STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018379	A. BUILDING: _____ B. WING _____	R-C 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEES DIRECT CARE	**6755 NORTH 55TH STREET MILWAUKEE, WI 53223**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	INITIAL COMMENTS On 08/19/2025, with information gathered through 08/26/2025, Surveyors conducted a standard licensure survey and a verification visit for Statement of Deficiency (SOD) 29PB12 and SOD BSPH11, at Tees Direct Care. 8 deficiencies were identified. One of 8 deficiencies was a repeat deficiency identified in the following SODs: SOD 29PB12, dated 10/08/2024, M412 - Description of Services was a repeat deficiency. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. 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, record review, and interview, the provider did not ensure the home, and its operation complied with this chapter and all other laws governing the home and its operations potentially affecting 4 of 4 residents. The provider has been unable to maintain compliance with Chapter 88 of the Department of Health Services (DHS) -Licensed Adult Family Home (AFH) regulations. The provider did not follow Special Orders which resulted from previous Statement of Deficiency (SOD) 29PB12, dated 10/08/2024, and SOD BSPH11, dated 03/03/2025.	M 216		

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

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M 216	Continued From page 1 Findings include: On 08/19/2025, with information gathered through 08/26/2025, Surveyors conducted a standard survey and 2 verification visits at Tee's Direct Care. As a result of the survey, the provider was issued 8 deficiencies. One of the 8 was a repeat deficiency. The following 8 deficiencies, which includes this violation, were identified: 88.04(2)(a) - Responsibilities 88.05(4)(b)1 - Fire Safety - Smoke Detectors 88.06(3)(d)1 - Description Of Services - This is a repeat deficiency. 88.06(3)(d)5 - Signed Statement Of Agreement 88.07(3)(a) - Prescription Medications 88.07(3)(e)1 - Medication - Record Keeping 88.10(3)(a) - Fair Treatment 88.10(3)(q) - Medications Statement of Deficiency 29PB12 - On 01/07/2025, the Department issued SOD 29PB12, which included the following Special Orders from Notice and Order Letter: "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Tees Direct Care: 1.Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., WITHIN 5 days of receipt of this notice, the licensee shall provide the legal representative and case manager of [Resident 1] with a copy of Statement of Deficiency (SOD) 29BP12 and a copy of this Notice and Order letter. The licensee shall retain evidence to verify compliance with	M 216		

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M 216	Continued From page 2 Order #1. Acceptable documentation will include signed and dated verification letter or email, or certified mail receipt. Documentation will be made available to department representatives upon request. Additionally, WITHIN 14 DAYS of receipt of this notice, the licensee shall hold care conferences for [Resident 1] with their respective legal representatives and case managers (if any), for the purpose of developing (or revising) and discussing the residents' individual service plans. The ISPs will include individualized services, approaches, and interventions to address resident mobility (i.e., type of transfer assistance needed) and potentially harmful behavior (i.e. aggression, suicidal ideation, substance use, and managing symptoms of mental illness). The licensee will obtain a statement of agreement with the plan, dated and signed by all persons involved in developing the plan. All staff responsible for providing services will review the updated ISPs and will provide services in accordance with the plan." On 08/19/2025, Surveyor reviewed Resident 1's ISP dated 01/31/2025. Licensee A did not obtain a statement of agreement with the plan, dated and signed by all persons involved in developing the plan. Licensee A and Resident 1's legal guardian did not sign the statement of agreement. Statement of Deficiency BSPH11 - On 06/03/2025, the Department issued SOD BSPH11, which included a Notice and Order Letter with the following Special Orders: SPECIAL ORDERS	M 216		

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"Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Tees Direct Care:

1. Pursuant to Wis. Admin. Code §§ DHS 88.03(6)(g)2.b., and 2.e., the licensee will protect and promote each resident's right to self-direction and treatment choice as prescribed in accordance with Wis. Admin. Code § DHS 88.10(3)(a) and Wis. Admin. Code § DHS 88.10(3)(g). The licensee will ensure each resident's right to be treated as an adult with dignity, respect, and individuality in a homelike environment. In the absence of a documented treatment plan, based on clinical or therapeutic indications, no restriction on a resident's freedom of choice (e.g., restricted access to areas of the home or food or beverages) will be arbitrarily imposed. The licensee will develop (or review/revise) written procedures to include:

Fair Treatment

- Measures the licensee will take to ensure all caregivers protect and promote each resident's right to make decisions related to care, activities, daily routines and other aspects of life which enhance the resident's self-reliance and support the resident's autonomy and decision-making.

- Resident rights training for all employees. Training will be provided by a qualified professional (e.g., certified social worker, ombudsman, resident rights specialist). Before providing the training, the instructor will be provided with copies of Statement of Deficiency

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BSPH11, and this notice and order letter. Documentation of training will be maintained in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content.

2. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for each resident with a copy of Statement of Deficiency BSPH11 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request."

On 08/19/2025 through 08/26/2025, Surveyors reviewed facility documents and identified the following:

On 07/14/2025, 41 days after receipt of SOD BSPH11 and the Notice and Order Letter, Licensee A sent a copy to Resident 1's case manager and guardian. Evidence was not provided copies were sent to Resident 2, Resident 3, and Resident 4's legal representatives/case managers. Per Department Special Orders, Licensee A was ordered to send these documents to all residents' legal representatives and case managers within 7 days of receipt of the notice.

On 08/08/2025, 66 days after receipt of SOD BSPH11 and the Notice and Order Letter, Licensee A sent a copy to Instructor N. The

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M 216	Continued From page 5 resident rights training certificates and materials provided by Licensee A did not include a signature from Trainer N, or her/his qualifications. Resident rights training for employees was held on 08/09/2025, 67 days after receipt of the Notice and Order Letter. Licensee A did not provide training certificates for her/himself or Caregiver O. On 08/26/2025, at approximately 10:12 AM, Surveyor interviewed Licensee A and confirmed receipt of SOD 29PB12, SOD BSPH11 and the accompanying Notice and Order Letters. Licensee A confirmed s/he did not obtain a statement of agreement, dated and signed by all persons involved in developing the plan for Resident 4. Licensee A confirmed the statement of agreement was not signed by him/her or Resident 4's legal guardian. Licensee A confirmed s/he had provided all documentation requested by Surveyors. Licensee A did not offer further information as to her/his non-compliance with the timeframes listed in the special orders.	M 216		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of	M 334		

