STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021439	A. BUILDING: _____ B. WING _____	C 09/30/2025

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LANCASTER AFH LLC	W5990 FRIEDEL RD FORT ATKINSON, WI 53538

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M 000	INITIAL COMMENTS From 09/29/2025 to 09/30/2025, Surveyor conducted 2 complaint investigations at Lancaster AFH LLC, an AFH in Fort Atkinson. Eleven deficiencies were identified. Two of 2 complaints were substantiated. Census: 1	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report a significant change in a resident's status to the department within 24 hours. The provider did not report Resident 1's hospitalization for hyperglycemia with a blood sugar of 671. Findings include: From 09/29/2025 to 09/30/2025, Surveyor	M 134		

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

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M 134	Continued From page 1	M 134		

conducted 2 complaint investigations alleging the provider did monitor a resident's health.

On 09/29/2025 at 6:00 a.m., Surveyor reviewed hospital records, obtained by Surveyor. A hospital RN note, dated 09/16/2026, documented that Resident 1 was admitted to the hospital on 09/16/2025 at approximately 1:46 p.m. from the provider's home after Guardian C spoke with Resident 1 via telephone, noted confusion and called paramedics. A physician note, dated 09/16/2025 stated Resident 1 presented with a critically high glucose level of 671 resulting at 2:21 p.m. and would be admitted to the intensive care unit on an insulin drip.

On 09/29/2025 at 7:00 a.m., Surveyor reviewed the department's records for the facility and was unable to locate documentation of a self-report regarding Resident 1's hospitalization.

On 09/29/2025 at 8:20 a.m., Surveyor reviewed Resident 1's record, provided by Caregiver B. Resident 1 was admitted to the provider's home on 08/30/2025. Resident 1's record did not include progress notes or incident reports. Surveyor was unable to locate any documentation regarding Resident 1's 09/16/2025 hospitalization.

On 09/29/2025 at approximately 4:00 p.m., Surveyor asked Licensee A if s/he reported Resident 1's significant change in status to the department.

On 09/29/2025 at approximately 5:30 p.m., Licensee A replied to Surveyor stating s/he did not report the significant change because his/her staff went to the hospital and was kicked out without finding out anything about Resident 1.

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M 134	Continued From page 2 Resident 1 did not return to the provider's hospital following the hospitalization.	M 134		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure the home and its operations complied with all laws governing the home and its operation. Findings include: From 09/29/2025 to 09/30/2025, Surveyor conducted 2 complaint investigations alleging resident care and home cleanliness concerns, resulting in 11 deficiencies. The following concerns were identified: Environment: - The provider did not ensure medications were securely stored. - The provider did not ensure food was stored in a sanitary and safe way. Resident Care: - The provider admitted a non-ambulatory resident when they were licensed to provide care for ambulatory residents only. - The provider did not ensure a service agreement was completed prior to admission.	M 216		

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M 216	Continued From page 3	M 216		

- The provider did not monitor the health of Resident 1, who was diabetic.
- The provider did not ensure a written order permitting staff to administer medications was received for 2 of 2 residents.
- The provider did not ensure medication administration was accurately documented at the time of administration for 2 of 2 residents reviewed.
- The provider did not ensure 1 of 2 residents reviewed received prompt and adequate treatment when hyperglycemic.
- The provider did not ensure 2 of 2 residents reviewed received all medications as prescribed.

On 09/29/2025 at 8:50 a.m., Surveyor reviewed environmental and medication concerns with Caregiver B. Caregiver B stated "Mistakes happen sometimes," and that s/he didn't like to stress out Licensee A because s/he just had twins.

On 09/30/2025 at 2:00 p.m., Surveyor reviewed environmental and care concerns with Licensee A. Licensee A stated there was an admission problem with Resident 1 and that the provider did not follow the proper steps for Resident 1's admission. Licensee A stated s/he had been out of town during Resident 1's admission and was out of town during Surveyor's visit.

