STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 410094	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARFA TERRACE	**54 W ARNDT ST , FOND DU LAC, Wisconsin, 54935**

(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) COMPLETION DATE
N0000	Initial Comments On 09/29/2026 with additional information gathered through 10/01/2026, Surveyor conducted a standard survey, complaint investigation and reviewed a facility self-report. As a result two (2) deficiencies were identified. One (1) of 1 complaint was substantiated. Census: 27	N0000		
N0220	Employees screened for communicable disease. 83.17(2)(a) The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees reviewed were screened for clinically apparent communicable disease within 90 days before the start of employment. This is a repeat deficiency and is being cited for the second time. See Statement of Deficiency (SOD) 9TDE12, dated 11/14/2022. Findings include:	N0220		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 410094	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2026

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N0220	Continued from page 1 The provider is licensed to care for 32 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 09/29/2026, Surveyor requested health screening documentation for two (2) employees. ~RA (Resident Assistant)-B was hired on 04/08/2019. RA-B's file included results of a TB screen and test but there was no documentation indicating RA-B had been screened by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse for clinically apparent communicable disease ~RA-C was hired on 01/26/2026. RA-C's file included results of a TB screen and test but there was no documentation indicating RA-C had been screened by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse for clinically apparent communicable disease. On 09/29/2026 at approximately 3:50 PM, Surveyor reviewed the above information with ADON (Assistant Director of Nursing)-A and ED (Executive Director)-D. Both ADON-A and ED-D verified the provider did not have evidence the above employees were screened for clinically apparent communicable disease by a qualified reviewer. Surveyor discussed in addition to the employee TB screen/test the requirement indicates the need for documentation by a qualified reviewer that all employees have been screened for clinically apparent communicable disease. ED-D indicated they would correct this by conducting audits on all employee files.	N0220		
N0432	Medication administration. 83.38(1)(h) As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	N0432		

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N0432	Continued from page 2 Based on interviews and record review, the provider did not provide medication services, including procedures to assure the accurate administering of all medications, to meet the needs of residents. Resident 1 was prescribed Humulin R U-500 KwikPen per sliding scale for Type II diabetes mellitus. On 08/14/2026, a significant insulin error occurred due to a shortage of required pen needles for Resident 1's Humulin U-500 KwikPen. As an alternative to the shortage of pen needles, ADON (Assistant Director of Nursing)-A instructed staff to withdraw insulin directly from the pen device using a syringe. Consequently, RA (Resident Assistant)-B administered 450 units of insulin (five times the intended amount) instead of 90 units as prescribed. As a result, Resident 1 required emergency hospital admission and was diagnosed with acute metabolic encephalopathy alongside uncontrolled diabetes with hypoglycemia and a urinary tract infection (UTI). This is a repeat deficiency and is being cited for the second time. See Statement of Deficiency (SOD) 9TDE12, dated 11/14/2022. Findings include: The Department received a complaint about diabetes management. According to www.drugs.com/mtm/humulin-r-kwikpen-concentrated-u-500.html, "Humulin R KwikPen is concentrated U-500 insulin. Insulin is a hormone that works by lowering levels of glucos (sugar) in the blood. Concentrated (U-500) insulin is a long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours. U-500 insulin is five times more concentrated than regular U-100 insulin." The Prescribing information for HUMULIN R U-500 KwikPen, revised July 2026 indicated, "2.3 Delivery of HUMULIN R U-500 Using the HUMULIN R U-500 Disposable Prefilled KwikPen Device...DO NOT transfer HUMULIN R U-500 from the HUMULIN R U-500 KwikPen into any syringe for administration as overdose and severe hypoglycemia can occur [see Warnings and Precautions (5.3)] ...5.3	N0432		

