STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018088	A. BUILDING: _____ B. WING _____	R-C 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOS SAFE HOUSE	2550 NORTH 10TH STREET MILWAUKEE, WI 53206

(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 07-02-2025, Surveyors completed a verification visit at SOS Safe House. As a result, 7 of the previous 15 deficiencies were corrected and 8 deficiencies were recited. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 2	{M 000}		
{M 216}	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the provider did not ensure the home, and its operation complied with this chapter and all other laws governing the home and its operations potentially affecting 2 of 2 residents. The provider has been unable to maintain compliance with Chapter 88 of the Department of Health Services-Licensed Adult Family Home regulations. This is a repeat deficiency. See Statement of Deficiency (SOD) HOYO11, dated 02/07/2025. Findings include: On 06/25/2025, Surveyor reviewed department files and identified the following: On 04/18/2025, the department issued Statement of Deficiency HOYO11 and Notice and Order	{M 216}		

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
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{M 216}	Continued From page 1 Letter notifying the provider of the results of a standard survey at SOS Safe House. As a result of the survey, the following 15 deficiencies were identified: M0212 88.04(1)(b) Service Provider Age M0216 88.04(2)(a) Responsibilities M0232 88.04(2)(g)1. Health Screening For Staff M0278 88.05(3)(b) Free of Hazards M0344 88.05(4)(d)2.a. Fire Safety Evacuation Plan Review M0346 88.05(4)(d)2.b. Fire Evacuation Annual Evaluation M0380 88.06(2)(a) Admission - Health Exam M0384 88.06(2)(b) Service Agreement Except Respite M0406 88.06(3)(b) Persons Involved With ISP & Assessment M0410 88.06(3)(d) Individual Service Plan M0464 88.07(3)(d) Medication - Written Order M0466 88.07(3)(e)1. Medication - Record Keeping M0472 88.07(4)(b) 3 Nutritious Meals and Snacks M0570 88.10(3)(l) Safe Physical Environment M0582 88.10(3)(q) Medications The Special Orders from the Notice and Order Letter included the following: " . . . ORDER TO COMPLY WITH REQUIREMENTS CONSULTANT REQUIRED 1. Pursuant to Wis. Admin. Code §§ DHS 88.03(6)(g)2.b. and 2.e., EFFECTIVE IMMEDIATELY, the licensee shall comply with requirements specified by Wis. Admin. Code § DHS 88.04(2)(f). That is, the licensee will not permit the existence or continuation of a condition	{M 216}		

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{M 216}	Continued From page 2 in the home which places the health, safety or welfare of a resident at substantial risk of harm. The licensee shall ensure that residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. The licensee shall develop and implement corrective measures in consultation with a registered nurse (RN) not currently affiliated with the licensee. The RN will have knowledge of assisted living regulations (e.g., Wis. Admin. Code Ch. 88, Wis. Stat. Ch. 50) and knowledge of the client groups served by SOS Safe House. The licensee will provide the consultant with a copy of the Statement of Deficiency (SOD) HOYO11, along with this Notice and Order letter prior to providing consultation services. Consultation will include, at a minimum, the development (or review) of written procedures and training for all service providers to address: Individual Service Plan/Assessment - A comprehensive written assessment and individual service plan (ISP) are completed and on file for each resident within 30 days after placement. - Resident assessments and ISPs will identify services, approaches and interventions appropriate to meet the needs of the resident. - Each resident's ISP will be reviewed at least once every 6 months by the licensee, the resident, the resident's legal representative, and the placing agency, if applicable. The resident will be participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to	{M 216}		

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{M 216}	Continued From page 3 update the plan as necessary. A statement of agreement with the plan, dated and signed by all persons involved in developing the plan will be obtained. - All staff responsible for providing services to a resident will review the ISP and provide services in accordance with the plan. Medication Management, to include how the licensee will: - document medication orders, medication administration, and missed/refused doses; - administer medications to ensure residents receive medications at the intervals and dosages prescribed; - prevent medication errors and respond to medication errors if they occur; - securely store and manage medications; and - dispose of discontinued and outdated medications. Resources are available at: https://www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm Consultation activities, including dates of consultation, will be documented, signed and dated by the consultant. Copies of all written procedures required by Order #1 will be made available to department representatives upon request. All training records will be maintained in personnel files and include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. 2. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative	{M 216}		