Cross Reference:
M0134 DHS 88.03(5)(e)1. Significant Change To The Resident
M0216 DHS 88.04(2)(a) Responsibilities
M0262 DHS 88.05(2)(a) Difficulty Walking
M0384 DHS 88.06(2)(b) Service Agreement Except Respite
M0448 DHS 88.07(2)(b)5. Monitoring Health
N0458 DHS 88.07(3)(a) Prescription Medications

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M 216	Continued From page 4 M0464 DHS 88.07(3)(d) Medication - Written Order M0466 DHS 88.07(3)(e)1. Medication - Record Keeping M0474 DHS 88.07(4)(c) Food Prepared And Stored Sanitary Way M0580 DHS 88.10(3)(p) Prompt And Adequate M0582 DHS 88.10(3)(q) Medications	M 216		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the exits were ramped to grade with a hard surfaced	M 262		

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M 262	Continued From page 5	M 262		

pathway with handrails for a resident that walked with the assistance of a walker or used a wheelchair.

Resident 1 required a walker or wheelchair for mobility and the provider only had 1 ramped entrance to grade.

Findings include:

From 09/29/2025 to 09/30/2025, Surveyor conducted 2 complaint investigations alleging the provider did not complete necessary admission paperwork prior to admission.

The home is licensed to serve up to 4 ambulatory residents with diagnoses including advanced age, developmentally disabled, pregnant women/counseling, alcohol/drug dependent, irreversible dementia/Alzheimer's and emotionally disturbed/mentally ill.

Chapter DHS 88 defines "ambulatory" as walking without difficulty or help.

On 09/29/2025 at 8:10 a.m., Surveyor arrived to the home and observed 3 exits to the home. One exit was the front door, which required an individual to navigate steps to utilize. One exit was the patio door, which required an individual to navigate a step to utilize. One exit was the garage door, which had a ramped exit.

On 09/29/2025 at 8:20 a.m., Surveyor reviewed Resident 1's record, provided by Caregiver B. Resident 1 was admitted to the provider's home on 08/30/2025. Resident 1's individual service plan (ISP), signed and dated by Licensee A on 08/30/202025, stated Resident 1 required assistance with mobility. Caregiver B clarified that

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M 262	Continued From page 6 Resident 1 used a walker and wheelchair for mobility. On 09/29/2025 at 8:45 a.m., Surveyor reviewed a report from Guardian C, which stated Licensee A reported s/he had a ramp installed in the home's garage for Resident 1 on 08/28/2025. On 09/29/2025 at approximately 9:00 a.m., Surveyor interviewed Caregiver B and asked if the home had a 2nd ramped entrance to the home. Caregiver B replied, "No. Just the [garage]." On 09/29/2025 at approximately 9:15 a.m., Surveyor interviewed Licensee A. Licensee A confirmed Resident 1 used a walker and wheelchair for mobility. Surveyor shared concern that the home was not accessible for non-ambulatory residents and that the home was licensed to provide care for ambulatory residents only. Surveyor asked Licensee A if s/he was aware the home was licensed to serve ambulatory residents only. Licensee A replied, "Yes." On 09/30/2025 at approximately 1:30 p.m., Surveyor received Resident 1's pre-admission assessment, dated 08/25/2025, from Licensee A, which documented Resident 1 used a wheelchair and walker, indicating Licensee A was aware of Resident 1's non-ambulatory status prior to admission. On 09/30/2025 at 2:00 p.m., Surveyor interviewed Licensee A and asked why a non-ambulatory resident was admitted to the home when the home was not licensed to provide care for non-ambulatory residents. Licensee A stated s/he accepted Resident 1 because Guardian C stated	M 262		

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M 262	Continued From page 7 Resident 1's admission was an emergency.	M 262		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a service agreement was completed with 1 of 2 residents reviewed prior to admission. A service agreement was not completed with Resident 1's guardian. Findings include: From 09/29/2025 to 09/30/2025, Surveyor conducted 2 complaint investigations alleging the provider did not complete necessary admission paperwork prior to admission. On 09/29/2025 at 8:20 a.m., Surveyor reviewed Resident 1's record, provided by Caregiver B. Resident 1 was admitted to the provider's home on 08/30/2025. Resident 1 had a legal guardian.	M 384		

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M 384	Continued From page 8 Resident 1's record included a service agreement that was signed and dated by Licensee A on 08/30/2025. The service agreement did not include a signature from Resident 1's legal guardian. On 09/29/2025 at approximately 9:15 a.m., Surveyor interviewed Licensee A and asked why Resident 1's service agreement was not signed by the legal guardian. Licensee A stated s/he was out of town when Resident 1 admitted to the provider's facility. On 09/30/2025 at 1:10 p.m., Guardian C forwarded an email from Licensee A that indicated Licensee A emailed Guardian C on 09/16/2025 at 3:37 p.m., 17 days after admission and after Resident 1 had admitted to the hospital, requesting that Guardian C sign the service agreement.	M 384		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents reviewed had their health monitored by observing and documenting changes in the resident's health and referring to health care providers when necessary. The provider did not check Resident 1's blood	M 448		

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M 448	Continued From page 9	M 448		

sugar 5 times daily as ordered and did not document Resident 1 exhibiting confusion and transferring to the hospital for hyperglycemia.

