STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018896	A. BUILDING: _____ B. WING _____	01/10/2025

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M 000	INITIAL COMMENTS On 01/03/2025, with information obtained through 01/10/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a standard licensing survey at Ebenezer Family Home, an adult family home (AFH) located in Madison, WI. As a result of the survey, 9 deficiencies were identified. Census: 3	M 000		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 2 residents reviewed, Resident 2, received a health exam by a physician to identify health problems or was screened for communicable disease by a physician, registered nurse, or physician assistant within 90 days prior to admission or within 7 days after admission.	M 380		

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

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M 380	Continued From page 1 Findings include: On 01/03/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/31/2023 and was documented as having a legal guardian. There was no evidence of a health exam completed for Resident 2. One document in Resident 2's record, dated 08/31/2023 (approximately 1 month after his/her admission) and signed by his/her medical provider, documented that Resident 2 had been treated for a positive tuberculosis test in the past and as a result would "always test positive on [purified protein derivative (PPD)] testing and do not recommend routine [tuberculosis] screening with PPD testing." There was no other evidence of any other communicable disease screening completed for Resident 2. At approximately 4:09 p.m., Surveyor sent an e-mail to Licensee A requesting Resident 2's admission health exam and asking if any other communicable disease screening, outside of tuberculosis, was completed for Resident 2. No evidence of a health exam was received. On 01/07/2025, at approximately 11:55 a.m., Surveyor interviewed Licensee A. Licensee A confirmed that no other communicable disease screening was completed for Resident 2. On 01/10/2025, at approximately 2:01 p.m., Surveyor interviewed Licensee A again. Licensee A confirmed s/he had no evidence of a health exam or any other communicable disease screening completed for Resident 2.	M 380		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE	M 384		

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M 384	Continued From page 2 An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that there was a service agreement completed prior to admission for 2 of 2 residents reviewed. Findings include: Example 1 - Resident 1 On 01/03/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/12/2024 and was documented as having a legal guardian. There was no evidence of a signed service agreement in Resident 1's record. At approximately 4:09 p.m., Surveyor requested from Licensee A the service agreement for Resident 1. Nothing further was provided. On 01/07/2025, at approximately 2:15 p.m., Surveyor interviewed Licensee A. Licensee A reported that in looking through Resident 1's record s/he was unable to find a service agreement for Resident 1. Licensee A reported	M 384		

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M 384	Continued From page 3 that since Surveyor's request s/he had sent out a service agreement to Resident 1's guardian for review and signature. Example 2 - Resident 2 On 01/03/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/31/2023 and was documented as having a legal guardian. There was no evidence of a signed service agreement in Resident 2's record. At approximately 4:09 p.m., Surveyor requested from Licensee A the service agreement for Resident 1. Nothing further was provided. On 01/07/2025, at approximately 2:15 p.m., Surveyor interviewed Licensee A. Licensee A reported that in looking through Resident 2's record s/he was unable to find a service agreement for Resident 2. Licensee A reported that since Surveyor's request s/he had sent out a service agreement to Resident 2's guardian for review and signature.	M 384		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following: This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plans (ISPs) for residents identified the level of	M 410		

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supervision required inside the home for 3 of 3 residents reviewed, health monitoring needs for 1 of 3 residents reviewed (notably in the context of his/her diabetes management), and information regarding agreed-upon electronic restrictions for Resident 2.

Findings include:

Example 1 - Supervision needs

On 01/03/2025, at approximately 9:10 a.m., Surveyor toured the environment with Caregiver B. All 3 resident bedrooms were located on the main level of the home. Within the basement, a bedroom was observed. Caregiver B reported that this was a staff bedroom where staff could sleep at night. While touring the environment, Surveyor observed contact door sensors located on the front door, patio door, and door leading to the garage (3 of 3 doors leading out of the home). The sensors gave an audible chime whenever the doors were opened. Caregiver B confirmed that the sensors were typically on.

