STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 01/05/2024, with information obtained through 01/09/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a monitoring visit at Yasmins Loving Care, an adult family home (AFH) located in Madison, WI. As a result of the survey, 5 deficiencies were identified. Census: 4	M 000		
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 and interview, the provider did not ensure that 1 of 2 emergency exits for the	M 262		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 262	Continued From page 1	M 262		

home were ramped to grade with a hard surfaced pathway and handrails for residents who experienced difficulties walking.

Findings include:

The provider is licensed to serve up to 4 ambulatory residents in the client groups of irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, terminally ill, advanced aged, developmentally disabled, and public funding.

On 01/05/2024, from approximately 10:15 - 10:20 a.m., Surveyor toured the environment with Caregiver B. While discussing the home's exits, Caregiver B confirmed that none of provider's 4 residents used a wheelchair, but that a couple of them used walkers for ambulation. Surveyor observed the front door, which appeared to have a ramp to grade to the outside of the home. Caregiver B showed Surveyor the second accessible exit, which consisted of a door to the garage and then a service door on the opposite side of the garage which accessed the outside of the home. The door between the garage and the home's interior appeared ramped to grade. The service door between the garage and the outside appeared to be elevated approximately 5-6" from the ground on both sides of the door, with no grade. Caregiver B confirmed that the provider did not have a ramp for the service door access and reported that s/he thought residents might be able to evacuate using the electric garage door, which was observed to be closed at that time.

At approximately 12:12 p.m., Surveyor attempted to review resident records to obtain information about residents' ambulation status and needs. Caregiver B reported that s/he did not have any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 262	Continued From page 2 resident records on site other than residents' medication administration records (MARs). At approximately 12:15 p.m., Surveyor interviewed Licensee A. Licensee A reported that s/he used to keep resident records at the home but confirmed that as of the survey s/he no longer was doing so. Licensee A reported s/he was out of town and did not have access to any resident records until s/he returned on approximately the evening of 01/07/2024. At approximately 12:50 p.m., Surveyor observed Resident 7's room. Surveyor observed a 4-wheeled walker, located near his/her bed. Cross Reference: N0482 DHS 88.09(1)(a) Resident Records	M 262		
M 320	88.05(3)(l) BEDROOMS-PRIVACY A resident's bedroom shall provide comfort and privacy, shall be enclosed by full height walls and shall have a rigid door that the resident can open and close. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that Resident 5's bedroom was enclosed by full height walls. Findings include: On 01/05/2024, at approximately 10:18 a.m., while touring the environment with Caregiver B, Surveyor observed Resident 5's bedroom. The wall containing Resident 5's bedroom door was not full height, and appeared to stop	M 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 320	Continued From page 3 approximately 3' below the ceiling (see Photos 1 and 2). Immediately outside of Resident 5's bedroom was an empty living space that had access to an outside deck on one side and on another side, access to the kitchen and dining areas through an open entryway (no door) located approximately 6' from Resident 5's bedroom. Caregiver B reported that a couple of the residents walked through the common area out onto the deck to smoke. On 01/09/2024, at approximately 10:30 a.m., Surveyor interviewed Licensee A. Licensee A reported Resident 5's room had been added later to the home and asked Surveyor what s/he could do to fix it. Licensee A denied having any exemptions or Department approval for one of Resident 5's bedroom walls not being full height.	M 320		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that residents who required assistance with prescription medication received assistance for communicating effectively with their respective medical providers regarding medication discrepancies for 2 residents.	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 462	Continued From page 4 Resident 5's scheduled cetirizine, on an approximate monthly cycle, was last filled on 06/29/2023. Staff documented administering it to him/her daily as prescribed from 12/06/2023 through 01/04/2024 despite not having the medication, as evidenced by the on-hand medication pouches for Resident 5's 01/02/2024 medications not containing it. Resident 7's scheduled risperidone was last dispensed on 11/29/2023 with a 28-day supply, which would've lasted until approximately 12/27/2023 (1 week prior to the survey). Staff documented administering it to him/her twice daily as prescribed from 12/27/2023 through the morning of 01/04/2024 despite not having the medication, as evidenced by the on-hand medication pouches for Resident 5's 01/02/2024 medications not containing it. There was no evidence that the provider helped to communicate with Resident 5's medical provider regarding either medication. Staff assisted with Resident 7's medication management and administration as evidenced by securely storing all of his/her medications, except for his/her as needed (PRN) albuterol inhaler, with keyed access to the medication closet maintained solely by staff; maintaining and signing off on his/her MARs, and Caregiver B's report of staff administering all of Resident 7's medications to him/her. There was no evidence that the provider helped Resident 7 to communicate with his/her medical provider regarding 3 PRN medications that s/he was prescribed on 10/02/2023 but were not on hand - Mylanta Extra Strength (an antacid prescribed for gastrointestinal upset), diclofenac gel (a topical gel prescribed for pain), and loperamide (prescribed for loose stools).	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 462	Continued From page 5 Findings include: Example 1 - Resident 5 On 01/05/2024, at approximately 10:22 a.m., Surveyor reviewed Resident 5's medications and medication administration record (MAR), dated 12/06/2023 - 01/05/2024, with Caregiver B. Surveyor observed a roll of 3 medication pouches which were labeled as containing Resident 5's 01/02/2024 medications: 1 pouch for 8:00 a.m. medications and 2 pouches for 8:00 p.m. medications. All 3 pouches still had medications in them. At the bottom of the roll there was a handwritten annotation of "brought extra." Caregiver B reported that s/he wasn't working that day, but maybe the pharmacy had brought extra medication and that was why that was written. In looking at the medications in the pouches compared to the medications on Resident 5's MAR, Surveyor observed the following discrepancies: - Cetirizine 10 mg tablet with MAR instructions to take 1 tablet daily: Initialed as administered daily from 12/06/2023 through 01/04/2024, however, medication was not observed in the 01/02/2024 pouches or any of the remaining supply of medication pouches on hand - Risperidone 1 mg tablet (an anti-psychotic medication) with MAR instructions to take 1 tablet every morning and 2 tablets every night at bedtime: Initialed as administered twice daily at 8:00 a.m. and 8:00 p.m. from 12/06/2023 through the 8:00 a.m. administration on 01/04/2024, however, medication was not observed in the 01/02/2024 pouches or any of the remaining supply of medication pouches on hand	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 462	Continued From page 6	M 462		