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{M 216}	Continued From page 4 and case manager (if any) for each current resident with a copy of Statement of Deficiency HOYO11 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request." On 06/25/2025, Surveyors completed a verification visit at SOS Safe House. As a result of the survey, the provider was issued 8 deficiencies. Eight of 8 were repeat deficiencies. The following deficiencies were identified: M0216 88.04(2)(a) Responsibilities M0232 88.04(2)(g)1. Health Screening for Staff M0278 88.05(3)(b) Free of Hazards M0346 88.05(4)(d)2. b. Fire Evacuation Annual Evaluation M0406 88.06(3)(b) Persons Involved with ISP & Assessment M0410 88.06(3)(d) Individual Service Plan M0570 88.10(3)(l) Safe Physical Environment M0582 88.10(3)(q) Medications On 06/25/2025, at 1:40 PM, Surveyors interviewed Licensee A. Licensee A reported s/he had coordinated with an RN consultant, RN G. Licensee A reported RN G developed and implemented corrective measures outlined in SOD HOYO11, dated 04/18/2025. Surveyors requested date of hire for RN G. Licensee A reported RN G worked for the facility since it opened. Surveyors informed Licensee A the special orders required Licensee A to hire a consultant who was not currently affiliated with	{M 216}		

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{M 216}	Continued From page 5 the licensee during the period of SOD HOYO11. Licensee A stated s/he was unaware of the requirement. Surveyors requested training, policy, and/or procedure for completing ISPs and assessments. Licensee A reported the training conducted using ISP binder Surveyors reviewed. Surveyors informed Licensee A the special orders required, at a minimum, the development (or review), of written procedures and training for all service providers. Licensee A reported s/he was unaware of the requirement.	{M 216}		
{M 232}	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 caregivers (Caregiver H) was screened for communicable diseases, including tuberculosis (TB), within 90 days before the start of providing cares. Caregiver H was not screened for communicable diseases before providing cares.	{M 232}		

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{M 232}	Continued From page 6 This is a repeat deficiency. See Statement of Deficiency (SOD) HOYO11, dated 02/07/2025. Findings include: On 06/25/2025, at 11:48 AM, Surveyors reviewed Caregiver H's staff file. Caregiver H was hired on 06/20/2025. Caregiver H was screened for TB on 06/16/2025. Caregiver H's file did not contain evidence s/he was screened for communicable diseases. On 06/25/2025, at 1:40 PM, Surveyors interviewed Licensee A. Licensee A reported s/he was unsure of the code requirement. Licensee A reported s/he received Caregiver H's TB screening via email and believed this met the code requirement for communicable disease screening.	{M 232}		
{M 278}	88.05(3)(b) FREE OF HAZARDS The home shall be free from hazards and kept uncluttered and free of dangerous substances, insects and rodents. This Rule is not met as evidenced by: Based on record review, observation and interview, the provider did not ensure the home was free of hazards for 1 of 2 residents. There were unsecured toxic chemicals and cleaning compounds located in the first-floor bathroom, office, and kitchen.	{M 278}		

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{M 278}	Continued From page 7 This is a repeat deficiency. See Statement of Deficiency (SOD) HOYO11, dated 02/07/2025. Findings include: On 06/25/2025, at 12:10 PM, Surveyors reviewed Resident 3's file. Resident 3 was admitted on 01/10/2025 with diagnoses which included diabetes mellitus, chronic kidney disease, intellectual disability, schizophrenia, depression, bulimia, post-traumatic stress disorder (PTSD), psychosis, and borderline personality disorder. Resident 3's individual support plan (ISP), dated 02/05/2025, indicated Resident 3 had uncontrollable behavior, agitation beyond control, uncontrollable thoughts, and self-harm behaviors. Resident 3's file contained a telehealth after-visit summary (AVS), dated 04/20/2025, which identified Resident 3 had attention seeking behaviors, auditory hallucinations, suicidal ideations and suicide attempts. Surveyors reviewed an after-visit summary (AVS) from Aurora Health Care, dated 05/22/2025. The AVS disclosed Resident 3 was hospitalized from 5/20/2025 to 05/22/2025 after s/he was diagnosed with suicidal ideations. Surveyors reviewed an after-visit summary (AVS) from Aurora Health Care, dated 06/05/2025. The AVS disclosed Resident 3 was hospitalized from 5/25/2025 to 06/05/2025 after s/he "drank hair tonic to take [her/his] life." Surveyors reviewed Resident 3's safety plan. The safety plan was created on 04/10/2024 and updated on 05/26/2025. The safety plan included the following steps:	{M 278}		