Findings include:

From 09/29/2025 to 09/30/2025, Surveyor conducted 2 complaint investigations alleging the provider did monitor a resident's health.

On 09/29/2025 at 8:20 a.m., Surveyor reviewed Resident 1's record, provided by Caregiver B. Resident 1 was admitted to the provider's home on 08/30/2025 with diagnosis including diabetes. Resident 1's record included an individual service plan (ISP), signed and dated by Licensee A on 08/30/2025, that indicated Resident 1 required blood sugar checks, staff to assist with medication management and staff to monitor his/her physical and mental health. The following concerns with health monitoring were identified:

Blood Sugar Checks:

Resident 1's physician orders included an order, dated 09/10/2025, to check his/her blood sugar 5 times daily at 8:00 a.m., 12:00 p.m., 2:00 p.m., 5:00 p.m. and 8:00 p.m. The record included documentation of blood sugar checks, dated 09/04/2025 to 09/16/2025 at 8:00 a.m., 12:00 p.m., 2:00 p.m. and 5:00 p.m. Surveyor was unable to locate documentation indicating Resident 1's 8:00 p.m. blood sugar was taken and recorded.

On 09/29/2025 at approximately 9:15 a.m., Surveyor interviewed Licensee A and shared concern that Resident 1's 8:00 p.m. blood sugar check was not documented in the record. Licensee A replied, "Okay."

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M 448	Continued From page 10 Hospital Admission: On 09/29/2025 at 6:00 a.m., Surveyor reviewed hospital records, obtained by Surveyor. A hospital RN note, dated 09/16/2026, documented that Resident 1 was admitted at approximately 1:46 p.m. from the provider's home after Guardian C spoke with Resident 1 via telephone, noted confusion and called paramedics. The RN documentation stated the provider's staff did not have any documentation to provide paramedics upon arrival, including blood sugar checks or a medication list. The RN documentation stated Caregiver F later arrived to the hospital stating Resident 1's insulin was discontinued 09/12/2025, but didn't have any documentation to provide hospital staff. A physician note, dated 09/16/2025 stated Resident 1 presented with a critically high glucose level of 671 at 2:21 p.m. and was admitted to the intensive care unit on an insulin drip. On 09/29/2025 at 8:20 a.m., Surveyor reviewed Resident 1's record and noted Resident 1's record did not include any physician notes regarding the 09/16/2025 hospitalization. On 09/29/2025 at approximately 9:15 a.m., Surveyor interviewed Licensee A and asked the provider if s/he had any additional documentation regarding Resident 1, including documentation of the 09/16/2025 hospitalization. Licensee A replied, "No. [S/he] just needed assistance with incontinence and showers." Licensee A stated other than blood sugar checks, s/he had no further documentation. Licensee A added that the provider was working on getting an electronic charting program set up.	M 448		

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M 448	Continued From page 11 On 09/29/2025 at 12:47 p.m., Surveyor interviewed Caregiver E. Caregiver E stated Resident 1 was "jumpy" and not his/her usual self prior to the transfer to the hospital. The provider did not document Resident 1's change in condition and hospitalization in his/her record. Cross Reference: M0580 DHS 88.10(3)(p) Prompt And Adequate	M 448		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all medications were securely stored. Wegovy insulin was stored unsecured in the provider's refrigerator. Findings include:	M 458		