At approximately 10:30 a.m., Surveyor interviewed Caregiver B regarding staffing patterns. Caregiver B reported that there was typically one staff per shift, including during the overnight (NOC) shift. Caregiver B reported that NOC shift staff sometimes slept and were sometimes awake.

At approximately 11:32 a.m., Surveyor interviewed Caregiver B about resident needs. When asked about the door sensors, Caregiver B reported s/he thought they were being used due to Resident 2 having a history of eloping. Caregiver B reported s/he was unaware of any elopement attempts made by Resident 2 in the

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past year. Regarding Resident 1's needs, Caregiver B reported s/he had a history of suicidal ideation.

On 01/03/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/12/2024 with diagnoses including schizophrenia, bipolar disorder, and Asperger's syndrome. Resident 2 was documented as being under legal guardianship. Surveyor reviewed observation notes for Resident 1 and observed a note dated 01/01/2025, which documented: " ...After taking night meds [s/he] returned to complain to staff about [his/her] mental health issues. [S/he] shared how it impacted [him/her] in the past and how [s/he] currently had suicide ideations ..."

Surveyor reviewed Resident 1's most recent ISP, last signed as reviewed on 10/14/2024. The ISP documented the following regarding his/her supervision needs:

- "Is 24-hour supervision required both at home and in the community? [S/he] rides to some medical appointments unaccompanied- to get [his/her] monthly injections." A handwritten annotation in this section documented, "is not self-motivating. Some help." Underneath that, the following was documented: "If not, please describe the circumstances for which and length of time that the team has determined is safe to be without supervision: [S/he]'s afraid of some transportation because being in a big city is new ..."

There was no information regarding the in-home supervision Resident 1 required or how this was managed with the staff nighttime sleep arrangements.

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M 410	Continued From page 6 On 01/03/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 01/10/2023 (no diagnosis information documented). Resident 2 was documented as being under legal guardianship. Resident 3's most recent ISP available onsite, last signed as reviewed on 04/04/2024, documented the following regarding his/her supervision needs: - "Can be left unsupervised at home for up to 2 hours." On 01/03/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/31/2023. Resident 2 was documented as being under legal guardianship. An assessment located in Resident 2's record, dated 06/02/2023 (prior to his/her admission), documented the following need: "Overnight Supports: Care team reports [Resident 2] wakes up 1-2x each night, requiring caregivers to redirect [him/her] back to bed to prevent/eliminate behaviors from occurring ...Furthermore, [Resident 2] also requires overnight supervision due to cognitive impairment. [Resident 2] has a history of inviting strange [people] into [his/her] old apartment overnight, putting [him/herself] at risk. [Resident 2]'s caregivers have intervened to stop this from happening and becoming a safety issue. [Adult family home (AFH)] has an alarm system on the doors and windows to ensure [Resident 2] is safe ...Care team reports caregivers are not able to get at least six hours of uninterrupted sleep due to [Resident 2] having to be redirected back to bed 1-2x per night ..." Surveyor reviewed Resident 2's most recent ISP, last signed as reviewed on 11/21/2024. The ISP documented the following regarding his/her	M 410		

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supervision needs:

- "Is 24-hour supervision required both at home and in the community? Yes." Underneath that, the following was documented: "If not, please describe the circumstances for which and length of time that the team has determined is safe to be without supervision: [Resident 2] may take the bus to an agreed upon location and return on the bus at agreed upon times and with staff supervising on Life 360."

One section in Resident 2's ISP documented the following: " ...continue to make good choices around safety with [people] - (only go out with [people] [family members] know about and have approved), Continue [sic] to stay off drugs. Safety: let staff know where [s/he] is going and estimated arrival time, (take Uber or Bus [sic] when approved - Staff will be able to track on Life 360)."

There was no information regarding the in-home supervision Resident 1 required or how this was managed with the staff nighttime sleep arrangements.

