

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020668	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/21/2026
NAME OF PROVIDER OR SUPPLIER HOPE HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1205 MENDOTA ST MADISON, WI 53714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	INITIAL COMMENTS On 08/11/2026, with information obtained through 08/21/2026, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation and standard licensing survey at Hope Home Care, an adult family home (AFH) located in Madison, WI. As a result of the survey, 19 deficiencies were identified. The complaint was substantiated. Census: 2	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. Admin. Code ch. 88. Findings include: On 08/11/2026, Surveyor reviewed Department records for the provider. The provider has been licensed since 01/03/2025 and is licensed to serve up to 3 residents in the client groups of irreversible dementia/Alzheimer's, developmentally disabled, advanced aged, emotionally disturbed/mental illness, terminally ill, physically disabled, and traumatic brain injury.	M 216		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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M 216	Continued From page 1 On 08/11/2026, with information obtained through 08/21/2026, Surveyor conducted a complaint investigation and standard licensing survey. The complaint was substantiated and the following 19 deficiencies were identified: M0216 88.04(2)(a) Responsibilities M0230 88.04(2)(f) Condition Which Represents Risk or Harm M0232 88.04(2)(g)1 Health Screening for Staff M0235 88.04(2)(h) Comply with OSHA M0244 88.04(5)(a) Training - 15 Hours Within 6 Months M0332 88.05(4)(a) Fire Safety - Fire Extinguishers M0336 88.05(4)(b)2 Smoke Detectors - Testing and Maintenance M0346 88.05(4)(d)2.b Fire Evacuation Annual Evaluation M0384 88.06(2)(b) Service Agreement Except Respite M0420 88.06(3)(d)5 Signed Statement of Agreement M0424 88.06(3)(f) Review of ISP M0448 88.07(2)(b)5 Monitoring Health M0458 88.07(3)(a) Prescription Medications M0462 88.07(3)(c) Medication Assistance	M 216		

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M 216	Continued From page 2 M0464 88.07(3)(d) Medication - Written Order M0482 88.09(1)(a) Resident Records M0530 88.09(2)(a)8 Training Documentation M0580 88.10(3)(p) Prompt and Adequate Treatment M0582 88.10(3)(q) Medications On 08/21/2026, at approximately 2:20 p.m., Surveyor interviewed Licensee A. In discussing the regulatory concerns in the above areas, Licensee A reported that s/he learned a lot through the survey process. Licensee A reported that s/he realized s/he needed to have better documentation. Licensee A denied having any questions or concerns about the above areas discussed with Surveyor.	M 216			
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on record review and interview, the licensee permitted the existence and continuation of a condition in the home which placed the safety and welfare of residents at substantial risk of harm by having 3 of 3 staff reviewed, who were not trained in catheter, ostomy, and gastrostomy	M 230			

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M 230	Continued From page 3 tube (g-tube) management, provide services in these areas for 2 residents. Findings include: On 08/11/2026, at approximately 8:30 a.m., Surveyor interviewed Caregiver B regarding the home's 2 residents. Caregiver B reported that Resident 3 utilized a catheter and ostomy bag since his/her admission, which staff were expected to empty. Caregiver B also reported that staff changed out Resident 3's ostomy bag. On 08/11/2026, Surveyor reviewed training records for Caregiver B and Executive Director C, provided by Licensee A. The record for Caregiver B, hired 08/21/2025, did not contain evidence of training in catheter management or ostomy management. The record for Executive Director C, hired approximately 08/01/2025, did not contain evidence of training in catheter management or ostomy management. In reviewing the staff training records, Surveyor observed that there were no training records for Caregiver D, hired 05/11/2026. At approximately 10:16 a.m., Surveyor requested from Licensee A any training records for Caregiver D. Licensee A reported that there were no records since Caregiver D was newer and still within his/her timeframe to receive initial training. At approximately 2:25 p.m., Surveyor interviewed Licensee A regarding the care needs of Resident 2, who was a former resident that resided with the provider from 10/13/2025 - 06/07/2026. Licensee A reported that Resident 2 required g-tube feedings for nutrition during his/her entire admission. Licensee A reported that Resident 2 was the first resident the provider had that had a	M 230			

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M 230	Continued From page 4 g-tube. Surveyor noted from earlier review of the training records for Caregiver B and Executive Director C that neither had received training in g-tube management. On 08/21/2026, at approximately 2:20 p.m., Surveyor interviewed Licensee A regarding the above training concerns. Licensee A reported s/he recalled at one point that Resident 2's home health agency had conducted g-tube training for Resident 2. Licensee A confirmed s/he did not have documentation of this training, however, and was not able to provide information regarding the specific details of the training. Regarding potential risks involving catheter, ostomy, and g-tube cares or management: - Healthcare-associated infections "are a significant source of preventable harm" and commonly involve catheter-associated urinary tract infections. Routine hand hygiene at "key moments" are "essential" to help minimize infection risk (Source: Tobin, EH & Zahra F. (2025) Nosocomial infections, StatPearls, https://www.ncbi.nlm.nih.gov/books/NBK559312/ (retrieval date - August, 21, 2026).). - G-tube placement can involve complications that include tube dislodgement, gastric occlusion (clogging or blocking of the tube), pericatheter leakage (which can cause "significant skin irritation and breakdown"), and tube deterioration. Awareness of these complications are recommended to minimize the severity or incidence of them (Source: Peters, G., Bittman, R., & Sankhla, T. (2025). Complications of gastrostomy tube placement, Seminars in	M 230		

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M 230	Continued From page 5 interventional radiology, 42(1), https://pmc.ncbi.nlm.nih.gov/articles/PMC12058295/ (retrieval date, August 21, 2026). - Risks related to stoma maintenance, such as for an ostomy, includes skin irritation and stoma leakage, which may relate to an ill-fit of the pouch system. Caring for the stoma as part of overall ostomy management includes proper cleaning of the stoma and ostomy pouch, pouch changes, and pouch-emptying (Source: Mayo Clinic, Colostomy: surgery, bags and stoma care, May 16, 2025, https://www.mayoclinic.org/tests-procedures/colostomy/about/pac-20583139 (retrieval date, August 21, 2026).). Cross-Reference: M0235 88.04(2)(h) Comply with OSHA	M 230			
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by:	M 232			

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M 232	Continued From page 6 Based on record review and interview, the provider did not ensure that documentation was obtained from a physician, registered nurse, or physician's assistant indicating that Executive Director C was screened for illness detrimental to residents, including for tuberculosis. Findings include: On 08/11/2026, Surveyor reviewed the illness screening records for the provider's staff, provided by Licensee A. There was no evidence of an illness screen completed for Executive Director C. At approximately 3:47 p.m., Surveyor interviewed Licensee A about the missing screen for Executive Director C. Licensee A reported s/he believed it was maybe in his/her office offsite. On 08/12/2026, at approximately 8:12 a.m., Surveyor gave Licensee A a deadline of 12:00 p.m. that day to send the screen document for Executive Director C. Nothing further was received. At approximately 11:50 a.m., Licensee A e-mailed Surveyor and reported, "I've looked everywhere for [Executive Director C]'s [tuberculosis] screen papers unfortunately no luck yet."	M 232		
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	M 235		

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M 235	Continued From page 7 blood-borne pathogens. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Caregiver B completed universal precautions training in accordance with the U.S. Occupational Safety and Health Administration (OSHA) standard. Caregiver B, hired 08/21/2025 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. [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. Additionally, according to OSHA, "Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens." (Source: OSHA, Bloodborne pathogens, https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030/ (retrieval date -	M 235			

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M 235	Continued From page 8 August 14, 2026.) On 08/11/2026, at approximately 8:30 a.m., Surveyor interviewed Caregiver B regarding the home's 2 residents. Caregiver B reported that Resident 3 utilized a catheter and ostomy bag since his/her admission, which staff were expected to empty. Caregiver B also reported that staff changed out Resident 3's ostomy bag. On 08/11/2026, Surveyor reviewed the resident roster, provided by Licensee A, which identified that Resident 3 admitted to the provider on 07/31/2025. On 08/11/2026, Surveyor reviewed training records for Caregiver B, hired on 08/21/2025. The records contained no evidence of training in universal precautions. At approximately 3:47 p.m., Surveyor discussed the above concern regarding universal precautions training with Licensee A. Licensee A appeared to take notes of Surveyor's concern and reported understanding of his/her concern. Cross-Reference: M0230 88.04(2)(f) Condition Which Represents Risk or Harm	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	M 244		

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M 244	Continued From page 9 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 completed training in fire safety prior to or within 6 months after starting to provide care. Findings include: On 08/11/2026, Surveyor reviewed training records for Caregiver B and Executive Director C, provided by Licensee A. The record for Caregiver B, hired 08/21/2025, did not contain evidence of training in fire safety. On 08/11/2026, at approximately 10:16 a.m., Surveyor interviewed Licensee A regarding the above training concern. Licensee A reported understanding of Surveyor's concern and confirmed s/he had no other training records for Caregiver B.	M 244			
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A	M 332			

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M 332	Continued From page 10 fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the adult family home was equipped with one or more fire extinguishers on each floor. Findings include: On 08/11/2026, at approximately 2:20 p.m., Surveyor toured the basement of the home with Licensee A. The basement contained a staff living area, which Licensee A reported was for Caregiver B. Surveyor did not observe a fire extinguisher in the basement. After asking Licensee A about it, Licensee A confirmed s/he could not locate a fire extinguisher in the basement. At approximately 3:47 p.m., Surveyor reviewed the fire extinguisher concern with Licensee A.	M 332		

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M 336	Continued From page 11	M 336			
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure each smoke detector within the home was checked monthly to ensure its operation. Findings include: On 08/11/2026, Surveyor reviewed smoke detector check documentation, provided by Licensee A. The records showed that the home's smoke detectors were last checked in May 2026. There was no evidence of checks having been done more recently than that. At approximately 10:10 a.m., Surveyor interviewed Licensee A about the checks. Licensee A reported that s/he knew they were supposed to be done monthly but s/he had gotten busy.	M 336			
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated	M 346			

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M 346	Continued From page 12 annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 1 applicable residents reviewed, Resident 3, was evaluated annually for his/her evacuation ability using the Department's form. Findings include: On 08/11/2026, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 07/31/2025. The most recent evacuation evaluation within Resident 3's record was dated 08/01/2025 (greater than 1 year from the survey date). There was no evidence of a more recently completed evacuation evaluation. At approximately 1:55 p.m., Surveyor interviewed Licensee A. Licensee A reported s/he was intending to complete the form this week. Licensee A asked Surveyor to confirm if the evacuation evaluations were due annually.	M 346		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite	M 384		

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M 384	Continued From page 13 care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the service agreement for 1 of 3 residents reviewed, Resident 1, was dated and signed by his/her legal guardian. Findings include: On 08/11/2026, at approximately 8:30 a.m., Surveyor interviewed Caregiver B regarding Resident 1. Caregiver B reported that Resident 1 had a legal guardian. At approximately 10:40 a.m., Surveyor interviewed Licensee A. Licensee A confirmed Resident 1 had a legal guardian and reported s/he was under guardianship since his/her admission to the provider. On 08/11/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 04/27/2026. Resident 1's record indicated that s/he had a legal guardian upon his/her admission and documented his/her name and contact information. Resident 1's service agreement was signed on 04/27/2026 by Resident 1, but not his/her legal guardian. At approximately 3:47 p.m., Surveyor discussed	M 384		

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M 384	Continued From page 14 the above concern with Licensee A. Licensee A reviewed Resident 1's service agreement and confirmed it was not signed by Resident 1's legal guardian. Licensee A reported s/he must have forgot to have him/her sign the agreement.	M 384		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. 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 Resident 1 had a statement of agreement with the plan that was dated and signed by his/her legal guardian. Findings include: On 08/11/2026, at approximately 8:30 a.m., Surveyor interviewed Caregiver B regarding Resident 1. Caregiver B reported that Resident 1 had a legal guardian. At approximately 10:40 a.m., Surveyor interviewed Licensee A. Licensee A confirmed Resident 1 had a legal guardian and reported s/he was under guardianship since his/her admission to the provider. On 08/11/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 04/27/2026. Resident 1's record indicated that	M 420		

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M 420	Continued From page 15 s/he had a legal guardian upon his/her admission and documented his/her name and contact information. Resident 1's ISP was dated 05/30/2026 and signed by Licensee A and Resident 1. There was no signature from Resident 1's legal guardian. At approximately 3:47 p.m., Surveyor discussed the above concern with Licensee A. Licensee A reported s/he recalled that Resident 1's legal guardian was present when Resident 1's ISP was discussed. Licensee A reported s/he just didn't have him/her sign the ISP.	M 420		
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.	M 424		

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M 424	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plans (ISPs) for 2 of 2 residents reviewed were updated whenever their needs changed substantially, accurately reflected the services needing to be provided to meet the emerging needs, identified the level of supervision they required, and described services provided by outside agencies. Resident 1's ISP did not identify his/her supervision needs or his/her reported need of having direct 1:1 staffing for approximately 12 hours daily. During Resident 2's admission with the provider s/he experienced concerns of skin integrity and wound management in at least 6 different areas, which directed for the provider's staff to follow unique regimens to each wound, use a pressure offloading boot, follow specific bed positioning directives, and limit Resident 2's sitting time. On at least 1 occasion there was observed noncompliance with Resident 2's boot use, which was used as part of an overall regimen to treat a chronic wound on his/her foot. These needs were not documented in his/her ISP. Home health nurses provided wound care services to Resident 2 throughout nearly his/her entire admission, information of which was also not documented in his/her ISP. Resident 2 was known to have epilepsy and had a vagus nerve stimulator (VNS) placed while s/he was admitted with the provider. This potentially required staff to use a magnet associated with the stimulator, and on one occasion staff used it during a seizure s/he experienced. Resident 2's neurologist directed for Resident 2's seizures to	M 424			

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M 424	Continued From page 17 be tracked and identified a protocol that the clinic was to be contacted in the event of Resident 2 experiencing a "major" seizure. Information regarding Resident 2's VNS and his/her needs related to the associated magnet's use, seizure tracking, and clinic notification parameters were not documented in his/her ISP. During Resident 2's admission, the direction was given by his/her managed care organization (MCO) team and home health nursing staff for the provider's staff to use a Hoyer lift to safely transfer him/her. His/her ISP did not identify the need for any Hoyer lift and Caregiver D reported that Resident 2 was typically transferred by being physically lifted and carried by 2 staff, a method which was also reported to be observed on 2 occasions by one of his/her home health nurses. Representatives from both Resident 2's MCO and home health agency identified concerns with how the provider's staff managed Resident 2's transfers. Resident 2 received all nutrients, both feedings and water, through his/her gastrostomy tube (g-tube). His/her ISP only identified that s/he was to receive "4 tube feedings daily" but did not indicate any flush frequency/quantity or feeding quantity/timing. The only evidence Licensee A was able to provide Surveyor onsite of Resident 2's g-tube regimen was an excerpt from a medical note that also did not specify feed timings and gave a flush regimen than was different from what s/he had reported to Surveyor. Additionally, Licensee A's reported understanding of Resident 2's g-tube regimen differed in both timing and quantities of formula when compared to Caregiver D's reported understanding of the regimen. The only evidence Licensee A was able to provide of staff's compliance with Resident 2's	M 424		

