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M 000	INITIAL COMMENTS On 02/06/2026 with information gathered through 02/10/2026, Surveyor conducted a standard survey at Bonding Love Waukesha. Seven deficiencies were identified. Census: 4	M 000		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident 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 update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the individual service plan (ISP) was updated in writing when a resident's needs or preferences changed substantially and resident records did not contain evidence the ISP was reviewed by the Licensee, resident, service coordinator (if any)	M 424		

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

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M 424	Continued From page 1 and placing agency for 3 of 3 residents reviewed. Resident 1's ISP did not identify self-administration of insulin or staff's responsibilities with insulin administration. Resident 2's ISP did not address his/her sleeping in damp clothes. Resident 3's ISP did not identify his/her refusals to allow staff to assist with cleaning his/her room and did not identify nonpharmacological interventions to prevent behaviors. Resident 1's, Resident 2's and Resident 3's ISPs were not signed or dated. Findings include: On 02/10/2026 Surveyor reviewed Resident 1's, Resident 2's and Resident 3's records (received via multiple emails dated 02/06/2026 at 9:19 AM to 02/09/2026 from Manager A). Example 1- Resident 1 On 02/06/2026 at 8:21 AM, Surveyor observed Caregiver B hand Resident 1 an insulin pen. Resident 1 injected the insulin into his/her abdomen. On 02/06/2026 at 8:21 AM, Surveyor interviewed Caregiver B who stated Resident 1 independently checked his/her own blood sugar and administered insulin. Resident 1 was admitted 04/25/2025. Diagnoses included type 2 diabetes mellitus with hyperglycemia. His/her face sheet identified Resident 1 had a placing agency. No Power of Attorney for Health Care agent or guardian was	M 424		

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listed on the face sheet (indicating Resident 1 made his/her own health care decisions).

ISP (not signed or dated):
In the area of Medication Management- " ...Requires staff to administer medications ...To receive assistance from staff administering medications ..."

The ISP did not identify Resident 1 independently injecting insulin or staff's responsibilities with insulin administration and the signature sheet was blank.

Example 2- Resident 2
On 02/06/2026 at 9:59 AM, Surveyor observed Caregiver B tell Resident 2 to change his/her clothes because s/he smelled "funky."

On 02/06/2026 at 10:01 AM, Surveyor interviewed Caregiver B who stated after showering at night Resident 2 dressed for the next day while still wet from showering, then slept in the same clothes so s/he would not have dress in the morning. Caregiver B stated because Resident 2 slept in damp clothes, the clothes had an odor.

Resident 2 was admitted 08/26/2024. The resident roster identified Resident 2 had placing agency. No Power of Attorney for Health Care agent or guardian was listed on the face sheet (indicating Resident 2 made his/her own health care decisions).

ISP (not signed or dated):
In the area or Dressing: " ...Monitor and provide cues when needed to assist with dressing and undressing ...Requires monitoring and verbal prompts and cues with dressing and undressing

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and choosing proper attire ..."
In the area of Bathing: " ...Monitor for safety and provide cues when needed to assist with bathing/showering ...Requires staff monitoring, verbal prompts and cues with bathing/showering needs ..."
Resident 2's ISP did not address resident dressing at night while still wet from showering then sleeping in those clothes so s/he did not have to dress in the morning, and the ISP signature sheet was blank.

Example 3- Resident 3
On 02/06/2026 at 9:21 AM, Surveyor interviewed Resident 3 who stated s/he did not mind washing dishes however chemicals stored under the kitchen sink were a "trigger" for his/her mental health. Resident 3 stated s/he wished staff would stay with him/her while doing the dishes or at least keep the dish soap near the sink.

On 02/06/2026 at 9:38 AM, Surveyor observed Resident 3's room. Approximately 95% of the floor was covered with his/her belongings except a path from the door to the bed and approximately 25% of the bed (foot end of bed) was covered with belongings. The mattress was bare except where it was covered with fitted mattress protector at the foot of the bed under the belongings. A fitted sheet was rolled up into a ball lying on the bed.

On 02/06/2026 at 9:59 AM, Surveyor observed Resident 3 ask Caregiver B for a "PRN" (as needed medication). Caregiver B responded "You're just upset because you don't clean your room and people call you out on it. It doesn't make any sense."

