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M 000	INITIAL COMMENTS On 11/12/2025 with additional information gathered through 11/18/2025, Surveyors conducted an abbreviated survey and complaint investigation at Debra Program. As a result, 1 of 1 complaints was substantiated and 5 deficiencies were identified. Census: 4	M 000		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation, interview and record review, the licensee permitted a condition of risk which placed the health, safety, and welfare of residents at substantial risk of harm. Resident 2 displayed both verbal and physical behaviors that were harmful to residents and staff. The provider did not implement effective interventions to keep Resident 1, Resident 3 and Resident 4 safe from physical harm initiated by Resident 2. Findings include: The provider is licensed to care for up to 4 residents who may be developmentally disabled, emotionally disturbed/mentally ill, physically disabled, advanced age, terminally ill, alcohol/drug dependent, irreversible	M 230		

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

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dementia/Alzheimer's and/or have a traumatic brain injury.

On 11/12/2025, Surveyors conducted an onsite visit to the home to complete an abbreviated survey and complaint investigation.

On 11/12/2025 at 12:30 PM, during a tour of the home accompanied by Executive Director (ED) C, Surveyor observed Resident 2's room. Resident 2 entered his/her room and was grumbling inaudibly and told ED C and Surveyor to "vacate" and "get the [explicit] out." Resident 2 appeared agitated and proceeded to encourage Surveyor to leave his/her room more quickly by walking towards Surveyor. Resident 2 again mumbled inaudibly and then slammed his/her door.

At 12:45 PM, while Surveyor was interviewing Certified Nursing Assistant (CNA E) in the hallway between the kitchen and living room, Surveyor observed Resident 2 pacing around. Resident 2 appeared slightly agitated and was grumbling inaudibly when s/he took Surveyor's pen and drew an "X" on Surveyor's notes. Resident 2 gave Surveyor his/her pen back and walked away after making a spitting sound with his/her mouth. CNA E reported Resident 2 admitted to hospice services on 10/16/2025 with a diagnosis of dementia. CNA E reported Resident 2 was not initially accepting of him/her, but s/he has slowly become more accepting. CNA E stated Resident 2 will not shower for him/her and will not even allow him/her in his/her room. CNA E stated, "The first day I met [Resident 2], [s/he] spit in my face."

At 2:25 PM, during an interview with ED C, Resident 2 walked into the living room area where Surveyors and ED C were sitting and again appeared agitated. Resident 2 was again

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mumbling inaudibly, stating to "vacate" and walked up to Surveyor standing close enough to touch Surveyor's left arm. Resident 2 was hovering over Surveyor trying to read what was on Surveyor's paper. Surveyor heard ED C ask Resident 2 if s/he wanted to go outside for a cigarette, but s/he did not try to intervene. Resident 2 then grabbed Surveyor's sticky note and crumbled the paper up as s/he walked away. ED C made a comment indicating that they were hoping Resident 2 did not hit Surveyor.

On 11/12/2025 at 1:30 PM, Surveyor reviewed Resident 2's record to include his/her most recent ISP provided by ED C. The following was noted:

Resident 2 admitted to the facility on 07/03/2017 with diagnoses to include but not limited to, paranoid schizophrenia, psychosis, schizoaffective disorder, alcohol dependence with alcohol-induced dementia, anxiety, depression and stage 3 chronic kidney disease. Resident 2 has a managed care organization (MCO) and legal representative. Resident 2 admitted to hospice services on 10/16/2025.

Resident 2's ISP dated 11/12/2025 read in part:

"Interpersonal Relationships - ... will make sexual comments to staff and peers, about their body parts and what [s/he] will do to them ... will also grab at [fe/male] staff towards their private body parts ... will also tell staff they [sic] fat, ask if they are pregnant and any person of color [s/he] will makes [sic] very racial slurs towards them ... encourage [Resident 2] not to grab staff, redirect with hobbies [s/he] likes to talk about - Cars ... encouraged to talk to staff and [his/her] peers more appropriately ... will also work on not grabbing staff."