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M 424	Continued From page 18 g-tube regimen was through progress notes, however, the sample notes reviewed identified multiple inconsistencies in staff's completion of Resident 2's feedings when compared to the regimen Surveyor obtained through an outside medical record request. The inconsistencies observed were both in the frequency and distribution of Resident 2's feedings, and on at least 8 days, indicated that less feedings were completed than were directed from his/her regimen. The notes also infrequently provided evidence of water flushes and at no point documented the amount of water administered, which was noteworthy given the already existing inconsistencies between Licensee A's report of Resident 2's flush needs, the document s/he provided regarding Resident 2's regimen, and the regimen from Resident 2's medical records obtained by Surveyor offsite. Caregiver D's reported understanding of the regimen, besides differing from Licensee A's, was also inconsistent with either documented regimen. Of note, interview identified concerns with staff's compliance of Resident 2's g-tube regimen, and Resident 2 was documented as having a 21% weight loss from 85 lbs to 67 lbs during his/her admission with the provider - a loss that medical records identified as having no pathologically-identified causes, was categorized as "severe," and was suspected to be due to insufficient caloric intake through his/her feedings. Additionally, medical records identified the provider's staff reporting that Resident 2 typically experienced hard, small, ball-like stools - a finding consistent with constipation and dehydration. On 4 occasions Resident 2 experienced dislodgment of his/her g-tube while at the provider's home, which warranted emergency	M 424		

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M 424	Continued From page 19 medical services (EMS) transport and Resident 2 to be admitted to the emergency department each time. Resident 2's ISP did not identify any needs regarding his/her g-tube management, nor any interventions attempted or used to mitigate dislodgements. Resident 2 required 2:1 direct staffing for 16 hours each day during his/her admission, which was not documented in his/her ISP. Outside records obtained by Surveyor identified at least 4 occasions that this level of supervision was not provided. Resident 2 required staff to provide transportation to his/her medical appointments, but this need was not documented in his/her ISP. On at least 2 occasions, Resident 2 missed these appointments despite evidence that staff were made aware of them. One appointment was for an outpatient wound clinic visit during a period that Resident 2 was experiencing active wounds, and another appointment was for his/her neurologist, of which warranted ongoing management of his/her epilepsy. Findings include: On 08/11/2026, Surveyor conducted a complaint investigation into allegations of resident care needs not being met. Example 1 - Resident 1 On 08/11/2026, at approximately 8:58 a.m., Surveyor interviewed Licensee A regarding the home's staffing. Licensee A reported that there was typically 2 staff on shift from 8:00 a.m. - 8:00 p.m., specifically because Resident 1 required direct 1:1 staffing during those hours and the only	M 424		

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M 424	Continued From page 20 other resident in the home, Resident 3, required only general supervision which was provided by the second staff member. On 08/11/2026 Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 04/27/2026. The record contained 2 ISPs, both dated and signed 05/30/2026. Neither ISP identified the level of supervision that Resident 1 required or that s/he required 1:1 direct staffing 12 hours/day. On 08/21/2026, at approximately 2:20 p.m., Surveyor discussed the concern that Resident 1's required supervision level was not documented in his/her ISP. Licensee A asked, "It isn't?" and reported, "I'll have to get that reviewed." Surveyor confirmed that it was not. Example 2 - Resident 2 On 08/11/2026, at approximately 8:30 a.m., Surveyor interviewed Caregiver B who identified 2 residents of the home, Resident 1 and Resident 3. Caregiver B reported s/he had been working with the provider since around September 2025 and s/he was familiar with Resident 1 and Resident 3 being the only residents who resided with the provider. On 08/11/2026, Surveyor reviewed Resident 2's record. Resident 2 resided with the provider from 10/13/2025 until his/her hospitalization and subsequent discharge on 06/07/2026. Resident 2's diagnoses included Rett syndrome, spastic quadriparesis, and developmental non-verbal disorder. Resident 2 was documented as having a legal guardian throughout his/her admission. Resident 2's ISP, signed as created on 11/13/2025 and last reviewed on 05/14/2026,	M 424			

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M 424	Continued From page 21 identified that s/he was nonverbal and required total assistance by staff for all cares. The only information regarding Resident 2's g-tube was, "Total assistance with g-tube feedings." The associated intervention was, "Staff assists with 4 tube feedings daily," and the associated goal was, "Continue with daily routine feeding schedule." There was no evidence of flushing needs/timing/quantities for hydration and no evidence of the specific feeding schedule staff were to follow. At approximately 2:25 p.m., Surveyor interviewed Licensee A regarding Resident 2. Licensee A reported that Resident 2 had weekly home health nursing visits throughout his/her entire admission with the provider. Licensee A reported recalling that these visits were to treat a foot wound and a buttocks-area wound. Licensee A reported that these wounds were present prior to Resident 2's admission. Licensee A reported that Resident 2 was fed only through a g-tube throughout his/her admission and that s/he required staff assistance to conduct these feedings. Licensee A reported that his/her g-tube regimen called for water flushes to be done before and after meals as well as approximately 3-4 other times per day. Licensee A reported that Resident 2's feeding/flush regimen was based on medical provider orders. Surveyor then requested Licensee A for this order and observed him/her to look through Resident 2's record. Licensee A reported s/he believed the feedings were to be completed at 6:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m. Licensee A reported that s/he believed Resident 2 was to receive 1 carton of formula for each of the 4 feedings (4 cartons/day total). Licensee A reported s/he believed that water flushes were to be conducted approximately 2 hours in between each feeding	M 424		

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M 424	Continued From page 22 using 180 cubic centimeters (cc) of water with each flush. Licensee A reported that s/he believed 60 cc of water were to be used for flushing immediately before and after each feeding. Licensee A reported s/he was unaware of any issues related to Resident 2's g-tube feeding regimen or staff's compliance with it. Licensee A reported s/he had only been informed recently, since Resident 2's discharge, about weight loss that Resident 2 experienced during his/her admission but that s/he hadn't noticed any weight loss. Licensee A reported s/he did not have a scale at the home to take Resident 2's weight. Licensee A reported that upon learning of these concerns s/he checked to ensure Resident 2 received feedings and found that s/he had. Surveyor again requested documentation specifying Resident 2's g-tube regimen, which Licensee A continued to look for. At approximately 2:50 p.m., Surveyor interviewed Caregiver D regarding Resident 2. Caregiver D reported that Resident 2 was nonverbal and that s/he had to rely on reading Resident 2's facial expressions to anticipate his/her needs. Caregiver D reported that Resident 2 utilized a high-backed wheelchair for mobility, which had to be propelled by staff. When asked how staff transferred Resident 2, Caregiver D reported that Resident 2 did not require a lift and that 2 staff got on either end of him/her (head end and lower extremity end) to physically lift him/her from his/her bed to his/her chair. When asked about Resident 2's g-tube regimen, Caregiver D replied that Resident 2 received feedings at approximately 8:30 a.m., 11:30 a.m. / 12:00 p.m., and 3:30 p.m. / 4:30 p.m. Surveyor noted that this totaled 3 feedings during the daytime hours. Caregiver D reported s/he believed that night shift did a feeding for Resident 2 as well and that	M 424			

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M 424	Continued From page 23 Resident 2 ultimately received feedings 4-5 times per day. Caregiver D reported that staff were to administer 2 cartons of formula with each feeding. When asked to confirm if this meant that Resident 2 received approximately 6-8 cartons of formula per day, Caregiver D replied that s/he did. (Surveyor noted that this regimen was inconsistent with the regimen reported by Licensee A.) As part of the same interview, Caregiver D reported that s/he had some concerns about staff's compliance with Resident 2's feeding regimen. Caregiver D reported that on approximately 3 occasions s/he had arrived to work and noticed a formula carton sitting on a small table in Resident 2's room that was approximately half-full. Caregiver D reported knowing that this seemed unusual because Resident 2's g-tube regimen called for the administration of full cartons, not partial amounts. Caregiver D reported that the staff involved in all of these occasions was Former Caregiver I. Caregiver D reported that s/he confronted Former Caregiver I about the occasions but Former Caregiver I acted like s/he didn't know what Caregiver D was talking about. Caregiver D reported that s/he reported the concern to Licensee A and that Licensee A said s/he would handle it. When asked about the timing of these occasions, Caregiver D replied that all 3 happened within a recent period up to Resident 2's hospitalization and subsequent discharge from the home. Caregiver D reported s/he was concerned that Former Caregiver I was not adequately feeding Resident 2 by following his/her g-tube regimen. At approximately 3:15 p.m., Surveyor interviewed Licensee A again. Licensee A reported s/he had	M 424		

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M 424	Continued From page 24 found the order. Surveyor reviewed the order, which appeared to be from a medical record dated 11/19/2025. The order documented: "...Your feeding plan is: 4 cartons; Your Flush Instructions are: 120 mL before and after; Your formula is Osmolite 1.5 Cal, Unflavored ..." Surveyor noted that there were no times associated with the regimen and that there were no other flush times established outside of meals as Licensee A had reported earlier. Surveyor also noted that the flush amounts documented were inconsistent from the flush amounts Licensee A reported earlier. Licensee A acknowledged the lack of feeding times from the order and reported s/he had spoken with Resident 2's dietician to establish feed and flush times. When asked for the name and phone number of who Licensee A spoke with, s/he replied that s/he could not recall the information. Regarding Resident 2's medical appointments, Licensee A reported that staff were responsible for transporting Resident 2 to his/her appointments and attending the appointments with him/her. Surveyor asked Licensee A how the provider ensured Resident 2's feedings were conducted. Licensee A reported that there was a white board "checklist" of tasks that Resident 2's feedings had been on. Surveyor noted that the whiteboard did not contain any historical information and only contained the care information for each day. Licensee A reported that staff would also document feedings in Resident 2's progress notes but other than that there was no documentation of his/her feedings. Licensee A reported that after Resident 2 discharged s/he created a g-tube feeding document template where staff could document g-tube feedings to verify that they had been completed. Licensee A reported that Resident 2 was the first resident the	M 424		

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M 424	Continued From page 25 provider had with a feeding tube and so s/he wasn't sure what staff were supposed to document in relation to his/her g-tube-related care. While reviewing Resident 2's record, Surveyor observed the following: - Three incident reports - dated 11/14/2025, 12/23/2025, and 04/07/2026, all documented instances of Resident 2's feeding tube having been disconnected from its stoma site. All incidents warranted staff to contact EMS and resulted in Resident 2 having to be seen in the emergency department. The 04/07/2026 report specifically documented that Resident 2 him/herself "accidentally pulled out [his/her] G-Tube." A medical after visit summary dated 04/09/2026 detailed a fourth time that Resident 2 was seen in the emergency department due to dislodgement of his/her g-tube and noted "some redness around g tube." Surveyor reviewed Resident 2's ISP and identified no information regarding his/her needs related to g-tube maintenance or interventions to mitigate dislodgements. - An incident report dated 02/20/2026 detailed a seizure Resident 2 experienced which warranted staff to use his/her VNS magnet and reposition him/her on his/her side to "keep airway clear." A medical after visit summary dated 12/31/2025 documented a neurology appointment Resident 2 had that day in which his/her VNS was turned on. Instructions within the summary directed for Resident 2 to, "Keep track of all seizures and episodes concerning for seizure on a calendar," and have his/her neurology team contacted "if you have any major seizures ..." The same directives were documented in after visit	M 424			

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M 424	Continued From page 26 summaries from additional neurology appointments Resident 2 attended on 01/13/2026 and 04/14/2026. Surveyor reviewed Resident 2's ISP. Other than the general identification that Resident 2 experienced seizures and had epilepsy, the only intervention documented was for staff to, "Monitor and manage all ongoing medical conditions as directed by the care plan and [his/her] physicians ...Communicate any changes in [his/her] condition ..." There was no information regarding a protocol for how staff were to address Resident 2's seizures, including the use of his/her magnet or the tracking and notification directives above identified by his/her medical provider. - Medical records from a hospitalization Resident 2 had from 10/21/2025 - 10/29/2025 due to sepsis. During the hospitalization Resident 2 was treated for "skin infection." The discharge records as part of this hospitalization identified several skin wounds Resident 2 experienced and documented the following post-hospitalization regimen to treat the wounds in a post-hospitalization care plan: 1) "G-tube site (under disc) pressure injury" - Remove old dressing, cleanse with wound cleanser, pat dry, and apply split gauze under the disk, 3 times daily and as needed (PRN). 2) "Coccyx wound" - Cleanse with wound cleanser, pat dry, ensure removal of all old cream, use a skin barrier wipe and let the skin dry, apply a 1/8" thick layer of Silvadene cream, cover with a layer of Cuticerin oil emulsion gauze, and secure with a bordered foam dressing. The identified frequency of this regimen was daily and PRN with incontinence episodes.	M 424		

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M 424	Continued From page 27 3) "Left plantar foot and Right medial malleolus wounds" - Cleanse with wound cleanser, pat dry, ensure all old gel is removed, use skin barrier wipe and let the skin dry, apply 1/8" layer of iodisorb gel to wound base, and dress wound with a bordered foam dressing. The identified frequency of this regimen was every Tuesday, Thursday, and Saturday. 4) "Right knee and Left posterior thigh wounds" - Cleanse wound, pat dry, use barrier wipe and let the skin dry, and cover with a bordered foam dressing. The identified frequency of this regimen was every 3 days and as needed. 5) "Bilateral feet (R foot D4 pressure injury)" - Cleanse both feet, use cleansed gauze or washcloth to floss between the toes, pat dry, and lace lamb's wool between the toes. The identified frequency of this regimen was daily. 6) "Left medial foot pressure injury" - Cleanse wound and cover with bordered foam dressing, every 3 days. The hospital record also directed for Resident 2 to only be on his/her left and right sides while in bed, specifically documenting, "Avoid supine," and that Resident 2 was to be limited to 2-hour sitting intervals. - Medical records from a hospitalization Resident 2 had from 11/17/2025 - 11/19/2025 due to dehydration and "possible" upper respiratory tract infection. The discharge records as part of this hospitalization identified the following wound concerns and associated regimen in a post-hospitalization care plan: 1) "[Bilateral lower extremity] foot/heel wounds" -	M 424		

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M 424	Continued From page 28 Cleanse wound, apply cleanser-dampened gauze compress for 3-5 minutes, pat dry, cover any open or blistered areas with custom cut oil emulsion gauze, wrap foot with antimicrobial Kerlix, and weave a thin piece of Kerlix between those toes. The identified frequency of this regimen was daily and specifically noted, "Replace daily with dressing change." The regimen also called for Resident 2's heels to be floated off his/her bed with pillows or offloading boots. 2) "Right knee wound" - Cleanse wound, pat dry, dress with foam border dressing, 2x/week "and as needed for drainage management." - Member-centered plan dated 12/01/2025 which documented that as of 11/19/2025 (approximately 1 month after Resident 2's admission) s/he had known "skin alteration to g tube site, coccyx wound, left plantar foot and right medial malleolus wounds, right knee, left posterior thigh, right foot, left medical foot, and redness to groin, buttock, and skin folds." Associated approaches to these concerns included, "Member's formal/informal supports will follow instructions from member's provider(s) regarding wound care and treatment," and, "...increased hydration, improved nutrition." Surveyor reviewed Resident 2's ISP. The ISP identified that Resident 2 had "history of skin breakdowns and wounds" with associated interventions of staff inspecting Resident 2's skin each shift, repositioning him/her "regularly" to relieve pressure, applying skin barrier cream, maintaining clean dry skin, and reporting any new skin breakdown or wounds. Surveyor did not observe any information identifying the specific wounds experienced by Resident 2 nor their associated specific regimens. Of note, the wound	M 424		