On 01/10/2024, Surveyor reviewed a more current ISP for Resident 3, provided by Licensee A, which was signed as reviewed on 11/19/2024. Regarding Resident 3's supervision needs, the following was documented:

- "Is 24-hour supervision required both at home and in the community? No." Underneath that, the following was documented: "If not, please describe the circumstances for which and length of time that the team has determined is safe to be without supervision: Guardian approves [s/he] can be left unsupervised at home for up to 2

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hours."

There was no information regarding how Resident 3's supervision needs were managed with the staff nighttime sleep arrangements.

On 01/10/2025, at approximately 2:01 p.m., Surveyor interviewed Licensee A. Licensee A confirmed that NOC shift slept at night and reported this was typical due to the residents sleeping through the night with no concerns. When asked about the information regarding Resident 2's elopement risk or safety, Licensee A replied that that information was no longer current. Licensee A reported that s/he thought that 24/7 supervision needs referred to staff being onsite 24/7, not necessarily awake and with residents 24/7.

Example 2 - Resident 2's health monitoring

On 01/03/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/31/2023 with diagnoses including type 2 diabetes mellitus. Resident 2 was documented as being under legal guardianship. Resident 2's physician orders, dated "January 2025" documented an order for test strips with instructions to, "Use twice daily to check blood sugar." Resident 2's medication administration record (MARs) from 12/01/2024 - 01/02/2025 contained entries for blood sugar checks to be conducted at 8:00 a.m. and 5:00 p.m. The entries were all blank for the above date range. There was no other evidence in Resident 2's record of blood sugar checks having been conducted.

Within Resident 2's record, Surveyor observed an "After Visit Summary" document from a medical visit s/he had on 12/30/2024. From the

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medication list on that summary, Surveyor observed orders for lancets and glucose blood test strips which contained instructions for use twice daily to check Resident 2's blood sugar.

Surveyor reviewed Resident 2's most recent ISP, last signed as reviewed on 11/21/2024. The ISP documented that staff were responsible for Resident 2's medication administration. The ISP documented the following regarding his/her health monitoring needs:

"Are there current health concerns? If so, please describe: "Prediabetic, (Low carb menu plan) ..."

There was no other information regarding Resident 2's health monitoring needs.

Of note, Surveyor observed that Resident 2's prescriptions included Trulicity 3 mg/0.5 mL injection (start date 08/27/2024) with instructions to, "Inject 3 mg under the skin once weekly," and Trulicity 4.5 mg/0.5 mL injection (start date 12/30/2024) with instructions to, "Inject 0.5 mL under skin once weekly." Both of these were prescribed due to type II diabetes mellitus, suggesting that Resident 2 was no longer "prediabetic" as documented in his/her ISP.

On 01/10/2025, at approximately 2:01 p.m., Surveyor interviewed Licensee A. Licensee A reported s/he didn't think Resident 2 had to do blood sugar checks anymore. Licensee A reported s/he wasn't sure when s/he thought the checks stopped for Resident 2 or if Resident 2 required staff assistance for them. Licensee A reported that Resident 2 attended his/her own medical appointments and so staff relied on the information s/he reported back regarding health changes from appointments. When Surveyor

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discussed that test strip supplies and instructions continued to be reflected in Resident 2's physician orders and medical visit notes, Licensee A replied that s/he would have to look into it.

Example 3 - Resident 2's electronic restrictions

On 01/03/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/31/2023. Resident 2 was documented as being under legal guardianship. Surveyor reviewed observation notes for Resident 2 from 10/01/2024 - 01/02/2025 and observed several notes regarding personal electronic belonging restrictions, including the following:

- 10/02/2024: " ...[S/he] took [his/her] pills and turned in electronics before going to bed."

- 10/08/2024: " ...Turned in electronics after taking night meds and retired to bed."

- 12/08/2024: " ...[S/he] got [his/her] night meds and turned in electronics before going to bed ..." Another entry that day documented, "Also, I noticed [s/he] was on call between 4-6am. This was strange because [s/he]'d turn in [his/her] phone and laptop before going to bed. And I locked these in the med cabinet. I plan to gather more evidence before asking [him/her] about this."

