STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020474	A. BUILDING: _____ B. WING _____	C 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAVA CARE OF HARTLAND	300 NORTH SHORE DRIVE CHENEQUA, WI 53029

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U 000	INITIAL COMMENTS On 09/25/2025, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation at Adava Care of Hartland located at 300 North Shore Drive in Hartland, WI. Two citations of noncompliance were issued. The complaint was substantiated. Census: 17	U 000		
U 129	89.23(4)(a)2. SERVICES PROVIDER QUALIFICATIONS. Service Providers. Nursing services and supervision of delegated nursing services shall be provided consistent with the standards contained in the Wisconsin nurse practice act. Medication administration and medication management shall be performed by or, as a delegated task, under the supervision of a nurse or pharmacist. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure supervision of delegated nursing services were provided consistent with standards, as required. The provider did not ensure medication administration and medication management were delegated under the supervision of a nurse or pharmacist, including Tenant 1's and Tenant 2's insulin injections performed by unlicensed caregivers.	U 129		

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

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U 129	Continued From page 1 A sample of 3 unlicensed caregivers, Caregiver I, Caregiver J, and Caregiver K, were not provided with delegation, as required. The findings include: On 09/25/2025 at approximately 10:30 A.M., Surveyor observed Caregiver H remove Tenant 1's Novolog and Basaglar insulin injection pens and Tenant 2's Lantus and Trulicity insulin injection pens from the facility's medication cart and medication room refrigerator. Caregiver H told Surveyor facility caregivers administer both Tenant 1's and Tenant 2's insulin on a daily basis, as prescribed. On 09/25/2025 at approximately 11:00 A.M., Surveyor received a copy of the facility's "Staff Roster Report" from Associate Administrator C. The documentation included, "[Current Facility Registered Nurse, RN G]. Date of hire: 07/01/2024. Took over the [medication] delegations [arrow to] 09/05/2025." On 09/25/2025 at 12:00 P.M., Licensee A provided Surveyor with a document titled "Delegation Overview" and signed by Licensee A. The documentation included, "Up to [08/05/2025] delegations were performed by our in-house RN [Previous Facility RN E] who managed this responsibility internally. [08/05/2025 - [through] 09/10/2025]: On [08/05/2025], delegation responsibilities were transitioned to [Previous RN Consulting F] an external RN consulting company. However, their services did not meet our operational needs. As a result, their contract and services ended on [09/10/2025]. [09/05/2025] - Present: On [09/05/2025], [Current Facility RN G] began performing delegations." The documentation included, "In July 2024,	U 129		

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U 129	Continued From page 2 [Current Facility RN G] rejoined [the facility] as a PRN RN consultant, primarily assisting with compliance issues. As of [09/05/2025], [s/he] has formally taken on delegation responsibilities across our facilities. In addition to delegating new staff, [Current Facility RN G] is actively re-delegating existing staff to ensure all records are current and in compliance with state requirements." On 09/25/2025, Associate Administrator C and Surveyor reviewed delegation documentation for Caregiver I, Caregiver J, and Caregiver K. Associate Administrator C told Surveyor all 3 caregivers were unlicensed caregivers and administer medications, including insulin injections, when they are on duty. Associate Administrator C told Surveyor all 3 caregivers have hire dates of 05/01/2024 when the facility's most recent change of ownership process began. However, all 3 caregivers were hired and worked at the facility prior to this date under the previous ownership. Caregiver I's most recent documentation of delegation was completed by Previous Facility RN D on 04/24/2024. Caregiver J's and Caregiver K's most recent documentation of delegation was completed by Previous Facility RN D on 01/30/2024. Associate Administrator C told Surveyor Previous Facility RN D left employment at the facility during the summer of 2024, prior to Previous Facility RN E starting employment. Associate Administrator C told Surveyor none of the 3 sample caregivers received delegation from Previous Facility RN E or Current Facility RN G. On 09/25/2025 at approximately 2:55 P.M., Surveyor conducted an exit interview with Administrator B and Associate Administrator C.	U 129		

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U 129	Continued From page 3 Administrator B told Surveyor Current Facility RN G recently took over responsibility for delegation and would be completing the process in the near future with each caregiver responsible for medication administration. Cross Reference: U0267 DHS 89.34(16) Tenant Rights	U 129		
U 267	89.34(16) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse medication unless there is a court order. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Tenant 1	U 267		

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received a prescribed medication, Basaglar [a long-acting insulin injection], in the dosage and at the intervals prescribed.

The findings include:

On 08/18/2025, the department received an allegation including tenant medications not being administered as prescribed.

On 09/25/2025 at approximately 10:30 A.M., Surveyor observed Caregiver H remove Tenant 1's Basaglar insulin injection pens from the facility's medication cart and medication room refrigerator. Caregiver H told Surveyor facility caregivers monitor Tenant 1's blood glucose levels and administer Tenant 1's insulin injections on a daily basis, as prescribed. Caregiver H told Surveyor the facility's caregivers order refills of Tenant 1's insulin electronically through the facility's electronic charting program and the pharmacy. Caregiver H told Surveyor the pharmacy delivered 2 Basaglar pens to the facility approximately once a month.

On 09/25/2025 at 12:24 P.M., Surveyor conducted an interview with Pharmacy Staff L regarding the facility's recent refills requests and pharmacy deliveries to the facility of Tenant 1's Basaglar insulin. Pharmacy Staff L said the pharmacy received a request for delivery of Tenant 1's Basaglar insulin on 07/10/2025, as a result 2 pens were delivered to the facility. Pharmacy Staff L said Tenant 1's 2 pens should have lasted approximately 23 days, if administered as prescribed. Pharmacy Staff L said the pharmacy received an early request for refill of Tenant 1's Basaglar insulin on 07/29/2025, in which 2 more pens were delivered to the facility on 07/29/2025.