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N0432	Continued from page 3 Hypoglycemia is the most common adverse reaction associated with insulins, including HUMULIN R U-500. Severe hypoglycemia can cause seizures, may be life-threatening or cause death. Severe hypoglycemia may develop as long as 18 to 24 hours after an injection of HUMULIN R U-500. Hypoglycemia can impair concentration ability and reaction time...Hypoglycemia can happen suddenly and symptoms may differ in each patient and change over time..." The Instructions for Use for HUMULIN R U-500 KwikPen, revised July 2026 indicated, "HUMULIN R U-500 KwikPen ("Pen") is a disposable single-patient-use prefilled pen containing 1500 units of HUMULIN R...Important: ...The Pen delivers your dose in insulin units. Insulin units may not be the same as syringe markings...Your HUMULIN R U-500 KwikPen (Pen) works differently from other pens. It dials 5 insulin units with each click...HUMULIN R U-500 is a concentrated insulin. Do not transfer HUMULIN R U-500 insulin from your Pen into a syringe. A severe overdose can happen, causing very low blood sugar, which may put your life in danger. DO NOT TRANSFER TO A SYRINGE SEVERE OVERDOSE CAN RESULT...Inject HUMULIN R U-500 only with your Pen. Do not transfer insulin from your Pen to a syringe...Supplies needed to give your injection: HUMULIN R U-500 KwikPen and KwikPen compatible Needle..." On 09/29/2026, Surveyor reviewed Resident 1's record. The record indicated Resident 1 was admitted to the facility on 01/15/2024 with diagnoses to include Type II diabetes mellitus with hyperglycemia and diabetic polyneuropathy, long term use of oral hypoglycemic drugs and vascular dementia. Resident 1 had an APOA (Activated Power of Attorney) and required staff to administer all his/her medications. On 09/29/2026, Surveyor reviewed Resident 1's "Medication Review Report" dated 08/18/2026, which indicated Resident 1 was prescribed, "Humulin R U-500 KwikPen subcutaneous solution Pen-Injector 500 Unit/ml (milliliter)- Prior to meals inject as per sliding scale." Blood sugars checks were ordered for 7 AM, 11 AM and 4 PM. Based on the pre-meal blood sugar reading the following units of insulin were to be administered: "If 0 - 70 = 0, 71 - 300 = 90 units, 301- 400= 100 units. Call provider if blood sugar less than 50 or greater than 400."	N0432		

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N0432	Continued from page 4 On 09/29/2026, Surveyor reviewed Resident 1's most recent ISP (Individual Service Plan) dated 09/28/2026. The ISP indicated, Resident 1 required assistance with bathing, dressing and toileting. Additionally, the ISP indicated Resident 1, "Will be supported to take all medications safely and as ordered: Does not know name, reason or time of medication...Needs help with medications due to cognitive loss, requires assistance with ordering meds, requires daily supervision of medication..." Review of Resident 1's "Medication Error" report dated 08/14/2026 at 9:00 PM indicated, "It was discovered resident was given too much insulin as staff ran out of insulin pen needles and drew up 90 units from the pen in a regular syringe. Given this was U-500 Humulin, 90 units in a syringe was over the amount that would've been administered through a pen needle...Immediate Action Taken: Resident went to hospital for worsening lethargy and weakness (has been ongoing for prior week). Blood sugar prior to leaving facility was in the 70s...Other Info: No proper needles available to administer Humulin..." On 09/30/2026, Surveyor reviewed the Hospital Discharge Summary for Resident 1 dated 08/17/2026 which indicated, "Date of Admit: 08/14/2026, Date of Discharge: 08/17/2026...Principal Diagnosis: Acute metabolic encephalopathy, Uncontrolled type 2 diabetes mellitus with hypoglycemia, Acute cystitis without hematuria...HOSPITAL COURSE: [Resident 1] with a history of type 2 diabetes mellitus...admitted for acute metabolic encephalopathy secondary to severe hypoglycemia and UTI. Acute Metabolic Encephalopathy- [Resident 1] was admitted with altered mental status and lethargy, found to have persistent severe hypoglycemia (blood glucose in the 30s and 40s) despite repeated dextrose administration, and a UTI. [Resident 1] mentation improved with correction of hypoglycemia and supportive care...Uncontrolled Type 2 Diabetes Mellitus with Hypoglycemia- [Resident 1] presented with hypoglycemia (blood glucose 30 mg/dL) and was managed with intravenous dextrose and glucose monitoring. [Resident 1] glycemic control was transitioned to insulin glargine and insulin aspart with low-dose sliding scale as blood glucose stabilized and rose above 200 mg/dL. Prior to admission, [s/he] was on U-500 insulin, which was held during hospitalization...Insulin still on hold at discharge, will tolerate hyperglycemia over hypoglycemia for now...Acute Cystitis without	N0432		