Caregiver B reported that s/he had started his/her shift on the afternoon of 01/04/2024 and had not yet signed off on administering any of Resident 5's 01/05/2024 morning medications or 01/04/2024 evening medications. When asked about Resident 5's cetirizine, Caregiver B reported that maybe the medication was discontinued sometime between 12/31/2023 and early January, but confirmed s/he did not have any documented evidence of the medication being discontinued. When asked about Resident 5's risperidone, Caregiver B reported that maybe this medication was also discontinued. When Surveyor discussed that the the medications were still signed off as being administered, even on 01/02/2023 when the med pouches on hand didn't contain them, Caregiver B stated, "I can't even tell you because I don't have this [referencing the MAR]." Upon Surveyor pointing out that Resident 5's MAR covered the current period, from 12/06/2023 through 01/06/2024, Caregiver B said nothing further. Surveyor requested a documented list of Resident 5's currently prescribed medications or any recent medical visit report that may have a list of his/her prescriptions. Caregiver B reported that other than the MAR, s/he did not have access to any other records for Resident 5. Caregiver B denied having spoken with Resident 5's medical provider or pharmacy about either of these medications.

At approximately 12:15 p.m., Surveyor interviewed Licensee A. Licensee A reported that s/he used to keep resident records at the home but confirmed that as of the survey s/he no longer was doing so. Licensee A reported s/he was out of town and did not have access to any resident records until s/he returned on approximately the evening of 01/07/2024. Licensee A reported the soonest s/he could get Surveyor any resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 462	Continued From page 7	M 462		

record information would be 01/08/2024.

At approximately 2:40 p.m., Surveyor interviewed Pharmacy Technician D, from the pharmacy that dispensed Resident 5's medications. Pharmacy Technician D reported that Resident 5's cetirizine hadn't been filled since 06/29/2023 but was still an active prescription. Pharmacy Technician D acknowledged that it was ordered as a scheduled medication, which would have been packaged and delivered as a cycled medication on an approximate monthly basis, but stated that this usually was a PRN medication. Pharmacy Technician D reported that Resident 5's risperidone was still an active prescription and was last filled as a 28-day supply on 11/29/2023. Based on this report, Surveyor noted that a 28-day supply of risperidone, provided on 11/29/2023, would have indicated that the medication ran out on approximately 12/27/2023 (approximately 1.5 weeks from the survey period). Pharmacy Technician D denied having any history of communication from the provider about either Resident 5's cetirizine or risperidone.