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M 230	Continued From page 3 "Leisure time activities - ... will stay in [his/her] room and watch tv or come out to the living room and watch tv ... likes to go outside and smoke cigarettes ... likes to go to McDonald's ... encourage [Resident 2] to come out of the room and participate in house outings ..." "Community Contacts - ... will on occasion participate with community outings ... can be very verbal and blunt to total strangers so we tend to shy away from community outings and events ... [s/he] also will touch or poke at strangers. Even when redirected not to ... encourage [Resident 2] to be pleasant towards strangers ..." "Communication Skills - ... difficulty maintaining socially appropriate conversations due to [his/her] mental illness ... encourage [Resident 2] to communicate [his/her] wants and needs in an appropriate and respectful manner ... encourage [Resident 2] to be out in the common areas to socialize with [his/her] peers on a daily basis ... tends to isolate ..." "Mental and Emotional Skills - ... overall attitude can be difficult to interrupt due to [his/her] mental illness ... struggles with everyday conversations and tends to say things unrelated ... will talk about random things, and accuse staff of being spies or call them thieves ... encourage [Resident 2] to communicate [his/her] wants and needs ..." "Interactions with Others - ... has a hard time interacting with others ... talks inappropriately or is on a whole different subject ... will talk about the staff or visitors body parts if they're fat or skinny etc ... says very explicit things to staff and visitors. If a person is another race or color other	M 230		

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than Caucasian or white [Resident 2] will make extremely derogatory comments ... encourage [Resident 2] to come out of the room and interact with [his/her] peers and staff ..."

"Aggressive/Combative - ... has a past history of aggressive and combative behaviors. [Resident 2] has been displaying this behavior again when staff are redirecting [him/her] [s/he] will shove them, or talk very sexually inappropriate towards staff and try to touch the [fe/male] staff. If [s/he's] coming down the hallway from [his/her] bedroom and someone is in [his/her] way [s/he] will push and or shove the other person ... encourage [Resident 2] to be more appropriate with staff and peers ..."

"Verbally Abusive - ... will become very verbally abusive with peers and staff, comment on staff teeth, weight, clothes they wear, the color of their skin. [S/he] will also say very racial slurs towards staff, clients and visitors ... will call them thieves and how they have a black heart. Staff can usually redirect with talking about cars and motorcycles to get [him/her] off the topic ... offering to go outside for a cigarette will help redirect [him/her] ... encourage positive comments and help [him/her] communicate [his/her] frustration ..."

"Bathing - ...1 assist with showering due to not wanting to take a shower or use soap ... let [Resident 2] fully undress and get in the shower, once staff can tell he's in the shower knock and ask if you can help [him/her] ... very short tolerance for showers so staff are recommended to wash [his/her] face/hair and private areas as fast as possible, the moment [Resident 2] gets agitated [s/he] will spray staff with shower head and hit staff ..."

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M 230	Continued From page 5 "Dressing - ... independent with dressing, staff sits [sic] out clothes daily so [Resident 2] is putting clean clothes on ... will try to wear the same clothes as long as [s/he] possibly can ... encouraged to put [his/her] clothes directly into the washer while [s/he] showering [sic] and set out clean clothes for [him/her] ... encourage to wear clean clothes ..." (Surveyor note: Resident 2's ISP was updated after Surveyor's onsite visit on 11/12/2025. Resident 2's ISP was silent to interventions related to refusals of cares specifically with bathing, dressing and medications. Additionally, the ISP did not identify additional effective interventions related to prevention and/or management of his/her behaviors. Resident 2's ISP also did not speak to his/her needs related to mobility, medication administration and supervision required in and out of the home.) On 11/13/2025, 11/14/2025 and 11/17/2025, Surveyor requested and reviewed additional information to include Resident 2's medication administration records (MARs), observation notes, task administration record (TAR), incident reports and face sheet. Review of Resident 2's observation notes from 09/01/2025 to 11/12/2025 noted the following in part: 09/10/2025, 7:45 AM: " ... refused to get in the shower ..." 09/13/2025, 8:00 AM: " ... did good just refused to take a shower ..." 09/14/2025, 7:45 AM: " ... took [his/her] meds but	M 230		

