STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 000	INITIAL COMMENTS From 09/17/2025 to 09/19/2025, Surveyor conducted a complaint investigation and standard survey at REM Millstone, an AFH in Madison. Thirteen deficiencies were identified. Four deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) HZSW12, dated 11/24/2021, SOD WW9V11, dated 02/02/2022, SOD HZSW13, dated 03/17/2022, SOD WW9V12, dated 07/18/2022 and SOD WV9V13, dated 01/16/2023 and WW9V14, dated 06/20/2023. The complaint was substantiated. Census: 4	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, the provider did not ensure the home and its operations complied with Chapter DHS 88 and all other laws governing the home. This is a repeat deficiency. See Statement of Deficiency (SOD) HZSW13, dated 03/17/2022. Findings include: From 09/17/2025 to 09/19/2025, Surveyor conducted a complaint investigation and standard survey. As a result of the survey, 13 deficiencies	M 216		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 216	Continued From page 1 were identified, 4 which were repeat deficiencies. The following concerns were identified: Environment: - One of 2 ramped exits was obstructed by furniture that needed to be disposed of. - One of 1 residents that had recently admitted to the facility had not been assessed for his/her ability to evacuate the home, using the department's form. - One of 1 residents reviewed that had resided in the home for greater than 1 year had not had his/her ability to evacuate the home, using the department's form, assessed in the past year. - Food was not stored in a safe manner. *Repeat concern. - Water temperatures exceeded 120 degrees F, creating an unsafe environment. Employee: - The provider did not request the criminal complaint when a background check identified that a caregiver had been charged with 947.01(1) (Disorderly Conduct in the past 5 years. Residents: - The provider managed a resident's funds without written authorization. - Two of 2 residents reviewed did not have changes in their health monitored and documented. *Repeat concern. - The provider administered medications to 1 of 2 residents reviewed without a physician order to do so. - Two of 2 residents reviewed did not receive medications as prescribed. - Two of 2 residents reviewed did not have the	M 216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 216	Continued From page 2 administration of medications accurately documented in their record. *Repeat concern. - One resident was restricted access to his/her room. On 09/17/2025 at approximately 10:30 a.m., Surveyor interviewed Program Director A and House Manager D. Surveyor reviewed concerns identified throughout the survey. Program Director A stated the program manager should have caught some of the concerns and that background checks were the responsibility of the hiring legal team. As Surveyor concluded his/her summary of concerns, Program Director A replied, "We bombed this." Cross Reference: M0338 DHS 88.05(4)(c)1. Exiting From The First Floor M0344 DHS 88.05(4)(d)2.a. Fire Safety Evacuation Plan Review M0346 DHS 88.05(4)(D)2.b Fire Evacuation Annual Evaluation M0398 DHS 88.06(2)(c)6. Personal Funds M0448 DHS 88.07(2)(b)5. Monitoring Health M0464 DHS 88.07(3)(d) Medication - Written Order M0466 DHS88.07(3)(e)1. Medication - Record Keeping M0474 DHS 88.07(4)(c) Food Prepared And Stored Sanitary Way M0556 DHS 88.10(3)(e) Self-Direction M0570 DHS 88.10(3)(l) Safe Physical Environment M0582 DHS 88.10(3)(q) Medications Z0010 DHS 50.065(2)(bb) Determine Final Disposition of Charge	M 216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

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M 338	Continued From page 3	M 338		
M 338	88.05(4)(c)1 EXITING FROM THE FIRST FLOOR Exiting from the first floor. The first floor of the home shall have at least 2 means of exiting which provides unobstructed access to the outside. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home had at least 2 means of exiting which provided unobstructed access to the outside. One of 2 exits was obstructed by furniture. Findings include: The provider's home is licensed to serve up to 4 residents with diagnoses including irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, advanced age, developmentally disabled, physically disabled and traumatic brain injury. On 09/17/2025 at approximately 10:30 a.m., Surveyor toured the provider's home. The provider's home has a wheelchair accessible exit out the front door and out the patio door. Surveyor observed the patio door had a large couch laying upside down just outside the patio door, blocking access to the exterior ramp. On 09/17/2025 at approximately 10:35 a.m., Surveyor shared concern with Program Director A that 1 of 2 exits was obstructed. Program Director A acknowledged Surveyor's observation and stated they had been waiting a few months for maintenance to remove the couch.	M 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