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{M 278}	Continued From page 8 Step 1 - Warning signs Step 2 - Internal coping strategies Step 3 - People and social settings that provide distraction Step 4 - People whom I can ask for help during a crisis Step 5 - Professionals or agencies I can contact during a crisis Step 6 - Making the environment safer On 06/25/2025, at 1:00 PM, Surveyors toured the home with Licensee A and observed the following: First-floor bathroom - A shelf above the toilet was a bottle of Febreze air mist spray. - In a linen closet in bathroom was a bottle of Suave renewing lotion, Equate baby oil, Suave conditioner, Suave shampoo, Equate mouthwash, and Head and Shoulders shampoo and conditioner. The bathroom linen closet did not have a door. Office - The office was located off the living room. The office did not contain a door. The office was separated from the living room by floor to ceiling curtains. A bottle of Febreze spray and a bottle of Lysol disinfecting spray were located on a filing cabinet. Surveyors did not observe a locking mechanism for the office. Kitchen - Top shelf of a shelving unit was a bottle of Kroger disinfectant spray.	{M 278}		

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{M 278}	Continued From page 9 On 06/25/2025, at 1:40 PM, Surveyors interviewed Licensee A. Licensee A reported Resident 3 had a history of suicide and self-harm behaviors. Licensee A reported Resident 3's behaviors included cutting, scratching her/his arms with items, suicidal ideations, and drank bodywash and reported to the hospital s/he was poisoned. Licensee A reported these behaviors usually occur at least once a month, and sometimes more. Licensee A reported s/he was aware of the requirement. Surveyors relayed concerns of the products not being in a secured area due to Resident 3's history of ingesting harmful substances. Licensee A reported the previous Surveyor did not say anything about Lysol. Licensee A questioned how to mitigate odors if air fresheners were locked in a secure area. When Surveyors inquired about the office not being secured, Licensee A reported residents were not allowed in the office area.	{M 278}		
{M 346}	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete an annual evacuation assessment review for 1 of 2 residents (Resident 2) who lived in the facility beyond one year.	{M 346}		

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{M 346}	Continued From page 10 Resident 2 did not have an evacuation assessment completed to date in 2025. This is a repeat deficiency. See Statement of Deficiency (SOD) HOYO11, dated 02/07/2025. Findings include: On 06/25/2025, at 12:10 PM, Surveyors reviewed Resident 2's record. Resident 2 was admitted to the facility on 08/24/2023. Resident 2's record contained a Resident Evacuation Assessment, dated 03/13/2022. Surveyors did not review any evidence in Resident 2's record of a completed evacuation assessment to date in 2025. On 06/25/2025, at 1:40 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he thought Resident 2's evacuation assessment was completed after the last survey visit in February 2025.	{M 346}		
{M 406}	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication.	{M 406}		

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{M 406}	Continued From page 11	{M 406}		

This Rule is not met as evidenced by:
Based on record review and interview, the facility did not ensure 2 of 2 resident's individual service plans (ISPs) were developed, signed, and dated by all persons involved in developing the plan. Resident 2's ISP was not signed by the Resident 2's guardian. Resident 3's ISP was not signed by Resident 3.

This is a repeat deficiency. See Statement of Deficiency (SOD) HOYO11, dated 02/07/2025.

Findings include:

On 06/25/2025, at 12:10 PM, Surveyors reviewed resident records and identified the following:

- Resident 2 was admitted on 03/13/2022. Resident 2's file contained an ISP dated 02/10/2025. Resident 2's file identified s/he had a legal guardian. Resident 2's ISP was not signed by Resident 2's legal guardian.

- Resident 3 was admitted on 01/10/2025 with diagnoses which included diabetes mellitus, chronic kidney disease, intellectual disability, schizophrenia, depression, bulimia, post-traumatic stress disorder (PTSD), psychosis, and borderline personality disorder. Resident 3 was her/his own person. Resident 3's file contained an ISP dated 02/05/2025. Resident 3's ISP was not signed by Resident 3.