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M 230	Continued From page 6 [s/he] refuses to take a shower ..." 09/15/2025, 6:15 PM (late entry): 8:15 AM ... looked gray in color ... combative with staff and was having tremors ... Resident 2 denied any falls at night ... continued to be combative to staff and other residents ... contacted management to report observations ... vitals were taken ... blood pressure 193/105 and pulse 97 ... heart rate was 113 "very faint had to be taken on [his/her] neck instead of wrist" ... temperature was 98.6 ... staff tried to get [him/her] to comply to take [him/her] to emergency room (ER) for observation ... Resident 2 refused and became more combative ... 911 called ... Resident 2 "would not comply with the paramedics and became combative with them" ... paramedics obtained vitals and they were still elevated ... paramedics explained to Resident 2 the importance of him/her to be seen by a doctor ... guardian was called and agreed Resident 2 should be taken to the hospital ... still being combative to everyone ... management felt the protocol to get Resident 2 to go to the ER would be worse than trying to get him/her to go willingly ... paramedics explained to staff the signs to watch for and staff could call and come back ... appointment will be made with doctor ASAP ... Resident 2 is resting in his/her room ... staff will perform bed checks every 5 minutes ... 09/19/2025, 7:15 PM: Resident 2 was picked up by staff from the hospital at 12:30 PM. "[Resident 2] appeared very paranoid on the way home ... kept yelling at staff to slow done [sic] saying [s/he] don't trust automobiles ... went out to smoke and was smoking a cigarette that wasn't lit ... having lots of highs and lows throughout the afternoon and evening ... joking and laughing one minute you could understand [him/her] completely and the next [s/he] was giving dirty looks mumbling	M 230		

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M 230	Continued From page 7 and being very rude ... took 100% of [his/her] meds ... did try to dumb [sic] [his/her] meds numerous times ..." 09/24/2025, 11:15 AM: " ... has been spitting on the floor and in [his/her] hands ..." 09/24/2025, 11:30 AM: " ... starting to be more aggressive with staff and starting to attack maintenance [person] every time [s/he] come verbally [sic all]." 09/24/2025, 7:00 PM: "Client refused to take [his/her] med." 09/25/2025, 8:15 AM: " ... was up 3 times during the night very worried about some being poisoned or overdosing ..." 09/26/2025, 7:45 AM: "Gave [Resident 2] milk with dinner [s/he] took two drinks and poured it on to the floor." 09/27/2025, 5:15 PM: "Staff was cooking diner [sic] and [Resident 2] picked up the pot of food and throw [sic] it in the garbage and spit in the pot of food." 09/28/2025, 7:45 AM: " ... just been having behaviors [sic] problems." 09/28/2025, 7:45 PM: " ...11am staff let [Resident 2] know lunch was ready. [Resident 2] came to the kitchen area to eat lunch. [Resident 2] repeatedly was spitting and throwing it on the floor along with [his/her] food saying people are trying to poison [him/her] ..." 10/01/2025, 5:30 PM: "Client was really disrespectful to everyone."	M 230		

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M 230	Continued From page 8 10/02/2025, 7:15 AM: " ... had a shower this morning ... sprayed staff with the shower head ... [Resident 2] did come in the kitchen and throw all the pancakes and eggs across the kitchen ... just redirected [him/her] and gave [him/her] a cigarette." 10/03/2025, 7:45 AM: "Refused to take a shower this morning ..." 10/05/2025, 7:15 AM: " ... spitting on the floor a lot and thrwing [sic] clothes ..." 10/06/2025, 11:45 AM: " ... dumped [his/her] bowl of food on the counter ..." 10/06/2025, 4:15 PM: " ... was making sandwich and [Resident 2] took other residents food and throw [sic] it at the wall staff told [him/her] that wasn't [his/her] food [s/he] said that that's [his/her] food ..." 10/06/2025, 5:30 PM: "[Resident 2] asked staff for milk staff gave [him/her] milk [s/he] took two sips and threw the cup of milk at staff." 10/08/2025, 7:15 AM: " ... had a rough night had to give night meds twice cause [sic] [s/he] through [sic] [his/her] pancake on the floor tried to run in [his/her] room with the keys was very agitated and aggressive had to redirect [him/her] several times ... got up several times all thru [sic] the night still agitated this morning ..." 10/08/2025, 8:15 AM: " ... [s/he] fought me for the house keys." 10/08/2025, 8:15 AM: "Last night at 8pm to 11pm [s/he] was trying to fight and spit and grab [s/he] is now a flight risk [s/he] tries to leave at all cost."	M 230		