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REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed that had admitted to the provider's home in the past 2 years was evaluated, using the department's form, immediately following placement to determine whether the resident was able to evacuate the home without any help within 2 minutes. Resident 1 had not been evaluated for his/her ability to evacuate the home, using the department's form. Findings include: On 09/17/2025 at approximately 9:00 a.m., Surveyor reviewed resident records. Resident 1 was admitted to the provider's home on 05/07/2024. Resident 1's record did not include an evacuation assessment. On 09/17/2025 at approximately 9:30 a.m., Surveyor shared concern with Program Director A that Resident 1's record did not include an evacuation assessment. Program Director A and House Manager D checked Resident 1's record and confirmed they were unable to locate an	M 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 344	Continued From page 5 evacuation assessment.	M 344		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated 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 1 of 1 residents reviewed that had resided at the provider greater than 1 year was evaluated, using the department's form, annually to determine whether the resident was able to evacuate the home without any help within 2 minutes. Resident 2 had not had an evacuation assessment completed, using the department's form, in greater than 2 years. Findings include: On 09/17/2025 at approximately 9:00 a.m., Surveyor reviewed resident records. Resident 2 was admitted to the provider's home on 09/17/2021. Resident 2's record included an evacuation assessment, dated 06/12/2023. On 09/17/2025 at approximately 9:30 a.m., Surveyor shared concern with Program Director A that Resident 2's record did not include an evacuation assessment, using the department's form, that had been completed in the past year. Program Director A made note of Surveyor's	M 346		

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 346	Continued From page 6 concern and did not have additional documentation to provide.	M 346		
M 398	88.06(2)(c)6 PERSONAL FUNDS How personal funds will be handled. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 service agreements reviewed addressed how personal funds would be handled. The provider handled Resident 2's funds without authorization. Findings include: On 09/17/2025 at approximately 9:00 a.m., Surveyor reviewed resident records. Resident 2 admitted to the provider's home on 09/17/2021. Resident 2 had a legal guardian. Resident 2's individual service plan (ISP), dated 08/20/2025, indicated Resident 2 had a prepaid card, handled by staff. Surveyor requested Resident 2's authorization to manage funds from Program Director A. On 09/17/2025 at approximately 10:00 a.m., Program Director A showed Surveyor a form that was signed by Resident 2' s legal guardian, but did not document whether or not Resident 2's legal guardian gave the provider permission to manage Resident 2's funds. Surveyor shared concern with Program Director A that the form was incomplete. Program Director A replied, "That's what I got back via email. [S/he] knows we spend money on [Resident 2]'s card."	M 398		
M 448	88.07(2)(b)5 MONITORING HEALTH	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 448	Continued From page 7	M 448		

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 2 of 2 residents reviewed was monitored and changes documented in the provider's record.

Resident 1's record did not document changes in Resident 1's health resulting in the hospitalization.

Resident 2's record did not include any documentation to indicate s/he had recently exhibited behaviors, had access to his/her room prohibited because of behaviors and required additional staffing due to behaviors.

This is a repeat deficiency. See Statement of Deficiency (SOD) WW9V11, dated 02/02/2022, SOD WW9V12, dated 07/18/2022 and SOD WV9V13, dated 01/16/2023.

Findings include:

On 09/17/2025 at approximately 9:00 a.m., Surveyor reviewed resident records and identified the following concerns:

Example 1 - Resident 1:

Resident 1 was admitted to the provider's home on 05/07/2024. Resident 1's record documented that s/he was in the hospital on 09/02/2025. The record did not include documentation regarding why Resident 1 was admitted to the hospital or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 448	Continued From page 8	M 448		

when Resident 1 returned. The Medication Administration Record (MAR) indicated Resident 1 was out of the home 09/01/2025 through 09/08/2025.