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U 267	Continued From page 5 On 09/25/2025 at 12:37 P.M. Surveyor conducted an interview with Tenant 1's funding agency Case Manager M. Case Manager M told Surveyor s/he received a phone call from Tenant 1 on Tuesday, 07/29/2025 alleging s/he had not received his/her Basaglar insulin since the evening of Sunday, 07/27/2025, and had missed 3 scheduled doses during that time frame and his/her blood glucose level was 438 when s/he called Case Manager M. Case Manager M said s/he reached out to the facility on 07/29/2025 and the facility staff reported they had run out of Tenant 1's Basaglar insulin too soon and his/her last dose was administered on the morning of Sunday, 07/27/2025. Case Manager M said the facility had not "looped [him/her] in" to the situation of Tenant 1's Basaglar insulin running low. Case Manager M stated Tenant 1's missed doses of Basaglar insulin could have been prevented if the facility had contacted him/her earlier. Case Manager M said Tenant 1's funding agency pharmacy department reached out to the pharmacy and was able to request an early refill of Tenant 1's Basaglar insulin to be delivered on 07/29/2025. On 09/25/2025, Associate Administrator C provided Surveyor with Tenant 1's record. Tenant 1 was admitted to the facility on 11/30/2023 with diagnoses including diabetes, hypertension, peripheral vascular disease, diabetic nephropathy (kidney disease), and diabetic neuropathy (nerve damage). Tenant 1 was legally blind in both eyes. Tenant 1's prescribed medications included a prescription dated 07/10/2025 for Basaglar Kwikpen insulin to be administered twice daily, an injection of 12 units every morning and an injection of 10 units every evening. Tenant 1's July 2025 medication administration	U 267		

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record [MAR] included the following documentation of missed doses: On 07/28/2025 at 7:42 A.M., Caregiver I documented "medication not available." On 07/28/2025 at 8:12 P.M., a caregiver documented, "medication not available." On 07/29/2025 at 7:19 A.M., Caregiver J documented "medication not available."
Tenant 1's blood glucose level was documented as "438" on 07/29/2025 at 7:49 A.M., a significantly high reading and the highest reading documented for Tenant 1 during the month of July 2025.
Associate Administrator C provided Surveyor with the following email documentation. An email on 07/29/2025 at 8:28 A.M. from Case Manager M to Associate Administrator C included, "[Tenant 1] called to report [s/he] has not had [his/her] long acting [Basaglar] insulin since Sunday [07/27/2028] and [his/her] blood sugar [glucose] is 438." An email on 07/29/2025 at 11:04 A.M. from Associate Administrator C to Case Manager M included, "When I [Associate Administrator C] tried to refill the medication [Basaglar] through our new pharmacy, they said it is too soon to fill the medication and that insurance won't [sic] pay for it until 08/01/2025. They dispensed the pens on 07/10/2025 and only sent us 2 pens but the 2 pens should have lasted until the 1st of August, but for some reason, it did not last that long. I spoke with the RN from [Tenant 1's] endocrinologist's [practitioner's] office just a little bit ago to try and brainstorm how they can help get [him/her] [his/her] long acting insulin by they wanted me [Associate Administrator C] to try talking to the pharmacy again and when I spoke with [the pharmacy] about 30 minutes ago, they said the only way they can send us [the facility] [his/her] long acting insulin is if [Tenant 1] pays for it and for 1 pen it is $80.40. They [pharmacy]

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sent me the authorization form, that way if [s/he] is willing to pay for it then I just fill out the form and send it back to them [pharmacy] and [Tenant 1] will be billed with the next billing cycle." An email on 07/29/2025 at 11:11 A.M. from Case Manager M to Associate Administrator C included, "We [Tenant 1's funding agency] hope to avoid [him/her] paying out of pocket. I [Case Manager M] have forwarded this to our pharmacy department to see if they can do an override." An email on 07/29/2025 at 12:42 P.M. from Case Manager M to Associate Administrator C included, "I [Case Manager M] believe the issue is resolved and the insulin is ready for pick up."

On 09/25/2025 at approximately 2:21 P.M., Associate Administrator C told Surveyor Tenant 1's service notes did not include documentation regarding Tenant 1's missed doses of Basaglar insulin on 07/28/2025 and 07/29/2025. Associate Administrator C said s/he did not document a medication omission/error report or investigation for Tenant 1's missed Basaglar insulin doses because s/he did not think of the situation as an "incident report" at that time. Associate Administrator C said s/he and the facility management were not sure why Tenant 1's Basaglar insulin delivered to the facility on 07/10/2025 ran out early. Associate Administrator C said s/he thought it ran out early possibly due to caregiver's dialing up the Basaglar insulin pen more than 2 units to prime the pen, but s/he could not confirm that was the issue. Associate Administrator C said s/he thought perhaps only 1 pen of Tenant 1's Basaglar insulin was delivered to the facility on 07/10/2025 but the pharmacy invoice for 07/10/2025 included 2 pens of Tenant 1's Basaglar insulin were delivered to the facility. Associate Administrator C said s/he did not

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U 267	Continued From page 8 consider one of Tenant 1's Basaglar pens could have been stolen because it was not a narcotic medication. Associate Administrator C did verbally acknowledge 1 pen of Basaglar was relatively expensive. On 09/25/2025 at approximately 2:55 P.M., Surveyor conducted an exit interview with Administrator B and Associate Administrator C. Associate Administrator C told Surveyor following the incident of Tenant 1's missing doses of Basaglar doses, s/he held team meetings including additional medication administrator training with caregivers and had started to check the MARs daily for any documentation of exceptions or missed doses of Tenant medications. Cross Reference: U0129 DHS 89.23(4)(a)2 Services	U 267		