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WISCONSIN CARE SOLUTIONS CORPORATION	804 JANA LN MADISON, WI 53704

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M 000	INITIAL COMMENTS On 08/18/2026, Surveyor conducted a complaint investigation at Wisconsin Care Solutions Corporation, an AFH in Madison. Thirteen 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 observation, interview and record review, Licensee A did not ensure the home complied with Chapter DHS 88 and all laws governing the home and its operation. Findings include: On 08/18/2026, Surveyors conducted a complaint investigation alleging concerns regarding resident care and maintaining a record. The investigation resulted in 13 deficiencies. The complaint was substantiated. The following concerns were identified: Environment: - The provider had cared for 3 residents who were not ambulatory since receiving a license to operate as an adult family home providing service to ambulatory residents only on 12/05/2025. - Food was not stored in sanitary conditions in the	M 216		

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

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M 216	Continued From page 1 home's refrigerators and freezers. Resident Care: - Four of 4 residents admitted since the provider received an adult family home license on 12/05/2026 did not have a health exam, including communicable disease screen and tuberculosis test prior to admission or within 7 days after admission. - Four of 4 residents admitted since the provider received an adult family home license on 12/05/2026 did not have a completed service agreement. - Two of 4 residents admitted since the provider received an adult family home license on 12/05/2026 did not have a complete record of medical visits, reports and recommendations. - Four of 4 residents admitted since the provider received an adult family home license on 12/05/2026 did not have their health monitored with changes documented in the record. - Medications were not stored secured. Insulin was stored unsecured in the refrigerator, which was accessed by residents. - Three of 3 residents who the provider administered medications for since the provider received an adult family home license on 12/05/2026 did not have physician orders permitting staff to administer medications. - Two of 3 residents who the provider administered medications for did not have their medication administration accurately documented. - Three of 3 residents who had received a 30-day notice of termination of placement did not have reasons for termination consistent with the provider's service agreement. - From 03/05/2026 to 04/19/2026, residents did not have their privacy respected. The provider had a camera in the kitchen.	M 216		

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M 216	Continued From page 2 - Two of 3 residents who the provider administered medications for since the provider received an adult family home license on 12/05/2026 did not have all medications administered as prescribed. EXIT: On 08/18/2026 at approximately 11:00 a.m., Surveyors reviewed environmental and resident care concerns with Licensee A. Licensee A asked for advice should s/he have concerns with a resident's managed care team in the future. Licensee A also stated s/he was aware the provider had areas to work on. Cross Reference: M0262 DHS 88.05(2)(a) Difficulty Walking M0380 DHS 88.06(2)(a) Admission-Health Exam M0384 DHS 88.06(2)(b) Service Agreement Except Respite M0446 DHS 88.07(2)(b)4. Record of Medical Visits and Reports M0448 DHS 88.07(2)(b)5. Monitoring Health M0458 DHS 88.07(3)(a) Prescription Medications M0464 DHS 88.07(3)(d) Medication - Written Order M0466 DHS 88.07(3)(e)1. Medication - Record Keeping M0474 DHS 88.07(4)(c) Food Prepped And Stored Sanitary Way M0480 DHS 88.08 Termination Of Placement M0550 DHS 88.10(3)(b) Privacy M0582 DHS 88.10(3)(q) Medications	M 216		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at	M 262		

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M 262	Continued From page 3 all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure exits were ramped to grade with a hard surfaced pathway with handrails for residents that were not able to walk or walked only with difficulty. The home, which was not equipped with exits ramped to grade with hard surfaced pathways and handrails, provided care for 3 individuals who were not ambulatory since receiving an adult family home license on 12/05/2025. Findings include: OBSERVATION:	M 262		

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M 262	Continued From page 4 Chapter DHS 88.02(6) defines ambulatory as able to walk without difficulty or help. On 08/18/2026 at 8:40 a.m., Surveyors arrived to the provider's home and observed the following 2 exits, which were identified by signage: - The front walkway (exterior) had a ramp, which was unsecured and did not include handrails, placed to even out the surface. - The back door exited to a deck, which required 3 steps to reach grade. The steps landed on grass, not a hard surfaced pathway. On 08/18/2026 at 8:57 a.m., Surveyors observed Resident 1 self-propel him/herself throughout the home in a manual wheelchair. Surveyors observed caregivers assist Resident 1 to/from the deck to have a cigarettes. RECORD REVIEW: On 08/18/2026 at 9:00 a.m., Surveyors reviewed resident records, which documented the following: - Resident 2 admitted to the provider's home on 03/05/2026. Resident 2's individual service plan (ISP), dated 04/28/2026, documented that s/he was non-ambulatory status post right above knee amputation, required a wheelchair scooter for mobility and required a slide board for transfers. - Resident 3 was admitted to the provider's home on 04/01/2026. Resident 3's ISP, dated 04/23/2026, documented that s/he had a diagnosis of unsteady gait and was ambulatory with assistance. - Resident 1 admitted to the provider's home on 07/27/2026. Resident 1's record did not include an ISP completed by the provider, but did include	M 262		