On 09/17/2025 at approximately 9:30 a.m., Surveyor shared concern with Program Director A that Resident 1's record indicated s/he was hospitalized, but did not document any changes in health resulting in the hospitalization. Program Director A stated Resident 1 was admitted to the hospital because s/he was not eating or drinking as much as usual. Program Director A stated Resident 1 returned to the provider's home on 09/09/2025 with hospice services. Program Director A acknowledged Resident 1's record did not document changes in Resident 1's health resulting in the hospitalization.

Example 2 - Resident 2:

Resident 2 admitted to the provider's home on 09/17/2021. Resident 2's individual service plan (ISP), stated Resident 2 could be aggressive with staff and peers, attempt self-harm and was an elopement risk. The record did not document any recent occurrences of behaviors.

On 09/17/2025 at approximately 9:30 a.m., Surveyor interviewed Program Director A and House Manager D. Program Director A stated the provider was planning to increase staffing due to Resident 2's behaviors. House Manager D stated Resident 2 had a history of refusing cares, refusing medications and refusing to go to day program. House Manager D stated due to these behaviors, staff had "bungee-corded" Resident 2's room shut for periods of time to prevent Resident 2 from staying in his/her room and refusing to come out for cares. Surveyor shared

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 448	Continued From page 9 concern with Program Director A and House Manager D that Resident 2's record did not include any documentation to indicate s/he had recently exhibited behaviors, had access to his/her room prohibited and required additional staffing. House Manager D confirmed s/he did not have any documentation to provide Surveyor.	M 448		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written order from a physician to permit the provider's staff to administer medication was obtained prior to administering 1 of 2 residents' medication. The provider administered Resident 1's medications for greater than 2 months prior to receiving a physician order to administer medications. Findings include: On 09/17/2025 at approximately 9:00 a.m., Surveyor reviewed resident records. Resident 1	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 464	Continued From page 10 was admitted to the provider's home on 05/07/2024. Resident 1's record indicated the provider's staff administered his/her medications. Resident 1's record included a physician order to administer medications, dated 07/23/2024. On 09/17/2025 at approximately 9:30 a.m., Surveyor shared concern with Program Director A that Resident 1's physician order to administer medications was dated greater than 2 months after his/her admission to the facility Program Director A acknowledged Surveyor's concern and stated the order took a while to get back from Resident 1's physician.	M 464		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of 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 observation, record review and interview, the provider did not ensure an accurate record of medication administration was maintained for 2 of 2 residents reviewed. Resident 1's record did not document administration of all medications.	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 466	Continued From page 11	M 466		

Resident 2's record documented administration of medications that were unavailable.

This is a repeat deficiency. See Statement of Deficiency (SOD) HZSW12, dated 11/24/2021.

Findings include:

On 09/17/2025 at approximately 9:00 a.m., Surveyor reviewed resident records and identified the following concerns:

Example 1 - Resident 1:

Resident 1 was admitted to the provider's home on 05/07/2024. Resident 1's record included a hospital discharge summary, dated 09/09/2025, with the following physician orders:

- Discontinue Hydralazine Hcl 25 mg 2 times daily
- Change Metoprolol 25 mg 2 times daily to Metoprolol 50 mg 1 time daily.
- Discontinue Atorvastatin 80 mg daily

Resident 1's record also included an order for Polyethylene Glycol 3350 powder (Start Date: 03/07/2025) - Dissolve 17 grams in 8 ounces of liquid and drink daily.