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M 230	Continued From page 9 10/09/2025, 8:30 PM: " ... [Resident 2] has been hitting and grabbing at staff ... spitting at least 10 times in one hour ... is also pushing staff and clients." 10/10/2025, 12:30 PM: " ... [Resident 2] walked in the kitchen and picked up the pot of rice and threw it in the garbage staff had to make a whole different lunch for others in the home." 10/10/2025, 7:45 PM: "[Resident 2] has been very aggressive with clients and staff today." 10/11/2025, 7:45 AM: " ... didn't want to get in the shower." 10/12/2025, 7:45 AM: " ... won't get in the shower for me ..." 10/13/2025, 7:45 AM: " ... don't want to take a shower ..." 10/16/2025, 8:00 AM: "Did bad this morning pour [his/her] meds out in the sink." 10/20/2025, 7:30 PM: " ... a couple behaviors but nothing not normal for [him/her] ..." 10/21/2025, 7:15 AM: " ... refused to get in the shower and using foul language towards staff." 10/21/2025, 1:45 PM: " ... [Resident 2] has been really aggressive with staff and spitting and taking staff's things and pushing [his/her] chair in front of the door so staff cannot get in. Behaviors are getting worse by day staff did contact management." 10/21/2025, 2:00 PM: "[Resident 2] was given a	M 230		

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cigarette staff told [him/her] to go outside [s/he] so [explicit] and was smoking in dinner room [sic all]."

10/22/2025, 7:30 AM: " ... refused to take a shower ..."

10/24/2025, 7:00 PM: " ... [Resident 2] locked [his/herself] in [his/her] room and put the chair in front of the door for staff wouldn't come in and spit on staff has been very aggressive all day staff tried to redirect but it was not working."

10/25/2025, 7:15 AM: " ... spitting and calling me names putting [his/her] hands on me been up all night back and forth to [his/her] room calling me names all night."

10/25/2025, 7:15 PM: "Did a lot of disrespectful things like spitting and calling me foul names."

10/26/2025, 7:15 AM: " ... didn't want to take a shower."

10/27/2025, 9:30 AM: "[Resident 2] hit one of [his/her] house mates."

10/30/2025, 7:30 AM: " ... refused to take a shower for me ... refused vitals."

10/31/2025, 7:45 AM: " ... refused to get in the shower ..."

11/05/2025, 7:15 AM: " ... refused to get in the shower even if I offer [him/her] a cig [sic] still don't."

11/06/2025, 2:00 PM: " ... behaviors have been progressively growing more aggressively, [s/he] was chasing staff and pushing them also

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swinging/punching them on night shift to the point they had to step into the garage to protect themselves."

11/08/2025, 7:45 AM: " ... didn't want to get in the shower for me."

11/10/2025, 7:30 AM: " ... refused to take a shower even if I bribe [him/her] with cigs [sic]."

Review of incident reports documented Resident 2 had 10 reported incidents from September 2025 to November 2025. The incident reports noted the following:

09/24/2025 - Resident 2 saw maintenance loading up his/her truck with things from the garage, got in his/her face and used foul language and said that they were stealing.
10/06/2025 - Resident 2 threw a cup of milk on staff.
10/10/2025 - Resident 2 was told to go to the car as staff had to go pick up another resident. Resident 2 told staff s/he would go for 2 cigarettes and staff told him/her s/he could have them when they get back to the home. Resident 2 pushed staff and punched him/her in the stomach and said "move little black [fe/male] get off my property ..."
10/10/2025 - Resident 2 was in the kitchen when another resident was cooking. Resident 2 was asked to move back from the stove while cooking. Resident 2 slapped the other resident on the arm.
10/21/2025 - Resident 2 walked to the middle of the street and stood there.
10/21/2025 - Resident 2 pushed his/her chair and television stand in front of the door and did not respond to staff.
10/21/2025 - Resident 2 was seen by hospice

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and told them to get out of his/her room, used foul language and slammed the door in staff's face.
10/27/2025 - Resident 2 and another resident were walking down the hallway and staff saw him/her hit the other resident in the stomach. The other resident told Resident 2 to not touch him/her. Staff moved both residents away from each other.
11/04/2025 - Resident 2 was trying to take things that were not his and another resident got upset with him/her. They exchanged words and then began pushing each other. Both residents were separated and Resident 2 was redirected to go to his/her room to calm down.
11/12/2025 - While staff was driving over the bridge, Resident 2 opened his/her car door.

On 11/12/2025 at 1:50 PM, Surveyor interviewed ED C who confirmed Resident 2 does not have a behavioral support plan. S/he stated s/he doesn't have one from the care team, but would work with them on creating one. ED C reported Resident 2 has had a lot of changes within in the last 2 months. S/he stated, "[Resident 2] had a hospital stay in September and was discharged with low sodium. [S/he] was then admitted to hospice." ED C acknowledged Resident 2's ISP was not updated to reflect his/her changes in condition. S/he discussed that staff should be attempting to shower Resident 2 daily, but sometimes they only occur once a week if not less due to his/her behaviors and only allowing certain staff. ED C reported, "[S/he's] really wild. [S/he] screams and physically fights staff. Nothing works."