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N0432	Continued from page 5 Hematuria- Urine cultures grew E. coli and K. pneumoniae; [s/he] was treated with intravenous ceftriaxone and transitioned to oral cefdinir. UA (Urinalysis) showed significant pyuria and bacteriuria...[Resident 1] was below baseline for ADLs and mobility at admission, requiring maximal assistance for transfers and peri-care. Physical therapy determined [s/he] was at [her/his] prior level of function and recommended return to assisted living with home health..." On 08/19/2026, the Department received a facility self-report which indicated, "On 08/14/2026 at 10 PM, [Resident 1] was administered a larger dose of [her/his] Humulin via standard insulin syringe versus being administered with [her/his] Humulin pen due to no pen needles being available. Incident Outcome: [Resident 1] was transported by EMS to the ER (Emergency Room) related to resident presenting lethargic and confused. [Resident 1] was admitted to hospital with diagnosis of acute metabolic encephalopathy, uncontrolled diabetes, with hypoglycemia and a UTI...Facility issued staff education on proper administration of insulin techniques in the CBRF setting. All med passers were re-delegated on administering insulin. Corrective action has been given to staff involved..." Additionally, the facility self-report indicated, "According to staff, the facility was almost out of insulin pen needles. Staff alerted members of management on 08/14/2026. [ADON-A] ordered a supply to be sent from the pharmacy stat but understood from staff they had enough to get through the evening. [ADON-A] did attempt to purchase some from a local pharmacy but was unable to secure any. [ADON-A] taught the med passers how to draw the insulin from the pen as a last resort...[Resident 1] had been displaying signs of weakness, lethargy, and confusion over the past week and facility was waiting on the results of a UA. [RA-B] tested resident's blood sugar and was found to be 185 around 5 PM on 08/14/2026. [Resident 1] has order for Humulin U-500 KwikPen to administer 90 units for blood sugar between 71 - 300. [RA-B] drew up 90 units of the Humulin from the pen as shown and administered to resident. Later in the evening, both [RA-B and RA-C] note resident was showing further signs of weakness and lethargy. [RA-C] grabbed the vital cart to obtain vitals and re-took [Resident 1's] blood sugar. Around 10:15 PM, [Resident 1's] blood sugar was 76. Due to the change in condition, EMS was called to transport resident to the hospital. Upon arrival at the hospital, [Resident 1's] blood sugar was 30 per [her/his] discharge summary. Upon medication administration	N0432		

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N0432	Continued from page 6 at the hospital, [Resident 1's] blood sugar did rise and [s/he] was admitted to the hospital for monitoring. [ED (Executive Director)-D] and [DON (Director of Nursing)-E] were alerted of situation and the possibility of a med error on the morning of 08/15/2026. Upon investigation, it was determined that [RA-B] did administer too much Humulin as 90 units in a pen of U-500, would be 0.18 ml and 0.9 ml was administered. [ADON-A] acknowledged [s/he] did instruct and teach the RAs how to draw up insulin from the insulin pen with a syringe...[ADON-A] reviewed other residents for potential med errors on 08/17/2026 and no other errors were identified. [ADON-A] immediately began efforts to re-delegate insulin administration to staff and education of proper administration was started for the med passers. [ED-D] and [DON-E] issued corrective action to [ADON-A] for giving improper instructions on handling the situation and not following recommendations to have a nurse from the SNF (Skilled Nursing Facility) be involved in administration if needed, as well as corrective action with [RA-B] for not following med administration orders and proper protocols." On 09/30/2026, Surveyor reviewed a "Corrective Action" form for ADON-A dated 08/19/2026 which indicated, "...Details of Occurrence: On 08/14/2026, [ADON-A] was made aware by CBRF staff that they were almost out of insulin pen needles. [ADON-A] demonstrated how to pull up insulin with a standard syringe as a backup in case the needles did not arrive in time from the pharmacy...CBRF staff ended up pulling a resident's insulin up in a syringe, and ended up giving too much insulin resulting in the resident's hospitalization...Expected improvement: Make sure staff have all the equipment needed to safely perform their job duties. Hold staff accountable to use resident specific items for those residents. Do not ask staff to operate outside of their delegated duties." On 09/30/2026, Surveyor reviewed a "Corrective Action" form for RA-B dated 08/19/2026 which indicated, "...Details of Occurrence: On 8/14/2026, [RA-B] administered medication in a way that was not within [her/his] scope or approved delegations which resulted in a resident receiving too much insulin and resident being hospitalized. [DON-E] had informed staff to wait until the supply of pen needles arrived from pharmacy to give insulin versus drawing into syringe as demonstrated by [ADON-A]...Expected improvement: Continue work within your scope of practice and delegations only,	N0432		