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M 262	Continued From page 5 a managed care organization (MCO) member centered plan, which documented that s/he required a wheelchair or scooter for mobility within the home and outside the home. INTERVIEW: On 08/18/2026 at 11:00 a.m., Surveyors interviewed Licensee A. Licensee A defined ambulatory residents as individuals that could mobilize without assistance. Surveyor asked why 3 of 4 residents reviewed, who were non-ambulatory, were admitted to the provider's home which was licensed to care for ambulatory only residents. Licensee A stated Resident 1 did not need a wheelchair at admission. Surveyor referenced MCO documentation in the record that referenced wheelchair use. Licensee A then stated Resident 1 did require a wheelchair at the time of admission and should not have been admitted. Licensee A confirmed Resident 2 and Resident 3 also met the definition of non-ambulatory and were not an appropriate placement for the home.	M 262		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90	M 380		

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M 380	Continued From page 6	M 380		

days prior to admission to the home or within 7 days after admission.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that 4 of 4 residents admitted had a health exam to identify health problems and be screened for communicable disease, including tuberculosis, within 90 days prior to admission or within 7 days after admission.

Resident 1, Resident 2, Resident 3 and Resident 4 did not have a health exam or communicable disease screen, including tuberculosis test, completed within 90 days prior to admission or within 7 days after admission.

Findings include:

RECORD REVIEW:

On 08/18/2026 at 9:00 a.m., Surveyors reviewed resident records, which documented the following concerns regarding admission health exams:

- Resident 1 admitted to the provider's home on 07/27/2026. Resident 1's record did not include a health exam or communicable disease screen, including tuberculosis.
- Resident 2 admitted to the provider's home on 03/05/2026. Resident 2's record did not include a health exam or communicable disease screen, including tuberculosis.
- Resident 3 was admitted to the provider's home on 04/01/2026. Resident 3's record did not include a health exam or communicable disease screen, including tuberculosis.
. Resident 4 admitted to the provider's home on

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M 380	Continued From page 7 03/26/2026. Resident 4's record did not include a health exam or communicable disease screen, including tuberculosis. INTERVIEW: On 08/18/2026 at 11:00 a.m., Surveyor interviewed Licensee A and Caregiver B. Surveyor discussed concern that 4 of 4 records reviewed did not include a health exam or communicable disease screen, including tuberculosis test. Licensee A provided Surveyor with Resident 4's Managed Care Organization information sheet which did not include a communicable disease screen or tuberculosis test. Licensee A stated the day of Surveyor's presence was the first day s/he had spoke with Resident 1's physician. Caregiver B commented that admissions happened quickly at times and it took time to get documentation in order.	M 380		
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 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:	M 384		

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M 384	Continued From page 8	M 384		

Based on record review and interview, the provider did not ensure a service agreement was signed and dated by the resident and/or resident's legal representative for 4 of 4 residents reviewed.

Resident 1, Resident 2, Resident 3 and Resident 4 did not have a signed service agreement.

RECORD REVIEW:

On 08/18/2026 at 9:00 a.m., Surveyors reviewed resident records, which documented the following:

- Resident 1 admitted to the provider's home on 07/27/2026. Resident 1 was his/her own decision maker. Resident 1's record did not include a signed service agreement.
- Resident 4 admitted to the provider's home on 03/26/2026. Resident 4 had an activated Health Care Power of Attorney (HCPOA). Resident 4's record did not include a signed service agreement.
- Resident 2 admitted to the provider's home on 03/05/2026 and discharged on 06/02/2026. Resident 2 was his/her own decision maker. Resident 2's record did not include a signed service agreement.
- Resident 3 admitted to the provider's home on 04/01/2026 and discharged on 07/28/2026. Resident 3 had an activated Health Care Power of Attorney (HCPOA). Resident 3's record did not include a signed service agreement.