On 09/17/2025 at 9:15 a.m., Surveyor reviewed Resident 1's medications with Program Director A and House Manager D. Resident medications were organized in a punch pack and House Manager D stated caregivers used the medication from the slot that corresponded with the date (Ex: Slot #9 would be punched out on the 9th day of the month). Surveyor observed the following:

- Hydralazine Hcl 25 mg remained available in Resident 1's medication storage and continued to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 466	Continued From page 12	M 466		

be administered in the evening from 09/09/2025 to 09/16/2025 and in the morning form 09/10/2025 to 09/17/2025.
- Metoprolol 25 mg remained available in Resident 1's medication storage and continued to be administered in the evening from 09/09/2025 to 09/16/2025 and in the morning 09/10/2025 to 09/17/2025 (in addition to Metoprolol 50 mg in the AM).
- Atorvastatin 80 mg remained available in Resident 1's medication storage and continued to be administered in the evening from 09/10/2025 to 09/16/20265.
- Polyethylene Glycol was not present in Resident 1's medication storage.

Resident 1's Medication Administration Record (MAR), dated 09/01/2025 to 09/17/2025, did not document the administration of Hydralazine Hcl 25 mg, Metoprolol 25 mg, Atorvastatin 80 mg and Polyethylene Glycol from 09/09/2025 to 09/17/2025.

On 09/17/2025 at approximately 10:30 a.m., Surveyor shared concern with Program Director A and House Manager D that Resident 1 continued to receive medications after they had been discontinued or unavailable, yet the administration or lack of was not documented in Resident 1's record. Program Director A acknowledged Surveyor's concern and stated his/her program manager should have caught the medication changes and removed discontinued medications from Resident 1's stock and that Polyethylene Glycol should have been reordered. House Manager D stated s/he didn't usually administer Resident 1's medications so s/he was unaware of the errors.

Example 2 - Resident 2:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 466	Continued From page 13 Resident 2 was admitted to the provider's home on 09/17/2021. Resident 2's physician orders included Polyethylene Glycol (Start Date: 06/21/2024) - Dissolve 17 grams in 8 ounces of water 3 times daily and Metronidazole .75% gel (Start Date: 03/01/2024) - Apply topically to affected area on face 2 times daily for acne rosacea. Resident 2's medication storage did not include Polyethylene Glycol and contained 1 empty bottle of Metronidazole drops, dated 11/05/2024. On 09/17/2025 at approximately 10:30 a.m., Surveyor shared concern with Program Director A and House Manager D that Resident 2 did not have 2 medications available to him/her for administration. Program Director A and House Manager D confirmed the medications were unavailable. House Manager D stated s/he was unsure the last time Resident 2 had all medications available for administration because s/he didn't typically administer Resident 2's medications. Review of Resident 2's MAR, indicated House Manager D had administered Resident 2's medications as recently as 09/15/2025, and s/he was unable to confirm s/he administered Polyethylene Glycol and Metronidazole gel.	M 466		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner.	M 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	190012	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM MILLSTONE	41 MILLSTONE RD MADISON, WI 53717

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M 474	Continued From page 14 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. This is a repeat deficiency. See Statement of Deficiency (SOD) WW9V14, dated 06/20/2023. Findings include: On 09/17/2025 at approximately 9:00 a.m., Surveyor toured the provider's kitchen. Surveyor observed the following concerns with food storage in the refrigerator: - A plastic container full of SpaghettiOs was not dated. - A plastic container of noodles was not dated. - The vegetable drawer contained remnants of vegetables and had hardened brown liquid on the interior of the drawer. - The vegetable drawer contained a grocery bag of a white solid substance that was not labeled or dated. - Smoked ham with a "Best Used By" date of 09/05/2025 and a handwritten date of 09/01/2025. - A package of smoked sausage that was left open to air and not dated. "Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) Sliced deli meet is good for 3 to 5 days after opening (Source: FoodSafety.gov, Cold Food	M 474		

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M 474	Continued From page 15 Storage Chart, September 19, 2023, https://www.foodsafety.gov/food-safety-charts/cold-food-storage-charts (retrieval date - September 17, 2025).) On 09/17/2025 at approximately 10:30 a.m., Surveyor interviewed Program Director A and House Manager D. Surveyor shared concerns with food storage and asked if House Manager D could identify the white solid substance. House Manager D stated s/he was unsure what was in the grocery bag, but that s/he had already thrown it out.	M 474		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 4 residents residing at the facility was provided the opportunity to make decisions related to his/her life in the adult family home. Resident 1 was restricted from his/her bedroom.	M 556		