On 11/12/2025 at 3:30 PM, Surveyor interviewed Manager H who acknowledged s/he was newer to his/her role. When Surveyor asked Manager H about Resident 2, s/he stated, "[S/he] makes me

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nervous due to [his/her] behaviors and it's a lot when there is only 1 staff working." Manager H discussed a recent incident where a night shift staff went into the garage because of Resident 2's behaviors and safety concerns. (Surveyor note: While Surveyor was speaking with Manager H in the dining room, Resident 2 came into the room numerous times and appeared agitated. Resident 2 mumbled inaudibly and stated, "vacate," "get off my property," and "leave now," and pointed to the door.)

On 11/18/2025 at 10:35 AM, Surveyor interviewed Nurse I who reported Resident 2 admitted to hospice services on 10/16/2025 for weight loss and general decline. Nurse I discussed when s/he went to the home to assess Resident 2 for services s/he slammed doors, threw things and used foul language. Nurse I reported when Resident 2 communicates his/her words are "incomprehensible" and s/he "mumbles." S/he reported s/he has had several contacts with Resident 2 and each time s/he has observed behaviors. Nurse I reported, "[S/he] doesn't let me access [him/her] or do anything with [him/her]." S/he stated, "It was suggested we do blood draws in the home for [his/her] medications, but we can't do them due to safety concerns. I am not comfortable with that. There is only 1 staff there during the day. It's the unpredictability with [him/her]. It's a huge safety concern on multiple levels." Nurse I discussed that Resident 2 would be more appropriate in a setting that could better manage his/her behaviors.

On 11/18/2025 at 12:00 PM, Surveyors interviewed ED C, Licensee D and Licensee F. Surveyor inquired about the staffing pattern and ED C reported there is one staff each 12-hour

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M 230	Continued From page 14 shift. ED C stated the house manager is also present during the weekday and fills in on shifts as needed. S/he discussed they have had several different house managers over the last few months. ED C reported, "[Manager H] started at the end of October. [Resident 2's] behaviors are a lot for [him/her]. I am not sure [s/he] will stay." When discussing Resident 2's behaviors towards staff and residents, Surveyor reviewed several observation notes and specifically the note from 11/06/2025 and Licensee D stated, "I've never heard of [him/her] having that much of an episode." License F reported, "I am surprised by this. This should have been an investigation the day this happened. If [s/he] is having higher behaviors, we should be communicating this." Licensee F confirmed they do not have a behavioral support plan in place for Resident 2, but they will work with the care team and legal guardian on implementing one. The licensee did not ensure the home was free from the existence or continuation of a condition which places the health, safety or welfare of residents at substantial risk of harm. Cross Reference: M0466 DHS 88.07(3)(e)1 Medication - Record Keeping M0458 DHS 88.07(3)(a) Prescription Medications	M 230		
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	M 232		

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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 2 of 2 employees reviewed (Caregiver A and Caregiver B) were screened for communicable illness, including tuberculosis (TB), within 90 days before the start of providing service.

Caregiver A was hired 03/04/2025. Caregiver A's employee file contained a TB test and no communicable disease screen.

Caregiver B was hired 08/06/2025. Caregiver B's employee file did not contain a TB test or communicable disease screen.

Findings include:

On 11/12/2025, Surveyors conducted an abbreviated survey and complaint investigation at the home. Surveyor requested Caregiver A and Caregiver B's employee files from Executive Director (ED) C.

On 11/12/2025 at 12:30 PM, Surveyor reviewed Caregiver A's employee file. Caregiver A was hired 03/04/2025 and had a documented TB test dated 03/03/2025. No documentation was located within the file to indicate Caregiver A had been screened by a physician, physician assistant or a

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registered nurse for illnesses detrimental to residents.

On 11/12/2025 at 12:40 PM, Surveyor reviewed Caregiver B's employee file. Caregiver B was hired on 08/06/2025. Caregiver B's file did not contain a TB test or documentation s/he had been screened by a physician, physician assistant or a registered nurse for illnesses detrimental to residents.