- 12/19/2024: "[S/he] took night pills, turned in electronics and went to bed ...Again, I noticed [him/her] talking on the phone at before [sic] 6am this morning. That's before staff returned [his/her] phone and laptop to [him/her]. I would ask [him/her] about this 'new phone' tomorrow."

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- 12/20/2024: "[S/he] turned in [his/her] electronics and went to bed ...Staff noticed [s/he] was talking again with her [friend] before getting back [his/her] phone and laptop. This was around 6am. Staff talked to [him/her] about the calls [s/he] makes. [S/he] said [his/her] [friend] calls on X-box. Staff reminded [him/her] that [s/he]'s not supposed to be calling when [s/he]'s supposed to be in bed ..."

- 12/23/2024: " ...[S/he] turned in electronics and went to bed. However, at about 11:30, staff noticed [s/he]'s on call with someone and reported to [Licensee A] who in turn forwarded the message to [Resident 2's guardian]. [Resident 2] was really livid that staff did that in the morning. Staff encouraged [him/her] to find a way to have conversation with his/her [guardian] on existing rules ..."

Other notes about Resident 2 turning in his/her electronics prior to him/her going to bed were documented on the following dates: 10/06/2024, 10/07/2024, 10/09/2024, 10/14/2024 through 10/17/2024, 10/19/2024 through 11/01/2024, 11/05/2024 through 11/07/2024, 11/09/2024 through 11/14/2024, 11/16/2024, 11/18/2024 through 11/24/2024, 11/26/2024 through 11/30/2024, 12/03/2024, 12/04/2024, 12/06/2024, 12/09/2024 through 12/18/2024, 12/21/2024, 12/24/2024, and 12/25/2024 through 12/30/2024.

Surveyor reviewed Resident 2's most recent ISP, last signed as reviewed on 11/21/2024. The ISP did not document any rules/restrictions related to access to his/her personal electronic belongings.

On 01/03/2025, at approximately 11:32 a.m., Surveyor interviewed Caregiver B about Resident 2's needs. Caregiver B confirmed that Resident 2

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M 410	Continued From page 12 was expected to turn his/her electronics, including his/her cell phone, laptop, and x-box, every night to staff, who in turn locked them in the medication closet. Caregiver B confirmed that staff returned the belongings to Resident 2 every morning. On 01/10/2025, at approximately 2:01 p.m., Surveyor interviewed Licensee A. Licensee A confirmed that Resident 2 was expected to turn his/her personal electronic belongings in at night. Licensee A reported that this was to help Resident 2 in sleeping throughout the night, otherwise with the belongings in his/her possession s/he was known to play on them all night. Licensee A confirmed that Resident 2's guardians were aware of and agreed with the plan and that this rule was something suggested by one of Resident 2's guardians.	M 410		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that every prescription medication	M 458		

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M 458	Continued From page 13 was securely stored. Findings include: On 01/03/2025, at approximately 10:13 a.m., Surveyor observed Resident 2's medication supply. Surveyor observed multiple boxes of Trulicity pens (an injectable diabetic medication) prescribed to Resident 2 located in the secured medication closet. Surveyor then observed 2 boxes of Trulicity pens, prescribed to Resident 2, located in the kitchen refrigerator on a shelf with other food (Photo 3). The boxes were unsecured and available to anyone who opened the refrigerator. While observing the boxes, Surveyor interviewed Caregiver B. Caregiver B confirmed that Resident 2's Trulicity pens were typically kept in the kitchen refrigerator. When asked if they were secured in any way, such as with a separate lock box, Caregiver B denied that they were. On 01/03/2025, Surveyor reviewed Resident 2's current prescriptions, one of which was for Trulicty 3 mg/0.5 mL injection with the instructions, "Inject 3 mg under the skin once weekly." 01/10/2025, at approximately 2:01 p.m., Surveyor interviewed Licensee A. Licensee A reported s/he was unaware that staff were keeping Resident 2's Trulicity pens in the kitchen refrigerator and thought that they were all located in the medication closet.	M 458		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident,	M 464		