INTERVIEW:

On 08/18/2026 at 11:00 a.m., Surveyor interviewed Licensee A and Caregiver B. Surveyor discussed concern that residents were

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M 384	Continued From page 9 admitted and currently residing at the provider's home without a signed service agreement. Licensee A stated s/he had not found a good time to have Resident 1 complete the service agreement. Caregiver B commented that admissions happened quickly at times and it took time to get documentation in order.	M 384		
M 446	88.07(2)(b)4 RECORD OF MEDICAL VISITS AND REPORTS Keeping a current record of all medical visits, reports and recommendations for a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a current record of all medical visits, reports and recommendations were maintained for 2 of 4 residents reviewed. Findings include: RECORD REVIEW: On 08/18/2026 at 9:00 a.m., Surveyors reviewed resident records, which documented the following: - Resident 4 admitted to the provider's home on 03/26/2026. Resident 4's individual service plan (ISP), dated 04/28/2026, indicated s/he required assistance with a feeding tube. Resident 4's record did not include documentation of physician visits or progress notes related to the feeding tube. - Resident 3 admitted to the provider's home on 04/01/2026. Resident 3's managed care organization notes, obtained by Surveyor,	M 446		

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M 446	Continued From page 10 indicated s/he was hospitalized on 04/11/2026 and 07/28/2026. A managed care organization note, dated 07/29/2026, indicated the provider was issuing a 30-day termination of placement notice due to Resident 3 being too medically complex and unable to do anything independently. Resident 3's record with the provider did not include documentation of the 04/11/2026 or 07/28/2026 hospital visits, along with any record of medically complex needs. INTERVIEW: On 08/18/2026 at approximately 11:00 a.m., Surveyor interviewed Licensee A and Caregiver B. Surveyor discussed concerns that documentation of medical visits and/or reports were not included in resident records. Licensee A stated documentation was likely in the car of the provider's RN, who had recently left the area for school.	M 446		
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 the health of 4 of 4 residents reviewed was monitored with changes documented in the record. Resident 1's blood glucose readings were not recorded.	M 448		

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M 448	Continued From page 11	M 448		

Resident 4's oral intake and tube feedings were not monitored and recorded. Resident 4's change in behavior, resulting in a 30-day termination of placement, was not documented.
Resident 2's record did not include documentation of an unresponsiveness episode that resulted in transfer to the hospital and subsequent hospitalization for cellulitis of the left lower extremity and sepsis with acute organ dysfunction.
Resident 3's record did not document changes in needs and health that resulted in a request for dedicated staffing and 30-day termination of placement notice.

Findings include:

Example 1 - Resident 1:

RECORD REVIEW:

On 08/18/2026 at 9:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 admitted to the provider's home on 07/27/2026. Resident 1's managed care organization (MCO) notes, obtained by Surveyor, indicated s/he required diabetic management. A note, dated 07/31/2026, stated pharmacy had orders for blood glucose testing 4 times daily and that provider had supplies. Resident 1's record included a medication administration record (MAR), dated 08/01/2026 to 08/18/2026, that documented blood glucose readings were taken 4 times daily from 08/01/2026 through 08/12/2026, but did not record readings. The record did not include acknowledgement of blood glucose checks from 08/13/2026 to 08/18/2026.

INTERVIEW:

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On 08/18/2026 at approximately 10:30 a.m., Caregiver C stated the provider checked blood glucose readings but did not record the readings.

Example 2 - Resident 4:

RECORD REVIEW:

On 08/18/2026 at 9:00 a.m., Surveyor reviewed Resident 4's record. Resident 4 admitted to the provider's home on 03/26/2026. Resident 4's record included the following:
- An individual service plan (ISP), dated 04/28/2026, that documented s/he received a modified diet due to dysphagia, which consisted of sift/bite sized food, nectar thick liquids and tube feedings if oral intake wasn't sufficient. Resident 4's record did not include documentation of his/her oral intake or tube feeds.
- A behavioral support plan (BSP), dated 04/28/2026, that documented behaviors of physical aggression, verbal escalation, non-compliance with care, communication related frustration and agitation. The record included a behavior tracker from 04/01/2026 to 05/31/2026 but did not document behaviors from 06/01/2026 to 08/18/2026. Managed Care Organization progress notes, obtained by Surveyor, documented that Licensee A requested dedicated staffing on 06/09/2026 due to behaviors, which was declined, and that Licensee A issued a 30-day termination of placement notice on 07/29/2026, due to Resident 4 being too difficult to care for with increased intoxication.