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N0432	Continued from page 7 never deviating. Contact another nurse manager or ED if in doubt." On 10/01/2026, Surveyor reviewed the staff schedule for 08/14/2026 and noted RA-B and RA-C were working in the facility during the above incident involving Resident 1. On 09/30/2026, Surveyor reviewed a written statement signed by RA-B which indicated, "On 08/14/2026, I was instructed by [ADON-A] on how to draw insulin up through residents insulin pen via plunger syringe...The resident had been displaying increased weakness and lethargy...and it was determined resident would be sent out to ER for further evaluation..." On 09/27/2026 at 2:50 PM, Surveyor interviewed RA-B regarding the above incident involving Resident 1. RA-B reported the facility did not have the required pen needles for Resident 1's insulin pen on 08/14/2026. RA-B stated, "[ADON-A] provided standard syringes from central supply and showed me how to draw up [Resident 1's] insulin directly from the KwikPen." RA-B indicated s/he was uncomfortable with this method, but proceeded as directed by ADON-A. RA-B then confirmed s/he used a standard syringe to administer 90 units of concentrated U-500 insulin to Resident 1, which delivered five times more insulin. On 09/30/2026, Surveyor reviewed a written statement signed by RA-C on 08/17/2026 which indicated, "On Friday August 14th, [RA-B] went to toilet [Resident 1]...After [RA-B] toileted [Resident 1], [RA-B] came and got me to take vitals on resident due to a recent change in condition. [Resident 1] was not speaking and was unable to keep [her/his] eyes open and head up for longer than a second and was warm to the touch. Vitals were taken...Notified on call that resident was sent out to ER...I would like to note that on that day, insulin had to be given via syringes. [RA-B] expressed to me [s/he] was nervous to do this, I offered to administer for [her/him] but [s/he] requested I speak to [ADON-A] and ask [her/him] to find the regular needles for the insulin pens. I spoke to [ADON-A], advising [her/him] of the situation, which [s/he] then assured me [s/he] would speak with [RA-B]. After some time passed, I asked [RA-B] if [s/he] felt ok to do the insulin and [s/he] said [s/he] did..."	N0432		

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N0432	Continued from page 8 On 09/27/2026 at 3:00 PM, Surveyor interviewed RA-C regarding the above incident involving Resident 1. RA-C verified on 08/14/2026 there were no pen needles in the facility for Resident 1's Humulin R U-500 insulin pen. RA-C confirmed RA-B withdrew 90 units of U-500 insulin directly from the pen using a syringe and administered it to Resident 1. On 09/30/2026, Surveyor reviewed the written statement by ADON-A regarding the 08/14/2026 incident involving Resident 1. ADON-A's written statement was dated 08/17/2026 and indicated, "...Facility staff were out of AutoShield Duo needles for insulin pens...Contacted the pharmacy immediately to request urgent refills. Educated and instructed staff on using standard insulin syringes to draw insulin directly from insulin pens as a temporary alternative...Instructed staff to contact me [ADON-A] directly with any questions or concerns. Staff verbalized understanding of these temporary instructions...Resident was transferred to the ER presenting with increased lethargy and Altered Level of Consciousness (ALOC)...Investigation Findings: Interviewed the medication passer involved. Discovered the resident was administered 90 units of Humulin R U-500 KwikPen Subcutaneous Solution Pen-injector 500 UNIT/ML using a standard insulin syringe instead of the dedicated U-500 syringe or pen needle...Staff Remediation: Mandatory re-education and re-delegation of all staff members will be completed immediately to ensure safe insulin administration protocols." On 09/27/2026 at 4:20 PM, Surveyor interviewed ADON-A regarding the above incident involving Resident 1. ADON-A confirmed s/he instructed staff to withdraw insulin from Resident 1's Humulin R KwikPen into a standard syringe as a last resort, noting s/he did not realize it was a U-500 concentration. ADON-A also indicated prior to the incident s/he was unaware of the manufacturer's prescribing information for the pen, which indicated, "DO NOT transfer HUMULIN R U-500 from the KwikPen into any syringe for administration." On 09/29/2026 at 10:45 AM, ED-D verified the above medication error involving Resident 1 occurred on 08/14/2026. ED-D confirmed RA-B administered 450 units (0.9 ml) of insulin instead of the prescribed 90 units (0.18 ml). ED-D indicated, "[RA-B] thought [s/he] was administering the correct	N0432		