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M 334	Continued From page 6 the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there was a smoke detector in 3 of 11 required locations. There was no smoke detector in the laundry room. There was no smoke detector in the office area. There was no smoke detector at the head of basement stairwell. Findings include: On 08/19/2025, at approximately 11:48 AM, Surveyor conducted a tour of the facility with Caregiver L and observed the following: -There was no smoke detector in the laundry room. -There was no smoke detector in the office area. -The head of basement stairwell did not contain a smoke detector. On 08/19/2025, at approximately 12:00 PM, Surveyor interviewed Caregiver L. Caregiver L confirmed that there were no smoke detectors in the above mentioned locations. On 08/26/2025, at approximately 11:00 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was not aware of this requirement.	M 334		

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M 412	Continued From page 7	M 412		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a description of services the licensee would provide to meet the assessed need for 1 of 2 residents (Resident 4) reviewed. Resident 4's Individual Service Plan (ISP) did not include his/her need for activities of daily living and the level of supervision required in the home and community. This is a repeat deficiency from Statement of Deficiency (SOD) 29PB11, dated 03/23/2023 and SOD 29PB12, dated 10/08/2024. Findings include: On 08/21/2025, Surveyor reviewed Resident 4's record and identified the following: -Resident 4 was admitted to the provider's home on 07/05/2022. -Resident 4's member centered plan (from the Managed Care Organization), dated 02/01/2025, stated the following: "[Resident 4] attends adult day care center program 5 days per week." -Resident 4's ISP was dated 08/05/2025.	M 412		

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M 412	Continued From page 8 Resident 4's ISP did not describe his/her vocational needs, and the level of supervision required in the home and community. On 08/26/2025, at approximately 10:11 AM, Surveyor interviewed Licensee A. Licensee A reported Resident 4 attends adult day care center program Monday-Friday. Licensee A confirmed Resident 4's ISP did not describe his/her vocational needs. Licensee A reported Resident 4 required 24-hour supervision. Licensee A confirmed Resident 4's ISP did not include Resident 4 required 24-hour supervision.	M 412		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents' (Resident 4) individual service plan (ISP) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 4's ISP did not include a signed statement of agreement with all parties involved. Findings include: On 08/21/2025, Surveyor reviewed Resident 4's record and identified the following: -Resident 4 was admitted to the provider's home	M 420		

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M 420	Continued From page 9 on 07/05/2022. -Resident 4 was his/her own person. -Resident 4's ISP, dated 08/05/2025, was not signed by him/her. On 08/26/2025, at approximately 10:12 AM, Surveyor interviewed Licensee A. Licensee A stated s/he would email Resident 4's most recent signed ISP to Surveyor by 5:00 PM. As of 08/26/2025 at 5:00 PM, Surveyor did not receive evidence of Resident 4's most recent signed ISP.	M 420		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 medications that required refrigeration were securely stored. Resident 1's insulin pens were stored in the common refrigerator, inside an unsecured lock box, which was accessible to the residents in the home.	M 458		

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M 458	Continued From page 10 Findings include: The home was licensed as a non-ambulatory adult family home caring for up to 4 residents in the client groups of advanced age, traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, physically disabled, irreversible dementia/Alzheimer's, and terminally ill. On 08/19/2025, at 9:05 AM, Surveyors conducted a tour of the kitchen and observed the following: Inside of the refrigerator was a lock box which was unsecured. The lock box contained a lock which could be opened with a 3-digit code. The box contained 3 insulin lispro kwik pens 100 units (U) per milliliter (mL) and 7 insulin glargine - interchangeable biosimilar (yfgn) 100 U/mL pens, which were labeled with Resident 1's name. Two of 4 residents were observed moving freely within the home throughout the survey. On 08/19/2025, at approximately 9:10 AM, Surveyor interviewed Caregiver M, and s/he confirmed medications were required to be secured. S/He reported the previous shift administered Resident 1's morning insulin and left the lock box unsecured. Caregiver M was unaware Resident 1's refrigerated medications were left unsecured and secured them when Surveyor informed her/him of it. Cross Reference: M0466 88.07(3)(e)1 - Medication Record Keeping	M 458		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of	M 466		

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M 466	Continued From page 11	M 466		

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 accurate records were kept of all prescription medications controlled, dispensed or administered for 1 of 2 resident records (Resident 1) reviewed.

The administration of a medication not listed on the medication administration record (MAR) was being documented under a different medication or not documented at all. Resident 1's blood sugar readings, units of insulin administered, and the number of carbohydrates in a meal were not recorded on multiple occasions. Staff were initialing the administration of medications, when the medications were not given. There were several occasions where the MAR was left blank, providing no record of the medication administrations.

Findings include:

On 08/19/2025, at approximately 11:30 AM, Surveyor reviewed Resident 1's record and identified the following:

- Resident 1 was admitted to the provider's home on 09/14/2023, with diagnoses including diabetes

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mellitus type 2 - insulin dependent diabetes mellitus (IDDM).
- Resident 1 had a case manager (CM) from a managed care organization (MCO) and a corporate guardian.
- Resident 1 required medication administration from staff at the adult family home (AFH).

Surveyor observed, hung on the wall of the office, 2 different sliding scales for Resident 1. One of the sliding scales was on an after-visit summary (AVS), dated 07/23/2025, and the other was on an AVS, dated 08/14/2025. The following includes the information listed for each of the sliding scales:

Sliding scale dated 07/23/2025 -

Try to aim for 30 grams (g) of carbohydrates (carbs) at meals.

Humalog before meals.

- Glucose 71-90: 0 U for small meals <30 g of carbs; 0 U for regular meals >30 g of carbs; bedtime 0 U
- Glucose 91-150: 4 U for small meals <30 g of carbs; 8 U for regular meals >30 g of carbs; bedtime 0 U
- Glucose above 150: 4 U for small meals <30 g of carbs; 9 U for regular meals >30 g of carbs; bedtime 0 U
- Glucose above 200: 5 U for small meals <30 g of carbs; 10 U for regular meals >30 g of carbs; bedtime 2 U
- Glucose above 250: 5 U for small meals <30 g of carbs; 11 U for regular meals >30 g of carbs; bedtime 3 U
- Glucose above 300: 6 U for small meals <30 g of carbs; 12 U for regular meals >30 g of carbs;