INTERVIEW:

On 08/18/2026 at approximately 11:00 a.m., Surveyor interviewed Licensee A regarding Resident 4's needs. Licensee A confirmed

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Resident 4 had a feeding tube up until the week prior to Surveyor's visit. Licensee A stated staff monitored Resident 4's intake, but did not document anything. Resident 4 stated staff flushed the feeding tube "maybe every other day" but did not document the cares. Licensee A confirmed s/he issued Resident 4 a 30-day notice and stated the notice was given because Resident 4's behaviors got worse mid-July and Resident 4's family member requested Licensee A issue the notice to assist with mental health treatment. Surveyor discussed concern that worsening behaviors were not documented since 05/31/2026 and not assessed or care planned since 04/28/2026.

Example 3 - Resident 2:

RECORD REVIEW:

Resident 2 admitted to the provider's home on 03/05/2026 and discharged on 06/03/2026. Resident 2's MCO notes, obtained by Surveyor, documented that s/he was admitted to the hospital with cellulitis of the left lower extremity and sepsis with acute organ dysfunction after being unresponsive at the provider's home. Resident 2's provider record did not include documentation of the unresponsiveness, transfer to the hospital or subsequent hospitalization.

INTERVIEW:

On 08/18/2026 at approximately 11:00 a.m., Surveyor interviewed Licensee A and Caregiver C. Surveyor discussed documentation concerns regarding Resident 2. Licensee A discussed frustration with Resident 2's MCO staff.

Example 4 - Resident 3:

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M 448	Continued From page 14 RECORD REVIEW: Resident 3 was admitted to the provider's home on 04/01/2026. Resident 3 did not return to the provider's home after a hospitalization on 07/28/2026. Resident 3's MCO notes included a note, dated 06/22/2026, requesting dedicated staffing and an increased reimbursement rate, as well as a note on 07/29/2026 that stated the provider was issuing a 30-day termination of placement notice because Resident 3 was too medically complex and couldn't do anything for him/herself. Resident 3's record did not document concerns related to staffing or medical complexity. INTERVIEW: On 08/18/2026 at approximately 11:00 a.m., Surveyor interviewed Licensee A and Caregiver B. Surveyor discussed concern that MCO notes indicated the provider had requested increased staffing due to a change in needs and was issuing a 30-day termination of placement due to being too medically complex, yet Resident 3's record did not document changes in need or health. Licensee A stated the provider had room to improve.	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.	M 458		

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This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure prescription medication was stored secured.

The provider stored insulin unsecured in the refrigerator.

Findings include:

OBSERVATION:

On 08/18/2026 at 10:29 a.m., Surveyor observed a Trulicity insulin pen in the provider's refrigerator, unsecured.

On 08/18/2026 at approximatley 11:00 a.m., Surveyor observed Resident 4 open the refrigerator indepedently.

INTERVIEW:

On 08/18/2026 at approximately 11:00 a.m., Surveyor reviewed concern with Licensee A and Caregiver B that the provider had unsecured medication in the refrigerator. Caregiver B stated the provider had an extra fridge in the lower level that could be secured and used for medication storage.

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M 464	Continued From page 16	M 464		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written order from the physician who prescribed medications specifying who was permitted to administer medications was received for 3 of 3 residents reviewed. The provider administered Resident 1, Resident 3 and Resident 4's medications without a physician order permitting the provider to do so. Findings include: RECORD REVIEW: On 08/18/2026 at 9:00 a.m., Surveyors reviewed resident records and identified the following concerns: - Resident 1 admitted to the provider's home on 07/27/2026. Resident 1's record indicated the provider's staff administered medications. The record did not include a physician order	M 464		

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M 464	Continued From page 17 permitting the provider's staff to administer medications. - Resident 3 was admitted to the provider's home on 04/01/2026. Resident 3's record indicated the provider's staff administered medications. The record did not include a physician order permitting the provider's staff to administer medications. - Resident 4 admitted to the provider's home on 03/26/2026. Resident 4's record indicated the provider's staff administered medications. The record did not include a physician order permitting the provider's staff to administer medications. INTERVIEW: On 08/18/2026 at 11:00 a.m., Surveyor interviewed Licensee A and Caregiver B. Licensee A confirmed the provider's staff administered Resident 1, Resident 3 and Resident 4's medications. Surveyor shared concern that the resident records did not include physician orders permitting the provider's staff to administer medications. Licensee A provided Surveyor with Resident 4's Managed Care Organization information sheet which included a medication list, but not an order specifying the provider's staff were permitted to administer medications. Licensee A stated the day of Surveyor's presence was the first day s/he had spoke with Resident 1's physician. Caregiver B commented that admissions happened quickly at times and it took time to get documentation in order.	M 464		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of	M 466		

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all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure medication administration was accurately documented for 2 of 3 residents reviewed.