On 11/12/2025 at 12:45 PM, Surveyor interviewed ED C who confirmed Caregiver A did not have a communicable disease screen. When Surveyor inquired about Caregiver B's screening for communicable disease including TB, ED C proceeded to ask Caregiver B who was working at the facility during the time of Surveyor's visit. Caregiver B reported s/he received a TB test at a previous employer, but did not know if s/he would be able to obtain the information. Surveyor asked for the information to be provided by 12:00 PM on 11/13/2025.

On 11/13/2025 at 10:26 AM, Surveyor received an email with attachments from ED C; however, the information did not contain evidence Caregiver B was screened for communicable disease including TB.

On 11/18/2025 at 12:00 PM, Surveyors interviewed ED C, Licensee D and Licensee F. ED C reported since Surveyor's onsite visit, both Caregiver A and Caregiver B went in to complete the communicable disease screening and TB test. ED C stated Caregiver A will not release the information to them, but Caregiver B completed both requirements. Surveyor asked ED C to email the documentation for both Caregiver A and Caregiver B. ED C reported they previously relied

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M 232	Continued From page 17 on staff to complete this upon hire; however, since this is not being done they will be changing their process going forward. On 11/18/2025 at 12:32 PM, Surveyor received an email with attachments from Assistant G. Surveyor reviewed the attached information which reflected Caregiver A did not return for the reading of his/her TB test administered on 11/14/2025 so the communicable disease screening was not completed. The documentation also confirmed Caregiver B was administered his/her TB test on 11/14/2025 with results on 11/17/2025 and was also screened for illnesses detrimental to residents. The provider did not ensure employees were screened for clinically apparent communicable disease, including tuberculosis (TB), within 90 days before the start of employment.	M 232		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interviews, the provider did not ensure the home was clean and well-maintained, having the potential to affect 4 of 4 residents.	M 276		

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M 276	Continued From page 18 Findings include: The provider is licensed to care for up to 4 residents who may be developmentally disabled, emotionally disturbed/mentally ill, physically disabled, advanced age, terminally ill, alcohol/drug dependent, irreversible dementia/Alzheimer's and/or have a traumatic brain injury. On 11/12/2025 at approximately 10:30 AM, Surveyors toured the home accompanied by Executive Director (ED) C and observed the following: RESIDENT 1's BEDROOM (located in the basement): - The mattress did not contain sheets or a mattress pad and was sunken in the middle. The mattress had black and brown colored stains in several areas. - The pillows were dirty/yellow stained. - There were cobwebs on the edges of the ceiling. - There was no light fixture cover on the ceiling. - There was a dent approximately 3 to 4 inches wide on the closet door. RESIDENT 2's BEDROOM (main level of the home/last room on the right): - Two (2) sets of white vinyl blinds were broken. - The carpet had several dark stains throughout the room. - There was a strong odor of uncleanliness and body odor. RESIDENT 3's BEDROOM (main level of the home/first room on the right): - The brown bi-fold closet doors were not secured	M 276		

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and were not able to close.
- There was dust/cobwebs on the wall and particles behind the bedroom door.

RESIDENT 4's BEDROOM (main level of the home/last room on the left):
- Two (2) sets of white vinyl blinds and the top of the windowsills were dusty.

SHARED BATHROOM (main level of the home):
- The vinyl blinds and windowsills were dusty.
- A vent on the floor near the toilet was speckled with a brown/red rust-like substance.
- The tiled shower had a black-like substance in the grout resembling mold.

KITCHEN/HALLWAY/LIVING ROOM/LAUNDRY ROOM:
- There was dried food/liquid splatter on the wall behind the garbage can. There was a piece of molding missing on the floor.
- Floor and ceiling vents throughout were covered in dust.
- A black couch in the living room was missing fabric on each of the 3 cushions.
- A microwave in the kitchen was visibly soiled with food splatter.
- The oven had tin foil lining the bottom which was covered in black char/residue. Oven interior surfaces had visible residue throughout appearing as though the oven had not been cleaned in an extended period of time.

On 11/12/2025 at 1:50 PM, Surveyor interviewed ED C who acknowledged Surveyor's concerns of lack of cleanliness in the home. ED C reported it is the staff's responsibility to clean.