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M 466	Continued From page 13 bedtime 3 U Semglee 11 U in the morning, 10 U at night. Sliding scale dated 08/14/2025 - Try to aim for 30 g of carbs at meals. Surveyor reviewed Resident 1's physician order sheet, dated active as of 08/19/2025 (printed date), and the MARs for July and August 2025, and the following was identified: 1. Insulin glargine (Semglee) - biosimilar (yfgn) 100 unit (U)/milliliter (mL) - 100 U/3 mL; Updated on 07/16/2025, at 12:30 PM; Inject 11 units subcutaneously in the morning and inject 12 units subcutaneously at bedtime. The July MAR documented this medication on line 38 and included a daily 8:00 AM (morning) administration. The August MAR documented this medication on line 16 and included a daily 8:00 AM (morning) administration. Neither MAR included a place to record a daily 8:00 PM (bedtime) administration, as ordered. 2. Insulin lispro kwikpen U-100 - 100 U/mL - Humalog 100 U/mL; Updated on 07/16/2025, at 12:30 PM; Inject subcutaneously at bedtime per sliding scale: if blood sugar is 200 or less = +0 units; if 201-249 = +2 units; if more than 250 = +3 units. The July MAR documented this medication on line 39 and included a daily 8:00 PM (bedtime) administration. The August MAR documented this medication on line 17 and included a daily 8:00 PM (bedtime) administration. 3. Insulin lispro kwikpen U-100 - 100 U/mL - Humalog 100 U/mL; Updated on 07/16/2025, at 12:30 PM; Inject subcutaneously 3 times a day	M 466		

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before meal(s) per sliding scale: if blood sugar 70 or less treat hypoglycemia and recheck in 15 minutes; if 71-90 = +0 units; 91-150 = +8 units; 151-200 = +9 units; 201-250 = +10 units; 251-300 = +11 units; 301 or greater = +12 units. The July MAR documented this on line 40 and included 8:00 AM (breakfast), 12:00 PM (lunch), and 4:00 PM (dinner) daily administrations. The August MAR documented this on line 18 and included 8:00 AM (breakfast), 12:00 PM (lunch), and 4:00 PM (dinner) daily administrations.

The physician order sheet and the MARs included different information from the 2 sliding scales. The physician order sheet and MARs were not updated when the sliding scale changed on 07/23/2025, and again on 08/14/2025.

Surveyor reviewed Resident 1's MAR from 07/23/2025 to 08/19/2025; On those dates, Resident 1's MAR omitted a line to record the 8:00 PM (bedtime) administration of insulin glargine ordered by Resident 1's physician. The omittance of that line resulted in 19 occurrences of insulin glargine documented with, or in place of, a different medication; and 8 occurrences of no documentation. There were 7 more occurrences where other medication administrations were not documented. There were 4 occurrences where Resident 1's BS was not recorded, which was needed to determine the units of insulin to administer. There were 22 occurrences where the units of insulin administered were not recorded. There were 4 instances where insulin was recorded as administered when it had not been. From 07/23/2025 - 08/13/2025, Resident 1's sliding scale required the medication passer to determine the total carbohydrates in a meal, which was used to determine the units of insulin

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M 466	Continued From page 15 lispro to administer to Resident 1. There were 50 occurrences where carbohydrates were not recorded or used to determine the number of units of insulin lispro to administer. Surveyor identified the following documentation errors on the July and August 2025 MARs: 07/23/2025 - At 4:55 PM (dinner) the number of carbs in Resident 1's meal was not recorded for purposes of determining the amount of insulin lispro to administer, based on the sliding scale. At 7:51 PM (bedtime), the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 39 documented, " . . . lispro not administered per sliding scale; however, 10 units of Semglee administered per 07/23/2025 new orders but not on electronic MAR yet [sic]." Insulin lispro was listed as administered when it was not, and the notes documented medication administration for insulin glargine on line 39, which was the line for insulin lispro. 07/24/2025 - At 7:40 PM (bedtime), the notes did not include the number of units of insulin lispro administered. There was no documentation of insulin glargine at bedtime. 07/25/2025 - At 12:00 PM (lunch), a blank box indicated Resident 1 did not receive her/his insulin lispro. There were no notes indicating a BS was recorded, or an explanation for the missed dose. At 7:26 PM (bedtime), Resident 1's BS was recorded as 188 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 39 documented, "adm [sic] only gave [Resident 1] 12 unit [sic] Semglee." The notes documented medication administration for insulin glargine on line 39, which was the line for insulin lispro.	M 466		

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M 466	Continued From page 16 07/26/2025 - At 8:04 AM (breakfast), at 11:45 AM (lunch), and at 4:01 PM, the number of units of insulin lispro administered was not recorded. At 7:03 PM (bedtime), the MAR notes for line 39 documented, "11 units giving of glargine not on mars [sic]." The notes documented medication administration for insulin glargine on line 39, which was the line for insulin lispro. 07/27/2025 - At 7:48 AM (breakfast), at 11:37 AM (lunch), and at 3:41 PM, the number of units of insulin lispro administered was not recorded. At 7:32 PM (bedtime), the number of units of insulin administered was not recorded. The MAR notes for line 39 documented, "14 unit giving glargine not on mars [sic]." The notes documented medication administration for insulin glargine on line 39, which was the line for insulin lispro. 07/28/2025 - At 7:47 AM (breakfast), the number of units of insulin lispro administered was not recorded. At 7:41 PM, Resident 1's BS was recorded as 70 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 39 documented, "adm gave [Resident 1] just [her/his] night semglee units just 10 [sic]." Insulin lispro was listed as administered when it was not, and the notes documented medication administration for insulin glargine on line 39, which was the line for insulin lispro. 07/29/2025 - At 7:30 PM (bedtime), Resident 1's BS was recorded as 126 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 39 documented, "adm only gave [Resident 1] [her/his] night insulin [s/he] got 10 unit base off [her/his] sliding sliding scale [sic]." The notes were unclear if insulin glargine or insulin lispro was administered.	M 466		

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M 466	Continued From page 17 07/30/2025 - At 7:25 PM (bedtime), Resident 1's BS was recorded as 193 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 39 documented, "lispro not administered per sliding scale - bs 193; however - 10 units Semglee administered, but is not in electronic MAR [sic]. House Manager [K] updated and acknowledged." The notes documented medication administration for insulin glargine on line 39, which was the line for insulin lispro. 07/31/2025 - At 7:14 PM (bedtime), Resident 1's BS was recorded as 162 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 39 documented, "armature [sic] 10 units in right arm at night." The notes were unclear if insulin glargine or insulin lispro was administered. 08/01/2025 - At 7:22 PM (bedtime), Resident 1's BS was recorded as 144 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 17 documented, "armature [sic] 10 units at night in right arm." The notes were unclear if insulin glargine or insulin lispro was administered. 08/02/2025 - At 7:41 AM (breakfast), the number of units of insulin lispro administered was not recorded. At 7:13 PM (bedtime), Resident 1's BS was recorded as 145 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 17 documented, "adm [sic]only gave [Resident 1] 10 units as requested every night." The notes were unclear if insulin glargine or insulin lispro was administered. 08/03/2025 - At 8:00 AM, a blank box indicated	M 466		

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Resident 1 did not receive her/his insulin lispro. There were no notes indicating a BS was recorded, or an explanation for the missed dose. At 7:21 PM, (bedtime), Resident 1's BS was recorded as 143 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 17 documented, "adm [sic] only gave [Resident 1] [her/his] night insulin 10 units." The notes were unclear if insulin glargine or insulin lispro was administered.