On 06/25/2025, at 1:40 PM, Surveyors interviewed Licensee A. Licensee A reported s/he was unaware of the requirement to have the ISPs signed by the guardians and/or resident at every review.

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{M 410}	Continued From page 12	{M 410}		
{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 the individual service plan (ISP) for 2 of 2 residents (Resident 2 and Resident 3) accurately identified current needs and abilities. Resident 2's and Resident 3's ISP did not identify all behaviors and behavioral interventions. This is a repeat deficiency. See Statement of Deficiency (SOD) HOYO11, dated 02/07/2025. Findings include: On 06/25/2025, at 12:10 PM, Surveyors reviewed resident records and identified the following: - Resident 2 was admitted to the facility on 03/13/2022 with unknown diagnoses. Resident 2's file contained an ISP dated 02/10/2025 indicated the following: Supports I need: bathing, dressing, and food preparation My Medical Needs: please review medical summary and history My Behavioral Health Needs: What is Working: "...my comfort chair. This chair soothes me. I feel safe and comfortable in my chair."	{M 410}		

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{M 410}	Continued From page 13 What is Not Working: "...when staff try to get me to get up and move. I get agitated, and upset" Resident 2's ISP did not identify interventions regarding Resident 2's noncompliance and behaviors. - Resident 3 was admitted on 01/10/2025 with diagnoses which included diabetes mellitus, chronic kidney disease, intellectual disability, schizophrenia, depression, bulimia, post-traumatic stress disorder (PTSD), psychosis, and borderline personality disorder. Resident 3 was her/his own person. Resident 3's individual support plan (ISP), dated 02/05/2025, indicated the following: Supports I need: showering, healthy eating, self-care, community outings, and behavioral tools My Medical Needs: maintain annual appointments as needed My Behavioral Health Needs: psychotherapy, group counseling, health coaching, art/music therapy, behavioral intervention What is Working: continuous focus on goals, self-esteem building, staying on task, community involvement, and health coaching What is Not Working: "...at times behavior can be a challenge. Stuffing my feelings. Finding immediate solutions. [Resident 3] not giving [her/himself] time to heal." Resident 3's ISP indicated stressors which included: having nightmares, hearing voices, agitated by others, coping with unexpected stressors, and talking about trauma. Resident 3's ISP indicated techniques for stressors which included: breathing techniques,	{M 410}		

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{M 410}	Continued From page 14 positive self-talk, yoga, contacting crisis mobile team/mental health emergency. Resident 3's file contained a telehealth after-visit summary (AVS), dated 04/20/2025, which identified Resident 3 had attention seeking behaviors, auditory hallucinations, suicidal ideations and suicide attempts. Surveyors reviewed an AVS, dated 05/22/2025. The AVS disclosed Resident 3 was hospitalized from 5/20/2025 to 05/22/2025 after s/he was diagnosed with suicidal ideations. Surveyors reviewed an AVS, dated 06/05/2025. The AVS disclosed Resident 3 was hospitalized from 5/25/2025 to 06/05/2025 after s/he "drank hair tonic to take [her/his] life." Surveyors reviewed Resident 3's safety plan. The safety plan was created on 04/10/2024 and updated on 05/26/2025. The safety plan included the following steps: Step 1 - Warning signs - depression, loss of relationships, loss of loved ones, poor appetite, feeling anxious or worried, shaky, lightheaded/dizzy, "I start crying sometimes" Step 2 - Internal coping strategies - exercise, word searches, write, read, paint color, focus on a positive thought, try to establish/maintain healthy routines, take medications as prescribed, go to sleep and wake up at the same time each day. Step 3 - People and social settings that provide distraction - [parent] and [friend] Step 4 - People whom I can ask for help during a crisis - [parent]	{M 410}		