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M 424	Continued From page 29 issues experienced by Resident 2 during his/her admission were more extensive and affected more areas than reported earlier by Licensee A. Surveyor reviewed Resident 2's record but did not identify any sort of follow up records of the identified wounds. As such, it was unclear from Resident 2's records how long each wound persisted and by extension, how long staff were to follow each wound's care regimen. Surveyor did not observe any interventions in Resident 2's ISP that included the medical provider directives detailed above for Resident 2's bed positioning (specific guidance to avoid supine positioning), 2-hour period sitting interval limits, and heel floating. On 08/13/2026, at approximately 10:00 a.m., Surveyor interviewed Registered Nurse (RN) Case Manager F, who had been part of Resident 2's care team during most of his/her admission with the provider, and Quality Compliance Nurse G - both from Resident 2's MCO. Regarding Resident 2's wound care needs, RN Case Manager F reported that Resident 2 had long-term wound care and that there was authorization for wound care that dated back to 10/30/2025. (Surveyor noted that this correlated with Resident 1's first hospitalization in which his/her various wounds were identified.) Surveyor noted that several of the wounds identified during that first hospitalization called for cares to be completed up to daily and asked if the expectation was that the provider's staff were to conduct the cares themselves. RN Case Manager F replied that home health nursing staff provided wound care teachings and education to the provider's staff with the expectation that the provider's staff would conduct cares on the days home health visits weren't scheduled. RN Case Manager F reported s/he believed during the	M 424		

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M 424	Continued From page 30 course of Resident 2's residence with the provider that nearly all of his/her wounds resolved except for his/her foot, which continued to receive home health wound care up to the point s/he discharged from the home. When asked about Resident 2's g-tube regimen, RN Case Manager F reported that the regimen was set by Resident 2's medical provider. RN Case Manager F reported that s/he was aware that staff identified the feedings to be completed each day on a whiteboard which was started over each day. RN Case Manager F reported s/he was not aware that staff had not been documenting Resident 2's feedings and flushes in a routine way. RN Case Manager F reported that staff documented feedings in Resident 2's progress notes but the notes were inconsistent. When asked about Resident 2's general care needs, RN Case Manager F reported that staff were supposed to be using a Hoyer lift to transfer him/her. RN Case Manager F reported there was a past occurrence where home health staff had observed staff physically lifting him/her to transfer him/her. RN Case Manager F reported that because of this, home health staff provided training for the provider's staff in safe transfers with the Hoyer lift. Of note in relation to Resident 2's g-tube regimen, on 08/14/2026 Surveyor reviewed medical records obtained directly from the hospital where Resident 2 was hospitalized immediately prior to his/her discharge from the provider (which started on 06/07/2026). The records included: - Discharge summary dated 07/01/2026 detailing that Resident 2 had been admitted inpatient from the emergency department on 06/08/2026 and	M 424		

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M 424	Continued From page 31 was hospitalized until 07/01/2026. The note detailed, "[Registered dietician nutritionist] determined after accurate weight in bed that patient's preadmission weight had decreased substantially 21% total body weight since last fall. No metabolic reason for weight loss identified. Concern was raised that patient was not receiving daily prescribed caloric requirements by tube feeding ...[Computed tomography] scans chest abdomen pelvis unremarkable for malignancy, alternate explanation of weight loss." - Nutritionist note dated 07/01/2026 identified a hospital timeline regarding Resident 2's nutrition concerns. The note identified that staff spoke with Executive Director C on 06/08/2026 to confirm Resident 2's g-tube feed/flush regimen and that Executive Director C "reported concern that [patient (pt)] has been bloated the last few days. Could not recall when pt had last [bowel movement], reported that pt typically passes hard stools like small, rounded balls ...New weight is concerning for severe degree of weight loss ...Last zeroed bedscale weight in Nov 2025 was 85 lb. Current zeroed bedscale weight is 67 lb. [His/her] [enteral nutrition] regimen [prior to admission] should have been providing ~36 kcal/kg based on previous weight of ~40 kg, sufficient to provide for weight regain given [his/her] low level of activity ..." (Of note, the Bristol Stool Chart "is a reference guide healthcare providers use" to classify stool based on shape and consistency. Type 1 stool is characterized by "separate hard lumps, like little pebbles" and is associated with dehydration and constipation (Source: Cleveland Clinic, Bristol Stool Chart, February 19, 2026, https://my.clevelandclinic.org/health/articles/bristol-stool-chart (retrieved August 8, 2026).).)	M 424		

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M 424	Continued From page 32 - The same nutritionist note above identified that Resident 2's g-tube regimen was 1 carton 4 times daily at 6:00 a.m., 10:00 a.m., 2:00 p.m., and 5:00 p.m. with water flushes of 180 mL after each feeding. (Of note, this documented formula regimen was generally consistent with Licensee A's report, except for the last feed being off by 1-hour. The flush regimen was inconsistent with Licensee A's report of his/her understanding of the regimen. The documented formula regimen was inconsistent in both timing and quantity with Caregiver D's report of the regimen.) - The same note above identified that upon hospital admission Resident 2 had to be placed on a fiber-containing g-tube formula due to constipation that was present upon his/her admission. The note also identified that when Resident 2 had to transfer to the intensive care unit on 06/14/2026, s/he required tube feedings to be changed to continuous feeds. On 08/14/2026, Surveyor reviewed a sample of progress notes from the provider's record for Resident 2 that were initially obtained onsite on 08/11/2026 in order to identify any documentation of staff's compliance with Resident 2's g-tube regimen. Of note, the progress notes were where staff documented their actions in relation to Resident 2's g-tube regimen per Licensee A. The sample progress notes reviewed encompassed 04/01/2026 through 06/07/2026 (when Resident 2 went to the emergency department and was subsequently hospitalized and discharged). From the notes, Surveyor observed no occurrences where staff documented the amount of formula administered or the amount of water flushed. Each day's note specified activities that occurred between 7:00 a.m. - 3:00 p.m. (correlating with	M 424		

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M 424	Continued From page 33 first shift) and activities that occurred between 3:00 p.m. - 11:00 p.m. (correlating with second shift). From the notes, Surveyor observed the following: - 04/01/2026: Staff documented administering water (unspecified amount) and a feeding upon Resident 2 waking up (time not specified) and at 12 p.m. The only other feeding was documented at 5:00 p.m., with no other flush information identified. Surveyor noted that the note documented only 3 total feedings completed. - 04/02/2026, 04/04/2026, 04/08/2026, 04/14/2026, 04/19/2026: Only 2 of the 4 documented feedings identified water flushes being conducted (unspecified amounts of water given). - 04/03/2026: Only 1 of the 4 documented feedings identified a water flush being conducted (unspecified amount of water given). - 04/05/2026, 04/09/2026, 04/10/2026, 04/13/2026, 04/16/2026, 04/21/2026, 04/22/2026, 04/23/2026, 04/28/2026: Three of the 4 documented feedings identified water flushes being conducted (unspecified amount of water given). - 04/07/2026: Only 1 feed documented. The note identified that Resident 2 was in the emergency department, however, when Surveyor reviewed his/her correlating medication administration record (MAR) for that day, staff initialed off on administering his/her 3:00 p.m., 5:00 p.m., and 8:00 p.m. medications. No water flushes were documented. - No notes for 04/17/2026, 04/18/2026,	M 424		

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M 424	Continued From page 34 04/24/2026, 04/25/2026, 04/29/2026, or 04/30/2026 - thereby no way to verify regimen compliance. - 05/01/2026: The first shift note (7:00 a.m. - 3:00 p.m.) documented that Resident 2 "was given [his/her] routine medications and feedings," but did not specify the number of feedings administered. The second shift note documented that 1 feeding was given before bedtime. No water flushes were documented. This similar general phrasing about "routine" feedings or just "feedings" conducted was also documented on the following days without identifying the actual number of feedings: 05/02/2026, 05/03/2026, 05/06/2026, 05/08/2026, 05/16/2026, and 05/24/2026. - 05/04/2026: The first shift note (7:00 a.m. - 3:00 p.m.) documented 1 feeding conducted during this period and the second shift note (3:00 p.m. - 11:00 p.m.) documented "routine" feedings conducted. However, Surveyor noted that this pattern, of 1 feeding during first shift hours, was not generally in accordance with his/her directed feeding schedule. The number of feedings conducted on second shift was also not specified. No water flushes were documented. This similar phrasing with similar spread of feedings (1 on first shift and an unspecified plural amount on second shift) was documented on 05/09/2026, 05/10/2026, and 05/18/2026. - 05/05/2026: The first shift note (7:00 a.m. - 3:00 p.m.) documented that s/he was "routinely given [his/her] medications and feedings," and the second shift note (3:00 p.m. - 11:00 p.m.) documented that Resident 2 was "given several more feedings." Surveyor noted that this pattern/distribution, besides not clarifying the	M 424			

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M 424	Continued From page 35 number of feedings conducted, was not generally in accordance with his/her directed feeding schedule. No water flushes were documented. Similar phrasing about "routine" feedings administered on first shift and "several" feedings on second shift were documented on 05/07/2026 and 05/14/2026. - 05/11/2026: Only 1 feeding was documented as having occurred throughout the day. No flushes were documented. - 05/12/2026: The first shift note (7:00 a.m. - 3:00 p.m.) documented 1 feeding and the second shift note (3:00 p.m. - 11:00 p.m.) documented "several more feeding [sic]." Surveyor noted that this pattern, besides not clarifying the number of feedings conducted, was not generally in accordance with his/her directed feeding schedule. No flushes were documented. A similar pattern, of 1 documented feed on first shift and "routine" or "several" feedings on second shift without specific numbers or times of feedings, was also documented on 05/13/2026, 05/15/2026, 05/26/2026, 05/27/2026, 05/28/2026, 05/29/2026, 05/30/2026, 05/31/2026, 06/05/2026, and 06/06/2026. - 05/17/2026: The first shift note (7:00 a.m. - 3:00 p.m.) documented, "[Resident 2] woke up at 8 AM and was given [his/her] feedings and medications. Staff changed [him/her] afterwards." No other notes about feedings conducted for Resident 1 were documented. No flushes were documented. Surveyor noted that this distribution was not in accordance with his/her directed feeding schedule, in addition to there being no evidence of other feedings throughout the day completed.	M 424		

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M 424	Continued From page 36 - 05/19/2026: First shift note (7:00 a.m. - 3:00 p.m.) documented only that, "[Resident 2] was transferred and transported to [his/her] appointment." The second shift note (3:00 p.m. - 11:00 p.m.) documented, "Upon returning staff routinely fed ..." Surveyor noted that this distribution, with no evidence of feedings on first shift and an unclear number conducted on second shift, was not in accordance with his/her directed feed schedule. Of note, medical records within Resident 2's record had identified this appointment as being at 10:30 a.m. in the same city as the provider's home. No water flushes were documented. This similar pattern, of no feeds documented on first shift and an unclear number of "routine" feedings on second shift was also documented on 05/20/2026. - 05/21/2026: First shift note (7:00 a.m. - 3:00 p.m.) documented, "Staff followed daily routine by feeding ..." and the second shift note (3:00 p.m. - 11:00 p.m.) documented no information about feeding. Surveyor noted that this distribution, of an unclear number of feeds conducted on first shift and no evidence of feeds on second shift, was not in accordance with his/her feeding schedule. No water flushes were documented. This similar pattern was documented on 06/04/2026. - 05/22/2026: First shift note (7:00 a.m. - 3:00 p.m.) documented that Resident 2 was administered "both [his/her] feedings." The second shift note (3:00 p.m. - 11:00 p.m.) documented that staff gave Resident 2 "several more feedings." Surveyor noted that this distribution of feedings, 2 during first shift hours and "several" during second shift, was generally not in accordance with his/her feeding schedule. No water flushes were documented.	M 424		

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M 424	Continued From page 37 - 05/23/2026: An unspecified number of "feedings" were documented as given during both first and second shift. No water flushes were documented. - 05/25/2026: First shift note (7:00 a.m. - 3:00 p.m.) documented 1 feeding while the second shift note (3:00 p.m. - 11:00 p.m.) documented 3 feedings. Surveyor noted that this distribution was not in accordance with his/her feeding schedule. No water flushes were documented. - 06/01/2026: "Food and water" was documented given at 7:30 a.m., 1 feeding documented at 12:00 p.m., and 1 feeding documented during the second shift note (3:00 p.m. - 11:00 p.m.). Besides this overall documenting only 3 of 4 daily feedings conducted for Resident 2, Surveyor noted that the distribution was inconsistent with his/her directed regimen. No mealtime flushes were documented other than the water documented as given with the first feeding, with an unspecified amount of water flushed. - 06/02/2026: Water and 1 feeding was documented as given at 7:30 a.m., 1 feeding documented at 4:00 p.m., and 1 feeding documented after his/her bedtime medication administration. Besides this overall documenting only 3 of 4 daily feedings conducted for Resident 2, Surveyor noted that the distribution was inconsistent with his/her directed regimen. No mealtime flushes were documented other than the water documented as given with the first feeding, with an unspecified amount of water flushed. - 06/03/2026: Water and 1 feeding was documented as given at 7:00 a.m., 1 feeding	M 424		

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M 424	Continued From page 38 documented at 12:00 p.m., and 1 feeding documented "shortly after" his/her 8:00 p.m. medications. Besides this overall documenting only 3 of 4 daily feedings conducted for Resident 2, Surveyor noted that the distribution was inconsistent with his/her directed regimen. No mealtime flushes were documented other than the water documented as given with the first feeding, with an unspecified amount of water flushed. - 06/07/2026: First shift note (7:00 a.m. - 3:00 p.m.) documented 1 feeding. No other feedings were documented. Resident 2 was taken to the emergency department this day, however, this did not occur until the evening as evidenced by both incident reports, describing the "incident" that led to his/her transport as occurring at 7:30 p.m., and outside medical records obtained by Surveyor which documented that Resident 2 arrived at the emergency department at 8:20 p.m. Surveyor noted overall that only 1 of 4 daily feedings was documented as being conducted for Resident 2. No flushes were documented. On 08/14/2026, at approximately 12:40 p.m., Surveyor interviewed Home Health RN H, from the agency that conducted Resident 2's home health wound care. Surveyor reviewed Resident 2's wound history from his/her hospital records with Home Health RN H. Home Health RN H reported that when s/he first began working with Resident 2, there was not a pressure injury on Resident 2's g-tube site but that there was redness and a suspicion for a lack of cleansing by the provider's staff. Home Health RN H reported that the coccyx wound Resident 2 had was superficial, healing, and more like a rash as opposed to a pressure wound. Home Health RN H reported awareness of a couple wounds on	M 424		