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M 464	Continued From page 14 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 that a written order from 1 of 2 residents' physicians was obtained specifying who was permitted to administer the medication. Findings include: On 01/03/2025, at approximately 9:55 a.m., Surveyor observed the medication storage closet with Caregiver B. Surveyor observed that Resident 1's medications were stored securely in the closet, within keyed control by Caregiver B. Caregiver B confirmed that staff assisted Resident 1 with medication administration. On 01/03/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/12/2024 and was documented as having a legal guardian. Surveyor reviewed medication administration records (MARs) for Resident 1 dated 12/01/2025 - 01/13/2025, which showed staff initialing off on each administration of Resident 1's prescribed medications. In reviewing Resident 1's records, there was no evidence of an order from his/her medical provider specifying that the provider's staff were permitted to administer Resident 1's medications to him/her.	M 464		

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M 464	Continued From page 15 At approximately 4:09 p.m., Surveyor requested from Licensee A an order from Resident 1's medical provider permitting staff to administer his/her medications. On 01/09/2025, Surveyor reviewed a record provided by Licensee A via e-mail that day at 11:53 a.m. The record showed an order from Resident 1's medical provider permitting the provider's staff to administer his/her medications. The order was dated that day, 01/09/2025 (approximately 7 months after Resident 1's admission). 01/10/2025, at approximately 2:01 p.m., Surveyor interviewed Licensee A. Licensee A confirmed that the physician order was dated 01/09/2025, after Surveyor had requested it. Licensee A reported that s/he may have missed obtaining this previously.	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 record review and interview, the	M 466		

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provider did not ensure that records maintained by the licensee which showed the medications administered by staff contained complete information showing the dates and times Resident 2 took medication as well as any omissions.

Resident 2's medication administration records (MARs) from 12/01/2024 - 01/02/2025 contained 6 of 6 total missing entries of his/her Trulicity administration and 2 of 2 missing applicable entries of his/her nicotine patch administration.

Twelve medications that were prescribed to Resident 2 and showing as current per his/her MARs and physician orders from January 2025 were not on hand in the provider's medication supply for Resident 2. The seven medications from these 12 that were scheduled were not documented as having been administered. A recent note from Resident 2's medical visit contained a medication list of which 3 of the 12 medications were listed. Between the discrepancies of the observed medication supply, medication list from his/her medical provider, physician orders, and MARs, it was unclear which medications were current for Resident 2.

Findings include:

Example 1 - Resident 2's medication administration documentation

On 01/03/2025, at approximately 10:13 a.m., Surveyor observed Resident 2's medication supply, which included boxes of Trulicity pens (an injectable diabetic medication) prescribed to Resident 2 located in both the secured medication closet, of which staff used a key to lock/unlock, and the kitchen refrigerator. While

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observing the supply, Surveyor interviewed Caregiver B who confirmed that staff assisted Resident 2 with medication administration. In reviewing Resident 2's medications from the medication closet, Surveyor observed nicotine patches prescribed to Resident 2.

On 01/03/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/31/2023 with diagnoses including type 2 diabetes mellitus. Resident 2's prescriptions included the following:

- Trulicity 3 mg/0.5 mL injection (start date 08/27/2024) with instructions to, "Inject 3 mg under the skin once weekly."
- Trulicity 4.5 mg/0.5 mL injection (start date 12/30/2024) with instructions to, "Inject 0.5 mL under skin once weekly."
- Nicotine 7 mg/24 hr [transdermal] patch (start date 12/30/2024) with instructions to, "Apply 1 patch to skin once daily for smoking cessation. Remove old patch before applying new patch ..."