08/04/2025 - At 7:46 PM (bedtime), Resident 1's BS was recorded as 108 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 17 documented, "armature [sic] 10 units in right side of [her/his] stomach." The notes were unclear if insulin glargine or insulin lispro was administered.

08/05/2025 - At 7:36 PM (bedtime), Resident 1's BS was recorded as 214 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 17 documented, "armature [sic] 10 units at night in right arm." The notes were unclear if insulin glargine or insulin lispro was administered.

08/06/2025 -At 7:59 PM (bedtime), the MAR notes for line 17 documented, " . . . no sliding scale administered per sliding scale [sic]; however, 11 units of Semglee administered as ordered but not on electronic MAR." The notes documented medication administration for insulin glargine on line 17, which was the line for insulin lispro.

08/07/2025 - At 7:20 PM (bedtime), the MAR notes for line 17 documented, "adm [sic] gave [Resident 1] 3 units of [her/his] lispro cause [her/his] sugar was 286 in adm still gave

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[Resident 1] [her/his] 10 units of glasrgine [sic]." The notes documented medication administration for insulin glargine on line 17, which was the line for insulin lispro.

08/08/2025 - At 7:20 PM (bedtime), the MAR notes for line 17 documented, " adm [sic] only gave [Resident 1] 10 units based on [her/his] sliding scale." The notes were unclear if insulin glargine or insulin lispro was administered.

08/09/2025 - At 8:00 AM (breakfast), 12:00 PM (lunch), 4:00 PM (dinner), the boxes were left blank for the insulin lispro. There were no notes indicating BS were recorded, nor were there explanations provided for the missed doses. At 8:00 AM (morning), the box was left blank for the insulin glargine. At 8:00 PM (bedtime), the box was initialed by staff for the insulin lispro, indicating the insulin was administered. There were no notes indicating a BS was recorded, or the number of units of insulin administered. The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR.

08/10/2025 - The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR.

08/11/2025 - At 7:51 AM (breakfast), the number of units of insulin lispro administered was not recorded. At 7:28 PM (bedtime), the MAR on line 17 documented, "adm [sic] gave [Resident 1] only [her/his] 10 units due to [her/his] sliding scale." The notes were unclear if insulin glargine or insulin lispro was administered.

08/12/2025 - At 7:18 PM (bedtime), the number of units of insulin lispro administered was not recorded. The 8:00 PM (bedtime) administration

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of insulin glargine was not documented on the MAR.

08/13/2025 - At 8:00 PM (bedtime), the number of units of insulin lispro administered was not recorded. The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR.

08/14/2025 - At 7:08 AM (breakfast), the number of units of insulin lispro administered was not recorded. At 8:00 PM (bedtime), the box was left blank, indicating Resident 1 was not administered insulin lispro. Resident 1's BS was not recorded and there were no notes. The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR.

08/15/2025 -At 8:22 PM (bedtime), the number of units of insulin lispro administered was not recorded. The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR.

08/16/2025 - At 10:10 AM (breakfast), the number of units of insulin lispro administered was not recorded. At 7:13 PM (bedtime), the MAR notes for line 17 documented, "ADM [sic] gave [her/him] 10 units Semglee and 3 units of the Humalog." The notes documented medication administration for insulin glargine on line 17, which was the line for insulin lispro.

08/17/2025 - At 7:53 AM (breakfast), the number of units of insulin lispro administered was not recorded. At 7:20 PM (bedtime), Resident 1's BS was recorded as 264 and the box was initialed by staff, indicating Resident 1 was administered insulin lispro. The MAR notes for line 17 documented, "adm [sic] gave [Resident 1] 2 units

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M 466	Continued From page 21 due to [her/his] sliding scale and gave [her/him] 10 unis [sic]." The notes documented medication administration for insulin glargine on line 17, which was the line for insulin lispro. 08/18/2025 - At 8:50 AM (breakfast), at 11:50 AM (lunch), at 3:26 PM (dinner), and at 7:30 PM (bedtime), the number of units of insulin lispro administered was not recorded. The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR. On 08/19/2025, at 12:00 PM, Surveyor interviewed Caregiver L and Caregiver M. Both Caregiver L and Caregiver M reported the following: The MAR did not provide an area to record the administration of insulin glargine at bedtime. They received instructions from the pharmacy to chart the administration of insulin glargine at bedtime under the insulin lispro. They reported they did not keep a log of the number of carbohydrates within meals provided to Resident 1 to determine a small meal versus a regular meal, which was needed (on the sliding scale used from 07/23/2025 - 8/14/2025) to determine the units of insulin to be administered. They reported a blank box on the MAR indicated the medication was not administered. Caregiver M reported s/he documented her/his initials on the MAR when s/he administered medication, as well as when insulin was not needed and not administered based on Resident 1's BS level and the sliding scale. Caregiver M was unsure of how to correctly document a medication not administered. Cross References: M0458 88.07(3)(a) - Prescription Medications	M 466		

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M 466	Continued From page 22 M582 88.10(3)(q) - Medications	M 466		
M 548	88.10(3)(a) Fair Treatment Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 4 residents (Resident 1 and Resident 4) were treated with courtesy, respect and full recognition of their dignity and individuality. Resident 1's room did not contain a dresser or a place to hang clothing and was not decorated/personalized like the other resident rooms in the home. Resident 1 was not given regular opportunities to attend church, as s/he wanted. Resident 1 was delayed by staff when going for a walk. Resident 4 was told to get off a phone call on her/his personal phone. Resident 4 was not provided with snacks and coffee when requested. Findings include: The home was licensed as a non-ambulatory adult family home (AFH) caring for up to 4 residents in the client groups of advanced age, traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, physically disabled, irreversible dementia/Alzheimer's, and terminally ill.	M 548		