On 11/13/2025 at 3:25 PM, Surveyor interviewed Licensee D who stated they bought a bed for

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M 276	Continued From page 20 Resident 1 and it should arrive soon. S/he reported, "I didn't know it was bad until a week ago." Licensee D also reported they also bought a new couch for the living room and that will arrive within a couple of weeks. Licensee D stated they will be addressing the other concerns as well. S/he reported, "The staff have cleaning checklists to follow, but they don't always do it." On 11/18/2025 at 12:00 PM, Surveyors interviewed ED C, Licensee D and Licensee F who acknowledged Surveyors concerns. Licensee D reported they will no longer be providing a new bed for Resident 1 as his/her guardian will now be purchasing one. Licensee F stated they will have their house managers work with staff to ensure cleanliness in the home. ED C reported, "The home has been neglected. I've been focusing on other homes."	M 276		
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	M 458		

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M 458	Continued From page 21 did not ensure all medications were securely stored. Lorazepam 1 milligram (mg) per 0.5 milliliter (ml) and haloperidol 1 mg per 1 ml were stored unsecured in the provider's refrigerator. Findings include: The provider is licensed to care for up to 4 residents who may be developmentally disabled, emotionally disturbed/mentally ill, physically disabled, advanced age, terminally ill, alcohol/drug dependent, irreversible dementia/Alzheimer's and/or have a traumatic brain injury. On 11/14/2025, Exectutive Director (ED) C provided an untitled document that on page 3 stated, "Storage of Medications: Every medication shall: ...Be securely stored (locked and with limited access); ...Be stored in a labeled locked box if medications are stored in a common refrigerator". On 11/13/2025 with additional information gathered through 11/17/2025, Surveyor conducted a complaint investigation alleging medication concerns at the provider's home. On 11/13/2025 at approximately 11:00 AM, Surveyor observed the provider's refrigerator. Surveyor observed a black, cloth bag with a built-in lock sitting in the refrigerator on a middle shelf. The lock was not engaged and Surveyor accessed two medications for Resident 2; lorazepam (schedule IV benzodiazepine used to treat anxiety) and haloperidol (antipsychotic medication). Surveyor immediately interviewed ED C who verified the observation and stated,	M 458		

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M 458	Continued From page 22 "That the bag should be locked." ED C asked Caregiver B if s/he knew why the locked bag was not locked. Caregiver B stated s/he was unaware because s/he had not administered medication from the bag yet during his/her current shift. On 11/13/2025 between 10:30 AM and 4:00 PM, Surveyor observed Resident 1, Resident 2, Resident 3 and Resident 4 in the kitchen and who were all able to independently ambulate and have access to the provider's refrigerator. On 11/18/2025 at 12:00 PM, Surveyors interviewed ED C, Licensee D and Licensee F who acknowledged Surveyor's concern the medications located in the refrigerator were not securely stored. Cross Reference: M0466 DHS 88.07(3)(e)1 Medication - Record Keeping M0230 DHS 88.04(2)(f) Condition Which Represents Risk or Harm	M 458		
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.	M 466		

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M 466	Continued From page 23 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an accurate record of medication administration was maintained for 2 of 4 residents (Resident 2 and Resident 3) reviewed. The medication administration records (MAR) for Resident 2 and Resident 3 did not contain accurate or complete documentation of medication administration. Findings include: The provider is licensed to care for up to 4 residents who may be developmentally disabled, emotionally disturbed/mentally ill, physically disabled, advanced age, terminally ill, alcohol/drug dependent, irreversible dementia/Alzheimer's and/or have a traumatic brain injury. On 11/12/2025, Surveyors conducted an onsite visit to complete an abbreviated survey and a complaint investigation alleging concerns with medication administration. Surveyor requested Resident 2's and Resident 3's MARs from September 2025 to November 2025 along with medication orders. On 11/14/2025, Executive Director (ED) C provided an untitled document that stated on pages 5 through 7: "How to Document Medications 1. Scheduled or Routine Medications- Routine medications must be signed out on the MAR by clicking on the appropriate cell on the MAR. By Clicking on designated cell, the professional caregiver is stating that the correct	M 466		

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medication was given to the correct client, at the correct dose, by the correct route, at the correct time.
2. PRN Medications- PRN medications must be signed out on the electronic MAR. The caregivers should document the date, time, medication and amount,
reason for the medication, effect of the medication, and the professional caregiver's initials in the appropriate cell on the MAR...