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{M 410}	Continued From page 15 Step 5 - Professionals or agencies I can contact during a crisis - [agencies for crisis] Step 6 - Making the environment safer - did not identify any lethal methods Resident 3's ISP did not identify Resident 3's suicidal ideations, suicidal attempts, self-harm behaviors, attention seeking behaviors, and hallucinations, or interventions of how staff should help manage Resident 3's behaviors. On 06/25/2025, at 1:40 PM, Surveyors interviewed Licensee A. Licensee A reported Resident 2 had a comfort chair which s/he would sit for a time to collect her/his thoughts. Licensee A reported Resident 2 would become physically aggressive. Licensee A reported Resident 2 required lead time prior to an activity change and needed to be talked through the process. Licensee A reported Resident 2 would refuse care, lose control of bowel and bladder, and refuse to go places. Licensee A reported Resident 2 wore depends during the day, rubber pants night, and required cues to use the bathroom every hour. Licensee A reported Resident 2 enjoyed singing and listening to gospel music. Licensee A reported s/he transported Resident 2 to and from day program. Licensee A reported Resident 3 had a history of suicide, different personalities, and self-harm behaviors. Licensee A reported Resident 3 has delusions of food poisoning, believed her/his adult child was deceased, and her/his sibling was "out to get [her/him]". Licensee A reported Resident 3's self-harm behaviors included cutting, scratching her/his arms with items, suicidal ideations, and drank bodywash and reported to	{M 410}		

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{M 410}	Continued From page 16 the hospital s/he was poisoned. Licensee A reported these behaviors usually occur at least once a month, and sometimes more. Licensee A reported an intervention they use is to call crisis, and crisis assists Resident 3 with her/his coping techniques. Licensee A reported Resident 3 enjoyed drawing, coloring, reading, going out to eat, shopping, and liked being well-groomed. Surveyors inquired how staff were aware of resident behaviors and interventions to utilize. Licensee A reported s/he reviewed resident ISPs with staff. Licensee A reported s/he discussed resident behaviors, non-verbal cues, and daily routines with staff.	{M 410}		
{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 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 for 2 of 2 residents. The lower section of the dryer vent consisted of a semi-rigid type of material.	{M 570}		

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{M 570}	Continued From page 17 This is a repeat deficiency. See Statement of Deficiency (SOD) HOYO11, dated 02/07/2025. Findings include: On 06/25/2025, at 1:00 PM, Surveyors toured the home with Licensee A. Surveyors observed the laundry area located in the basement. The dryer vent had approximately 4 feet of semi rigid flexible vent attached. On 06/25/2025, at 1:40 PM, Surveyors interviewed Licensee A. Licensee A reported s/he had a plumber replace the vent after s/he received the previous SOD. Licensee A was unable to provide evidence the dryer vent was approved for use by the dryer manufacturer. Licensee A reported s/he would replace the semi rigid dryer vent to ensure compliance.	{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 record review and interview, the provider did not ensure 1 of 1 resident received all prescribed medications from 06/05/2025 to	{M 582}		

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{M 582}	Continued From page 18 06/25/2025. Resident 3 did not receive her/his Novolog insulin as prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) HOYO11, dated 02/07/2025. Findings include: On 06/25/2025, at 12:10 PM, Surveyors reviewed Resident 3's record. Resident 3 was admitted on 01/10/2025 with diagnoses which included diabetes mellitus. Resident 3's after visit summary (AVS), dated 06/05/2025, indicated a change in Resident 3's insulin order. The AVS indicated the new insulin order was NovoLog FLEXPEN - Inject 15 units UNDER THE SKIN with meals PLUS correction scale. If blood sugar (BS) <100 -4 units, >150 +2 units, >200 +4 units, >250 +6 units. FOR nighttime SNACK give 5 units with correction scale. Hold if BS < 100 OR if not snacking. Prime 2 units BEFORE each DOSE. Maximum daily DOSE: 82 units. Surveyors requested Resident 3's physician order for insulin. Licensee A produced a handwritten document titled "Target Range for [Resident 3]". The document was not signed by a physician. The document indicated the sliding scale was as follows: if BS <100 -4 units, BS < 100 -2 units, BS 100-150 25 units, BS 150-200 +2 units, BS 200-250 +4 units, BS 250-300 +6 units, if BS > 200 give 10 units at bedtime. Resident 3's medication administration record (MAR) dated June 2025 indicated Resident 3's insulin sliding scale was: If BS <100 -2 units, BS 100-150 base dose, BS 150-200 +2 units, BS 200-250 +4 units, BS 250-300 +6 units.	{M 582}		