Resident 1's record did not document the administration of all medications administered and documented the administration of medications that were not available for administration.
Resident 4's record did not include documentation of medication administration from 08/11/2026 through 08/18/2026.

Findings include:

Example 1 - Resident 1:

RECORD REVIEW:

On 08/18/2026 at 9:00 a.m., Surveyors reviewed Resident 1's record. Resident 1 admitted to the provider's home on 07/27/2026. Resident 1's record did not include physician orders. Resident 1's record included a medication administration record (MAR), completed 08/01/2026 through

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08/12/2026, that documented the administration of Vilazodone 40 mg 1 time daily, Vitamin B-12 100 mcg 1 time daily, blood glucose checks 4 times daily, Refresh tears .5% 1 drop 4 times daily, Tramadol Hcl 50 mg 4 times daily, Famotidine 20 mg 2 times daily, Famotidine 40 mg 2 times daily, Nystatin cream 1 time daily, Nystatin ointment 2 times daily, Sudogest 30 mg 2 times daily, Symbicort inhaler 2 times daily, Gabapentin 300 mg 1 time daily, Lamotrigine 200 mg 1 time daily, Metoprolol 100 mg 1 time daily, Refresh ointment 1 time daily, Trazodone 50 mg 1 time daily, Trulicity .75 mg/.5 ml .75 mcg weekly, Klayesta powder 3 times daily, Glipizide 10 mg 2 times daily, Sulindac 200 mg 2 times daily and Cyclosporine .05% drops 2 times daily. The MAR did not document entries for 07/27/2026 through 07/31/2026 and 08/13/2026 through 08/18/2026.

OBSERVATION:

On 08/18/2026 at approximately 10:30 a.m., Surveyor reviewed Resident 1's medication supply and noted the following concerns:

- Resident 1 was receiving Lamotrigine 25 mg 2 tablets at 8:00 a.m., Losartan Potassium 25 mg 1 tablet at 8:00 a.m., Women's Multivitamin 1 tablet at 8:00 a.m., and Omeprazole 20 mg 1 tablet at 8:00 a.m., yet the medication administrations were not documented in the record. Resident 1 received Gabapentin 300 mg at 8:00 a.m. and 12:00 p.m. (in addition to the documented 8:00 p.m. administration), yet the medication administration was not documented.
- Resident 1 did not have a Symbicort inhaler or Klayesta powder available for administration; however, the provider's staff documented twice daily administration of the inhaler and 3 times

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daily administration of the powder from 08/01/2026 through 08/12/2026.

INTERVIEW:

On 08/18/2026 at approximately 11:00 a.m., Surveyor interviewed Licensee A and requested Resident 1's physician orders. Licensee A stated s/he did not have physician orders. Licensee A stated the provider's staff was administering the medications provided from Resident 1's previous facility and from the pharmacy. Licensee A acknowledged the provider did not have a Symbicort inhaler or Klayesta powder. Licensee A stated the medication administration for these medications was documented in error. Licensee A acknowledged the blank entries in the MAR but insisted that Resident 1 had received all medications when due. Licensee A stated there was a delay getting Resident 1 set up with a MAR, which was why there was no documentation of medication administration prior to 08/01/2026.

Example 2 - Resident 4:

RECORD REVIEW:

On 08/18/2026 at 9:00 a.m., Surveyors reviewed Resident 4's record. Resident 4 admitted to the provider's home on 03/26/2026. Resident 4's record indicated the provider's staff administered his/her medications. Resident 4's record did not include documentation of medication administration from 08/11/2026 through 08/18/2026.