On 02/06/2026 at 9:44 AM, Caregiver B informed

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M 424	Continued From page 4 Surveyor Resident 3 did not allow staff to assist in cleaning his/her room. Resident 3 was admitted 02/01/2024. Diagnoses included schizoaffective disorder, unspecified. His/her face sheet identified Resident 2 had a placing agency. No Power of Attorney for Health Care agent or guardian was listed on the face sheet (indicating Resident 2 made his/her own health care decisions). Diagnoses included bipolar disorder, unspecified. ISP (not signed or dated): In the area of Psychotropic Medications- " ...Using psychotropic medications related to specific behaviors ... Appropriate use of medications will be maintained. No adverse effects related to psychotropic medication use ..." In the area of Self Abusive: "Provide supervision and monitoring to help manage/redirect self-abusive behavior ...Requires supervision and monitoring to help manage/redirect self-abusive behavior ...maintain low level of self-abusive behavior with supervision/intervention from staff ..." In the area of Suicidal Tendencies: " ...Provide supervision and monitoring to help prevent/redirect suicidal thoughts or behaviors. Document and report incidents to appropriate licensed health care professional ...Requires supervision and monitoring to help prevent and re-direct suicidal thoughts and behaviors ...To re-direct/prevent suicidal tendencies with supervision from staff/direction of a licensed health care professional ..." In the area of Attitude: " ...Provide assistance maintaining a positive attitude. Provide	M 424		

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encouragement and redirect negative attitudes ...Requires staff assistance and encouragement maintaining appropriate/positive attitudes ...Maintain positive attitude with assistance and encouragement from staff ..."

In the area of Aggressive/Combative: " ...Provide supervision and monitoring to help manage/redirect aggressive or combative behaviors ...Requires supervision and monitoring to help manage/redirect aggressive/combative behaviors ...maintain low level of aggressive or combative behavior with supervision/intervention from staff ..."

In the area of Housekeeping: " ...Provide verbal assistance with upkeep of room. Prompt [Resident 3] to place items aaway [sic] and encourage organization ...Requires assistance with housekeeping needs ...To maintain a clean and orderly living space ..."

Resident 3's ISP did not identify stressors that triggered behaviors, clearly define the behaviors, or include individualized nonpharmocological interventions to prevent and manage the behaviors.
The ISP's signature sheet was blank.

On 02/10/2026 at 10:00 AM, Surveyor discussed concern with Manager A who stated s/he would update Resident 1's ISP to reflect self-administration of insulin. Manager A stated s/he was unaware Resident 2 was showering then sleeping in clothes so s/he would not have to get dressed in the morning. Manager A stated Resident 3 became very overwhelmed when staff offered to assist him/her with cleaning his/her room, so the intervention was to prompt Resident 3 to clean it his/herself. Manager B stated staff

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M 424	Continued From page 6 monitored the condition of Resident 3's room weekly and encouraged Resident 3 to empty his/her trash. Manager A stated none of 3 residents had a behavioral support plan. Cross Reference: N0548 DHS 88.10(3)(a) Fair treatment N0556 DHS 88.10(3)(e) Self Direction	M 424		
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 every prescription medication was securely stored. Unsecured medications were observed on the kitchen counter, in kitchen refrigerator's door, and on top of the ktichen refrigerator. Findings include: The adult family home is licensed to serve residents within the client groups of	M 458		

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M 458	Continued From page 7 developmentally disabled and emotionally disturbed/mental illness. On 02/06/2026 at 8:02 AM, Surveyor observed Caregiver B set a pharmacy medication strip containing medications on the kitchen counter and left the kitchen. At 8:07 AM, Surveyor observed the medication strip remained on the counter. The strip was comprised of 8 individual pouches each containing medications. Each pouch was pharmacy labeled with Resident 1's name and the name and dose of medication contained in the pouch. On 02/06/2026 at 9:34 AM, Surveyor observed 1 box of Zepbound injection pens in a clear plastic bag in the kitchen refrigerator's door. Pharmacy label identified: Resident 3's name Zepbound 2.5 MG/0.5 ML inject 0.5 mls (2.5 mg) subcutaneously in the morning once a week on Saturdays. Quantity: 2 pens On 02/06/2026 at 9:13 AM, Surveyor observed a basket on top of the kitchen refrigerator containing: -1 box of diclofenac sodium gel Pharmacy label identified: Resident 1's name Diclofenac sodium 1% gel apply 2 grams topically to both knees 4 times daily as needed. -1 bottle saline moisturizing spray Pharmacy label identified Resident 1's name Saline mist 0.66 % spray 1 spray in each nostril daily as needed -1 bottle fluticasone nasal spray	M 458		

