03/2025 (9:00 p.m.): "client sat up front with staff and gave yogurt called owner and shared sugar level 50 gave insulin after." - 10/13/2025 (6:15 p.m.): "...For lunch [s/he] ate a grilled cheese and soup with a reading of 484... [S/he] spent my shift in [his/her] room and outside." - 10/24/2025 (5:30 p.m.): "[Resident 1] sugar was extremely high when [s/he] woke up [s/he] spent most of the day in the living room watching tv [s/he] did not eat breakfast and [s/he] ate one slice of pizza for lunch [s/he] ate all of [his/her] dinner..." - 10/27/2025 (6:30 p.m.): "...For lunch [s/he] ate a sandwich and soup with a reading of 410...[S/he] spent my shift in [his/her] room and outside." - 11/05/2025 (6:15 p.m.): "...For lunch [s/he] ate a sandwich and fruit with a reading of 421...[S/he] spent my shift in [his/her] room and outside." There were no other notes regarding the above occurrences. Surveyor noted that for 18 of the 20 above occurrences in which Resident 1's blood sugar values were at or above 400 or below 70, there was no evidence that staff conducted any follow-up monitoring or further assessment of symptoms for Resident 1 with regards to hyper- and hypoglycemia precautions - symptoms for which would have warranted staff to contact Resident 1's medical provider, or in the event of low blood sugars, would have required a blood sugar re-check.	{M 448}		

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 11/07/2025

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 448}	Continued From page 18 At approximately 12:00 p.m., Surveyor interviewed Manager B. Manager B reported s/he believed staff assessed Resident 1 any time s/he experienced high and low blood sugars and only would document it if there were issues. Manager B reported s/he believed staff just didn't document their assessment of Resident 1 when s/he felt fine. Manager B reported that staff called him/her when they had concerns about Resident 1's blood sugar levels. Surveyor confirmed with Manager B the finding that on 2 occasions staff had documented assessing Resident 1 for symptoms in response to high blood sugars, but that on all other occasions there was no way to confirm from documentation that staff assessed Resident 1. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities	{M 448}		