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M 548	Continued From page 23 On 08/19/2025, at 8:58 AM, Surveyors conducted an onsite survey at Tee's Direct Care. Surveyors reviewed resident records and the following was identified: Resident 1 Surveyor did not observe a client's right limitation or waiver in Resident 1's file. Surveyor reviewed Resident 1's face sheet, assessment - dated 08/05/2025, individual service plan (ISP), and managed care organization (MCO) care plan. Resident 1 was admitted to the facility on 09/14/2023, with diagnoses including schizophrenia, depressive episodes, anxiety disorders, borderline personality disorder, and developmental disorder of scholastic skills. Resident 1 had a case manager (CM) from a MCO and a corporate guardian. Resident 1 was required to have a one-on-one (1:1) caregiver with her/him and required 24 hours per day supervision. Resident 1's ISP stated, "Housekeeping . . . Member is able to complete full task but need staff to be sure there are no items available to self harm [sic]. . . . Ensure member room is safe [sic]. . . . Suicidal Tendencies . . . Room proof with no glass, string, sharp objects etc. [sic]. . . . Upon shift changes staff will conduct room checks and complete check list to ensure room is safe from all dangerous items that appear to be unsafe and harmful to member." On 08/19/2025, at 9:20 AM, Surveyors toured Resident 1's room with Caregiver M and Resident 1, and observed the following: Resident 1's clothing was set on top of 2 small folding tables. Surveyor observed the closet contained 1 overhead shelf and was missing the	M 548		

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M 548	Continued From page 24	M 548		

bar for hanging clothing. The window in the bedroom was covered with a black tarp-like material, which was torn in some areas and was held up by Velcro. The walls of the room were painted blue and had many scratches. The bedroom was not personalized and did not include any décor items.

Surveyor interviewed Caregiver M during the tour and the following was reported:

When s/he was working as Resident 1's 1:1 staff, s/he folded Resident 1's clothing and stacked it on the tables next to her/his bed. Resident 1 liked to change clothes several times per day, due to her/his love for fashion. Caregiver M washed and folded Resident 1's clothes and confirmed there was nowhere to store them within Resident 1's room. Any belongings of Resident 1 which posed a potential danger to her/him were removed from her/his room, such as jewelry items or any wall hangings which were sharp. This was due to Resident 1's threats to harm her/himself.

Surveyor interviewed Resident 1 during the tour, and s/he reported the following:

Most of the furniture and stuff was removed from her/his room due to her/his behaviors. S/He had a love for fashion, and clothing and jewelry brought her/him joy. S/He pointed to the curtain on her/his bedroom window and stated, "I don't like that curtain." S/He walked over to Resident 4's bedroom and pointed at her/his curtains and stated, "I want to have curtains like that." The curtains s/he pointed at were decorative and hung up by a curtain rod. S/He then reported s/he would really like to decorate her/his bedroom and have it painted pink.

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M 548	Continued From page 25 Resident 1 showed Surveyor her/his baptism certificate, which was dated approximately 1 year ago and taped on her/his bedroom door. S/He reported s/he wanted to attend church but was not given the opportunity to go in the past few months. Resident 1 reported [Person Q], a sibling of Licensee A, had taken her/him to church on 3 occasions since her/his baptism. On 08/19/2025, at 9:32 AM, Surveyor reviewed Resident 1's record and the following was identified: Resident 1's Community Care - care plan, with a start date of 06/01/2025 and an end date of 11/30/2025, documented Resident 1's goals. Goal 4 documented, " Health Related - . . . Member continues to work towards losing weight. Member is going to the YMCA to walk and exercise. Member also takes walks outside . . . " The plan reported the AFH staff were responsible to provide physical/mental/behavioral health and wellness needs for Resident 1. Resident 1's Behavior Support Plan (BSP), updated on 05/06/2025, documented the following: - " . . . [Resident 1] is highly focused on [her/his] appearance and wants to always present as dressed/groomed appropriately. [S/He] greatly loves wearing makeup, having [her/his] nails painted, and wearing jewelry, including making it . . . - . . . Behaviors and Interventions from last review period - . . . Member is reminded of things [s/he] can do if [s/he] has positive behaviors such as going to church on Sunday . . .	M 548		

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M 548	Continued From page 26 - . . . Situations/Circumstances When Behaviors are likely to Occur - . . . When [s/he] feels [s/he] does not have choices and/or is being controlled. When [s/he] is bored or has limited activities to participate in . . . - . . . How Staff/Others Can Support and Encourage Appropriate Behavior - . . . [Resident 1's] transitional 1:1 staff should provide continuous monitoring; direct or immediate area for privacy. The role of 1:1 staff is to offer support, supervision, and activities to [Resident 1] . . . - Reinforce that [Resident 1] is doing well and wanted in the home; feelings of inclusion . . . - Engage [Resident 1] in activities as much as possible to keep [her/him] busy throughout the day. [Resident 1] enjoys: - Having [her/his] hair curled. - Make up and nail polish. - Shopping for clothes, jewelry, and make up. - Making jewelry. - Going out to eat and the movies . . . " Resident 1's assessment, dated 08/05/2025, documented the following: "Suicidal Tendencies - . . . Room proof with no glass, string, sharp objects etc. Bathroom no soaps, liquids, shower gels, upon shift changes staff will conduct room checks and complete check list to ensure room is safe from all dangerous items that appear to be unsafe and harmful to member [sic] . . . Activities - Participation Monitoring - . . . - Resident's Needs: . . . Member goes to the YMCA every Wednesday with nurse [Nurse P] and to food banks. Member is out on Wednesday is [sic] behavior permits it.	M 548		

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- Resident's Desired Outcomes: Find enjoyment/fulfillment and activities of choice.
- Measurable Goals (with specific time limit for attainment): Member would like to attend church, bingo and shopping when display [sic] good behaviors . . .

Spiritual Needs -
- Resident's Needs: Member would like to attend a non-denomination [sic] church.
- Resident's Desired Outcomes: To have all spiritual needs met.
- Measurable Goals (with specific time limit for attainment): Member would like to attend church on a regular basis . . . "

Resident 4

On 08/19/2025, Surveyors reviewed Resident 4's face sheet, which documented Resident 4 was admitted to the facility on 07/05/2022, with diagnoses including visual impairment and seizure disorder. Resident 4 had a CM from a MCO, and was her/his own person.

Resident 4's ISP, dated 08/05/2025, documented the following:

"Mental Illness. Resident Needs: [Resident 4] becomes anxiety [sic], [s/he] will attempt to pull hair and eyelashes out. Resident's Desired Outcomes: To control anxiety. Measurable Goals: To ensure [Resident 4] is monitored and observed by staff.

Eating - Independent. Resident Needs: Independent with eating. Resident's Desired Outcomes: To maintain adequate food/nutrition intake and independence with eating. Measurable Goals: Ensure healthy meals are prepared.