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M 458	Continued From page 8 Pharmacy label identified: Resident 1's name Fluticasone Propionate 50 mcg nasal spray 1 spray in each nostril daily On 02/06/2026 at 9:13 AM, Surveyor interviewed Caregiver B who stated the medications were kept on top of the refrigerator for staff convenience because they were administered to residents multiple times per day. On 02/10/2026 at 10:00 AM, Surveyor discussed concern with Manager A who stated on 02/08/2026 s/he bought a lock box to store refrigerated medications in. Manager A stated s/he did not know staff stored medications on top of the refrigerator and s/he would retrain staff.	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 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 physician's order for staff to administer medications was obtained	M 464		

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M 464	Continued From page 9 for each resident prior to staff administering medications to the resident for 1 of 2 residents reviewed. Resident 2's record did not contain a physician order for staff to administer medications to him/her. Findings include: On 02/10/2026 Surveyor reviewed Resident 2's record (received via multiple emails dated 02/06/2026 at 9:19 AM to 02/09/2026 from Manager A.) The record did not contain a physician's order for staff to administer medications to Resident 2. On 02/10/2026 at 10:00 AM, Surveyor discussed concern with Manager A who stated s/he had the order but could not find it and s/he would request a new one.	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:	M 466		

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Based on observation, record review and interview, the provider did not ensure medication administration was recorded accurately for 2 of 2 residents reviewed.

Caregiver B did not record each resident's medication administration at time of administration when s/he waited to record until after all 4 residents' medications were administered.
Staff did not record all medication administration in the electronic medication administration record (MAR).

Findings include:

On 02/06/2026 at 8:21 AM to 8:23 AM, Surveyor observed Caregiver B administer Resident 1's medications.

On 02/06/2026 at 8:29 AM, Surveyor observed Caregiver B documenting medication administration in the MAR and interviewed him/her. Caregiver B stated s/he was documenting administration of all 4 residents' AM medications. Caregiver B stated his/her usual medication administration routine was to prep and pass all 4 resident's medications, then document administration of all 4 resident's medication at once in the MAR because it was easier than prepping, administering and recording one resident at a time.

On 02/10/2026 Surveyor reviewed Resident 1's and Resident 2's records (received via multiple emails dated 02/06/2026 at 9:19 AM to 02/09/2026 from Manager A).

Example 1- Resident 1

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M 466	Continued From page 11 Resident 1 was admitted 04/25/2025. Physician orders for scheduled medications included: furosemide 20 MG 1 tablet in am on Monday, Wednesday and Friday (start date 06/18/2025); loratadine 10 MG 1 tablet in morning (start date 10/31/2025); multivitamin 1 tablet in morning (start date 07/11/2025); omeprazole 20 MG 1 capsule in morning (start date 12/31/2025); citalopram HBR 1-0 MG 3 tablet in morning (start date 12/31/2025); fluticasone propionate 50 MCG 1 spray in each nostril twice daily (start date 12/31/2025); nortriptyline HCL 1-0 MG 1 capsule in morning (start date 02/04/2026); lactase 3,000 Unit 1 tablet 3 times daily in morning, noon and evening with meals (start date 07/02/2025); vitamin E 18- MG 1 capsule twice daily (start 06/19/2025); vitamin D3 2,000 Unit 3 capsules in morning (start date 06/19/2025); vitamin D3 50,000 unit 1 capsule in morning on Friday (start date 07/02/2025); levothyroxine sodium 75 MCG 1 capsule at 8 PM (start date 07/02/2025); celecoxib 200 MG 1 capsule twice daily in morning and evening with meals (start date 04/25/2025); metoprolol succinate 50 MG 1 tablet in morning (start date 10/01/2025); acetaminophen ER 650 MG 2 tablets twice daily in morning and evening (start date 01/23/2026); aripiprazole 15 MG 1 tablet in morning (start date 01/23/2026); hydroxyzine HCL 50 MG 1 tablet twice daily (start date 01/23/2026); and rosuvastatin calcium 10 MG at bedtime (start date 01/23/2026). MAR: Resident 1's MAR identified medications were administered at 8:00 AM (morning), 12:00 PM, 4:00 PM (evening), and 8:00 PM (bedtime). From 01/01/2026-02/05/2026, staff did not document (left MAR blank):	M 466		