How To Document a Medication Not Given
1. Client Refusal- if a client refuses to take a medication, the professional caregiver should ask the reason for refusal and document the refusal by clicking on detail mode, click on cell, select refused, type in comment, and save. You then must complete a general event report.
Refusals of medications should be reported to the physician after 2 consecutive days of refusal or as soon as possible if the client's refusal appears to be medically contraindicated
2. Other Reason Medication Cannot Be Given- If there is any reason a
medication cannot be given for 2 consecutive days or if missing the dose is medically contraindicated, contact the prescribing practitioner as soon as possible
Examples- medication not received from the pharmacy, medication damaged, client is ill, or medication forgotten. Select detail mode and select reason.
3. Holds- A hold on a medication is when the prescribing practitioner has decided to temporarily stop a medication for a specific purpose. Only a health care practitioner can make this decision. Otherwise the missed medication is either an error or refusal. This is an option in detail mode."

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M 466	Continued From page 25 Between 11/12/2025 and 11/17/2025, Surveyor reviewed Resident 2's MAR. Resident 2's November 2025 medication orders included: - Acetaminophen 500 milligram (mg) tablet by mouth twice daily - Senna laxative 8.6 mg tablet by mouth every night at bedtime - Atorvastatin 10 mg tablet once daily for increased cholesterol - Memantine 10 mg tablet by mouth twice daily for decline in cognition due to a brain disease - Multigen Plus caplet by mouth daily - Pantoprazole sodium DR 40 mg tab by mouth daily in the morning before breakfast - Vitamin C 500 mg tablet by mouth twice daily - Vitamin D3 2000 IU (international units) Gel 1 capsule by mouth daily - Haloperidol 2 mg/ml syringe take 1 ml (2 mg) by mouth/Sub-L (sublingual, under tongue) 3 times daily for restlessness/agitation - Clonidine 0.1 mg/day patch every 7 days for aggressive behavior/agitation/restlessness - Clozapine OTD (orally disintegrating) 100 mg tablet take 3 tablets (300 mg) by mouth twice daily with 50 mg=350 mg Resident 2's MAR was reviewed for completion of documentation. The following completion rate was identified: 09/01/2025 - 09/30/2025 included 67 missed documentation's out of 490 opportunities indicated an 86.33% completion rate. 10/01/2025 - 10/31/2025 included 88 missed documentation's out of 435 opportunities indicated an 79.77% completion rate. 11/01/2025 - 11/11/2025 included 33 missed documentation's out of 200 opportunities indicated an 83.5% completion rate.	M 466		

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M 466	Continued From page 26 Between 11/12/2025 and 11/17/2025, Surveyor reviewed Resident 3's MAR. Resident 3's November 2025 medication orders included: - Valsartan 80 mg tablet by mouth twice daily in the morning and evening - Aripiprazole 5 mg tablet by mouth nightly with 2 mg=7 mg for conduct disorder - Aripiprazole 2 mg tablet by mouth nightly with 5 mg=7 mg for conduct disorder - Hydroxyzine 25 mg capsule by mouth every morning for itching - Metoprolol Succinate ER 100 mg tablet by mouth once daily - Pantoprazole Sodium DR 40 mg tablet by mouth once daily - Premarin 0.625 mg tablet by mouth once daily - Vitamin B complex + vitamin C tablet by mouth once daily - Vitamin D3 2000 IU Gel one capsule by mouth once daily - Medigrip size E apply as directed to bilateral lower extremities for venous insufficiency *every morning check wound and change Tubigrip - SSD 1% cream 50 gm jar apply 0.0625 inch (1/16th of an inch or nickel thick) thickness to affected area once daily - Rexulti 1 mg tablet by mouth once nightly Resident 3's MAR was reviewed for completion of documentation. The following completion rate was identified: 09/01/2025 - 09/30/2025 included 83 missed documentation's out of 420 opportunities indicated an 80.23% completion rate. 10/01/2025 - 10/31/2025 included 75 missed documentation's out of 436 opportunities indicated an 82.79% completion rate.	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018196	A. BUILDING: _____ B. WING _____	C 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEBRA PROGRAM	1953 DICKINSON ROAD DE PERE, WI 54115

(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 27 11/01/2025 - 11/11/2025 included 17 missed documentation's out of 154 opportunities indicated an 88.96% completion rate. On 11/12/2025 at 3:00 PM, Surveyor interviewed ED C who stated s/he was aware staff were not documenting appropriately in Resident 2 and Resident 3 MARs and medical record. ED C stated the facility is having a mandatory meeting on 11/13/2025 which will in part include education related to documentation. ED C was receptive of the findings and acknowledged the need to improve documentation. Cross Reference: M0458 DHS 88.07(3)(a) Prescription Medications M0230 DHS 88.04(2)(f) Condition Which Represents Risk or Harm	M 466		