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M 556	Continued From page 16 Findings include: On 09/17/2025, Surveyor conducted a complaint investigation alleging staff prevented resident access to a resident's room with use of a bungee cord. On 09/17/2025 at approximately 8:00 a.m., Surveyor reviewed documentation, obtained by Surveyor, from a managed care organization that stated on 08/22/2025, Guardian E visited Resident 2 and observed Resident 2's bedroom door kept shut with use of a bungee cord, so Resident 2 did not have access to his/her bedroom. The note documented that staff stated Resident 2 had been refusing medications, refusing to eat and refusing assistance with personal care and would just lie in his/her bed, refusing to get up. A follow up note, dated 08/26/2025, stated staff had expressed it was difficult to assist Resident 2 with cares once s/he went into his/her bedroom. On 09/17/2025 at approximately 9:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 admitted to the provider's home on 09/17/2021 with diagnoses including developmental disorder, atypical behavior and impulse disorder. Resident 2's individual service plan (ISP), dated 08/20/2025, documented that Resident 2 had a history of behaviors including aggressive to staff and peers, self-harm and an elopement risk. Resident 2's progress notes, dated 06/01/2025 to 09/17/2025, did not document behavioral concerns. On 09/17/2025 at approximately 10:30 a.m., Surveyor interviewed Program Director A and House Manager D. Program Director A confirmed staff had restricted Resident 2's access to his/her	M 556		

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M 556	Continued From page 17 room. House Manager D explained that once Resident 2 was in his/her room, it was difficult to get him/her to come out, particularly to attend day program in the morning or have cares completed in the evening. House Manager D stated staff had strung Resident 2's door knob to the hallway handrail to prevent access in the morning and in the afternoon for "not that long" periods of time for approximately 1 month. House Manager D and Program Director A acknowledged Resident 2 should have full access to his/her room and stated staff were no longer restricting access.	M 556		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents were safeguarded from environmental hazards. The home's water temperature exceeded 120 degrees F. Findings include: The provider's home is licensed to serve up to 4	M 570		

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M 570	Continued From page 18 individuals with diagnoses including irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, advanced age, developmentally disabled and traumatic brain injury. On 09/17/2025 at approximately 9:10 a.m., Surveyor tested the water temperature of the provider's bathroom, used by residents. Surveyor's thermometer read a temperature peaking at 125.6 degrees F. Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA publication P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017). On 09/17/2025 at approximately 9:30 a.m., Surveyor reviewed the provider's documentation of water temperatures, completed by House Manager D, which read bathroom temperatures of 100 degrees F and kitchen faucet temperatures of 105 degrees F for each month in 2025. Surveyor asked House Manager D to check water temperatures using the thermometer s/he used when completing monthly water checks. House Manager D checked the same faucet Surveyor checked and had a reading of 121 degrees F. House Manager D did not state the last time his/her thermometer had been	M 570		

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M 570	Continued From page 19 calibrated.	M 570		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure 2 of 2 residents reviewed received all prescribed medication. Resident 1 continued to receive medications after the medications were discontinued and was unable to receive a medication due to unavailability. Resident 2 did not receive 2 medications as prescribed due to the medications being unavailable for administration. Findings include: On 09/17/2025 at approximately 9:00 a.m., Surveyor reviewed resident records. Resident 1 was admitted to the provider's home on 05/07/2024. Resident 1's record included a hospital discharge summary, dated 09/09/2025,	M 582		