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M 466	Continued From page 12 -8:00 AM- any medications on 01/09/2026, 01/16/2026, 01/20/2026, 01/22/2026; and 02/04/2026. -12:00 PM- any medications 01/09/2026, 01/16/2026, 01/20/2026, 01/22/2026, 01/25/2026, 01/27/2026, 01/28/2026; and 02/04/2026. -4:00 PM-any medications on 01/01/2026, 01/09/2026, 01/10/2026, 01/11/2026, 01/12/2026, 01/13/2026, 01/16/2026, 01/17/2026, 01/8/2026, 01/19/2026, 01/20/2026, 01/22/2026, 01/23/2026, 01/25/2026, 01/27/2026, 01/30/2026, 01/31/2026, 02/01/2026, 02/03/2026, 02/04/2026, and 02/05/2026. -8:00 PM- any medications 01/09/2026, 01/12/2026, 01/15/2026, 01/20/2026, 01/30/2026, 01/31/2026, 02/01/2026, and 02/04/2026; vitamin E on 01/11/2026 and levothyroxine on 01/13/2026. Example 2- Resident 2 Resident 2 was admitted 08/26/2024. Physician orders for scheduled medications included: divalproex sodium ER 500 MG 1 tablet at bedtime (start date 12/18/2025); clonazepam 1 MG 1 tablet in morning (start date 12/18/2025); clozapine (200 MG +100 MG to =300 MG) at bedtime (start date 12/18/2025); quetiapine 50 MG 1 tablet in morning; quetiapine 100 MG at bedtime (start date 12/19/2025, stop date 01/23/2026); famotidine 20 MG 1 tablet twice daily (start date 11/26/2025); and lorazepam 1 MG 1 tablet at bedtime (start date 12/18/2025). Resident 1's MAR identified medications were administered at 8:00 AM and 8:00 PM.	M 466		

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M 466	Continued From page 13 From 01/01/2026-02/05/2026, staff did not document (left MAR blank): -8:00 AM- any medications on 01/05/2026, 01/09/2026, 01/16/2026, 01/20/2026, and 02/04/2026. -8:00 PM-any medications on 01/02/2026, 01/04/2026, 01/06/2026, 01/09/2026, 01/12/2026, 01/17/2026, 01/20/2026, 01/30/2026, 01/31/2026, 02/01/2026, and 02/04/2026; and quetiapine on 01/01/2026, 01/03/2026, 01/05/2026, 01/10/2026, 01/13/2026, 01/16/2026, 01/18/2026, and 01/19/2026. On 02/10/2026 at 10:00 AM, Surveyor discussed concern with medication administration documentation with Manager A who stated s/he was not aware of the situation until s/he emailed Surveyor the MARs on 02/06/2026. Manager A stated s/he has since spoken with staff about it.	M 466		
M 548	88.10(3)(a) Fair Treatment Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the residents were treated with courtesy, respect and full recognition of their dignity. Findings include: The adult family home is licensed to serve residents within the client groups of developmentally disabled and emotionally	M 548		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019723	A. BUILDING: _____ B. WING _____	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 548	Continued From page 14 disturbed/mental illness. On 02/06/2026 at 8:31 AM, Surveyor observed Resident 2 ask Caregiver B when s/he would take his/her medications. Caregiver B stated s/he took them when his/her [family member] was there. (Note: Surveyor observed Resident 2's family member at the home at 8:10 AM). Resident 2 stated s/he had not received any medications. Caregiver B replied loudly "Yeah, you did!" On 02/06/2026 at 9:21 AM, Surveyor interviewed Resident 3 who stated Caregiver B raised his/her voice and argued about everything. Resident 3 stated one day Caregiver B asked him/her to do dishes and when s/he asked Caregiver B to stay with him/her because chemicals stored under the kitchen sink triggered his/her mental health symptoms, Caregiver B argued with him/her. Resident 3 stated when s/he asked Caregiver B if they could discuss issues, Caregiver B argued and became louder. On 02/06/2026 at approximately 9:30 AM, Caregiver B was bent over at the waist holding his/her stomach and Resident 3 was sitting on the couch. Surveyor asked if they minded if Surveyor went to tour the upstairs, Caregiver B stated "No." Resident 3's bedroom door was open and Surveyor observed the room from the doorway. On 02/06/2026 at 9:44 AM, Surveyor observed Resident 3 ask Caregiver B why Surveyor had looked at his/her bedroom. Caregiver B turned to Surveyor and explained Resident 3 did not allow staff to assist with cleaning the room. Resident 3 swore and stated Surveyor had no right to. Caregiver B raised his/her voice and stated to Resident 3, "I'm trying to explain it to [him/her]. You got a problem with it you can go up to your	M 548		