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M 424	Continued From page 39 Resident 2's knees that were more like abrasion-type wounds than pressure wounds and seemed to be on-again/off-again. Home Health RN H reported awareness of the noted bilateral foot wounds and reported that Resident 2 had experienced moisture-related skin changes with his/her feet which s/he suspected was due to staff not cleaning well between his/her toes. Home Health RN H reported that there was a chronic wound on Resident 2's left lateral foot that home health nurses had been treating for awhile and was still active at the end of Resident 2's time with the provider. When asked if there was an expectation for staff to have followed any directed wound care regimen on their own, Home Health RN H replied, "Oh yeah, absolutely." Home Health RN H reported that throughout Resident 2's admission home health was only 3 days per week on Mondays, Wednesdays, and Fridays and so there was an expectation for the provider's staff to handle any cares warranted more frequently than that and to be able to handle cares in the event a dressing fell off. Home Health RN H reported that when home health was first initiated for Resident 2, nursing staff had to conduct a lot of staff education regarding caring for Resident 2's skin and managing his/her g-tube. Home Health RN H reported that this was challenging because there was frequent staff turnover and so it was unclear how well the training carried over. When asked about any sort of heel offloading needs for Resident 2, Home Health RN H reported that Resident 2 received an air boot for his/her left foot due to the wound there. Home Health RN H reported that s/he sometimes saw it wasn't on when it was supposed to be when s/he arrived for a session. Home Health RN H	M 424		

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M 424	Continued From page 40 reported that s/he reminded the provider's staff of Resident 2's wear schedule, which was that the boot was to be on when s/he was in bed. Home Health RN H reported that s/he had to repeat this education a lot. When asked about Resident 2's transfer needs, Home Health RN H confirmed that staff were supposed to use a Hoyer lift to transfer Resident 2. Home Health RN H reported s/he was not sure that this was happening. Home Health RN H reported that one time when s/he was there s/he had to stop the provider's staff in the middle of transferring Resident 2 because of his/her safety concerns. Home Health RN H reported that s/he observed 2 staff trying to pick Resident 2 up and transfer him/her from his/her wheelchair to his/her bed. Home Health RN H reported that the staff told her that was how they always transferred Resident 2. Home Health RN H reported s/he instructed them to always use a Hoyer lift for Resident 2, which they confirmed having. Home Health RN H reported there was an occasion after this s/he saw staff trying to physically lift Resident 2 to transfer him/her. On 08/14/2026, Surveyor reviewed outside records obtained through Resident 2's MCO. A case note dated 11/03/2025 identified that Resident 2 was receiving wound care services three times per week and would continue to receive it with that frequency. An RN assessment dated 05/19/2026 identified that Resident 2 had an ongoing foot wound and continued to receive home health services to manage this wound. The assessment also identified use of a Hoyer lift for Resident 2 and pressure-reducing boots. An updated member-centered plan dated 06/01/2026 identified interventions active since at least 05/21/2026 of Hoyer lift use for transfers and	M 424			

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M 424	Continued From page 41 pressure-reducing boots. An intervention that same date also documented, "Member is receiving wound care daily from AFH staff to [his/her] left foot and G-tube site in between home health nurse visits 3 days a week." On 08/14/2026, Surveyor reviewed outside records obtained through Resident 2's home health agency. The list of orders included the following: - Left lateral foot wound care regimen, active since at least 04/24/2026, with dressing changes "to be done daily with [skilled nursing] to complete 3x weekly." - Left butt abrasion skin care regimen active as of 12/22/2025 - [Bilateral lower extremity] foot/toes wound care regimen active as of 12/15/2025 that directed for, "Change dressing daily 3x/wk M/W/F by HH nurse and AOD by caregivers." - [Bilateral lower extremity] foot/heel wound regimen active as of 11/21/2026 with the same instructions as the above regimen. - Right knee wound skin regimen active as of 11/21/2025 that directed for dressing changes 2x/week on Mondays and Fridays by the home health nurse and as needed by caregivers. A note on 06/01/2026 identified the established intervention for staff to float Resident 2's heel with his/her pressure offloading boot when s/he was in bed. The narrative section of that note documented that Resident 2 was in bed upon the home health nurse arriving for his/her session and the nurse observed Resident 2's air boot was	M 424		

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M 424	Continued From page 42 not on. A note on 06/05/2026 identified that the pressure wound to Resident 2's lower left plantar foot was stage III. From the above records and interviews from Resident 2's home health agency and MCO, Surveyor identified known interventions of pressure offloading boot use, use of a Hoyer lift for transfers, both historic and current wound care needs for various wounds that warranted the provider's staff to follow wound care regimens, and the involvement of home health for wound care throughout nearly the entirety of Resident 2's admission. Surveyor's review of Resident 2's ISP identified none of this information. Regarding transfers, Resident 2's ISP specifically documented that s/he required the assistance of 1 staff for all transfers. Surveyor noted that even this was inconsistent with Caregiver D's earlier report that 2 staff physically transferred Resident 2. In reviewing Resident 2's MCO record on 08/14/2026, Surveyor reviewed the following notes that identified issues with staff supervision: - Note dated 12/23/2025 from an encounter dated 12/22/2025: " ...Wound care nurse reported that there was only 1 staff present, and AFH has a negotiated Rate [sic] for 2:1 staffing. Guardian is concerned about staffing and care quality ..." - Note dated 12/24/2025 from an encounter that same day: " ...visited with Member for health and safety check. Also present was AFH employee [Licensee A]. [Care Coordinator (CC)] inquired if there was another caregiver on staff and [Licensee A] said there was but caregiver was taking out the garbage. CC visited with Member for roughly 30 minutes and never saw second	M 424			

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M 424	Continued From page 43 caregiver ...CC asked if there was normally two caregivers on at a time and [Licensee A] said yes but that day the other caregiver called in so there was only one caregiver on during that shift. CC asked if caregiver was coming back today and [Licensee A] said when they were done taking out the trash but never appeared during the 30 minutes CC was there ..." - Note dated 02/20/2026 from an encounter dated 02/19/2026: "[Resident 2] was in bed; House was not staffed properly. ([Resident 2] is 2:1, there was [2] staff present but both residents were present ..." - Note dated 02/27/2026 from an encounter dated 02/26/2026: "Only 1 staff present and 2 residents were present ...Staff told [interdisciplinary team] that 2nd staff was off running an errand for the other resident ...was able to confirm that other resident was present - so there should be 3 staff ..." From the above, Surveyor noted at least 4 observed occasions that Resident 2 was not receiving the level of direct staffing that the MCO identified s/he was to receive. In reviewing Resident 2's ISP, Surveyor did not observe any documented information regarding his/her needs for 2:1 direct staffing. In reviewing Resident 2's MCO record, Surveyor also reviewed the following notes that identified issues with medical appointment attendance: - Note dated 12/08/2025 documented that Resident 2 missed his/her outpatient wound clinic appointment that was scheduled for 11/28/2025. The note documented that clinic staff had been attempting to contact the AFH to reschedule after	M 424		

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M 424	Continued From page 44 the missed visit. The note's author reported that s/he also sent a follow-up message to the provider about the missed appointment. An update to the note detailed an encounter on 11/24/2025 (prior to the outpatient wound appointment) where a representative from Resident 2's MCO reminded AFH staff about the outpatient wound clinic appointment on 11/28/2025 via e-mail. (Of note, Surveyor observed that this corroborated with information from an "After Hospital Care Plan" document that the provider had in Resident 2's record with a print date of 11/19/2025. Two separate lines within that document identified that Resident 2 had an outpatient follow up appointment with the wound clinic on 11/28/2025.) - Note dated 12/22/2025 documented that Resident 2's guardian had called Resident 2's care team to discuss the concern that Resident 2 was not taken to his/her neurology appointment that day. The note documented, "...Staff stated they planned to get [him/her] to appointment but were prohibited by the wound care nurse showing up and taking to [sic] long. This is the 3rd neurology appointment since moving to this AFH that member has missed. The wound care nurse stated to guardian that when [s/he] arrived (around 10am), [Resident 2] was lying in bed covered by a blanket. When the blanket was removed, [Resident 2] had no clothing on. Wound care nurse assisted getting [Resident 2] dressed and then completed [his/her] wound care and left. Wound care nurse reported that there was only 1 staff present, and AFH has a negotiated Rate [sic] for 2:1 staffing ...Called AFH to follow up. [Licensee A] stated [s/he] thought the appointment was 12/23 (Tomorrow) ..." Of note in relation to the missed appointments,	M 424		

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M 424	Continued From page 45 on 08/14/2026 Surveyor reviewed medical records obtained directly from the hospital where Resident 2 was hospitalized immediately prior to his/her discharge from the provider (which started on 06/07/2026). The emergency department medical provider note dated 06/08/2026 documented that s/he had contacted adult protective services "to further evaluate if there is concern for neglect. Of note, patient does have several no-show appointments in the past month." From the above, Surveyor noted at least 2 identified occasions that Resident 2 missed medical appointments. In reviewing Resident 2's member-centered plan on 08/14/2026, which Surveyor initially reviewed onsite as part of the provider's record for Resident 2, Surveyor identified an intervention active since 05/16/2025 (prior to Resident 2's admission) that the provider "provides member transportation for all medical appointments." In reviewing Resident 2's ISP that same day, Surveyor did not observe any documented information regarding his/her needs for medical appointment transportation. On 08/14/2026, at approximately 11:49 a.m., Surveyor e-mailed Quality Compliance Nurse G from Resident 2's MCO for additional clarification regarding Resident 2's direct staffing needs and the missed medical appointments Resident 2 experienced. At approximately 2:48 p.m., Quality Compliance Nurse G reported that Resident 2 had moved in on a rate agreement with the provider of 2:1 direct staffing. Surveyor reviewed e-mail correspondence that Quality Compliance Nurse G attached, which identified Resident 2's need for 2:1 direct staffing for cares for 16 hours/day and 1:1 direct staffing for 8 hours overnight as of 09/25/2025 (at least 2 weeks prior	M 424		

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M 424	Continued From page 46 to his/her admission to the provider). Quality Compliance Nurse G reported that when the staffing issues were identified with Licensee A on 03/13/2026, a manager with the MCO sent an e-mail that Resident 2's rate was going to be adjusted for 1:1 direct staffing instead of 2:1. Quality Compliance Nurse G reported that the provider was not willing to negotiate this. Surveyor reviewed e-mail correspondence that Quality Compliance Nurse G attached, corroborating his/her report of the course of events that showed e-mail communication to Licensee A. Regarding Resident 2's missed medical appointments, of which there were at least 2 from the above identified occurrences, Quality Compliance Nurse G reported there was no communication from the provider regarding the missed appointments. On 08/21/2026, at approximately 2:20 p.m., Surveyor discussed the above concerns with Licensee A regarding the lack of Resident 2's needs and related services documented in his/her ISP. Regarding the wound care regimens, skin integrity directives, and seizure-related directives, Licensee A reported s/he was not aware that that level of detail was required to be part of an ISP. Regarding Resident 2's Hoyer lift, Licensee A reported that the home never had a Hoyer lift for Resident 2. Licensee A reported that s/he talked to Resident 2's care team about it for "months" and they were not able to acquire one for him/her. Licensee A reported that without the Hoyer lift Resident 2 should have received the assistance of 2 staff to transfer. (Of note, this was still inconsistent with Resident 2's ISP which called for the assistance of 1 staff to transfer him/her.) Surveyor gave Licensee A an opportunity to send any evidence s/he had of the Hoyer acquisition difficulties and related alleged communications,	M 424		

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M 424	Continued From page 47 due at 5:00 p.m. Regarding the concerns regarding Resident 2's g-tube regimen and related concerns to the lack of staff compliance with the regimen, Licensee A stated, "OK." Regarding Resident 2's direct staffing needs, Licensee A stated s/he believed Resident 2 required 2:1 staffing "only for the first month [s/he] was there." Licensee A reported s/he recalled an e-mail where Resident 2's care team told him/her they were going to reduce his/her rate for 1:1 staff. Surveyor reported that this was consistent with the e-mail correspondence that had been provided by Resident 2's MCO but that this e-mail was not sent until 03/13/2026 (5 months after Resident 2's admission) and that Licensee A him/herself disputed the adjustment. Licensee A confirmed s/he had disputed it but thought Resident 2 still only required 1:1 staffing. Licensee A then later stated, "I got it taken care of." Surveyor gave Licensee A an opportunity to send any evidence s/he had of Resident 2's direct staffing needs changing from 2:1, due at 5:00 p.m. Regarding Resident 2's transportation needs, Licensee A asked Surveyor to confirm that the needs were not documented in the ISP. Surveyor reviewed the ISP with Licensee A and confirmed there was no evidence of transportation needs and related services. Licensee A stated, "Oh, ok. I should add that." Licensee A acknowledged the missed appointments and stated, "Yes, transportation arrived and just got there late...They were rescheduled." Surveyor reviewed the MCO records with Licensee A, specifically for Resident 2's 12/22/2025 missed neurology appointment in which Licensee A him/herself reported having the wrong appointment date. Licensee A said nothing further.	M 424		

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M 424	Continued From page 48 Nothing further was received from Licensee A, and at 5:26 p.m., Surveyor e-mailed him/her to confirm that nothing was received.	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 2's health was monitored with documented changes when s/he experienced a change in left thumb condition thought to have started as a small cut which progressed into thumb necrosis and osteomyelitis over the course of approximately 1 week. Resident 2 was also found to have skin breakdown in his/her thenar webspace which was not identified in any of the provider's records for him/her. As a result of the developments, Resident 2 was hospitalized for further treatment and monitoring. Resident 2 experienced septic shock, presumably due to the infection per the medical records, and while hospitalized, underwent a partial amputation of his/her left thumb in order to control the infection. Findings include: On 08/11/2026, Surveyor investigated allegations that residents' health was not being adequately monitored.	M 448		

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M 448	Continued From page 49 At approximately 8:30 a.m., Surveyor interviewed Caregiver B who identified 2 residents of the home, Resident 1 and Resident 3. Caregiver B reported s/he had been working with the provider since around September 2025 and s/he was familiar with Resident 1 and Resident 3 being the only residents who resided with the provider. On 08/11/2026, Surveyor reviewed Resident 2's record. Resident 2 resided with the provider from 10/13/2025 until his/her hospitalization and subsequent discharge on 06/07/2026. Resident 2's diagnoses included Rett syndrome, spastic quadriparesis, and developmental non-verbal disorder. Resident 2 was documented as having a legal guardian throughout his/her admission. Resident 2's individual service plan (ISP), signed as created on 11/13/2025 and last reviewed on 05/14/2026, identified that s/he was nonverbal and required total assistance by staff for all cares, including to conduct gastrostomy tube (g-tube) feedings. Resident 2's ISP documented that s/he had a "history of skin breakdowns and wounds" and identified a corresponding intervention of, "Inspect skin each shift." Additionally, Resident 2's ISP identified that staff were to monitor and manage all ongoing medical conditions for Resident 2 and communicate any changes in his/her condition. Two incident reports for Resident 2 appeared to detail the same incident and were authored by the same person, Caregiver B. Both reports dated 06/07/2026, 7:30 p.m. One report detailed the following: "Earlier this week, a wound care nurse clipped and wrapped [Resident 2]'s finger. The nurse informed staff that the finger would be reassessed on Friday during his/her next scheduled visit. Today staff removed the dressing to change and disinfect the area and observed	M 448		