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M 548	Continued From page 28 Method for Delivering Care/Who is Responsible: [Resident 4]." On 08/19/2025, after 9:00 AM, Surveyors overheard conversations amongst the care staff, House Manager K, and Resident 4. Resident 4 was supposed to go to day program earlier and when the transport van came to pick her/him up, s/he became dizzy and almost passed out. The care staff did not send Resident 4 to day program. When House Manager K arrived at the home, s/he questioned staff as to why Resident 4 was not at day program. At approximately 10:00 AM, Surveyors observed Resident 4 was sitting at the dining room table talking on her/his cell phone. House Manager K approached Resident 4, stood over her/him and loudly ordered her/him to hang up the phone. Resident 4 told the person s/he was speaking with s/he needed to get off the phone. House Manager K told Resident 4 s/he needed to take her/his vitals, and again, spoke loudly ordering Resident 4 to hang up the call. Resident 4 stated s/he wanted coffee and reported s/he thought s/he might have been feeling dizzy due to not having her/his usual morning cup of coffee. House Manager K did not provide Resident 4 coffee. At approximately 10:45 AM, Resident 4 requested a granola bar as a snack. Caregiver L was going to get the granola bar and House Manager K stated, "No. S/He does not need a granola bar; s/he's about to eat lunch." Resident 4 was not given a granola bar. House Manager K left the AFH at approximately 11:15 AM, and Caregiver L provided Resident 4 with coffee and a granola bar.	M 548		

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M 548	Continued From page 29 At approximately 1:30 PM, Caregiver M (Resident 1's 1:1) was preparing to take Resident 1 to go on a walk outside; Caregiver L was informed of this. House Manager K arrived back at the residence, approached Caregiver M and Resident 1, and questioned where they were going. A verbal argument occurred between House Manager K and Caregiver M, while Resident 1 was present and waiting to go on a walk with her/his 1:1 staff. Caregiver M walked into the residence visibly upset and crying. Resident 1 followed her/him inside and was also visibly upset and stated, "I don't know ...[House Manager K]." Resident 1's walk was delayed by approximately 30 minutes, due to the confrontation. On 08/26/2025, at approximately 10:12 AM, Surveyor interviewed Licensee A and s/he reported the following: Resident 1 wanted the small folding tables in her/his room. Resident 1 saw the other residents had folding tables in their rooms, and s/he requested them for her/his room. There was an incident where Resident 1 took her/his dresser and barricaded her/himself in her/his room by moving the dresser in front of the door. Licensee A removed the dresser from her room. The curtain rod and closet hanging pole were removed from Resident 1's room due to behaviors which caused her/him to use those items as weapons or to harm her/himself. Licensee A reported s/he had provided Resident 1 with a small shelving system, which was designed to hang in the closet. The shelving system and closet pole to hang were not present during the survey. Licensee A reported s/he would obtain decorative curtains for Resident 1 and have them placed in her/his room. Licensee A did not offer further information in regard to the lack	M 548		

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M 548	Continued From page 30 of personalization and décor in Resident 1's bedroom. S/He reported Nurse P took Resident 1 to church on Wednesdays. When asked why Resident 1 stated s/he had not been to church in a few months, Licensee A reported Resident 1 had not been to church in over 2 months and had not showed any interest in going back to church. Surveyors informed Licensee A of the interactions House Manager K had with staff and residents during the survey. Licensee A confirmed Resident 4 should have been provided with a snack and coffee upon request and should not have been told s/he could not have them. Licensee A reported House Manager K took on the role of House Manager as of 07/01/2025. Licensee A reported House Manager K had been doing a "good job" and "holds them (caregivers) accountable." S/He did not offer any further information about the care and fair treatment of the residents.	M 548		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, the	M 582		

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provider did not ensure each resident received all prescribed medications in the dosage and at the intervals prescribed by the residents' physicians for 2 of 2 residents (Resident 1 and Resident 4) reviewed.

Resident 1 did not receive insulin glargine (Semglee) - interchangeable biosimilar (yfgn) and insulin lispro kwikpen (Humalog) in the correct dosages and at the correct intervals, as prescribed. Resident 1's medication administration had a total of 33 errors within a 28-day period, between 07/23/2025 and 08/19/2025.

Resident 4 did not receive his/her sulfamethoxazole and trimethoprim (SMZ-TMP) as prescribed. Resident 4 had a total of 4 medications not administered between 07/04/2025 and 07/08/2025.

Findings include:

Resident 1

On 08/19/2025, at approximately 11:30 AM, Surveyor reviewed Resident 1's record and identified the following:

- Resident 1 was admitted to the provider's home on 09/14/2023, with diagnoses including diabetes mellitus type 2 - insulin dependent diabetes mellitus (IDDM).
- Resident 1 had a case manager (CM) from a managed care organization (MCO) and a corporate guardian.
- Resident 1 required medication administration from staff at the adult family home (AFH).

Surveyor reviewed Resident 1's physician order

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M 582	Continued From page 32 sheet, dated active as of 08/19/2025, and the MARs for July and August 2025, and the following was identified: 1. Insulin glargine (Semglee) - yfgn 100 unit (U)/milliliter (mL) - 100 U/3 mL; Updated on 07/16/2025, at 12:30 PM; Inject 11 units subcutaneously in the morning and inject 12 units subcutaneously at bedtime. The July MAR documented this medication on line 38 and included a daily 8:00 AM (morning) administration. The August MAR documented this medication on line 16 and included a daily 8:00 AM (morning) administration. 2. Insulin lispro kwikpen U-100 - 100 U/mL - Humalog 100 U/mL; Updated on 07/16/2025, at 12:30 PM; Inject subcutaneously at bedtime per sliding scale: if blood sugar is 200 or less = +0 units; if 201-249 = +2 units; if more than 250 = +3 units. The July MAR documented this medication on line 39 and included a daily 8:00 PM (bedtime) administration. The August MAR documented this medication on line 17 and included a daily 8:00 PM (bedtime) administration. 3. Insulin lispro kwikpen U-100 - 100 U/mL - Humalog 100 U/mL; Updated on 07/16/2025, at 12:30 PM; Inject subcutaneously 3 times a day before meal(s) per sliding scale: if blood sugar 70 or less treat hypoglycemia and recheck in 15 minutes; if 71-90 = +0 units; 91-150 = +8 units; 151-200 = +9 units; 201-250 = +10 units; 251-300 = +11 units; 301 or greater = +12 units. The July MAR documented this on line 40 and included 8:00 AM (breakfast), 12:00 PM (lunch), and 4:00 PM (dinner) daily administrations. The August MAR documented this on line 18 and included 8:00 AM (breakfast), 12:00 PM (lunch), and 4:00 PM (dinner) daily administrations.	M 582		