INTERVIEW:

On 08/18/2026 at 11:11 a.m., Surveyor

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M 466	Continued From page 21 interviewed Licensee A and discussed documentation concerns. Licensee A stated the provider had room for improvement.	M 466		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored in a sanitary manner. Findings include: On 08/18/2026 at 10:29 a.m., Surveyor observed 2 of 2 refrigerators and freezers in the home's kitchen and noted the following concerns: - A casserole dish was not dated or labeled. - A container of provolone cheese was 2/3 covered in grayish-blue mold. - An open package of cooked ham was not dated. - An open package of frozen ground turkey was left open to air and had freezer burn. - A frozen bag of sausage links was left open to air and had freezer burn. - A bag, dated 08/06/2026, contained a rotisserie chicken that was left open to air. - An open container of beef broth was not dated. - An open package of hot dogs was not dated and was left open to air. - A package of fajita chicken did not have a date of opening and was left open to air.	M 474		

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M 474	Continued From page 22 - A package of mixed vegetables did not have a date of opening and was left open to air. - A package of tortilla shells was left open to air. On 08/18/2026 at approximately 11:00 a.m., Surveyors interviewed Licensee A and Caregiver B regarding food safety concerns. Licensee A held up the package of provolone cheese and questioned that the grayish-blue covering on the cheese was mold. Licensee A then pointed out the concern to a caregiver and questioned the caregiver's cleaning. Caregiver B stated food storage was his/her area and s/he would address the concerns.	M 474		
M 480	88.08 TERMINATION OF PLACEMENT TERMINATION OF PLACEMENT. A licensee may terminate a resident's placement only after giving the resident, the resident's guardian, if any, the resident's service coordinator, the placing agency, if any and the designated representative, if any, 30 days written notice. The termination of a placement shall be consistent with the service agreement under s. HSS 88.06(2)(c)7. The 30 day notice is not required for an emergency termination necessary to prevent harm to the resident or the other household members. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a resident was issued a 30-day notice of termination of placement consistent with the service agreement for 3 of 3 30-day notices issued.	M 480		

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Resident 4, Resident 2 and Resident 3 received 30-day notices of termination that were not consistent with the provider's service agreement.

Findings include:

On 08/18/2026 at 9:00 a.m., Surveyor reviewed the provider's service agreement, which documented the following:

- Services Provided: 24-hour supervision by trained caregivers, assistance with [activities of daily living], bathing, dressing, grooming, mobility, toileting, and eating, meal preparation (three nutritious meals plus snacks daily), laundry and housekeeping, health monitoring and coordination with medical professionals, social and recreational activities encouraging community participation and transportation to medical and community appointments.
- Transfer and Discharge Policy: Per DHS 88.08, discharge occurs only for non-payment, care needs exceeding capacity, resident danger to self/others, or facility closure. Thirty-day written notice is provided except in emergencies. Residents may voluntarily terminate within 30-day notice.

Example 1 - Resident 4:

RECORD REVIEW:

On 08/18/2026 at 9:00 a.m., Surveyor reviewed Resident 4's record. Resident 4 admitted to the provider's home on 03/26/2026. Resident 4's record included a behavioral support plan (BSP), dated 04/28/2026, that documented behaviors of physical aggression, verbal escalation, non-compliance with care, communication related

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frustration and agitation. The record included a behavior tracker from 04/01/2026 to 05/31/2026 but did not document behaviors from 06/01/2026 to 08/18/2026. A Managed Care Organization (MCO) progress note, obtained by Surveyor and dated 07/29/2026, stated that Licensee A issued a 30-day termination of placement notice due to Resident 4 being too difficult to care for with increased intoxication.

INTERVIEW:

On 08/18/2026 at approximately 11:00 a.m., Surveyor interviewed Licensee A. Licensee A confirmed s/he issued Resident 4 a 30-day notice and stated the notice was given because Resident 4's behaviors got worse mid-July and Resident 4's family member requested Licensee A issue the notice to assist with mental health treatment. Surveyor shared concern that documentation did not identify a change in behaviors. Licensee A stated the provider had room to improve [with documentation].

Example 2 - Resident 2:

RECORD REVIEW:

On 08/18/2026 at 9:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 admitted to the provider's home on 03/05/2026 and discharged on 06/03/2026. Resident 2's MCO Member Centered Plan, dated 02/01/2026, indicated s/he required assistance with bathing, grooming, dressing, toileting, transferring, meal preparations and laundry/chores. A MCO note, obtained by Surveyor and dated 04/30/2026, stated Licensee A called and informed the MCO that Resident 2 was given a 30-day notice and Licensee A didn't want Resident 2 to stay past 05/21/2026. The

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note stated Licensee A said Resident 2 required 1:1 staffing, Licensee A should get paid for [that staffing] and that Resident 2 required cares not in the care plan and Licensee A wasn't going to provide those cares. Resident 2's individual service plan (ISP), dated 04/28/2026, indicated Resident 2 required assistance with bathing, dressing, toileting, transfers, meal preparations and laundry and had behaviors including verbal aggression, repeated requests, nighttime disruption and food-related behaviors. Resident 2's provider record did not include documentation of behaviors or documentation of additional care needs that were not addressed in the ISP.