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M 448	Continued From page 50 active bleeding from the finger and signs of infection ...Staff immediately contacted emergency services for medical assistance and assisted [him/her] to the hospital ..." The second report detailed, "Wednesday, June 3rd a nurse clipped [Resident 2]'s finger and wrapped it up afterwards. The nurse proclaimed that [s/he]'ll check back on it on Friday. Today staff unwrapped [his/her] cast to properly change and disinfect it after noticing the cast looking off. Upon unwrapping it staff was alarmed to see [Resident 2]'s hand looking very bloody and destroyed ...Staff immediately dialed for paramedics to come and followed precautions over the phone from the operator which insisted [sic] of holding [his/her] hand with cloth to stop the bleeding ..." Resident 2's progress notes from 06/03/2026 (the date the alleged finger clipping happened) through 06/07/2026 (the day s/he was hospitalized and later discharged from the home) detailed the following with regard to his/her finger: - 06/03/2026 ("7am-3pm"): " ...Nurse came to look at [his/her] foot wound and helped trim [Resident 2]'s nails.." - 06/03/2026 ("3pm-11pm"): " ...Staff member [Caregiver D] noticed a wound on [Resident 2]'s hand and wrapped it up ..." - 06/06/2026 (3pm-11pm)": " ...Staff checked [Resident 2]'s hand and feet ..." - 06/07/2026 ("3pm-11pm)": "Staff went to inspect [Resident 2]'s hand and seen it got worse. Staff immediately contacted paramedics and [s/he] was transferred to the hospital."	M 448		

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M 448	Continued From page 51 There were no other records in Resident 2's record describing the course of his/her hand/finger condition. From the available records, Surveyor noted that it was unclear which finger from which hand had even been affected. The "wound" Caregiver D noticed on Resident 2's hand on 06/03/2026 had no further details specifying its extent, location, or appearance. There was no objective or description of what the incident reports referred to as Resident 2's finger looking "very bloody and destroyed" or having "signs of infection." At approximately 2:25 p.m., Surveyor interviewed Licensee A about the above incident. Licensee A reported that Resident 2 had received home health nursing care throughout his/her admission to the provider due to wounds s/he experienced. Licensee A reported that during one of these visits, the visiting registered nurse (RN) clipped Resident 2's fingernails and accidentally clipped one of them low, which caused one of Resident 2's fingers to bleed. Licensee A reported that the RN wrapped the finger, told Caregiver D about it, and said that the finger would again be looked at on Friday. When asked when the incident happened, Licensee A reported that s/he thought it happened on the Wednesday that preceded Resident 2's hospitalization. Licensee A reported that the day after the incident. Thursday, Caregiver D noticed the finger was still bleeding and wrapped a dressing him/herself around the finger. Licensee A reported that the next day, Friday, a home health nurse came and addressed the routine wound care with Resident 2's foot but did not notice his/her finger. Licensee A reported s/he was unsure what Resident 2's finger looked like then because s/he believed it was still wrapped. Licensee A reported s/he did not believe	M 448		

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M 448	Continued From page 52 anyone had unwrapped it to check it until Caregiver B checked it on Saturday. Licensee A reported that Caregiver B took off Resident 2's dressing and saw that his/her finger looked discolored and swollen. Licensee A reported that Caregiver B called emergency medical services (EMS) and Resident 2 was transported and subsequently hospitalized. (From the above, Surveyor noted that the Wednesday prior to Resident 2's hospitalization would have been 06/03/2026, consistent with the incident reports. The above identified day of hospitalization as reported by Licensee A, Saturday, would have been 06/06/2026 and inconsistent with the documentation identifying Sunday 06/07/2026 as the day Resident 2 was hospitalized.) At approximately 2:50 p.m., Surveyor interviewed Caregiver D. Caregiver D confirmed that Resident 2 was non-verbal and relied on staff observations of him/her to anticipate his/her needs. Caregiver D reported s/he was working on the day Resident 2's finger was cut. Caregiver D reported that Resident 2 had a home health nursing visit that day to address a foot wound s/he had. Caregiver D reported that prior to the nurse leaving, s/he reported to him/her that Resident 2 had "a little ouchie" on his/her finger that s/he obtained while the nurse was trimming his/her nail. Caregiver D reported that the nurse told him/her that s/he put a band-aid on the finger and that it wouldn't need to be on for more than a day. Caregiver D reported that the nurse also said that staff could remove the band-aid when the bleeding stopped. Caregiver D reported that the next day s/he took the band-aid off and cleaned Resident 2's finger with a wound wash solution and peroxide. Caregiver D stated, "It was ok. It ended up being	M 448		

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M 448	Continued From page 53 OK." Caregiver D reported s/he was unsure what caused Resident 2 to have to be hospitalized and end up being discharged from the provider. As part of the same interview, Caregiver D reported there was a separate incident where s/he observed blood in the middle of Resident 2's hand. Caregiver D reported s/he cleaned Resident 2's hand and saw that blood was coming from the finger that had been cut earlier. Caregiver D reported s/he put a bandage on Resident 2's finger and wrapped it up. Caregiver D reported that the finger was not bleeding heavily. Caregiver D reported s/he kept monitoring the wound. Caregiver D reported that later that same evening s/he took the bandage off because management staff told him/her to let Resident 2's finger get some air. Caregiver D stated, "It ended up being okay." On 08/13/2026, Surveyor reviewed medical records, obtained directly from the hospital that treated Resident 2 on 06/07/2026. The emergency department (ED) medical provider's note, dated 06/08/2026, documented that Resident 2 presented to the ED "with chief complaint of R[ight] thumb infection ...Group home person reported that patient had [his/her] nails trimmed one week ago and clipped some of [his/her] L[eft] thumb. They have been doing wound care, but group home caregiver noticed that [his/her] L thumb was black. Was concerned for infection, so patient was brought to the ED via EMS for further evaluation ..." Within the same note, the ED provider assessed that Resident 2 had a "black thumb of L hand with wound to web space between thumb and index finger of L hand ..." The note detailed that Resident 2 had "necrosis of L thumb" and that	M 448			

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M 448	Continued From page 54 imaging showed "evidence of a osteomyelitis of 1st distal phalanx." The medical provider also noted concerns for Resident 2 having sepsis due to the osteomyelitis and experiencing tachycardia (having a fast heart rate). Hospital admission was recommended due to Resident 2's thumb. The medical provider documented that s/he personally contacted adult protective services due to concern of neglect given the necrosis of Resident 2's left thumb and a second wound to his/her left hand. The discharge summary note, dated 07/01/2026 detailed the course of Resident 2's hospitalization which occurred from 06/08/2026 (when s/he was admitted from the emergency department to inpatient) through 07/01/2026. The discharge note documented that Resident 2 was treated with intravenous antibiotics upon his/her admission but experienced a seizure on 06/13/2026, which was thought to be due to him/her in the early stages of septic shock, causing his/her seizure threshold to be lowered. The note documented that Resident 2 was found to experience septic shock on 06/14/2026 and was in the intensive care unit from then until 06/16/2026. The note documented that Resident 2 underwent a left thumb amputation on 06/18/2026. The operative note, dated 06/18/2026, documented that the operating orthopedic surgeon conducted an amputation with direct neurectomy and closure of the left thumb at the level of the mid-proximal phalanx (approximately halfway between the 2 knuckles of the thumb) that day. The surgeon documented that Resident 2 had developed necrosis of his/her left thumb and was presumed to have sepsis due to this. The surgeon documented that Resident 2's	M 448			

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M 448	Continued From page 55 thumb "appeared to be primarily dry gangrene with a little bit of moist gangrene proximally." The note documented that the amputation was indicated in order to control the residual infection and promote Resident 2's thumb healing. Various photos included with the medical record showed the appearance of Resident 2's thumb from his/her admission throughout the course of his/her hospitalization. One photo, taken 06/07/2026 at 8:24 p.m. (approximately 4 minutes after him/her presenting to the hospital) showed Resident 2's left hand. The entire distal part of his/her thumb (the part of the thumb past the interphalangeal joint (IJ), or, the joint closest to the nail) appeared black. On the dorsal (back) surface of Resident 2's thumb, the skin appeared thinned and black to the level of his/her IJ. On the palmar surface of his/her thumb, the skin appeared black to level extending just past his/her IJ. This necrotic area overall encompassed nearly half of his/her thumb. His/her thenar webspace, the area extending from the blackened thumb to the metacarpophalangeal joint (MJ, or big knuckle) of his/her index finger, appeared with splotchy redness. The thin area of his/her webspace appeared to have skin breakdown with the tissue underneath visible. On 08/13/2026, at approximately 10:00 a.m., Surveyor interviewed RN Case Manager F, who had been part of Resident 2's care team during most of his/her admission with the provider, and Quality Compliance Nurse G - both from Resident 2's managed care organization. RN Case Manager F reported that Resident 2 had long-term wound care needs throughout nearly his/her entire admission with the provider. When asked about the above incident, RN Case	M 448		

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M 448	Continued From page 56 Manager F reported that the home health nurse said s/he had nicked the edge of Resident 2's thumb when trimming his/her nail. RN Case Manager F reported that less than a week later Resident 2's left thumb was necrotic. RN Case Manager F reported s/he was not sure how Resident 2's thumb got to this point and that it was "shocking" to him/her. RN Case Manager F reported s/he wondered how staff didn't intervene earlier or ask home health nurses about it when they came for their scheduled visits after the thumb was nicked. RN Case Manager F reported that Resident 2 was known to put his/her fingers in his/her mouth. Quality Compliance Nurse G reported that from their own investigation into the manner, the incident where Resident 2's thumb was cut occurred on 06/01/2026. Quality Compliance Nurse G reported that there seemed to be some sort of miscommunication between the provider's staff and home health staff. Quality Compliance Nurse G reported that home health nurses came in for routine wound care on 06/03/2026 and 06/05/2026 but did not assess Resident 2's thumb. RN Case Manager F reported that when the incident occurred, the home health nurse had put some sort of dressing on Resident 2's thumb and told staff to remove it later that day and continue to monitor it. RN Case Manager F reported that s/he spoke with hospital staff and there was confusion between the clinicians for how Resident 2's thumb progressed to the extent it had from just a nick during nail trimming. (Of note, the above reported date of the incident being 06/01/2026, was inconsistent with Licensee A's interview and the provider's records regarding the incident as having occurred 2 days later on 06/03/2026.)	M 448		

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M 448	Continued From page 57 On 08/14/2026, at approximately 12:40 p.m., Surveyor interviewed Home Health RN H, from the agency that conducted Resident 2's home health wound care. Home Health RN H reported that s/he was the nurse who was there during Resident 2's thumb incident. Home Health RN H reported that s/he was trimming Resident 2's nails during a visit on 06/01/2026 around mid-day. Home Health RN H reported that Resident 2 moved his/her hand at the last second, which caused him/her to clip the side of his/her thumb. Home Health RN H reported that s/he had just "nicked" the skin and it bled a little bit. When asked to clarify the injury more, Home Health RN H reported that it was a pinpoint-sized cut as it had just been caught with the edge of his/her clippers. Home Health RN H reported that the level of bleeding was scant and that after s/he cleaned the thumb, it had already stopped bleeding. Home Health RN H reported that there were no band-aids available in the home so s/he applied a little bit of gauze over Resident 2's thumb with a piece of tape to hold it in place. Home Health RN H reported that this wasn't to stop any sort of bleeding, since the bleeding had already stopped, but was just in case the thumb started bleeding again. Home Health RN H reported Resident 2 was known to put his/her fingers in his/her mouth and so s/he wanted to block the cut to minimize any infection risk. Home Health RN H clarified that the amount of gauze s/he used was just enough cover the distal phalanx of Resident 2's thumb - just from the tip to the knuckle. Home Health RN reported that s/he informed the 2 caregivers on duty, Caregiver D and Former Caregiver I about what happened and told them to check on Resident 2's thumb a couple times a day to ensure the cut didn't reopen. Home Health RN H reported s/he doubted the cut was going to reopen because of	M 448			

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M 448	Continued From page 58 how small it was and how it had already stopped bleeding before s/he had applied the gauze. Home Health RN H reported that both staff reported understanding of his/her instructions. Home Health RN H confirmed that this incident occurred on 06/01/2026 and reported that it could not have occurred on 06/03/2026 as the provider indicated because that s/he is routinely off of work on Wednesdays. (Of note, the above reported date of the incident being 06/01/2026 was consistent with the interview from Resident 2's managed care organization but inconsistent with Licensee A's interview and the provider's records regarding the incident as having occurred 2 days later on 06/03/2026. Surveyor noted that amount and placement of gauze, as reported by Home Health RN, would have still allowed the part of Resident 2's thumb from the furthest knuckle to the base to be visible as well as the thenar webspace - areas that had appeared to be affected in the emergency department photos on 06/07/2026, detailed above.) SUMMARY: The provider's records indicated that on 06/03/2026, Resident 3's finger was cut by a home health nurse (no laterality or specific finger identified, or any other description of the cut and its effect). Despite the records indicating that the nurse made the staff on duty aware of the incident, a progress note that same day documented that Caregiver D "noticed a wound on [Resident 2]'s hand and wrapped it up ...". There was no clarification regarding the location, extent, or description of this observed wound; information indicating whether this was related to the cut Resident 2 experienced earlier, or	M 448		

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M 448	Continued From page 59 information as to exactly what treatment was applied by Caregiver D wrapping Resident 2's finger and how this treatment was assessed as being appropriate for the type of injury Resident 2 demonstrated. A progress note 3 days later on 06/06/2026 indicated that staff checked Resident 2's hand with nothing further documented. The provider's incident reports on 06/07/2026 indicated that when staff "unwrapped" Resident 2's finger "cast" his/her finger was observed to be bleeding and showing signs of infection with his/her "hand" appearing "very bloody and destroyed." However, there were no other details documented to provide clarifying information to these observations. Licensee A confirmed the incident occurred on 06/03/2026 and that staff had noticed the change in finger condition upon unwrapping a dressing on Resident 2's finger for the first time since it was placed by Caregiver D on Thursday (06/05/2026) in response to Resident 2's finger bleeding. Of note, there were no notes regarding any skin changes warranting left thumb wrapping on 06/05/2026 or notes that specified the type of dressing/wrap applied by staff. This was inconsistent with Resident 2's own ISP which directed for skin inspections to be done each shift. Caregiver D's report indicated awareness of 2 separate incidents regarding Resident 2's finger - the first of which involved the cut from the home health nurse. Caregiver D reported that s/he was able to remove Resident 2's "band-aid" the day after the incident and Resident 2's finger was fine. The second incident involved Caregiver D noticing bleeding come from the same finger that had been cut. Caregiver D reported that s/he had placed a bandage on the finger but that s/he took	M 448		