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M 582	Continued From page 33 Surveyor observed, hung on the wall of the office, 2 different sliding scales for Resident 1. One of the sliding scales was on an after-visit summary (AVS), dated 07/23/2025, and the other was on an AVS, dated 08/14/2025. The following includes the information listed for each of the sliding scales: Sliding scale dated 07/23/2025 - Try to aim for 30 grams (g) of carbohydrates (carbs) at meals. Humalog before meals. - Glucose 71-90: 0 U for small meals <30 g of carbs; 0 U for regular meals >30 g of carbs; bedtime 0 U - Glucose 91-150: 4 U for small meals <30 g of carbs; 8 U for regular meals >30 g of carbs; bedtime 0 U - Glucose above 150: 4 U for small meals <30 g of carbs; 9 U for regular meals >30 g of carbs; bedtime 0 U - Glucose above 200: 5 U for small meals <30 g of carbs; 10 U for regular meals >30 g of carbs; bedtime 2 U - Glucose above 250: 5 U for small meals <30 g of carbs; 11 U for regular meals >30 g of carbs; bedtime 3 U - Glucose above 300: 6 U for small meals <30 g of carbs; 12 U for regular meals >30 g of carbs; bedtime 3 U Semglee 11 U in the morning, 10 U at night. Sliding scale dated 08/14/2025 - Try to aim for 30 g of carbs at meals.	M 582		

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M 582	Continued From page 34 Humalog before meals. Semglee 11 units in the morning, 10 units at night. - Blood sugar 71-90: Humalog with breakfast 0 U; Humalog with lunch 0 U; Humalog with dinner (small meal dose) 0 U; Humalog at bedtime 0 U - Blood sugar 91-150: Humalog with breakfast 10 U; Humalog with lunch 8 U; Humalog with dinner (small meal dose) 4 U; Humalog at bedtime 0 U - Blood sugar above 150: Humalog with breakfast 11 U; Humalog with lunch 9 U; Humalog with dinner (small meal dose) 4 U; Humalog at bedtime 0 U - Blood sugar above 200: Humalog with breakfast 12 U; Humalog with lunch 10 U; Humalog with dinner (small meal dose) 5 U; Humalog at bedtime 2 U - Blood sugar above 250: Humalog with breakfast 13 U; Humalog with lunch 11 U; Humalog with dinner (small meal dose) 5 U; Humalog at bedtime 3 U - Blood sugar above 300: Humalog with breakfast 14 U; Humalog with lunch 12 U; Humalog with dinner (small meal dose) 6 U; Humalog at bedtime 3 U The physician order sheet and the MARs included different information from the sliding scales, and were not updated when the sliding scale changed on 07/23/2025, and again on 08/14/2025. Both sliding scales, provided by Resident 1's physician, indicated Resident 1 was to receive 10 units of insulin glargine - yfgn (Semglee) at night. The physician order sheet and MARs documented Resident 1 was to receive 12 units of insulin glargine - yfgn (Semglee) at night. The	M 582		

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physician order sheet and the MARs documented instructions for the administration of insulin lispro 3 times per day before meals (breakfast, lunch, and dinner), which also included a sliding scale to follow. The sliding scale documented on the physician order sheet and MARs only included the numbers for regular meals (>30 g of carbs) or lunchtime (12:00 PM) administration. The sliding scale, provided by Resident 1's physician on 07/23/2025, included different numbers for small meals (<30 g of carbs), regular meals, and bedtime. The sliding scale, provided by Resident 1's physician on 08/14/2025, included different numbers for breakfast, lunch, dinner, and bedtime.

Between 07/23/2025 and 08/19/2025, Surveyor identified 12 occasions when Resident 1 did not receive the correct dosage of insulin, based on the active sliding scale provided by the physician; One occasion when Resident 1 received insulin at the wrong interval; Sixteen occasions when Resident 1 did not receive insulin and should have; and 4 occasions Resident 1 was administered insulin when it should not have been given. The following were the details of the medication errors:

07/23/2025 - At 4:55 PM (dinner), Resident 1's blood sugar (BS) was recorded as 122 and the box was initialed by staff, indicating insulin lispro was administered .The MAR notes for line 40 documented, "9 units administered per NEW sliding scale orders obtained today." The newly active sliding scale indicated Resident 1 was to receive 4 units of insulin for a small meal and 8 units for a regular meal if her/his BS was 91-150. Resident 1 was administered the incorrect dose of insulin lispro.

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M 582	Continued From page 36 07/24/2025 - At 7:40 PM (bedtime), Resident 1's BS was recorded as 87 and the box was initialed by staff, indicating insulin lispro was administered. Insulin lispro should not have been administered according to the sliding scale. There was no documentation indicating Resident 1 was administered insulin glargine at bedtime, when s/he should have been administered 10 units. 07/25/2025 - At 12:00 PM (lunch), a blank box indicated Resident 1 did not receive her/his insulin lispro. There were no notes indicating a BS was recorded, or an explanation for the missed dose. At 7:26 PM (bedtime), Resident 1's BS was recorded as 188 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 39 documented, "adm [sic] only gave [Resident 1] 12 unit [sic] Semglee." Resident 1 was administered the incorrect dose of insulin glargine. The sliding scale indicated s/he should have been administered 10 units of insulin glargine. 07/26/2025 -At 7:03 PM (bedtime), Resident 1's BS was recorded as 195 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 39 documented, "11 units giving of glargine not on mars [sic]." Resident 1 was administered the incorrect dose of insulin glargine. The sliding scale indicated s/he should have been administered 10 units of insulin glargine. 07/27/2025 - At 7:32 PM (bedtime), Resident 1's BS was recorded as 211 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 39 documented, "14 unit giving glargine not on mars [sic]." Resident 1 was administered the incorrect dose of insulin glargine. The sliding scale indicated s/he should	M 582		

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M 582	Continued From page 37 have been administered 10 units of insulin glargine. 07/28/2025 -At 4:08 PM, Resident 1's BS was recorded as 151 and s/he was administered 8 units of insulin. The sliding scale indicated Resident 1 was to receive 4 units of insulin for a small meal and 9 units for a regular meal if her/his BS was above 150. Resident 1 was administered the incorrect dose of insulin lispro. 08/03/2025 - At 8:00 AM, a blank box indicated Resident 1 did not receive her/his insulin lispro. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/05/2025 - At 7:36 PM (bedtime), Resident 1's BS was recorded as 214 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 17 documented, "armature [sic] 10 units at night in right arm." The sliding scale indicated Resident 1 was to receive 2 units of insulin lispro if her/his BS was above 200 and should have also been administered 10 units of insulin glargine. Resident 1 was administered the incorrect dose of insulin lispro and missed her/his dose of insulin glargine. 08/06/2025 - At 4:00 PM (dinner), Resident 1's BS was recorded as 236 and s/he was administered 11 units of insulin. The sliding scale indicated Resident 1 was to receive 5 units of insulin for a small meal and 10 units for a regular meal if her/his BS was above 200. Resident 1 was administered the incorrect dose of insulin lispro. At 7:59 PM (bedtime), Resident 1's BS was recorded as 79 and the box was initialed by staff, indicating insulin lispro was administered. The MAR notes for line 17 documented, " . . . no sliding scale administered per sliding scale [sic];	M 582		

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	0018379	A. BUILDING: _____ B. WING _____	R-C 08/26/2025

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however 11 units of Semglee administered as ordered but not on electronic MAR." The sliding scale indicated Resident 1 was to receive 10 units of insulin glargine. Resident 1 was administered the incorrect dose of insulin glargine.