Surveyor reviewed Resident 2's MARs from 12/01/2024 - 01/02/2025 and observed the following:

- Trulicity (3 mg/0.5 mL injection): 5 of 5 applicable weekly entries blank - 12/04/2024, 12/11/2024, 12/18/2024, 12/25/2024, 01/01/2025
- Trulicity (4.5 mg/0.5 mL injection): 1 of 1 applicable weekly entry blank - 01/01/2025
- Nicotine patches: 2 of 2 applicable daily entries blank - 01/01/2025, 01/02/2025

01/10/2025, at approximately 2:01 p.m., Surveyor interviewed Licensee A. Licensee A acknowledged Surveyor's concerns that there were blank entries in Resident 2's MARs and

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reported s/he would follow up on the concern.

Example 2 - Resident 2's record of prescription medications

In reviewing Resident 2's current prescription list, which was on a document titled "Physician's Orders" and dated "January 2025," Surveyor observed the following scheduled medications:

- Benzoyl Peroxide 5% gel with instructions to, "Apply 1-2 times daily."
- Clotrimazole 1% cream with instructions to, "Apply topically to rash twice daily until gone, then use once daily topically for prevention."
- Diclofenac 1% gel with instructions to, "Apply 2 gm topically to affected area(s) 4 times daily."
- Lidocaine 4% patch with instructions to, "Apply 1 patch topically once daily, remove after 12 hours."
- Polyethylene glycol 3350 powder with instructions to, "Mix 17 grams (fill cap to line) in 4-8 oz liquid, stir well and drink once daily to avoid constipation."
- Terbinafine 1% cream with instructions to "Apply twice daily."
- Triamcinolone 0.1% cream with instructions to, "Apply to affected area twice daily."

In reviewing Resident 2's MARs from 12/01/2024 - 01/02/2025, Surveyor observed the above medications documented as entries with scheduled time entries, but all entries were blank with no annotations.

Surveyor also observed the following as needed (PRN) medications from Resident 2's physician orders document:

- Betamethasone valerate 0.1% cream with instructions to, "Apply to affected area 3 times

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daily as needed for itching."
- Erythromycin 2% gel with instructions to, "Apply to affected area(s) twice daily as needed."
- Lidocaine 4% cream with instructions to, "Apply to affected area 3 times daily as needed."
- Nystatin 100,000 units/gm powder with instructions to, "Apply to affected area(s) twice daily as needed for rash under skin folds."
- Proctozone-HC 2.5% cream with instructions to, "Apply topically to perianal area 4 times daily as needed for irritation."

The above PRN medications were also recorded in Resident 2's MARs with no entries indicating administration or any other annotations indicating their status.

In reviewing Resident 2's record, Surveyor did not observe discontinuation orders or any other notes indicating the status of these medications as not active to contradict Resident 2's January 2025 physician orders. Surveyor observed an "After Visit Summary" document from a medical visit Resident 2 had on 12/30/2024. From the medication list on that summary, 3 of the medications listed above were documented: Terbinafine 1% cream, erythromycin 2% gel, and nystatin 100,000 units/gm powder.

At approximately 1:41 p.m., Surveyor observed Resident 2's medication supply with Caregiver B. None of the above scheduled or PRN medications were observed on hand for Resident 2. Caregiver B reported s/he was unaware of these discrepancies and was only aware of the medications that were located in the medication closet for Resident 2.

On 01/10/2025, at approximately 2:01 p.m., Surveyor interviewed Licensee A. Licensee A

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M 466	Continued From page 20 acknowledged Surveyor's concern that in comparing Resident 2's MARs, physician order list from January 2025, overall record showing lack of medication discontinuation orders, medications the provider had on-hand, and medical provider medication list, it was unclear which of Resident 2's medications were current. Licensee A reported s/he was aware that Resident 2's orders contained several medications which s/he didn't think were current, with some s/he thought were not current even upon Resident 2's admission. Licensee A reported s/he would follow up with the pharmacy and Resident 2's medical provider and review Resident 2's medications.	M 466		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses contraband. The resident shall be present for the search. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that residents had the right to privacy in their living arrangements by having a	M 550		