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M 448	Continued From page 60 it off later that evening and it "ended up being okay." Neither of these accounts were consistent with the course of Resident 2's left thumb and thenar webspace skin breakdown. Outside records and interviews identified the cut incident as occurring on 06/01/2026. Hospital records identified that Resident 2 was found on emergency department admission on 06/07/2026 to have a necrotic left thumb, with osteomyelitis, and a wound to his/her left thenar webspace. Photos that accompanied the admission that day showed the entire distal portion of Resident 2's thumb to have been black, with the necrotic-appearing tissue having extended past the 1J on the palmar side of his/her thumb (a total area of nearly half of his/her thumb). The area of skin breakdown in his/her thenar webspace was observed, with redness extending the entire way from his/her thumb, through the webspace, and up his/her index finger. Resident 2 was hospitalized for intravenous antibiotic treatment, but experienced a seizure that was thought to have been due his/her seizure threshold having been lowered in the context of emerging septic shock. As a result, Resident 2 was then treated for approximately 2-3 days in the intensive care unit. On 06/18/2026, Resident 2 underwent a partial amputation of his/her left thumb in order to control the infection. On 08/21/2026, at approximately 2:20 p.m., Surveyor interviewed Licensee A regarding the above health monitoring concerns related to Resident 2's thumb and thenar webspace injuries. Licensee A reported understanding of Surveyor's concerns and reported that s/he made note to have better documentation in the future. Licensee A acknowledged concerns that from the provider's own documentation there was no way	M 448		

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M 448	Continued From page 61 to confirm the laterality and affected digit of the wounds or the extent of the wounds. Additionally, Licensee A acknowledged Surveyor's concerns that the records did not accurately reflect the timeline of events. Licensee A reported s/he was unaware of the extent of Resident 2's injuries.	M 448		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that all prescription medications were securely stored. Findings include: On 08/11/2026, at approximately 2:03 p.m., Surveyor observed the kitchen fridge contents while touring the home. A door shelf contained a container of 5 insulin pens prescribed to Resident 1 (Photo 1). Underneath that, Surveyor observed a box of Lantus insulin pens prescribed to Resident 1 (Photo 2). Surveyor observed 2 pens in the box (Photo 3). All of the observed pens	M 458		

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M 458	Continued From page 62 were unsecured and available to anyone who opened the fridge. While observing the pens, Surveyor interviewed Licensee A. Licensee A reported understanding of Surveyor's concerns that Resident 1's insulin pens were not stored securely.	M 458		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that service providers helped Resident 1, who required assistance for medication administration, take the correct insulin doses at the correct times. Resident 1 was reported to demonstrate non-compliance with his/her Novolog insulin administration - specifically with refusing doses or only accepting a dose of his/her own choosing which was not in accordance with his/her prescribed doses. While his/her ISP documented that s/he tended to delay his/her Novolog administration and overall needed prompting to take medications, the specific issues with his/her	M 462		

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M 462	Continued From page 63 alleged self-directed scaled dosing were not documented. On occasions across 25 days, discrepancies were identified either in the timing of his/her Novolog insulin administration or dose administered, but there was no information to suggest whether the discrepancies were due to staff error or Resident 1's self-direction, or that staff had attempted to administer the correct prescribed dose at the correct time. On 17 occasions across 9 days, discrepancies were identified in the amount of Lantus insulin administered to Resident 1. Despite Licensee A reporting that this was due to the direction of Resident 1 him/herself, there was no evidence to corroborate this and no evidence to suggest that staff attempted to administer the correct prescribed dose. Resident 1 was prescribed a correctional dose that applied to both daytime Novolog administrations and bedtime, however, his/her medication administration record (MAR) only showed an entry of 8:00 p.m. for this dose. On at least 44 of the 52 days during the review period there was at least 1 occasion in which Resident 1's meal consumption and documented blood sugar level would have warranted at least a calculation of the needed correctional dose - evidence for which was not present. On 5 of the 52 days, blood sugar level recordings were missing which made it unable to be determined if Resident 1 would have required a correctional dose. Of note, Licensee A was unable to explain what the correctional dose meant as it was written by Resident 1's medical provider. On multiple occasions, Resident 1 was documented having blood sugar levels in the 400s - 500s and warranted involvement from emergency medical services (EMS).	M 462		

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M 462	Continued From page 64 Findings include: On 08/11/2026, Surveyor interviewed Caregiver B regarding Resident 1's needs. Caregiver B reported that Resident 1 required staff assistance to administer his/her medications. Caregiver B reported that this used to include regular blood sugar checks and insulin administration throughout the day but that recently s/he had received an insulin pump that handled his/her insulin administration. At approximately 11:01 a.m., Surveyor interviewed Licensee A regarding Resident 1's needs. Licensee A reported that since admission, Resident 1 required staff assistance to conduct blood sugar checks 4 times per day. Licensee A reported that Resident 1 was prescribed fast-acting insulin 4 times per day and long-acting insulin twice per day. Licensee A reported that Resident 1 was known to not routinely take his/her insulin. Licensee A clarified that on some days Resident 1 refused his/her fast-acting insulin completely but the majority of the time s/he wanted to adjust the dose s/he would take him/herself and would refuse the dose as prescribed. Licensee A reported that approximately a week ago Resident 1 received an insulin pump which automatically handled his/her insulin administration without staff intervention. On 08/11/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 04/27/2026 with diagnoses including diabetes mellitus type I. Resident 1 was documented as having a legal guardian. An individual service plan (ISP), signed 05/30/2026, identified that Resident 1 required "constant reminders on taking medication and checking blood sugar." A	M 462		

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M 462	Continued From page 65 note under his/her medication list documented, "Continue to ask [Resident 1] to take [his/her] Novolog Flexpen, [s/he] will try to delay. Be patient and kind." Information under his/her behaviors section documented, "Sometimes can't follow instructions from staff without refusing. Needs to be persuaded to take medications or check blood sugar." Another ISP, with the same date, documented the following with regards to Resident 1's medications: - "...Forgets to take medications sometimes ..." - "Staff will remind [Resident 1] to take insulin daily as well as other medications. Staff will educate [Resident 1] about the importance of taking medications on time." - "[Resident 1] has problems with taking medicine daily. [S/he] often forgets and needs reminders. Staff will ensure [Resident 1] when to take [his/her] medications. Staff will monitor [Resident 1] during the administration of medicine." Associated goal: "Become better at medication management and refusals to take medications." Resident 1's prescriptions included the following: - Lantus SoloStar 100 units/mL, active since 04/27/2026, with instructions to, "Inject 13 units subcutaneously twice daily ..." - Novolog FlexPen 100 units/mL, active since 04/27/2026. 3 separate orders documented a set number of units to be administered before each meal: 11 units "before breakfast," 7 units "before lunch," and 9 units "before supper." The MAR documented these as 3 separate entries associated with each mealtime dose.	M 462		

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M 462	Continued From page 66 - Novolog FlexPen 100 units/mL, active since 04/27/2026, with the instructions, "Plus correction 2:40>140 during the day. 1:40>180 at bedtime." Despite the order calling for daytime dosing (associated with meals) and bedtime dosing, the only MAR entry showed an administration time of 8:00 p.m. Surveyor reviewed Resident 1's MARs from 06/09/2026 through 07/30/2026. On 07/31/2026, progress notes documented that Resident 1 received his/her insulin pump, which automatically administered his/her insulin from that point. Surveyor observed that information regarding Resident 1's insulin administration was documented in both the daily entry boxes and handwritten annotation lines in the MARs as well as in Resident 1's progress notes. From both the MARs and the progress notes, Surveyor observed the following discrepancies: - Throughout the entire review period, staff documented that Resident 1 refused his/her correctional Novolog dose, even when s/he had been documented as taking Novolog insulin such as during the below entries. However, the MAR entry showed only an 8:00 p.m. administration time for the correctional dose and there was no acknowledgement of correctional doses calculated in accordance with the prescribed scale or attempted administration of the correctional dose during any of his/her 3 meal times throughout the month. From the available records, Surveyor noted that there was at least 1 occasion on 44 of the 52 days in the review period in which Resident 1's meal consumption and documented blood sugar level would have warranted at least a calculation of the needed correctional dose. On 5 of the 52 days, blood sugar level recordings were missing which made	M 462		

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M 462	Continued From page 67 it unable to be determined if Resident 1 would have required a correctional dose. - 06/09/2026: The lunch insulin dose showed staff initialing the MAR, but a MAR annotation entry of 12:35 p.m. documented that 4 units were administered (as opposed to the 7 prescribed). A corresponding progress note documented that Resident 1 took his/her insulin at that time with no acknowledgement that this was not the correct dose. - 06/10/2026: Both his/her lunch and supper insulin entries were initialed as administered. However, MAR annotation entries at 4:00 p.m. and 7:00 p.m. documented that 3 units were administered each (neither the correct prescribed dose). A corresponding progress note documented that, "At 3:30 staff had [him/her] take [his/her] blood sugar and it was at 454 so staff had [him/her] take some insulin. After, [Resident 1] began to cook [him/herself] some dinner with staffs [sic] help. At 5pm staff had [Resident 1] check [his/her] blood sugar it was at 366. [S/he] refused to take insulin because [s/he] said it was going down. [Resident 1] then had [his/her] dinner ..." It was not clear from the annotations and note if the 3:30 p.m. insulin administration was directly correlated with a meal as prescribed, such as a late lunch, especially in the context of the note which documented that after insulin Resident 1 began to cook dinner (which had its own separate MAR annotation). Regardless, there was no acknowledgement that the 3 units administered at that time were not in accordance with any prescription dose. The progress note indicated Resident 1's refusal of his/her supertime insulin, but this contradicted the MAR in which staff initialed administration for that mealtime dose.	M 462		

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M 462	Continued From page 68 - 06/11/2026: The supper insulin dose showed staff initialing the MAR, but a MAR annotation entry of 5:40 p.m. documented that 4 units were administered (as opposed to the 9 prescribed). A corresponding progress note documented no acknowledgement of the discrepancy. - 06/12/2026: The lunch insulin dose showed staff initialing the MAR but a MAR annotation entry of 12:30 p.m. documented that 4 units were administered (as opposed to the 7 prescribed). A corresponding progress note documented no acknowledgement of the discrepancy. - 06/13/2026: The lunch and supper insulin doses showed staff initialing the MAR for each entry. MAR annotations at 2:00 p.m. and 6:00 p.m. documented that 3 units at each time were administered (as opposed to the 7 units and 9 units that were prescribed, respectively). A corresponding progress note documented that Resident 1's blood sugar was checked at 2:00 p.m. and that Resident 1 took his/her insulin at that time with no acknowledgement that this was not the correct dose. The next note referencing insulin documented, "After eating, [Resident 1] checked [his/her] [blood sugar] level once more at (118). [His/her] bedtime insulin was administered." Between the MAR and progress note, Surveyor observed that this line correlated with his/her supper insulin. However, there was no acknowledgement that this was the incorrect dose and administered at the incorrect time (after the meal versus before the meal as prescribed). - 06/14/2026: The lunch insulin dose was initialed as administered and the supper insulin dose was marked as refused, however, an annotation at 8:00 p.m. documented that Resident 1 was administered 7 units of Novolog insulin (as	M 462			

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M 462	Continued From page 69 opposed to the 9 units that would be warranted given the meal timing). The only corresponding entry was for a shift note from 3:00 - 11:00 p.m. where staff documented, " ...Staff ordered delivery for [Resident 1], [s/he] ate while watching TV. [S/he] checked once more for [his/her] blood sugar. (367) A fast acting was administered ..." There was no acknowledgement that this was the incorrect dose and administered at the incorrect time (after the meal versus before the meal as prescribed). - 06/15/2026: The lunch insulin dose was initialed as administered. The corresponding progress note documented that Resident 1, " ...returned at 12:15 pm ate lunch and re-checked his/her [blood sugar] at 1:00 p.m. + it was 352, [s/he] took Novolog FlexPen 4 units injected at ..." There was no acknowledgement that this was the incorrect dose and administered at the incorrect time (after the meal versus before the meal as prescribed). - 06/16/2026: The lunch insulin dose was initialed as administered and supper insulin dose was marked as refused, however, a MAR annotation at 6:00 p.m. documented that Resident 1 was administered 7 units. Between the MAR and progress note, there was no acknowledgement that this was the incorrect dose in accordance with the meal timing. Of note, Resident 1's corresponding blood sugar reading at that time was 500. - 06/17/2026: The supper insulin dose was initialed as administered with an annotation at 5:40 p.m. documenting that 4 units were administered. A corresponding progress note documented that Resident 1 took his/her insulin at that time with no acknowledgement that this was not the correct dose.	M 462		

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M 462	Continued From page 70 - 06/18/2026: The lunch insulin was marked as administered and the supper insulin dose was marked as refused, however, an annotation documented that at 5:00 p.m. 5 units of insulin were administered. The corresponding progress note documented that Resident 2 "ate lunch and rechecked [his/her] blood sugar again at 1:30 p.m...they returned at 5pm and [Resident 1] took [his/her] [blood sugar] which was 405, [Resident 1] took 5 units of Novolog Flexpen Insulin ..." The note then mentioned Resident 1 preparing and eating dinner. Surveyor noted that this correlated with the MAR annotation time but did not correlate with the entry itself documenting that the supertime dose was marked as refused. The note documented no acknowledgement that the amount administered (5 units) was not consistent with what was prescribed (9 units). - 06/19/2026: Both the lunch and supper insulin doses were marked on the MAR as having been refused, however, a MAR annotation entry at 5:00 p.m. documented that Resident 1 was administered 7 units of insulin. A correlating progress note documented that after lunch and running errands, " ...Staff + [Resident 1] returned at 5:00 pm and staff had [Resident 1] take [his/her] [blood sugar] again which was 330, [s/he] took 7 units of Novolog Insulin, ate 1/2 of a protein bar + 1/2 coffee." The note documented no acknowledgement that the amount administered (7 units) was not consistent with any directed dose according to what Resident 1 ate and the timing of this meal/snack. - 06/20/2026: The lunch insulin dose was marked on the MAR as administered. While a MAR annotation entry documented that 4 units of insulin were administered at 1:00 p.m., a	M 462			

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M 462	Continued From page 71 correlating progress note documented that Resident 1's guests, "arrived at noon and ate dinner together. [Resident 1] headed out with [his/her] company at 1PM, staff checked [his/her] [blood sugar] before leaving ..." The note documented no acknowledgement that the amount administered (4 units) was not consistent with what was prescribed (7 units) nor clarified the discrepancy in the timing administration (before the meal versus after). - 06/22/2026: The lunch insulin dose was marked as administered and the supper insulin dose was marked as refused. A corresponding progress note documented that Resident 1 returned to the home at 3:45 p.m., took his/her blood sugar, which was 408, and was administered 4 units of insulin. There was no acknowledgement that the amount administered was inconsistent with what was prescribed (7 units). - 06/23/2026: The lunch insulin dose was marked as administered. A corresponding progress note documented that at 1:00 p.m. Resident 1 was administered 3 units of insulin prior to leaving the home. There was no acknowledgement that the amount administered was inconsistent with what was prescribed (7 units). Of note, Resident 1's corresponding blood sugar at that time was 386. - 06/25/2026: The lunch insulin dose was marked as administered and the supper insulin dose was marked as refused. A corresponding progress note documented, " ...[Resident 1] took [his/her] [blood sugar] again at 2:45pm when staff asked which was (471), [s/he] took 4 units of Novolog ...Staff assisted [Resident 1] with supper + [s/he] took [his/her] [blood sugar] (286) 8 units at 5pm of Novolog Insulin ..." There was no acknowledgement of the discrepancy between	M 462		