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M 458	Continued From page 12 The home is licensed to serve up to 4 residents with diagnoses including advanced age, developmentally disabled, pregnant women/counseling, alcohol/drug dependent, irreversible dementia/Alzheimer's and emotionally disturbed. On 09/29/2025, Surveyor conducted a complaint investigation alleging cleanliness concerns at the provider's home. On 09/29/2025 at approximately 8:45 a.m., Surveyor observed Resident 2, who was ambulatory and able to independently access the provider's refrigerator. On 09/29/2025 at 9:15 a.m., Surveyor observed the provider's refrigerator. Surveyor observed 2 Wegovy insulin pens stored in the refrigerator, unlocked. On 09/29/2025 at 9:20 a.m., Surveyor interviewed Caregiver B and asked if the provider had a lock box to keep the 2 Wegovy insulin pens secured. Caregiver B replied, "No."	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, 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	M 464		

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M 464	Continued From page 13 order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written order from the resident's physician permitting the provider's staff to administer medications was obtained for 2 of 2 residents reviewed. The provider did not have a written order from a physician permitting his/her staff to administer Resident 1 and Resident 2's medications. Findings include: From 09/29/2025 to 09/30/2025, Surveyor conducted 2 complaint investigations alleging the provider did not complete necessary admission paperwork prior to admission. On 09/29/2025 at 8:20 a.m., Surveyor reviewed resident records, provided by Caregiver B. The following concerns were noted: Example 1 - Resident 1: Resident 1 was admitted to the provider's home on 08/30/2025. Resident 1's individual service plan (ISP), dated 08/30/2025, indicated the provider's staff administered his/her medications. Resident 1's record did not include a physician order permitting the provider's staff to administer medications. Example 2 - Resident 2: Resident 2 resided at the provider's home when it became licensed as an adult family home on	M 464		

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M 464	Continued From page 14 07/31/2025. Caregiver B stated staff completed Resident 2's medication administration. Resident 2's record did not include a physician order permitting the provider's staff to administer medications. On 09/29/2025 at 4:00 p.m., Surveyor asked Licensee A if s/he had physician orders permitting his/her staff to administer Resident 1 and Resident 2's medications. On 09/29/2025 at approximately 5:30 p.m., Licensee A provided Surveyor with medication lists for Resident 1 and Resident 2, but no physician orders permitting staff to administer medications. On 09/30/2025 at 2:05 p.m., Surveyor interviewed Licensee A, who confirmed s/he did not have a physician order permitting staff to administer medications.	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 an accurate record was maintained of all prescription medications controlled, dispensed or administered by the provider's staff.

Resident 1's medication administration was not documented as medications were administered.

Resident 2's medications were documented as administered by the provider's staff when Resident 2 was staying outside the facility.

Findings include:

From 09/29/2025 to 09/30/2025, Surveyor conducted 2 complaint investigations alleging concerns with the provider's medication management.

On 09/29/2025 at 8:20 a.m., Surveyor reviewed resident records, provided by Caregiver B. The following concerns were noted:

Example 1 - Resident 1:

Resident 1 was admitted to the provider's home on 08/30/2025. Resident 1's individual service plan (ISP), dated 08/30/2025, indicated the provider's staff administered his/her medications. Resident 1's record included a medication administration record (MAR), completed by a pharmacy, that had medications listed with a start date of 09/15/2025. The MAR had medications signed off as administered from 09/04/2025 to 09/16/2025.

On 09/29/2025 at 3:40 p.m., Surveyor interviewed Pharmacist D. Pharmacist D stated the pharmacy did not receive electronic prescriptions from the provider until 09/10/2025, had billing difficulties

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and was unable to reach the provider on 09/15/2025 and did not deliver medications until 09/24/2025. Surveyor asked Pharmacist D if there was documentation the pharmacy had provided a MAR on or before 09/04/2025. Pharmacist D replied, "No." Surveyor shared observation that the MAR, prepared by pharmacy, listed medications that started on 09/15/2025 indicating the MAR would have been prepared on or after 09/15/2025. Pharmacist D confirmed Surveyor's observation.

On 09/30/2025 at approximately 2:00 p.m., Surveyor interviewed Licensee A and shared observation that Resident 2's MAR appeared to be prepared by pharmacy on or after 09/15/2025, yet medications were signed off since 09/04/2025. Licensee A stated s/he was unsure what caregivers were documenting on during Resident 1's stay and s/he was unable to confirm who provided the MAR and when.