Example 2 - Resident 7

On 01/05/2024, at approximately 11:22 a.m., Surveyor reviewed Resident 7's medications and MAR, dated 12/01/2023 - 01/05/2024, with Caregiver B. Surveyor observed Caregiver B pull a container which stored Resident 7's medications from a locked closet in the home, where the provider was storing all residents' medications. Caregiver B confirmed that the provider stored Resident 7's medications and administered them to him/her. Surveyor observed that all the medications in Resident 7's medication container were pharmacy-packed pouches of tablets and capsules. No other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 462	Continued From page 8	M 462		

medications were observed in Resident 7's medication container. While comparing Resident 7's observed medications to his/her MAR, Surveyor observed the following discrepancies:

- PRN aluminum hydroxide; Magnesium Hydroxide; Simethicone (Brand name: Mylanta Maximum Strength, an antacid medication) was listed on the MAR with an order date of 10/02/2023 and instructions to take 20 mL every 8 hours as needed for [gastrointestinal] upset. The medication did not appear to be administered any time from 12/01/2023 - 01/05/2023 based on the MAR. This medication was not observed in Resident 7's container.

- PRN diclofenac 1% gel was listed on the MAR with an order date of 10/02/2023 and instructions to apply 2 grams topically to an affected area every 6 hours as needed for pain. The medication did not appear to be administered any time from 12/01/2023 - 01/05/2023 based on the MAR. This medication was not observed in Resident 7's container.

- PRN loperamide 2 mg capsule was listed on the MAR with an order date of 10/02/2023 and instructions to take 1 capsule every 4 hours as needed for loose stools. The medication did not appear to be administered any time from 12/01/2023 - 01/05/2023 based on the MAR. This medication was not observed in Resident 7's container.

Caregiver B confirmed that s/he did not have any the solution, gel, or loperamide capsules for Resident 7 and that the medications s/he showed Surveyor were all the medications s/he had on hand. Caregiver B reported not being aware of the Mylanta solution, diclofenac gel, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 462	Continued From page 9	M 462		

loperamide capsules and reported s/he didn't think the provider ever had these meds on hand for Resident 7. Caregiver B reported that Resident 7 managed his/her own medical appointments and medication refill needs and so maybe s/he knew more about them. Surveyor requested a documented list of Resident 7's currently prescribed medications or any recent medical visit report that may have a list of his/her prescriptions, as as well as an assessment or care plan that described Resident 7's needs when it came to medication management. Caregiver B reported that other than the MAR, s/he did not have access to any other records for Resident 7. Caregiver B denied having spoken with Resident 7's medical provider or pharmacy about these medications. When asked if Caregiver B had any record of or knew when Resident 7 was admitted to the provider, s/he denied having access to any such record but recalled that Resident 7 had at least been with the provider since around Halloween (10/31/2023).

At approximately 12:15 p.m., Surveyor interviewed Licensee A. Licensee A reported that Resident 7 was his/her own legal decision maker and was known to communicate with his/her pharmacy about medications. Licensee A reported that when Resident 7 was admitted to the provider, s/he recalled going over a medication list with him/her. According to Licensee A, Resident 7 reported at that time that the medications s/he currently had on hand were the only ones s/he was taking. When requesting access to Resident 7's record in order to verify the details provided by Licensee A, Licensee A reported s/he was out of town and did not have access to any resident records until s/he returned on approximately the evening of 01/07/2024. Licensee A reported the soonest s/he could get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 462	Continued From page 10 Surveyor any resident record information would be 01/08/2024. At approximately 12:50 p.m., Surveyor interviewed Resident 7. Resident 7 reported that other than his/her inhaler, s/he did not maintain any other medications in his/her room. Resident 7 reported being unaware of any other medications other than what staff were administering to him/her. Cross Reference: N0482 DHS 88.09(1)(a) Resident Records	M 462		
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 provider did not ensure that a record of all prescription medications controlled, dispensed, or administered by the licensee was maintained, or that a record of prescription medications administered showed the date and time the resident took the medication for 3 of 4 residents reviewed.	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 466	Continued From page 11	M 466		

Resident 1 was prescribed as needed (PRN) Acetaminophen tablets with a dosage range of 325-650 mg (1-2 tablets). On 69 of 69 administrations across 35 days (from 12/01/2023 - 01/03/2024), staff initialed off on administering Resident 1 PRN Acetaminophen but did not document the dosage administered or time of administration.

The provider did not have any record of Resident 4's medication administration from 12/01/2023 - 01/05/2024 (date of survey) and did not have any documentation to show Resident 4's current medication regimen. Caregiver B's report of Resident 4's insulin dosing was inconsistent with the medical provider order provided by Resident 4's pharmacy.

Resident 7 began a new medication (guanfacine) and started an additional dose of a current medication (furosemide) - both on 12/28/2023. From then through 01/05/2024, approximately 8 days of administration, staff did not document administering either medication to Resident 7. Resident 7 was also prescribed PRN Ibuprofen 200 mg tablets which were administered on 3 occasions between 12/02/2023 - 12/15/2023. Staff did not record the time of administration for any of the 3 administrations.