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N0432	Continued from page 9 dose but didn't realize the insulin in [Resident 1's] pen was five times more concentrated than regular U-100 insulin." ED-D also acknowledged that on 08/14/2026, the facility lacked the required pen needles for Resident 1's insulin pen. ED-D indicated staff were commingling residents' diabetes supplies; specifically pen needles, lancets and strips, instead of utilizing each resident's individual inventory. ED-D stated the facility is actively working on separating these items to ensure staff do not use a resident's supplies for another when stock runs low. ED-D provided Surveyor with 'Medication Administration Education' dated 08/18/2026 and verified the education was conducted following the medication error incident involving Resident 1 on 08/14/2026. Surveyor reviewed the 08/18/2026 "Medication Administration Education" staff signature sheet. The document acknowledged staff understood and agreed to follow all facility policies regarding medication administration. Surveyor verified the signatures against the facility's active staff roster and confirmed all staff members responsible for passing medications at the time of the incident signed the document. The education indicated, "The purpose of this education is to ensure all medication administrators understand the proper and safe use of insulin pens, follow insulin orders exactly as written, and use only resident-specific medication supplies and equipment...2. Insulin Pens Require Pen Needles- When administering insulin from an insulin pen, use a new, sterile pen needle for each injection. Standard insulin syringes/needles should NEVER be used to withdraw insulin from an insulin pen. An insulin pen is designed to be used with an appropriate pen needle and the pen's dosing mechanism. Each pen uses it's own pen needle, they should not be interchanged. DO NOT: *Insert a standard insulin syringe into an insulin pen cartridge *Withdraw insulin from a pen using a syringe *Attempt to "draw up" a pen dose into a standard syringe *Use a syringe to convert or estimate the amount contained in a pen *Use a pen in a manner that is inconsistent with the manufacturer's instructions or facility policy. Using the wrong device can result in significant dosing errors. Remember: PEN=PEN NEEDLE. If the appropriate pen needle is unavailable, do not improvise. Stop and contact the nurse/supervisor...5. Resident-Specific Supplies...Never use a resident's insulin pen, medication, or resident-specific supply for another resident. If the facility does not have the appropriate insulin or supplies for a resident, do not substitute another resident's supplies. Contact the nurse/supervisor and follow the facility's process for obtaining the correct medication or supplies. Do	N0432		

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TARFA TERRACE	**54 W ARNDT ST , FOND DU LAC, Wisconsin, 54935**

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N0432	Continued from page 10 not wait until supplies run out to get a new supply ordered..." In conclusion, due to a shortage of pen needles, insulin was inappropriately transferred from Resident 1's pen delivery system into a standard syringe, resulting in Resident 1 receiving an incorrect dose of Humulin R U-500. Consequently, Resident 1 required emergency hospital admission and was diagnosed with acute metabolic encephalopathy alongside uncontrolled diabetes with hypoglycemia and UTI. In response to the medication error, the facility retrained all medication passers on safe insulin pen use and issued corrective actions to the staff involved.	N0432		