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M 462	Continued From page 72 the MAR and progress notes regarding Resident 1's supper dose administration (refused vs. administered), nor was there any acknowledgement that neither his/her lunch nor supper insulin amounts administered (4 units and 8 units, respectively) were inconsistent with what was prescribed (7 units and 9 units, respectively). - 06/26/2026: The lunch insulin dose was marked as refused, however, a corresponding progress note documented that Resident 1 was administered 4 units of insulin at the time of his/her lunch. There was no acknowledgement of the discrepancy between the MAR and progress note regarding this, nor was there any acknowledgement that the dose administered (4 units) was inconsistent with what was prescribed (7 units). - 07/01/2026: The breakfast insulin dose was marked as refused and the lunch insulin dose was marked as administered, however, a corresponding progress note documented, " ...At 9:51 AM [Resident 1] asked staff for [his/her] fast acting Novolog Insulin taking 4 units ...[Resident 1] had lunch at 12:30 pm ..." There was no acknowledgement that the dose administered (4 units) was inconsistent with any prescribed dose of his/her insulin. The progress note documented that s/he took 3 units of insulin with his/her supper dose, but there was no acknowledgement that this dose was inconsistent with the 9 units prescribed for that meal. Of note, Resident 1's corresponding blood sugar level at that time was 441, and staff documented blood sugar levels later that evening after supper of 425 and 400. Additionally, the note later documented that Resident 1 "was given [his/her] Novolog along with [his/her] Lantus for bed." Surveyor noted that the only bedtime Novolog insulin prescribed was	M 462			

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M 462	Continued From page 73 a correctional dose with the associated order, "1:40>180 at bedtime." The bedtime Novolog MAR entry documented a refusal, and there was no documentation anywhere of the number of bedtime Novolog units staff administered to Resident 1, which would have been warranted as it was a scaled dose. - 07/03/2026: A MAR annotation documented that at 3:45 p.m., Resident 1 was administered 4 units of insulin. The only correlating MAR entry was his/her lunch dose that day. A corresponding progress note documented the same information, but there was no acknowledgement that the dose administered (4 units) was inconsistent with his/her prescribed dose (7 units). - 07/04/2026: A MAR annotation documented that at 5:00 p.m. Resident 1 was administered 4 units of insulin. The only correlating MAR entry was his/her lunch dose that day. There was no documented acknowledgement that this administered dose was inconsistent with any prescribed dose. - 07/10/2026: A MAR annotation documented that at 7:00 p.m. Resident 1 was administered 6 units of insulin, however, his/her lunchtime dose was documented as administered and his/her supper dose was documented as refused. A correlating progress note documented that Resident 1 had been out of the home and "returned at 6 PM. Staff checked [his/her] [blood sugar] as it read (580) staff by protocol called paramedics ...Staff checked [Resident 1]'s [blood sugar] again after [s/he] took [his/her] fast acting insulin ..." There was no clarification as to the discrepancy between the marked refusal administration timing, nor was there any acknowledgement if the 6 units administered were in accordance with any	M 462			

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M 462	Continued From page 74 sort of order or direction (such as from EMS providers), as it was not in accordance with any of his/her prescribed doses. - 07/11/2026: A MAR annotation documented that at 5:00 p.m. Resident 1 was administered 7 units of insulin, however, his/her lunchtime insulin dose was marked as administered and his/her supper dose was marked as refused. The corresponding progress note documented, "...[Resident 1] ate lunch while watching TV. At 1 PM staff checked [his/her] [blood sugar] at 500 and gave [him/her] [his/her] fast acting ...At 5 PM staff checked [his/her] [blood sugar] which gotten lower. (193) [S/he] made [him/herself] dinner as well ..." There was no acknowledgement of the discrepancy between this note and the MAR entry which indicated that mealtime insulin was only administered at lunch versus the annotation in the MAR which documented the only mealtime insulin administration at 5:00 p.m. There was also no acknowledgement of the discrepancy in the timing of the lunch dose administration (administered after his/her meal versus before as prescribed). - 07/12/2026: A MAR annotation documented that at 8:00 p.m. Resident 1 was administered 3 units of Novolog insulin, however, his/her lunchtime dose was the only Novolog dose marked as administered that day. There was no acknowledgement of this timing discrepancy, nor any acknowledgement that the dose administered (3 units) was not consistent with any of his/her prescribed insulin doses. - 07/16/2026: A MAR annotation documented that at 3:00 p.m. Resident 1 was administered 7 units of insulin, however, his/her lunchtime dose was the only Novolog dose marked as administered	M 462			

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M 462	Continued From page 75 that day. A corresponding progress note documented that, "[Resident 1] came out of [his/her] room mid-morning + was asked by staff to check [his/her] [blood sugar] at 10:40 a.m. which was (475), [s/he] took 5 units of [his/her] Novolog Insulin ...Staff proceeded to call the paramedics by protocol ...Staff asked [Resident 1] to check [his/her] [blood sugar] again at 1pm [blood sugar] device read 'HI,' Staff called paramedics, they checked [his/her] [blood sugar] which was (439) at 1:20 p.m. [Resident 1] took 6 units of Novolog Insulin ..." There was no acknowledgement that the 5 units and 6 units of insulin administered at 10:40 a.m. and 1:20 p.m., respectively per the progress note, were in accordance with any sort of order or direction, as they were not in accordance with any of his/her prescribed doses. Additionally, it was unclear why Resident 1 was administered 7 units at 3:00 p.m. (per his/her MAR annotation) when s/he had already received a Novolog dose at 1:20 p.m. - 07/21/2026: A MAR annotation documented that Resident 1 was administered 3 units of insulin at 5:00 p.m. The only correlating MAR entry was his/her breakfast dose that day. There was no acknowledgement that the dose administered (3 units) was inconsistent with his/her prescribed breakfast dose (11 units), or any dose, and no acknowledgement of the timing discrepancy - with Resident 1's breakfast dose being the only mealtime dose administered but the entry documenting that the dose was administered at 5:00 p.m. - 07/22/2026: A MAR annotation at 9:50 a.m. documented that staff administered 15 units of Lantus insulin, which was inconsistent with his/her prescribed dose of 13 units. The only corresponding progress note documented, "	M 462		

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M 462	Continued From page 76 ...staff checked [his/her] [blood sugar] and administered [his/her] insulin ..." There was no acknowledgement of this being the incorrect dose. - 07/23/2026: MAR annotations at 10:00 a.m. and 10:00 p.m. documented that staff administered 15 units of Lantus insulin, which were inconsistent with his/her prescribed doses at those times of 13 units. The only corresponding progress note documented, "[Resident 1] woke today at 9:45 a.m. and was asked to take [his/her] [blood sugar] (152), took 15 units of [his/her] Lantus Insulin ...Staff administered [his/her] bedtime insulin as well." There was no acknowledgement of these being incorrect doses. - 07/24/2026: MAR annotations at 8:10 a.m. and 9:00 p.m. documented that staff administered 15 units of Lantus insulin, which were inconsistent with his/her prescribed doses at those times of 13 units. The only corresponding progress notes documented, " ...checked [his/her] [blood sugar] (182) and took [his/her] Lantus Insulin of 15 units ...Staff checked [Resident 1]'s [blood sugar] once more before bed along with administering [his/her] bedtime insulin (107)." There was no acknowledgement of these being incorrect doses. - 07/25/2026: MAR annotations at 9:00 a.m. and 10:00 p.m. documented that staff administered 15 units of Lantus insulin, which were inconsistent with his/her prescribed doses at those times of 13 units. The only corresponding progress notes documented that staff administered his/her insulin. There was no acknowledgement of these being incorrect doses. - 07/26/2026: MAR annotations at 9:00 a.m. and 10:00 p.m. documented that staff administered 15	M 462			

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M 462	Continued From page 77 units of Lantus insulin, which were inconsistent with his/her prescribed doses at those times of 13 units. The only corresponding progress notes documented that staff administered his/her insulin. There was no acknowledgement of these being incorrect doses. - 07/27/2026: A MAR annotation at 1:40 p.m. documented that staff administered 6 units of insulin. The only correlating MAR entry was his/her lunch dose that day. The only correlating progress note documented, "... Staff re-checked [Resident 1]'s [blood sugar] again at 12:45 pm that read (562), asked [him/her] to check it again at 1:00 pm (512), staff called Paramedics by protocol, they arrived, checked [his/her] [blood sugar] at 1:40 pm (482). [S/he] took Novolog Insulin 6 units after eating lunch ..." There was no acknowledgement that the 6 units administered were in accordance with any sort of order or direction, as it was not in accordance with any of his/her prescribed doses. There was also no acknowledgement of the discrepancy in the timing of the dose administration (administered after his/her meal versus before as prescribed). Additionally, the progress note for that day documented that at approximately 9:45 a.m., Resident 1 "took [his/her] Lantus Insulin (6 units)," however, the corresponding MAR entry for his/her morning Lantus dose was initialed as administered and an annotation documented that 15 Lantus units were administered at 9:45 a.m. There was no acknowledgement of the discrepancy in dose administration or why this administered dose was differed from what was prescribed. Additionally, a MAR annotation documented 15 units of Lantus insulin administered at 9:00 p.m., with the correlating progress note only documenting that staff administered his/her insulin. There was no	M 462			

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M 462	Continued From page 78 acknowledgement of this also being the incorrect dose. - 07/28/2026: MAR annotations at 9:00 a.m. and 9:00 p.m. documented that staff administered 15 units of Lantus insulin, which were inconsistent with his/her prescribed doses at those times of 13 units. The only corresponding progress notes documented that staff administered his/her insulin. There was no acknowledgement of these being incorrect doses. - 07/29/2026: MAR annotations at 9:50 a.m. and 9:00 p.m. documented that staff administered 15 units of Lantus insulin, which were inconsistent with his/her prescribed doses at those times of 13 units. The only corresponding progress notes documented that staff administered his/her insulin. There was no acknowledgement of these being incorrect doses. - 07/30/2026: MAR annotations at 9:50 a.m. and 9:00 p.m. documented that staff administered 15 units of Lantus insulin, which were inconsistent with his/her prescribed doses at those times of 13 units. The only corresponding progress notes documented that staff administered his/her insulin. There was no acknowledgement of these being incorrect doses. At approximately 12:00 p.m., Surveyor interviewed Licensee A. After reviewing some of the above Novolog insulin examples with him/her, Licensee A acknowledged Surveyor's concern that despite his/her report that Resident 1 was known to adjust his/her own insulin dose in accordance with what s/he wanted, there was no evidence from the above occasions to suggest that staff were aware of the administered doses being incorrect and that the incorrect doses	M 462			

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M 462	Continued From page 79 administered were specifically at Resident 1's request/direction. On 08/20/2026, at approximately 8:22 a.m., Surveyor e-mailed Licensee A reporting his/her observation of staff starting to document administering 15 Lantus insulin units to Resident 1 on 07/22/2026 instead of his/her prescribed 13 units. Surveyor asked Licensee A to send any updated order documenting this prescription change by the end of the day. At approximately 4:42 p.m., Licensee A e-mailed Surveyor back, reporting, "As you know, [Resident 1] has a history of making [his/her] own decisions regarding [his/her] own insulin dosage and has had ongoing difficulty following [his/her] prescribed orders. This has been an ongoing concern since [his/her] admission ...[Resident 1] has stated that [s/he] felt 13 units was not enough and that [s/he] believed [s/he] needed 15 units to maintain [his/her] lifestyle and manage [his/her] blood sugar. The decision to use 15 units was based on what [Resident 1] felt [s/he] personally needed, rather than an updated order from [his/her] medical provider." On 08/20/2026, Surveyor again reviewed Resident 1's record. There was no evidence of for the 9 instances from 07/22/2026 through 07/30/2026, documented above, that the administration of 15 Lantus units was done so at Resident 1's request and/or insistence. There was also no evidence of staff attempting to assist Resident 1 in taking the correct dose during those occasions. On 08/21/2026, at approximately 2:20 p.m., Surveyor interviewed Licensee A. Licensee A acknowledged Surveyor's concerns that there	M 462		

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M 462	Continued From page 80 was limited evidence in Resident 1's record to support his/her report that the incorrect doses of Resident 1's administered insulin were done at his/her own direction and that staff attempted to assist him/her in taking the correct doses. When Surveyor reviewed Resident 1's insulin orders with Licensee A, Licensee A reported initial confusion at Surveyor's report of a Novolog dose being prescribed at bedtime, reporting that s/he was only aware of the Lantus insulin being prescribed at bedtime. Surveyor corrected Licensee A and reviewed the Novolog correctional dose order with him/her. Surveyor reviewed the Novolog correctional dose instructions with Licensee A (2:40>140 during the day and 1:40>180 at bedtime) and asked him/her to explain what that order meant. Licensee A replied, "The diabetes educator was telling us something about this when we sat down with [him/her]." Licensee A then said that the correctional dose order "has to do with 2 units for every ...I don't want to say anything incorrect." Licensee A then said that s/he would have to go back and try to remember.	M 462			
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.	M 464			

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M 464	Continued From page 81 This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure that for 3 of 3 residents reviewed a written order was obtained from their prescribing physicians specifying who by name or position was permitted to administer their medications before the licensee and service providers administered the medications. Findings include: Example 1 - Resident 1 On 08/11/2026, at approximately 8:30 a.m., Surveyor interviewed Caregiver B regarding the needs of Resident 1. Caregiver B reported that staff administered Resident 1's medications. On 08/11/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 04/27/2026. There was no order from a medical provider who prescribed his/her medications specifying who by name or position was permitted to administer his/her medications. At approximately 12:15 p.m., Surveyor requested the above order from Licensee A. Licensee A was observed looking in Resident 1's record for several minutes. At approximately 12:29 p.m., Licensee A reported s/he didn't think s/he had such an order and was unfamiliar with the regulation. Surveyor reviewed the regulation with Licensee A. Licensee A then reported s/he would work on obtaining the order. Example 2 - Resident 2	M 464		

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M 464	Continued From page 82 On 08/11/2026, at approximately 2:25 p.m., Surveyor interviewed Licensee A. Licensee A confirmed that when Resident 2 resided with the provider, staff were responsible for administering his/her medications. On 08/11/2026, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 10/13/2025 where s/he resided until 06/07/2026. There was no order from a medical provider who prescribed his/her medications specifying who by name or position was permitted to administer his/her medications. At approximately 2:00 p.m., Surveyor interviewed Licensee A. Licensee A reported did not have this order for Resident 2. Licensee A reported s/he was unfamiliar with the regulation. Example 3 - Resident 3 On 08/11/2026, at approximately 8:30 a.m., Surveyor interviewed Caregiver B regarding the needs of Resident 3. Caregiver B reported that staff administered Resident 3's medications. On 08/11/2026, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 07/31/2025. There was no order from a medical provider who prescribed his/her medications specifying who by name or position was permitted to administer his/her medications. At approximately 2:00 p.m., Surveyor interviewed Licensee A. Licensee A reported did not have this order for Resident 3. Licensee A reported s/he was unfamiliar with the regulation but after reviewing the regulation with Surveyor, reported s/he would work on obtaining the order.	M 464			

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M 482	Continued From page 83	M 482		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the June medication administration record (MAR) for Resident 2, for the 7 days of that month that s/he resided with the provider, was located as part of his/her record within the home. Findings include: On 08/11/2026, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 10/13/2025 where s/he resided until 06/07/2026. Surveyor reviewed Resident 2's MARs throughout his/her admission and observed that there was no MAR for June, for the 7 days that month s/he resided with the provider. At approximately 1:45 p.m., Surveyor requested the Resident 2's June MAR from Licensee A. Licensee A was then observed looking through his/her record for several minutes. At approximately 1:49 p.m., Licensee A confirmed s/he could not locate it and reported that it was maybe at his/her office. At approximately 3:47 p.m., Surveyor discussed the above concern with Licensee A that the	M 482		