INTERVIEW:

On 08/18/2026 at approximately 11:00 a.m., Surveyor interviewed Licensee A and Caregiver B. Surveyor asked why Resident 2 was issued a 30-day notice. Licensee A stated Resident 2's MCO kept filing complaints, s/he was in a disagreement with the MCO regarding Resident 2's reimbursement rate and Resident 2 had a change in need. Surveyor reviewed documentation and noted the only difference between Resident 2's MCO Member Centered Plan, completed prior to admission, and the provider's ISP, completed after the 30-day notice was issued, was behaviors; however, Resident 2's record did not include any additional documentation of behaviors. Licensee A acknowledged Surveyor's concern and stated the provider had room to improve [on documentation].

Example 4 - Resident 3:

RECORD REVIEW:

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M 480	Continued From page 26 On 08/18/2026 at 9:00 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's home on 04/01/2026 and did not return to the home after a 07/28/2026 hospitalization. Resident 3's ISP, dated 04/23/2026, documented that s/he required assistance with bathing, dressing, toileting, eating, transfers and mobility. Resident 3's MCO notes, obtained by Surveyor, documented the following: - 06/22/2026: Provider request for 1:1 dedicated staffing requested. Discussed with Power of Attorney for Health Care (POAHC), who does not think dedicated staffing would be appropriate. Request for dedicated staffing denied. - 06/23/2026: POAHC called and stated Licensee A asked him/her to support the increase in provider reimbursement. - 06/24/2026: Licensee A called and stated POAHC wanted to talk with MCO Case Manager. Case Manger had no missed calls but called POAHC. POAHC stated Licensee A had called him/her and stated s/he cannot afford to pay staff because Resident 3's rate was too low and Licensee A was having to pay $15/hour out of pocket. Licensee A stated Resident 3 needed 1:1 staffing. POAHC stated Licensee A had called multiple times on 06/22/2026 and 06/23/2026 regarding the reimbursement rate and POAHC was becoming anxious that Resident 3 would be kicked out of the home if s/he didn't agree with Licensee A. POAHC reported 1:1 dedicated staffing was not appropriate, and s/he did not agree with Licensee A. - 07/29/2026: POAHC called crying because the provider's RN called and informed Resident 3 was medically too much for the provider's staff and a 30-day notice would be issued. Licensee A called MCO Case Manager and stated Resident 3	M 480		

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M 480	Continued From page 27 was too medically complex and couldn't do anything independently. Licensee A stated Resident 3 needed assistance with everything and they need more staff for 'one to one' support. Resident 3 currently hospitalized for hyponatremia, altered mental status and pulmonary embolism. - 08/06/2026: Hospitalized and on hospice. The provider is refusing to accept resident back to the home. INTERVIEW: On 08/18/2026 at approximately 11:00 a.m., Surveyor interviewed Licensee A and Caregiver B. Surveyor discussed concern that Resident 3 was issued a 30-day notice due to being too medically complex and change in needs; however, his/her record did not include documentation supporting the reported change in needs. Licensee A stated the provider had room to improve [on documentation].	M 480		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses	M 550		

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	0021309	A. BUILDING: _____ B. WING _____	C 08/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WISCONSIN CARE SOLUTIONS CORPORATION	804 JANA LN MADISON, WI 53704

(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 550	Continued From page 28	M 550		

contraband. The resident shall be present for the search.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure residents had the right to privacy.

From 03/05/2026 to 04/19/2026, the provider had cameras in the home.

Findings include:

OBSERVATION:

On 08/18/2026 at approximately 9:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 admitted to the provider's home on 03/05/2026 and discharged on 06/03/2026. Resident 3's record included a "Video and Audio Monitoring Consent, Notice, and Acknowledgement" form. The document stated areas monitored included exterior entrances, driveways, parking areas, front door, mudroom, entryway, hallways, common stairwells, kitchen, dining room, living room and shared common rooms.

INTERVIEW:

On 08/18/2026 at 9:12 a.m., Surveyor interviewed Licensee A regarding the consent form. Licensee A confirmed the provider had cameras posted in the kitchen from 03/05/2026 to 04/19/2026. Licensee A stated, "In March, there were so many false allegations concerning food. Member had thrown food. The case manager filed so many complaints. I had to put a camera in [kitchen]." Licensee A stated after sending recordings to the managed care organization, the cameras were removed.