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M 548	Continued From page 15 room!" On 02/06/2026 at 9:59 AM, Surveyor observed Resident 3 ask Caregiver B for a "PRN" (as needed medication). Caregiver B responded, "You're upset because you don't clean your room and people call you out on it, it doesn't make any sense. You either clean it or let us help you clean it." Surveyor then observed Caregiver B tell Resident 2 to go upstairs and change clothes because "you smell funky." Resident 2 replied that his/her ride would arrive in less than 5 minutes. Caregiver B stated in a loud tone, "Go upstairs and change!" Resident 2 went upstairs but came back down right away. His/her transportation arrived at 10:06 AM. On 02/06/2026 at 10:14 AM, Surveyor interviewed Caregiver B who stated s/he could have handled the earlier interactions with Resident 2 and Resident 3 better. Caregiver B stated s/he had been working 16-hour double (PM/night) shifts Sunday thru Friday since Summer 2024 and dealing with minor issues was irritating to him/her. Caregiver B stated s/he wanted to work the 16-hour shifts and was not mandated to. On 02/10/2026 at 10:00 AM, Surveyor discussed concern with Manager A who stated Caregiver B slept 8 hours of the 16 hour shifts. Manager A stated because the residents had mental illnesses s/he spoke with staff frequently about their challenging behaviors. Manager A stated s/he would address Caregiver B's attitude with him/her. Cross Reference: N0424 DHS 88.06(3)(f) Review Of ISP N0556 DHS 88.10(3)(e) Self Direction	M 548		

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M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure restrictions on a residents freedom of choice were not imposed unless the restriction was specifically identified in the home's program statement or the residents individual service plan (ISP). Caregiver B restricted residents from the 1st/main floor of the home from 10:00 PM to 8:00 AM. Findings include: The adult family home is licensed to serve residents within the client groups of developmentally disabled and emotionally disturbed/mental illness. The kitchen, living room and a bathroom were located on the 1st/main floor and resident bedrooms and a bathroom were located on the 2nd floor. On 02/06/2026 at 7:30 AM, Surveyor arrived at	M 556		

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M 556	Continued From page 17	M 556		

the adult family home. Surveyor knocked on the front door several times and after approximately 5 minutes, Caregiver B answered the door. Surveyor observed all lights were off and curtains were closed in the living room, kitchen/dining area, and hallway of the 1st floor. Caregiver B squinted and rubbed his/her eyes when s/he answered the door due to the light shining in from outside. Caregiver B stretched and yawned and asked why Surveyor was there so early and stated, "We're all still sleeping yet. Why are you here so early? Why didn't you let us know you were coming?" When Surveyor asked Caregiver B if any residents were home, s/he stated they were all upstairs yet.