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M 550	Continued From page 21 camera located in the home's living room. Findings include: On 01/03/2025, at approximately 9:10 a.m., Surveyor toured the environment. Surveyor observed a device, consistent in appearance with a camera, located in an upper corner of the living area, facing towards the living area. The device was plugged into a wall outlet located near the ground and had a light indicator (unlabeled) which was lit (Photos 1 & 2). At approximately 11:32 a.m., Surveyor observed the device with Caregiver B and interviewed him/her about it. Caregiver B reported that s/he thought it was a camera. When asked what it was for, Caregiver B replied it was initially put up to monitor a former resident that had been discharged a couple of months ago. On 01/10/2025, at approximately 2:01 p.m., Surveyor interviewed Licensee A. Licensee A confirmed that the device in the living room was a camera, which was put up to monitor a former resident who snuck in male guests. Licensee A acknowledged understanding Surveyor's concern that the camera was violating residents' privacy. Licensee A reported s/he would take the camera down.	M 550		
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	M 570		

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M 570	Continued From page 22 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 a safe physical environment with residents safeguarded from environmental hazards from which they were likely to be exposed. The faucet water temperature of the sole resident bathroom sink reached 145.4° Fahrenheit (F). Findings include: The provider is licensed to serve up to 3 adults in the client groups of emotionally disturbed/mental illness, developmentally disabled, and advanced aged. On 01/03/2025, at approximately 9:46 a.m., Surveyor tested the water temperature of the sink in the sole resident bathroom which reached 145.4° F. According to the Wisconsin Department of Health Services, "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents 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	M 570		

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M 570	Continued From page 23 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." Sustained contact with water at or above 127° F can result in second or third-degree burns in approximately 1 minute (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017). On 01/10/2025 at approximately 2:01 p.m., Surveyor interviewed Licensee A. Licensee A reported s/he was unaware of the sink water temperature concern because it wasn't an issue the last time it was tested. Licensee A reported s/he would follow up with his/her maintenance staff to address the concern.	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, record review, and interview, the provider did not ensure that Resident 2 received his/her econazole nitrate 1% cream at the intervals prescribed by his/her	M 582		

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medical provider.

Resident 2's econazole cream was initiated on 10/24/2024 with his/her current cream tube having been dispensed on 12/13/2024. The medication administration records (MARs) throughout the period Surveyor reviewed, from 12/01/2024 - 01/02/2025, did not document any administrations of the cream. Upon observation of the tube on hand, its seal was still intact. Since at least the cream was last dispensed on 12/13/2024, Resident 2 did not receive any administrations of it (approximately 20 administrations).

Findings include:

On 01/03/2024, at approximately 9:55 a.m., Surveyor observed the medication storage closet with Caregiver B. Surveyor reviewed a cream tube within Resident 2's medication section that was in a bag. The bag contained a pharmacy label which documented that the cream was econazole nitrate 1% cream, prescribed to Resident 2, and dispensed on 12/13/2024 (Photo 4). Upon observing the cream tube, the seal was still observed intact over the opening of the tube (Photo 5). The pharmacy label indicated the following prescription directions: "Apply topically once daily for cutaneous candidiasis."

While observing the econazole nitrate cream, Surveyor interviewed Caregiver B about it. Caregiver B reported s/he thought it was used for a rash at Resident 2's chest area. Caregiver B reported s/he believed the medication was to be used on an as needed (PRN) basis.

On 01/03/2024, Surveyor reviewed Resident 2's record. Resident 2's physician orders, dated

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M 582	Continued From page 25 "January 2025," documented that Resident 2's econazole cream began on 10/24/2024 and gave the same administration instructions as observed by Surveyor on the econazole's pharmacy label (above). Surveyor then reviewed Resident 2's MARs from 12/01/2024 - 01/02/2025. All entries within this range of his/her econazole administration were blank. On 01/10/2025 at approximately 2:01 p.m., Surveyor interviewed Licensee A. Licensee A reported s/he was unaware of any issues with medication administration for Resident 2 and reported s/he would follow up on the concern.	M 582		