Example 2 - Resident 2:

Resident 2 resided at the provider's home when it became licensed as an adult family home on 07/31/2025. Caregiver B stated staff completed Resident 2's medication administration. Caregiver B stated Resident 2 had resided at his/her family member's home from 09/27/2025 AM to 09/28/2025 just before 8:00 p.m. Surveyor observed Resident 2's MAR, dated 09/01/2025 to 09/29/2025, documented Resident 2's 09/27/2025 PM and 09/28/2025 AM medications as administered by Caregiver B.

On 09/29/2025 at approximately 8:40 a.m., Surveyor interviewed Caregiver B and asked if s/he administered Resident 2's medications while Resident 2 was away from the home. Caregiver B

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M 466	Continued From page 17 replied, "No," and explained that s/he signed off on the medications since s/he had sent the medications with Resident 2's family member. Cross Reference: M0582 DHS 88.10(3)(q) Medications	M 466		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored in a sanitary manner. Findings include: From 09/29/2025 to 09/30/2025, Surveyor conducted a complaint investigation alleging cleanliness concerns at the provider's home. On 09/29/2025 at 9:15 a.m., Surveyor observed the provider's refrigerator and freezer, which contained the following concerns: - Hardened white liquid on the shelves. - A plastic container of leftovers without a label or date. - A half-cut onion wrapped in paper towel. - Romaine lettuce that had turned brown in color with a "Best if used by" date of 09/11/2025. - A package of string cheese that was left unsealed. The cheese had hardened.	M 474		

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M 474	Continued From page 18 - Two packages of frozen chicken that had been left open to air. - Frozen beef patties that had wax paper covering the top and bottom, with the sides left open to air. - Approximately 10 frozen meatballs that were not in any sort of packaging in the freezer. - French fries, food particles and built-up ice on the surface and food packages in the freezer. "Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) "Storing food in the freezer ... Wrap the food properly or put it in sealed containers. If you do not seal your food it can get "freezer-burn". This means that water escapes from the food and moves to the coldest part of the freezer - leaving your food dehydrated." (Source: Safefood website, Storing food in the freezer, 2025, https://www.safefood.net/food-storage/freezing (retrieval date - October 2, 2025).) On 09/29/2025 at approximately 9:20 a.m., Surveyor interviewed Caregiver B regarding the condition of the refrigerator and freezer. Caregiver B stated s/he was going to throw some of the food out today.	M 474		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the	M 580		

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resident's needs.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 2 residents reviewed received prompt and adequate treatment when experiencing hyperglycemia.

The provider did not respond to Resident 1 when experiencing hyperglycemia and delayed paramedics ability to treat Resident 1.

Findings include:

From 09/29/2025 to 09/30/2025, Surveyor conducted 2 complaint investigations alleging the provider did monitor a resident's health.

On 09/29/2025 at 6:00 a.m., Surveyor reviewed hospital records, obtained by Surveyor. A hospital RN note, dated 09/16/2026, documented that Resident 1 was admitted at approximately 1:46 p.m. from the provider's home after Guardian C spoke with Resident 1 via telephone, noted confusion and called paramedics. The RN documentation stated the provider's staff did not have any documentation to provide paramedics upon arrival, including blood sugar checks or a medication list. The RN documentation stated Caregiver F later arrived to the hospital stating Resident 1's insulin was discontinued 09/12/2025, but didn't have any documentation to provide hospital staff. A physician note, dated 09/16/2025, stated Resident 1 presented with a critically high glucose level of 671 resulting at 2:21 p.m. and was admitted to the intensive care unit on an insulin drip.

On 09/29/2025 at 8:20 a.m., Surveyor reviewed Resident 1's record, provided by Caregiver B.

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M 580	Continued From page 20 Resident 1 was admitted to the provider's home on 08/30/2025 with diagnosis including diabetes. Resident 1's record included an individual service plan (ISP), signed and dated by Licensee A on 08/30/2025, that indicated Resident 1 required blood sugar checks, staff to assist with medication management and staff to monitor his/her physical and mental health. Resident 1's record did not include progress notes or incident reports. On 09/29/2025 at 8:45 a.m., Surveyor reviewed a report from Guardian C, which documented that while speaking with Resident 1 on 09/16/2026 at 12:36 p.m., s/he noted Resident 1 to be confused. The report stated Guardian C attempted to contact Licensee A at 12:40 p.m., Caregiver B at 12:50 p.m. and Caregiver E at 12:52 p.m. with no response. The report documented that Guardian C called paramedics to respond to the home at 12:53 p.m. On 09/29/2025 at 8:50 a.m., Surveyor interviewed Caregiver B regarding the 09/16/2026 incident. Caregiver B stated s/he was sleeping during the entire duration paramedics were at the home and had no interaction with Resident 1 at that time or paramedics. On 09/29/2025 at 12:47 p.m., Surveyor interviewed Caregiver E. Caregiver E stated at the time of Resident 1's 09/16/2025 hyperglycemic episode s/he was assisting Resident 2 with bathing. Caregiver E stated s/he had asked Caregiver B to help Resident 1 while s/he bathed Resident 2. Caregiver E denied any interaction with paramedics. Caregiver E denied any caregiver other than Caregiver B being present.	M 580		