Findings include:

Example 1 - Resident 1

On 01/05/2024, at approximately 11:05 a.m., Surveyor reviewed Resident 1's medications and medication administration records (MARs) from 12/01/2023 - 01/05/2024 with Caregiver B. In reviewing Resident 1's January MAR, Surveyor observed that under his/her PRN Acetaminophen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 466	Continued From page 12	M 466		

325 mg tablet entry, staff initialed twice each day along 2 separate rows, from 01/01/2024 through the morning of 01/04/2024, indicating administration of the tablets. The MAR entry for Resident 1's PRN Acetaminophen documented the following directions: "Take 1-2 tablets (325-650 mg) by mouth every 4 hours as needed for pain..." Surveyor did not observe any evidence of times of administration or number of tablets administered to Resident 1 documented in his/her January MAR. Surveyor reviewed Resident 1's December MAR, where staff appeared to document Resident 1's PRN Acetaminophen administration the same way (2 rows of initials of twice daily administration). Surveyor observed that one row was handwritten as "AM" and one row was handwritten as "PM." Surveyor did not observe any evidence of times of administration or number of tablets administered to Resident 1 documented in his/her December MAR. In total, Surveyor observed 69 administration entries across 34 days for his/her PRN Acetaminophen, none of which documented the dosage administered or time of administration.

Caregiver B reported that Resident 1 typically takes 1 tablet of PRN Acetaminophen at 8:00 a.m. and 1 tablet of PRN Acetaminophen at 8:00 p.m. Caregiver B confirmed Surveyor's observation that the number of tablets administered to Resident 1 and the times of administration of his/her PRN Acetaminophen were not documented in his/her MAR.

Example 2 - Resident 4

On 01/05/2024, at approximately 12:00 p.m., Surveyor reviewed Resident 4's medications with Caregiver B. Surveyor requested Resident 4's January and December MARs from Caregiver B,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 466	Continued From page 13	M 466		

however, Caregiver B replied that s/he did not have them and was not able to find them. Caregiver B reported that s/he last remembered signing off on Resident 4's MAR on 12/29/2023 (approximately 1 week prior to the survey). Caregiver B reported that s/he wasn't sure what happened to the MARs but that s/he just noticed it missing that morning. Caregiver B denied asking Caregiver C, who had worked the shift prior to him/her starting work on 01/04/2024, about Resident 4's MAR. Caregiver B denied asking Licensee A about Resident 4's MAR. Caregiver B denied documenting the medications that s/he had been administering to Resident 4 since s/he started his/her shift on 01/04/2024. Surveyor requested from Caregiver B any information regarding Resident 4's current prescriptions. Caregiver B replied that other than the pharmacy labels on Resident 4's medications, s/he did not have any other documented information about Resident 4's medications.

While reviewing Resident 4's medications with Caregiver B, Surveyor observed 2 insulin pens - 1 was a Humalog KwikPen (100 units/mL) and 1 was a Lantus SoloStar (100 units/mL) pen. The pens contained manufacturer labels, but did not contain any prescription information or dates indicating first use or expiration. Caregiver B reported that Resident 4 received 20 units of his/her Humalog 3 times daily, prior to meals and that his/her blood sugar was also supposed to be checked 3 times daily. Caregiver B reported s/he knew how much insulin Resident 4 required because s/he has had the same routine for awhile.

On 01/05/2024, at approximately 2:40 p.m., Surveyor interviewed Pharmacy Technician D, from the pharmacy that dispensed Resident 4's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 466	Continued From page 14	M 466		

medication. Pharmacy Technician D reported that the pharmacy sent MARs out "all the time" to the provider. Pharmacy Technician D reported that Resident 4's Humalog prescription directed 20 units to be administered 4 times daily (as opposed to 3 times daily that Caregiver B reported). Pharmacy Technician D reported that s/he wondered if staff were administering Humalog correctly to Resident 4 because his/her last Humalog refill was in October and s/he thought Resident 4 would've needed more Humalog by now.

On 01/05/2024, Surveyor reviewed the prescription for Resident 4's Humalog, provided by Pharmacy Technician D. The prescription was for "Insulin Lispro 100 unit/mL Subcutaneous Solution Pen-injector (Humalog KwikPen)" and the directions were to, "Inject 20 (twenty) units subcutaneously 4 times daily." The order date was 09/26/2023.