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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 observation, interview and record review, the provider did not ensure 2 of 3 residents reviewed received all medication as prescribed. Resident 1 did not receive his/her Lorazepam, Hydroxyzine, Acetaminophen, Symbicort inhaler or Klayesta powder as prescribed. Resident 4 did not receive his/her Folic Acid or Hydroxyzine as prescribed. Findings include: Example 1 - Resident 1: RECORD REVIEW: On 08/18/2026 at 9:00 a.m., Surveyors reviewed Resident 1's record. Resident 1 admitted to the provider's home on 07/27/2026. Resident 1's record did not include physician orders. Resident 1's record included a medication administration record (MAR), completed 08/01/2026 through	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 582	Continued From page 30	M 582		

08/12/2026, that documented the following:

- Lorazepam .5 mg ½ tablet every 12 hours PRN for anxiety: Administered 1 time daily (No time specified).
- Hydroxyzine Hcl 10 mg 1 tablet 2 times daily PRN for anxiety: Administered daily at 4:00 p.m.
- Acetaminophen 500 mg 1 tablet 4 times daily PRN for pain: Administered daily at 4:00 p.m.

INTERVIEW:

On 08/18/2026 at 10:45 a.m., Surveyor interviewed Caregiver C. Surveyor discussed concern that the MAR and medication labels indicated Lorazepam, Hydroxyzine and Acetaminophen were PRN medications, yet the MAR indicated staff were administering the medications as scheduled. Caregiver C confirmed the provider was administering the medications at a set time each day. Caregiver C stated Resident 1 needed medication for anxiety 24/7 because s/he had memory loss. Caregiver C stated Resident 1 received Lorazepam every 12 hours and Hydroxyzine and Acetaminophen at 4:00 p.m. daily.

OBSERVATION:

On 08/18/2026 at approximately 10:30 a.m., Surveyor reviewed Resident 1's medication supply and noted the following concerns:

- Resident 1's medication supply included Lamotrigine 25 mg 2 tablets at 8:00 a.m., Losartan Potassium 25 mg 1 tablet at 8:00 a.m., Multivitamin 1 tablet at 8:00 a.m., and Omeprazole 20 mg 1 tablet at 8:00 a.m., yet the medication administrations were not documented on the record. Resident 1's medication supply

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included Gabapentin 300 mg at 8:00 a.m. and 12:00 p.m. (in addition to the documented 8:00 p.m. administration), yet the medication administrations were not documented.
- Resident 1 did not have a Symbicort inhaler or Klayesta powder available for administration; however, the provider's staff documented twice daily administration of the inhaler and 3 times daily administration of the powder from 08/01/2026 through 08/12/2026.

INTERVIEW:

On 08/18/2026 at approximately 10:00 a.m., Surveyor interviewed Licensee A and requested Resident 1's physician orders. Licensee A stated s/he did not have physician orders. Licensee A stated the provider's staff was administering the medications provided from Resident 1's previous facility and from the pharmacy. Licensee A acknowledged the provider did not have a Symbicort inhaler or Klayesta powder available for administration.

Example 2 - Resident 4:

RECORD REVIEW:

On 08/18/2026 at 9:00 a.m., Surveyors reviewed Resident 4's record, which identified the following concerns:

- Resident 4's managed care organization (MCO) documentation, obtained by Surveyor, included a note dated 06/05/2026, that stated Resident 4 had not received Folic Acid in weeks and a note, dated 06/10/2026, that stated Licensee A reached out to the MCO inquiring about how to refill the Folic Acid prescription because Resident 4's physician was unable to renew the prescription

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M 582	Continued From page 32 without a follow up visit. - Resident 4's record included an After Visit Summary, dated 04/28/2026, with an order to discontinue scheduled Hydroxyzine and add Hydroxyzine 25 mg 2 times daily as needed. Resident 4's MAR, date 08/01/2026 to 08/18/2026, documented administration daily at 8:00 a.m. and 4:00 p.m. from 08/01/2026 to 08/10/2026, as well as a PRN administration on 08/02/2026 (time not documented). The MAR did not have any entries from 08/11/2026 through 08/18/2026. INTERVIEW: On 08/18/2026 at 11:11 a.m., Surveyor interviewed Licensee A and discussed medication administration concerns. Licensee A stated the provider had room for improvement.	M 582		