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{M 582}	Continued From page 19 Resident 3' BS and insulin administration was documented as follows: - 06/06/2025 AM BS illegible documentation - Noon BS 125 - 27 units, Evening (eve) BS 155 - 17 units, Bedtime (bed) BS 130 - 10 units - 06/07/2025 AM BS 192 Noon BS 165 - 27 units, Eve BS 219 - 29 units, Bed BS 114 - 10 units - 06/08/2025 AM BS 208 - 27 units, Noon BS 247 - 29 units, Eve BS 215 - 27 units, Bed BS 213 - 10 units - 06/09/2025 AM BS 255 - 34 units, Noon BS 233 - 34 units, Eve BS 152 - 23 units, Bed BS illegible - 10 units - 06/10/2025 AM BS 172 - 27 units, Noon BS not documented - not documented as administered, Eve BS 190 - 29 units, Bed BS 191 - 10 units - 06/11/2025 AM BS 260 - 31 units, Noon BS not documented - not documented as administered, Eve BS 114 - 25 units, Bed BS 123 - 10 units - 06/12/2025 AM BS 111 - 23 units, Noon BS 190 - 27 units, Eve BS 135 - 25 units, Bed BS 116 - 10 units - 06/13/2025 AM BS 108 - 25 units, Noon BS 118 - 25 units, Eve BS 131 - 25 units, Bed BS 113 - 10 units - 06/14/2025 AM BS 88 - 21 units, Noon BS 100 - 25 units, Eve BS 89 - 23 units, Bed BS 141 - 10 units	{M 582}		

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{M 582}	Continued From page 20 - 06/15/2025 AM BS 129 - 25 units, Noon BS 133 - 25 units, Eve BS 115 - 25 units, Bed BS 114 - 10 units - 06/16/2025 AM BS 88 - 21 units, Noon BS 293 - 31 units, Eve BS 90 - 23 units, Bed BS 120 - 10 units - 06/17/2025 AM BS 123 - 23 units, Noon BS not documented - not documented as administered, Eve BS 194 - 29 units, Bed BS 108 - 10 units - 06/18/2025 AM BS 105 - 23 units, Noon BS not documented - not documented as administered, Eve BS 95 - 23 units, Bed BS 114 - 10 units - 06/19/2025 123 - 23 units, Noon BS not documented - not documented as administered, Eve BS 132 - 23 units, Bed BS 126 - 10 units - 06/20/2025 AM BS 89 - 31 units, Noon BS 101 - 25 units, Eve BS 125 - 23 units, Bed BS 79 - 10 units - 06/21/2025 AM BS 133 - 33 units, Noon BS 147 - 23 units, Eve BS 134 - 23 units, Bed BS 187 - 10 units - 06/22/2025 AM BS 104 - 23 units, Noon BS 120 - 23 units, Eve BS 112 - 23 units, Bed BS 90 - 10 units - 06/23/2025 AM BS 120 - 25 units, Noon BS 109 - 25 units, Eve BS 98 - 21 units, Bed BS 98 - 10 units - 06/24/2025 AM BS 89 - 31 units, Noon BS not documented - not documented as administered, Eve BS 104 - 25 units, Bed BS 169 - 10 units	{M 582}		

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{M 582}	Continued From page 21 - 06/25/2025 AM BS 88 - 31 units On 06/25/2025, at 1:40 PM, Surveyors interviewed Licensee A. When Surveyors inquired if Licensee A was aware of Resident 3's insulin dosage change based on her/his AVS dated 06/05/2025, Licensee A reported s/he was unaware of the dosage change. Licensee A reported Resident 3's diabetic doctor [Physician Assistant (PA) H] told Licensee A the base dosage was 25 units. Surveyors inquired who reviewed the discharge paperwork. Licensee A reported s/he reviewed the discharge paperwork. Surveyors showed Licensee A the AVS which indicated the insulin dosage change signed by PA H. Licensee A repeated PA H told Licensee A the base dosage was 25 units. Surveyors inquired if Licensee A was a Registered Nurse (RN). Licensee A reported s/he was not a licensed RN. Surveyors relayed concerns regarding Resident 3's insulin administration, Licensee A did not acknowledge Surveyors concerns.	{M 582}		