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M 482	Continued From page 84 entirety of Resident 2's record was not located within the home. Licensee A reported s/he understood.	M 482		
M 530	88.09(2)(a)8 TRAINING DOCUMENTATION Documentation of successful completion of the training requirements under HSS 88.04(5). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the training documentation for Executive Director C verified that s/he successfully completed at least 15 hours of training prior to or within 6 months after starting to provide care. Findings include: On 08/11/2026, Surveyor reviewed the training records for Executive Director C, provided by Licensee A. The records consisted of training certificates, not all of which had the number of course hours documented. In total, the certificates with hours documented identified 12 hours of training completed by Executive Director C. Six training certificates within the records showed various topics that Executive Director C received training in but did not identify the number of hours the trainings included. At approximately 3:47 p.m., Surveyor discussed the above concern regarding training documentation with Licensee A. Licensee A appeared to take notes of Surveyor's concern and reported understanding of his/her concern.	M 530		

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M 580	Continued From page 85	M 580		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 2 received prompt treatment adequate to his/her needs by notifying a healthcare provider for guidance the day that Resident 2 ran out of baclofen tablets, a situation that a medical provider evaluated "likely" caused him/her to have seizure(s). Findings include: Baclofen is a medication used to treat spasticity, and the therapeutic use of baclofen can be associated with "withdrawal syndrome" - a disorder which requires "prompt recognition," constitutes a medical emergency, and can be associated with death. Those experiencing baclofen withdrawal may experience altered mental status, autonomic dysfunction, respiratory failure, cardiac arrest, and seizures, among other symptoms, within hours to days following the interruption in their baclofen. The most important treatment for baclofen withdrawal is the "re-initiation or supplementation of baclofen dosing," (Romito, J.W. et al. (2021). Baclofen therapeutics, toxicity, and withdrawal: A narrative review. SAGE Open Medicine, 9, https://pmc.ncbi.nlm.nih.gov/articles/PMC8182184/ (retrieval date - August 18, 2026).). On 08/11/2026, Surveyor reviewed resident incident reports. An incident report dated 02/21/2026 documented an incident on	M 580		

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M 580	Continued From page 86 02/20/2026 as follows: "Around 3:00 p.m. [Resident 2] had a breif [sic] seizure that lasted about ten seconds, shortly after [s/he] seemed to be shaking a bit more which is why staff decided to take [him/her] to the [emergency room] ...After speaking with the doctor we found that the likely reason for this incident [s/he] has not taken Baclofen in over three days. The corrective action will be to resume Baclofen starting today ..." On 08/11/2026, Surveyor reviewed Resident 2's record. Resident 2 resided with the provider from 10/13/2025 until his/her hospitalization and subsequent discharge on 06/07/2026. Resident 2's diagnoses included Rett syndrome, spastic quadriparesis, and developmental non-verbal disorder. Resident 2 was documented as having a legal guardian throughout his/her admission. Resident 2's individual service plan (ISP), signed as created on 11/13/2025 and last reviewed on 05/14/2026, identified that s/he was nonverbal and required total assistance by staff for all cares, which included the following: "Staff monitors and assists with all medication needs." Resident 2's ISP identified that s/he had a history of seizures. Resident 2's member-centered plan from his/her managed care organization (MCO), dated 12/01/2025, contained a goal active since 05/20/2025 which identified that his/her formal and informal supports would update providers with any medication refill needs or other medication-related concerns. An emergency department (ED) after visit summary dated 02/20/2026 documented: "You were seen in the Emergency Department for: seizures. We found you are likely having them because you stopped your baclofen abruptly. What to expect and do at home: Resume your baclofen ..." The summary documented that	M 580			

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M 580	Continued From page 87 Resident 2 was given a baclofen 5 mg tablet while s/he was admitted to the ED. Resident 2's prescriptions included baclofen 5 mg tablets, active since at least 10/03/2025 - prior to his/her admission to the provider. One prescription contained instructions to, "Take 1 tablet by gastric tube twice daily at 8AM & 3 PM." Another prescription for the same dose contained instructions to, "Take 2 tablets (10 mg) by gastric tube at bedtime." Resident 2's February medication administration record (MAR) identified a line through his/her 3x/day baclofen administration entries from 02/16/2026 through 02/20/2026 - a total of 15 administrations. Both prescription entries contained a handwritten annotation of "No Refill." On 08/12/2026, at approximately 3:42 p.m., Surveyor interviewed Representative E, from the pharmacy that dispensed Resident 2's medications, regarding Resident 2's baclofen. Representative E reported that in February there was an issue where Resident 2's baclofen required prior authorization and had to be removed from the cycle fill until the authorization was obtained. Representative E reported that the pharmacy maintained documentation showing that a biller from the pharmacy reached out to the provider on 02/09/2026 and spoke to Executive Director C to inform him/her of the issue, before Resident 2's baclofen ran out. Representative E reported that Executive Director C informed the biller that s/he would contact Resident 2's guardian to make him/her aware of the issue. Surveyor noted that this was approximately 1 week prior to Resident 2's baclofen running out. On 08/14/2026, Surveyor reviewed outside records obtained from Resident 2's managed	M 580			

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M 580	Continued From page 88 care organization (MCO). A case note on 02/20/2026 documented, "[AFH staff] advised that member has been fine but showing signs of discomfort with changes in [his/her] breathing patterns and grunting ...AFH staff notified [interdisciplinary team (IDT)] yesterday during visit that member was out of Baclofen and it was waiting for [prior authorization] to be able to fill it ...IDT staff messaged briefly and noted the potential for baclofen withdrawal to cause seizures. [Registered nurse (RN)] will reach out to AFH staff and educate on importance of notifying IDT of issues such as concerns with member running out of medications ..." Another note that day documented, "RN sent email back to AFH staff and requested that they reach out to IDT if ever any concerns with member potentially running out of any medication and/or if [s/he] does so IDT can assist in rectifying the issue. RN advised that withdrawal from Baclofen can cause seizures and other worse symptoms ..." At approximately 2:48 p.m., Surveyor received an e-mail from Quality Compliance Nurse G from Resident 2's MCO. Quality Compliance Nurse G confirmed that the provider's staff had not reached out to Resident 2's care team prior to his/her baclofen running out to identify any concerns with its supply. On 08/21/2026, at approximately 2:20 p.m., Surveyor interviewed Licensee A regarding the concern with Resident 2's baclofen. Licensee A stated, "We were trying our best with this." Licensee A reported recalling that staff had contacted Resident 2's legal guardian at some point. Surveyor reiterated that there was no evidence of any immediate follow up actions taken by the provider's staff, including notification of a healthcare provider, upon realizing that	M 580		

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(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 580	Continued From page 89 Resident 2's baclofen was out. Licensee A said nothing further.	M 580			
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 2 received all his/her prescribed medications in the dosage and at intervals prescribed by his/her medical providers. Resident 2 did not receive approximately 8 doses of his/her prescribed polyethylene glycol, 449 doses of his/her eye drops, 281 doses of his/her Desenex powder, 4 doses of his/her linezolid and 47 doses of his/her vancomycin. Resident 2 was prescribed silver sulfadiazine cream for the treatment of skin wounds, and a hospital medical provider on 10/29/2025 directed for staff to apply the cream daily and as needed with incontinence cares to a coccyx wound s/he had. Staff did not initial off on administering this cream within the months surrounding this nor was there any evidence that the cream was ever on hand.	M 582			

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M 582	Continued From page 90 Findings include: On 08/11/2026, Surveyor reviewed Resident 2's record. Resident 2 resided with the provider from 10/13/2025 until his/her hospitalization and subsequent discharge on 06/07/2026. Resident 2's diagnoses included Rett syndrome, spastic quadriparesis, and developmental non-verbal disorder. Resident 2 was documented as having a legal guardian throughout his/her admission. Resident 2's individual service plan (ISP), signed as created on 11/13/2025 and last reviewed on 05/14/2026, identified that s/he was nonverbal and required total assistance by staff for all cares, which included the following: "Staff monitors and assists with all medication needs." Resident 2's ISP identified that s/he was incontinent. Resident 2's member-centered plan from his/her managed care organization (MCO), dated 12/01/2025, contained a goal active since 05/20/2025 which identified that his/her formal and informal supports would update providers with any medication refill needs or other medication-related concerns. At approximately 2:25 p.m., Surveyor interviewed Licensee A regarding Resident 2's needs. Licensee A confirmed that staff were responsible for administering Resident 2's medications. On 08/12/2026, Surveyor reviewed Resident 2's medication administration records (MARs) throughout his/her admission as well as his/her prescriptions and observed the below medications and discrepancies: (Of note, Resident 2's June MAR was not available for review at the home. See citation for M0482 88.09(1)(a) Resident Records.)	M 582			

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M 582	Continued From page 91 - Polyethylene glycol (start date 07/23/2025) with instructions to, "Mix 17 grams ...in 4-8 oz liquid, stir well and drink once daily for constipation ..." An entry for polyethylene glycol showed on Resident 2's October and November MARs, but was never signed off as administered. Resident 2's record indicated s/he was hospitalized from the evening of 10/21/2025 through the morning of 10/29/2025. - Lubricant eye drops 0.5% (start date 07/23/2025) with instructions to, "Instill 2 drops in the left eye twice daily for eye irritation ..." Staff did not initial any administrations in October, November, January, February, April, or May. Staff initialed administering the drops 3 times in November and 6 times in March. Resident 2's record indicated that s/he was hospitalized from the evening of 10/21/2025 through the morning of 10/29/2025 as well as the evening of 11/17/2025 through the morning of 11/19/2025. - Desenex 2% powder (start date 11/19/2025) with instructions to, "Apply topically to affected area(s) twice daily for intertrigo." Despite the start date in November, Surveyor did not observe any entries for the powder in Resident 2's November MAR. The MARs showed that the powder was not initialed as administered for 20 administrations across 10 days in January, nor at any time from February through May. Of note, medical records within Resident 2's record identified hospital discharge instructions on both 10/29/2025 and 11/19/2025 that staff were to apply miconazole (the active ingredient of Desenex powder) powder to his/her bilateral buttocks, bilateral groin, and affected skin folds twice daily and as needed with incontinence care as part of an overall detailed regimen for preventing skin breakdown.	M 582			

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M 582	Continued From page 92 - Silver sulfadiazine 1% cream (start date: 07/29/2025) with instructions to, "Apply once daily to wound bed with dressing changes." Of note, hospital discharge instructions within Resident 2's record, dated 10/29/2025, identified that staff were to apply Silvadene cream (brand name for silver sulfadiazine) daily and as needed with incontinence to a wound s/he had on his/her coccyx. From that date, 10/29/2025, the MAR did not show any administrations of the cream throughout the last 2 days of October nor throughout November, December, January, February, April, or May. Staff initialed off on 1 administration in March, but the other 29 entries that month were blank. - Linezolid 100mg/5mL oral suspension (start date 10/29/2025) with instructions of, "(10/30-11/12/2025) Take 30 mL by mouth twice daily with meals for 14 days for infection ...". Resident 2's October MAR did not show 4 of 4 administrations across 2 days of his/her linezolid that would have been due as per his/her prescription instructions. - Vancomycin 50 mg/mL solution (start date 10/29/2025) with instructions of, "(10/30 - 11/12/2025) Take 2.5 mL via g-tube 4 times daily for 14 days." That entry showed 16 administrations that occurred from 11/07/2025 through 11/10/2025. A separate vancomycin order was also documented, with an order start date of 11/19/2025 and instructions of, "(11/19-12/01/2025) Take 2.5 mL (125 mg) by mouth twice daily for 12 days for infection ...". For this entry, Resident 2's MARs showed only 2 of 24 administrations initialed off on, for 12/01/2025 - the rest were blank. Of note, Resident 2's records identified that s/he had been hospitalized	M 582		

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M 582	Continued From page 93 from the evening of 11/17/2025 through the morning of 11/19/2025, which appeared to generally correlate with the start of the most recent vancomycin order. At approximately 3:42 p.m., Surveyor interviewed Representative E from the pharmacy that dispensed Resident 2's medications. Representative E reported the following with regards to the above medications: - Polyethylene glycol: Representative E confirmed that the order was from 07/23/2025 and was active until 10/29/2025 when there was an order on that day discontinuing it. Representative E reported that there had never been any dispensing and delivery of polyethylene glycol to the provider. (From the above, Surveyor noted that this period comprised of approximately 8 days of missed administration, due to the above referenced hospitalization Resident 2 had.) - Lubricant eye drops: Representative E confirmed that the order was from 07/23/2025 and was still an active order. Representative E reported that there had never been any dispensing and delivery of the drops to the provider. (From the above, Surveyor noted that this period comprised of approximately 449 missed doses across approximately 224 days when accounting for Resident 2's absences during hospitalizations.) - Desenex powder: Representative E confirmed that the order was from 11/19/2025 with one container having been dispensed and delivered to the provider on that day. Representative E confirmed that this was an active order. (From the above, Surveyor noted that the blank MAR entries indicated a total period of approximately 281	M 582			

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M 582	Continued From page 94 missed administrations across approximately 140 days.) - Silver sulfadiazine cream: Representative E confirmed that the order was from 07/29/2025 and that it was still an active medication. Representative E reported that there had never been any dispensing and delivery of the cream to the provider. (Of note, it was unclear as to how many missed doses Resident 2 experienced with this cream as there was no follow up documentation within his/her record regarding his/her coccyx wound and its potential resolution.) - Linezolid: Representative E confirmed that the order was from 10/29/2025 and that the medication was delivered in 2 separate deliveries on 10/29/2025 and 10/30/2025. (From the above, Surveyor noted that this period comprised of approximately 4 missed doses across 2 days.) - Vancomycin: Representative E reported that Resident 2's original vancomycin order was written on 10/28/2025 but due to issues with prior authorization, the medication was not delivered until 11/06/2025. Surveyor noted that this corroborated with staff having started initialing administrations of the vancomycin on 11/07/2025. Representative E reported that with receipt of the new vancomycin order on 11/19/2025 another bottle was dispensed and delivered that same day. (Of note, from the above information, once Resident 2's vancomycin was delivered s/he should have been able to complete approximately 11.5 days, or approximately 42 doses, of his/her 4x/daily vancomycin before s/he was hospitalized on 11/17/2025, instead of only the 16 doses that were initialed as administered (26 missed doses). Resident 2's 11/19/2025 vancomycin order course showed only one day of administration,	M 582			

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M 582	Continued From page 95 12/01/2025, but contained no information about the previous 11 days the medication was to be administered (22 doses). Surveyor noted this as a total of approximately 48 missed doses across approximately 18 days.) On 08/21/2026, at approximately 2:20 p.m., Surveyor interviewed Licensee A and discussed the concern that Resident 2 did not receive all his/her prescribed medications as evidenced by blank MAR entries and/or medications not having been available at the home. When asked if s/he conducted routine medication and MAR audits, Licensee A replied, "I do, a lot, actually," and then asked Surveyor (regarding the unavailable medications), "If they were prescribed, why weren't we getting deliveries?"	M 582			