Example 3 - Resident 7

On 01/05/2024, at approximately 11:22 a.m., Surveyor reviewed Resident 7's medications with Caregiver B. Surveyor observed the following 2 discrepancies between his/her observed on hand medications and his/her MAR, dated 12/01/2023 - 01/05/2024:

- Daily medication pouches timestamped for 4:00 p.m. contained 1 furosemide 20 mg tablet. The 8:00 a.m. medication pouches also contained 1 furosemide 20 mg tablet. On Resident 7's current MAR, the only administration entry was for 1 20 mg tablet of furosemide at 8:00 a.m. daily. There was no evidence of staff recording administration of Resident 7's 4:00 p.m. furosemide dose. Caregiver B reported that the dose was new but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 466	Continued From page 15	M 466		

was not able to recall the day it started. Caregiver B denied having any documentation or records, such as a physician order, showing when the dose was started. Caregiver B reported that s/he thought a separate pack of 4:00 p.m. medications were provided by the pharmacy late last month but that s/he wasn't sure of the name of the medication provided. Caregiver B confirmed Surveyor's observation that staff did not appear to document administration of Resident 7's 4:00 p.m. furosemide.

- A roll of medication pouches timestamped for 8:00 p.m. contained 1 guanfacine 1 mg tablet. On Resident 7's current MAR there was no entry for guanfacine tablet administration and no evidence of staff recording administration of Resident 7's guanfacine. Caregiver B reported that s/he wasn't sure when this medication was started but recalls that s/he administered a dose yesterday. Caregiver B reported that s/he thought the medication was delivered last week. Caregiver B denied having any documentation or records, such as a physician order, showing when the guanfacine was started. Caregiver B confirmed Surveyor's observation that staff did not appear to document administration of Resident 7's guanfacine.

Surveyor also observed that Resident 7 was prescribed PRN Ibuprofen 200 mg tablets with instructions to take 2 tablets every 6 hours as needed for mild pain. In reviewing Resident 7's MAR, Surveyor observed that staff initialed off on administering Ibuprofen on 12/02/2023, 12/05/2023, and 12/15/2023. There was no evidence that staff documented the times of administration. Caregiver B confirmed that staff did not appear to be documenting the times of administration for PRN medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 466	Continued From page 16 At approximately 3:15 p.m., Surveyor interviewed Pharmacist E, from one of the pharmacies that was dispensing Resident 7's medications. Pharmacist E reported that Resident 7's 4:00 p.m. furosemide dose started on 12/28/2023 and was dispensed that same morning to the provider. At approximately 3:33 p.m., Surveyor interviewed Pharmacy Technician F from another pharmacy that was dispensing Resident 7's guanfacine tablets. Pharmacy Technician F reported that Resident 7's guanfacine tablets were picked up in person on 12/28/2023. ADDITIONAL INTERVIEW: On 01/05/2024, at approximately 12:15 p.m., Surveyor interviewed Licensee A regarding the concerns with staff documenting medication administration for residents. Licensee A reported that s/he was looking into medication administration and documentation-related trainings for staff to take. Cross Reference: N0482 DHS 88.09(1)(a) Resident Records	M 466		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access.	M 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 482	Continued From page 17	M 482		

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure that resident records for 4 of 4 residents were maintained within the home.

Findings include:

On 01/05/2024, at approximately 12:12 p.m., Surveyor attempted to review resident records to verify the following for all 4 of the provider's residents: ambulation status and needs, required assistance for medication administration and health monitoring, records of medical visits, and information regarding active versus discontinued medications as verified by physician orders (see applicable cross references below). Surveyor requested records from Caregiver B. Caregiver B replied that s/he did not have any resident records on site other than residents' medication administration records (MARs). Caregiver B stated, "When we moved houses, [Licensee A] took all the records."

At approximately 12:15 p.m., Surveyor interviewed Licensee A. Licensee A reported that s/he used to keep resident records at the home but confirmed that as of the survey s/he no longer was doing so. Licensee A reported s/he was out of town and did not have access to any resident records until s/he returned on approximately the evening of 01/07/2024. Licensee A reported the soonest s/he could get Surveyor any resident record information would be 01/08/2024.

On 01/05/2024, Surveyor reviewed Department records. Licensee A previously operated an adult family home, under the same name, at a different location in Madison until that home closed on 06/29/2023. Licensee A's current license was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019774	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YASMINS LOVING CARE	1405 DROSTER RD MADISON, WI 53716

(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 482	Continued From page 18 effective that same date. Cross Reference: N0262 DHS 88.05(2)(a) Difficulty Walking N0462 DHS 88.07(3)(c) Medication Assistance N0466 DHS 88.07(3)(e)1 Medication - Record Keeping	M 482		