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M 580	Continued From page 21 On 09/30/2025 at approximately 8:30 a.m., Surveyor obtained the paramedic report for the 09/16/2025 response. The report documented that paramedics were dispatched to the home at 1:01 p.m. and met by staff who were unaware that paramedics were called. The report documented that Resident 1's blood sugar was checked by paramedics, resulting in a "HI" reading and Resident 1 was agreeable to transferring to the hospital. The report documented, "[Emergency medical services] questioned staff if they had any [Resident 1] paperwork for [Resident 1] or medical history and the staff stated that they only knew [s/he] was diabetic and had no med list or other information. Staff was asked if they had a way to check [Resident 1]'s blood sugar and the staff stated 'that they thought a device showed up but had no idea where it was or how to use it.' ... While exiting the house [to get the stretcher] the screen door was locked open and the front door left open. Once [Emergency medical services] arrived back to the front of the house the front door was locked at the dead bolt. The county sheriffs were contacted. The door was unlocked after the door bell was rang approximately 4 times and [emergency medical services] was allowed back into the residence." On 09/30/2025 at approximately 2:00 p.m., Surveyor interviewed Licensee A. Surveyor shared concern that staff were unable to provide paramedics with medical information for Resident 1 to provide adequate treatment. Surveyor shared concern that Resident 1's care was delayed when staff couldn't be reached by Guardian C and when paramedics attempted to reenter the home and the door had been locked. Surveyor also questioned if the home had a glucometer. Licensee A stated the home had medical	M 580		

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M 580	Continued From page 22 information for Resident 1, but was unable to access it for paramedics because they were assisting Resident 2 at the time. Licensee A denied his/her staff speaking with paramedics at all and stated the front door locked itself when paramedics left the home to get the stretcher. Licensee A stated the home had their own glucometer that they used with Resident 1. Cross Reference: M0448 DHS 88.07(2)(b)5. Monitoring Health	M 580		
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 provider did not ensure 2 of 2 residents reviewed received all medication as prescribed. Resident 1 did not receive his/her medications from 08/30/2025 to 09/04/2025. Resident 2 did not receive his/her Polyethylene Glycol as prescribed. Findings include:	M 582		

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M 582	Continued From page 23 From 09/29/2025 to 09/30/2025, Surveyor conducted 2 complaint investigations alleging the provider did not administer medications as prescribed. Surveyor identified the following concerns: Example 1 - Resident 1: On 09/29/2025 at 8:20 a.m., Surveyor reviewed Resident 1's record, provided by Caregiver B. Resident 1 was admitted to the provider's home on 08/30/2025 and discharged on 09/16/2025. Resident 1's Medication Administration Record (MAR), dated 09/01/2025 to 09/16/2025, documented that Resident 1 began receiving the following medications on 09/04/2025: Acetaminophen, Aspirin, Atorvastatin, Carvedilol, Donepezil, Duloxetine, Finasteride, Folic Acid, Tamsulosin, Vitamin B-12, Vitamin D-3, Metformin, Polyethylene Glycol, Lantus Solostar, and Trulicity. On 09/29/2025 at 8:45 a.m., Surveyor reviewed a report from Guardian C, which documented the following timeline: - 08/25/2025: Licensee A stated s/he would have Resident 1's prescriptions transferred to pharmacy and stated the 08/30/2025 admission would work. - 08/30/2025: Licensee A reported s/he would have medications picked up from previous facility before the medications were needed the next morning. - 08/31/2025: Licensee A requested Guardian C make an appointment for Resident 1 to establish care and that Licensee A would have prescriptions transferred to the pharmacy. - 09/02/2025: Medications were not picked up	M 582		

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from Licensee A or provider's staff.