08/09/2025 - At 8:00 AM (breakfast), 12:00 PM (lunch), 4:00 PM (dinner), the boxes were left blank for the insulin lispro, indicating the insulin was not administered. Resident 1 missed all 3 doses of insulin lispro. There were no notes indicating BS were recorded, nor were there explanations provided for the missed doses. At 8:00 AM (morning), the box was left blank for the insulin glargine, indicating the insulin was not administered. Resident 1 missed her/his morning dose of insulin glargine. The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR, indicating Resident 1 missed her/his bedtime dose of 10 units of insulin glargine.

08/10/2025 - The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR, indicating Resident 1 missed her/his dose of 10 units of insulin glargine.

08/11/2025 -At 11:34 AM, Resident 1's BS was recorded as 195. The MAR notes for line 18 documented, "adm [sic] gave [Resident 1] 5 untis [sic] due to [her/his] sliding scale in a s,all [sic] meal." The sliding scale indicated Resident 1 was to receive 4 units of insulin lispro for a small meal if her/his BS was above 150. Resident 1 was administered the incorrect dose of insulin lispro.

08/12/2025 - At 7:18 PM (bedtime), Resident 1's BS was recorded as 110 and the box was initialed

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by staff, indicating Resident 1 was administered insulin lispro. The sliding scale indicated Resident 1 was to receive 0 units of insulin lispro if her/his BS was 91-150. Insulin lispro should not have been administered according to the sliding scale. The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR, indicating Resident 1 did not receive her/his dose of 10 units of insulin glargine.

08/13/2025 - At 8:00 PM (bedtime), Resident 1's BS was recorded as 108 and the box was initialed by staff, indicating Resident 1 was administered insulin lispro. The sliding scale indicated Resident 1 was to receive 0 units of insulin lispro if her/his BS was 91-150. Insulin lispro should not have been administered according to the sliding scale. The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR, indicating Resident 1 did not receive her/his dose of 10 units of insulin glargine.

08/14/2025 -At 8:00 PM (bedtime), the box was left blank, indicating Resident 1 was not administered insulin lispro. Resident 1's BS was not recorded and there were no notes. The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR, indicating Resident 1 did not receive her/his dose of 10 units of insulin glargine.

08/15/2025 - At 7:02 AM (breakfast), Resident 1's BS was recorded as 297 and s/he was administered 11 units of insulin. The sliding scale orders, effective on 08/14/2025, indicated Resident 1 was to receive 13 units of insulin lispro if her/his BS was above 250. Resident 1 was administered the incorrect dose of insulin lispro. At 4:32 PM (dinner), Resident 1's BS was recorded as 240 and s/he was administered 10

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units of insulin. The sliding scale orders indicated Resident 1 was to receive 5 units of insulin lispro if her/his BS was above 200. Resident 1 was administered the incorrect dose of insulin lispro. The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR, indicating Resident 1 did not receive her/his dose of 10 units of insulin glargine.

08/17/2025 - At 4:55 PM, documented in the 12:00 PM (lunch) box was staff initials, indicating Resident 1 was administered insulin. Resident 1's BS was recorded as 260 and s/he was administered 11 units of insulin. At 5:01 PM, the 4:00 PM (dinner) box was initialed by staff, indicating Resident 1 was administered insulin. Resident 1's BS was recorded as 275 and s/he was administered 5 units of insulin. The 12:00 PM BS reading and insulin dose were taken and administered 4 hours and 55 minutes after it had been ordered for. The lunch and dinner BS readings and insulin doses were taken and administered 6 minutes apart. At 7:20 PM (bedtime), Resident 1's BS was recorded as 264 and the box was initialed by staff, indicating Resident 1 was administered insulin lispro. The MAR notes for line 17 documented, "adm [sic] gave [Resident 1] 2 units due to [her/his] sliding scale and gave [her/him] 10 unis [sic]." The sliding scale indicated Resident 1 was to receive 3 units of insulin lispro if her/his BS was above 250. Resident 1 was administered the incorrect dose of insulin lispro.

08/18/2025 -At 7:30 PM (bedtime), Resident 1's BS was recorded as 98 and the box was initialed by staff, indicating Resident 1 was administered insulin lispro. The sliding scale indicated Resident 1 was to receive 0 units of insulin lispro if her/his BS was 91-150. Insulin lispro should not have

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been administered according to the sliding scale. The 8:00 PM (bedtime) administration of insulin glargine was not documented on the MAR, indicating Resident 1 did not receive her/his dose of 10 units of insulin glargine.

On 08/19/2025, at 12:00 PM, Surveyor interviewed Caregiver L and Caregiver M. Both Caregiver L and Caregiver M reported the following:

When administering insulin to Resident 1, they followed the sliding scales, posted in the office area, to determine the number of units to administer. They reported the sliding scale was updated at Resident 1's appointment on 08/14/2025 and was not posted by House Manager K for staff to follow until 08/18/2025. For approximately 4 days, staff were following the previous sliding scale, when they should have had access to the updated sliding scale to administer the correct dosages and in the correct intervals ordered by Resident 1's physician. They were only administering insulin glargine at bedtime and not insulin lispro.

Resident 4

On 08/19/2025, Surveyor reviewed Resident 4's record and identified the following:

-Resident 4 was admitted to the provider's home on 07/05/2022.
-Resident 4 was his/her own person.

During the record review of Resident 4's Medication Administration Record (MAR) the following was identified:

8:00 AM

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M 582	Continued From page 42 -SMZ-TMP single 400-80 milligrams (mg) tablet was not administered on 07/04/2025, 07/06/2025 and 07/08/2025 (a total of 3 doses). 8:00 PM -SMZ-TMP single 400-80 milligrams (mg) tablet was not administered on 07/08/2025 (A total of 1 dose). On 08/26/2025, at approximately 12:50 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 1 and Resident 4 required staff to administer their medications. Licensee A reported staff documented medication administration in electronic care plans and on paper MARs. Licensee A stated s/he would email Resident 4's July 2025 MAR to Surveyors by 5:00 PM. As of 08/26/2025 at 5:00 PM, Surveyor did not receive Resident 4's paper MAR. Cross Reference: M0466 88.07(3)(e)1 - Medication Record Keeping	M 582		