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M 582	Continued From page 20 with the following physician orders: - Discontinue Hydralazine Hcl 25 mg 2 times daily - Change Metoprolol 25 mg 2 times daily to Metoprolol 50 mg 1 time daily. - Discontinue Atorvastatin 80 mg daily Resident 1's record also included an order for Polyethylene Glycol 3350 powder (Start Date: 03/07/2025) - Dissolve 17 grams in 8 ounces of liquid and drink daily. On 09/17/2025 at 9:15 a.m., Surveyor reviewed Resident 1's medications with Program Director A and House Manager D. Resident medications were organized in a punch pack and House Manager D stated caregivers use the medication from the slot that corresponds with the date (Ex: Slot #9 would be punched out on the 9th day of the month). Surveyor observed the following: - Hydralazine Hcl 25 mg continued to be administered in the evening from 09/09/2025 to 09/16/2025 and in the morning form 09/10/2025 to 09/17/2025. - Metoprolol 25 mg continued to be administered in the evening from 09/09/2025 to 09/16/2025 and in the morning 09/10/2025 to 09/17/2025 (in addition to Metoprolol 50 mg in the AM). - Atorvastatin 90 mg continued to be administered in the evening from 09/10/2025 to 09/16/20265. - Polyethylene Glycol was not present in Resident 1's medication storage. On 09/17/2025 at approximately 9:30 a.m., Surveyor shared concern with Program Director A and House Manager D that Resident 1 continued to receive medications after they had been discontinued. Program Director A acknowledged Surveyor's concern and stated his/her program	M 582		

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M 582	Continued From page 21 manager should have caught the changes. Program Director A stated s/he would work with hospice to address the concerns. House Manager D stated s/he didn't usually administer Resident 1's medications so s/he was unaware of the errors or that Polyethylene Glycol was unavailable for administration. House Manager D stated s/he would reorder the Polyethylene Glycol. Example 2 - Resident 2: Resident 2 was admitted to the provider's home on 09/17/2021. Resident 2's physician orders included Polyethylene Glycol (Start Date: 06/21/2024) - Dissolve 17 grams in 8 ounces of water 3 times daily and Metronidazole .75% gel (Start Date: 03/01/2024) - Apply topically to affected area on face 2 times daily for acne rosacea. Resident 2's medication storage did not include Polyethylene Glycol and contained 1 empty bottle of Metronidazole drops, dated 11/05/2024. On 09/17/2025 at approximately 10:30 a.m., Surveyor shared concern with Program Director A and House Manager D that Resident 2 did not have 2 medications available to him/her for administration. Program Director A and House Manager D confirmed the medications were unavailable. House Manager D stated s/he was unsure the last time Resident 2 had all medications available for administration because s/he didn't typically administer Resident 2's medications. Review of Resident 2's MAR, indicated House Manager D had administered Resident 2's medications as recently as 09/15/2025.	M 582		

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Z 010	Continued From page 22	Z 010		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by:	Z 010		

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Z 010	Continued From page 23 Based on record review and interview, the provider did not make every reasonable effort to obtain a copy of the criminal complaint related to Caregiver B's conviction of 947.01(1) Disorderly Conduct, which occurred within 5 years of employment. Findings include: On 09/17/2025 at 9:20 a.m., Surveyor requested employee records from Program Director A as part of a standard survey. Program Director A stated employee records were maintained offsite and would need to be sent to Surveyor. On 09/18/2025 at 9:10 a.m., Surveyor received Caregiver B's record. The record indicated Caregiver B was hired on 01/08/2024. Caregiver B's record included a Department of Justice background check that listed a charge of 947.01(1) Disorderly Conduct on 11/08/2024. The report did not list the disposition of the charge. On 09/18/2025 at approximately 1:00 p.m., Surveyor asked Program Director A if the provider made efforts made to obtain the criminal complaint related to Caregiver B's charge of 947.01(1) Disorderly Conduct. On 09/19/2025 at 11:00 a.m., Area Director C sent Surveyor an email stating s/he inquired with Caregiver B about the disorderly conduct citation and was provided a receipt for the fine. Suryeyor requested clarification of when Area Director C inquired about the charge. Area Director C stated there was no follow up completed at the time the provider obtained the background check listing the charge. Area Director C did not have documentation indicating the criminal complaint had been requested.	Z 010		

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