On 02/06/2026 at 9:04 AM, Surveyor interviewed Resident 1 who stated residents had to stay upstairs (2nd floor where bedrooms were located) from 10:00 PM to 8:00 AM and were not allowed "downstairs" (1s/ main floor) until after 8:00 AM because staff were still sleeping. Resident 1 stated because s/he went to bed at 8:00 PM, s/he often woke up between 4:00 AM-5:00 AM but had to stay upstairs in until 8:00 AM.

On 02/06/2026 at 9:15 AM, Surveyor interviewed Resident 2 who stated Caregiver B wanted the residents to stay upstairs from 10:00 PM to 8:00 AM.

On 02/06/2026 at 9:21 AM, Surveyor interviewed Resident 3 who stated residents were not allowed to be downstairs from 10:00 PM-8:00 AM so they stayed in their rooms. Resident 3 stated when s/he goes downstairs before 8:00 AM Caregiver B tells her s/he cannot be down there.

On 02/06/2026 at 9:57 AM, Surveyor interviewed Caregiver B who stated night shift staff were

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M 556	Continued From page 18	M 556		

allowed to sleep during their shift and the residents did not usually want to stay up past 10:00 PM so staff got residents to bed by 10:00 PM. Caregiver B stated the residents understood the rules. Caregiver B stated staff did not let Resident 2 smoke cigarettes after 8:00 PM. Caregiver B stated having the residents stay upstairs until 8:00 AM gave the staff "time to get a little sleep and get their meds ready."

On 02/06/2026 at 1:23 PM, Surveyor received Resident 1's, Resident 2's and Resident 3's ISP's (all unsigned and undated) via email from Manager A.

None of the ISPs identified a restriction from being on the 1st/main floor from 10:00 PM - 8:00 AM.

On 02/09/2026, Surveyor reviewed the adult family home's Program Statement (dated 05/18/2023) on file with the Department. The Program Statement did not identify a restriction from being downstairs from 10:00 PM- 8:00 AM.

On 02/09/2026 Surveyor reviewed the House Rules (received from Manager A via email on 02/09/2026 at 9:34 AM). The House Rules stated " ...Smoking hours are 7am until 10pm [sic] ..."

On 02/10/2026 at 10:00 AM, Surveyor discussed concern with Manager A who stated residents could smoke until 10:00 PM and were allowed downstairs at any time, however staff slept until 7:00 AM. Manager A stated s/he would discuss it with staff.

Cross Reference:
N0424 DHS 88.06(3)(f) Review Of ISP
N0556 DHS 88.10(3)(e) Self Direction

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M 558	88.10(3)(f) Financial Affairs Financial affairs. To manage his or her own financial affairs, including any personal allowances under federal or state programs, unless the resident delegates, in writing, responsibility for financial management to the licensee or someone else of the resident's choosing or the resident is adjudicated incompetent in which case the guardian or guardian's designee is responsible. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure authorization was obtained to manage Resident 2's personal funds. Findings include: On 02/06/2026 at approximately 8:15 AM, Surveyor observed Resident 2's family member give Caregiver B cash. On 02/06/2026 at 9:15 AM, Surveyor interviewed Resident 2 who stated his/her family member brought $40.00 which Caregiver B put in the medication closet. Resident 2 stated staff give him/her the money when s/he asked for it. On 02/10/2026 Surveyor reviewed Resident 2's record (received via multiple emails dated 02/06/2026 at 9:19 AM to 02/09/2026 1:00 PM from Manager A.) The record did not contain authorization for staff to manage Resident 2's funds.	M 558		

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M 558	Continued From page 20 Individual service plan (ISP) (not signed or dated): In the area of Finance Management- " ...Assist in management of money ...Daily @ [sic] As Needed ...Receives supervision and assistance managing their finances/money ...To keep money appropriately managed and accounted for ..." On 02/10/2026 at 10:00 AM, Surveyor discussed concern with Manager A who stated Resident 2's cash was kept locked in the medication closet. Manager A stated Resident 2 usually requested $5.00 to take to the community club and money when staff took him/her shopping. Manager A stated staff provided Resident 2's family member with shopping receipts but did not have Resident 2 sign for the cash. Manager A stated s/he would obtain authorization and consider setting up a tracking system.	M 558		