On 09/30/2025 at 12:24 p.m., Surveyor received the medication administration record (MAR), from Resident 1's previous facility which documented that Resident 1 was prescribed the following medications: Acetaminophen, Aspirin, Atorvastatin, Carvedilol, Vitamin, Donepezil, Duloxetine, Finasteride, Folic Acid, Glipizide, Lantus, Metformin, Polyethylene Glycol, Tamsulosin, Trazodone, Vitamin B-12, Vitamin D3 at the time of transfer to the provider's home.

On 09/30/2025 at 1:09 p.m., Surveyor received an email from Guardian C. The email included correspondence with Resident 1's previous facility that stated Resident 1's medications would be delivered to the provider's home on 09/03/2025. The email included Guardian C's report that s/he confirmed with Caregiver B via phone that medications had been delivered on 09/03/2025 at 4:35 p.m.

On 09/30/2025 at approximately 1:30 p.m., Surveyor received Resident 1's pre-admission assessment, dated 08/25/2025, from Licensee A, which documented the provider's pharmacy was to provide medication list and medications at time of admission. The assessment stated, "Per [pharmacy] - Acetaminophen, Aspirin, Melatonin, Metformin, Tamsulosin, Trazodone, Atorvastatin, Carvedilol, Cyanocobalamin, Donepezil, Dulaglutide, Duloxetine, Finasteride, Folic Acid, Insulin Glargine."

On 09/30/2025 at approximately 2:00 p.m., Surveyor interviewed Licensee A and shared concern that Resident 1 was admitted without his/her medications and did not receive medications as prescribed from 08/30/2025 to

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M 582	Continued From page 25 09/04/2025. Licensee A acknowledged Surveyor's concern and stated the provider did not follow the proper process for Resident 1's admission. Surveyor asked what action Licensee A made to obtain Resident 1's medications upon admission. Licensee A did not indicate s/he took any action to obtain Resident 1's medications at the time of admission. Example 2 - Resident 2: On 09/29/2025 at 8:20 a.m., Surveyor reviewed Resident 2's record, provided by Caregiver B. Resident 2 resided at the provider's home when it was licensed as an adult family home on 07/31/2025. Resident 2's record included an order for Polyethylene Glycol 3350 powder (Start Date: 02/14/2024) - Mix 17 gm in 4-8 ounces of liquid every morning. Resident 2's Medication Administration Record (MAR), dated 09/01/2025 to 09/30/2025, documented the Polyethylene Glycol as administered daily 09/01/2025 through 09/26/2025. The entries for 09/27/2025 through 09/30/2025 were left blank. On 09/29/2025 at approximately 8:45 a.m., Surveyor reviewed the provider's medication supply. Surveyor observed 1 bottle of Polyethylene Glycol for Resident 2, which expired 04/24/2025. Surveyor asked Caregiver B if the provider had additional Polyethylene Glycol for Resident 2 since the bottle in medication storage was expired. Resident 2 replied, "No," and stated Resident 2 may have had more Polyethylene Glycol at his/her family member's, where Resident 2 had just stayed 09/27/2025 to 09/28/2025. Caregiver B stated s/he had not administered Polyethylene Glycol that morning but did not give a reason.	M 582		

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M 582	Continued From page 26 On 09/29/2025 at 2:40 p.m., Surveyor interviewed Pharmacist D, who supplied Resident 2's medications. Pharmacist D stated the last delivery to the provider's home of Polyethylene Glycol was a 30-day supply on 11/14/2024, indicating Resident 2 had not had a new supply delivered in greater than 9 months. On 09/30/2025 at approximately 2:00 p.m., Surveyor interviewed Licensee A and shared concern that Resident 2's medication supply and refill history indicated s/he had not received Polyethylene Glycol as prescribed. Licensee A stated Resident 2's family member was "basically a nurse" and may have provided the medication. Licensee A stated s/he would follow up with Resident 2's family member and get back to Surveyor. Licensee A was given until 10/01/2025 to provide follow up documentation. No documentation regarding Resident 2's Polyethylene Glycol was provided. Cross Reference: M0466 DHS 88.07(3)(e)1. Medication - Record Keeping	M 582		