| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019371 | A. BUILDING: _____ B. WING _____ | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BILAN 1 | 118 EMMA CT MADISON, WI 53716 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| M 000 | INITIAL COMMENTS<br><br>On 09/30/2025, Surveyor conducted a standard survey at Bilan 1, an AFH in Madison.<br><br>Two deficiencies were identified.<br><br>Census: 3 | M 000 | | |
| M 448 | 88.07(2)(b)5 MONITORING HEALTH<br><br>Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure the health of 2 of 2 residents reviewed was monitored and changes documented.<br><br>Resident 1's blood sugar was not monitored or refusals documented 4 times daily as ordered.<br><br>Resident 2's record did not include documentation of a fall that resulted in a fracture.<br><br>Findings include:<br><br>On 09/30/2025, Surveyor conducted a standard survey. Surveyor identified the following monitoring concerns:<br><br>Example 1 - Resident 1:<br><br>On 09/30/2025 at 9:15 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 07/19/2024. Resident 1's | M 448 | | |

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

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| M 448 | Continued From page 1 | M 448 | | |

physician orders included an order, dated 03/24/2025, to check blood sugar (BS) 4 times daily - 1 in the morning when fasting and 1-2 hours after each meal. Resident 1's medication administration record (MAR), dated 09/01/2025 to 09/30/2025, documented the following concerns regarding BS checks:

- 09/12/2025: Only 3 BS checks completed or documented as refused.
- 09/13/2025: Only 1 BS checks completed or documented as refused.
- 09/14/2025: Only 2 BS checks completed - "No test strips available" was documented for the first BS due.
- 09/15/2025: Only 3 BS checks completed or documented as refused.
- 09/16/2025: Only 3 BS checks completed or documented as refused.
- 09/17/2025: Only 3 BS checks completed or documented as refused.
- 09/18/2025: Only 3 BS checks completed or documented as refused.
- 09/19/2025: Only 2 BS checks completed or documented as refused.
- 09/25/2025: Only 3 BS checks completed or documented as refused.
- 09/26/2025: Only 3 BS checks completed or documented as refused.
- 09/27/2025: Only 3 BS checks completed or documented as refused.
- 09/28/2025: Only 3 BS checks completed or documented as refused.

On 09/30/2025 at approximately 11:00 a.m., Surveyor reviewed concern with Licensee A and Caregiver B that Resident 1's BS checks were not monitored 4 times daily as ordered. Caregiver B explained that Resident 1 often refused, would sleep late or wouldn't be home when a BS check

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| M 448 | Continued From page 2 | M 448 | | |

was due. Surveyor shared that Resident 1's MAR consisted of several blank entries, leaving it unclear if Resident 1 refused the BS check or if the BS was not taken for some other reason. Licensee A and Caregiver B acknowledged Surveyor's concern and stated they would make sure all entries when BS checks were due had documentation if not taken.

Example 2 - Resident 2:

On 09/30/2025 at 9:15 a.m., Surveyor reviewed Resident 2's record with Caregiver B and Caregiver C present. Resident 2 was admitted to the provider's home on 06/24/2025. Resident 2's record included an After Visit Summary, dated 08/11/2025, that referenced a closed non-displaced avulsion fracture. Surveyor asked Caregiver C if Resident 2 had sustained a recent injury. Caregiver B replied, "Yes. [S/he] fell going out to smoke." Caregiver C stated Resident 2 had a boot for a while status post fall, but the boot was no longer in use. Surveyor reviewed Resident 2's binder with paper documentation and electronic record and was unable to locate documentation regarding a fall that resulted in a fracture.

On 09/30/2025 at approximately 11:00 a.m., Surveyor interviewed Licensee A and shared concern that Resident 2's record did not include record of a fall sustained that resulted in a fracture. Licensee A acknowledged Surveyor's concern and showed Surveyor an email sent to Resident 2's Managed Care Organization (MCO). Licensee A stated s/he did not document the fall in Resident 2's record. Licensee A stated the provider was not using their electronic charting program (ECP) at the time of the fall, but had since initiated ECP use and started

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| M 448 | Continued From page 3<br>observation/progress notes as needed. | M 448 | | |
| M 466 | 88.07(3)(e)1 MEDICATION- RECORD KEEPING<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure an accurate record of medication administration was maintained for 1 of 2 residents reviewed.<br><br>The administration of Resident 2's Ferrous Sulfate was not documented 6 times in September 2025.<br><br>Findings include:<br><br>On 09/30/2025 at 9:15 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's home on 06/24/2025. Resident 2's physician orders included an order for Ferrous Sulfate 325 mg (Start Date: 07/03/2025) - Take ½ tab every other day. Resident 2's Medication Administration Record (MAR), dated 09/01/2025 to 09/30/2025 indicated the mediation was due on odd days and Resident 2's medication supply indicated the pharmacy packed the medication | M 466 | | |

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| M 466 | Continued From page 4<br>every other day in a medication strip with all AM medications. Resident 2's MAR documented the following on odd days when Ferrous Sulfate would have been due:<br><br>- 09/05/2025: No Pass Per Vitals<br>- 09/07/2025: No Pass Per Vitals<br>- 09/11/2025: "Other - Takes every other day."<br>- 09/21/2025: "Other - Takes every other day."<br>- 09/27/2025: Blank<br>- 09/29/2025: No Pass Per Vitals - "Takes every other day."<br><br>On 09/30/2025 at approximately 11:00 a.m., Surveyor interviewed Licensee A and shared concern that Resident 2's record documented that his/her Ferrous Sulfate was not administered on days it was due. Licensee A reviewed Resident 2's MAR and confirmed Surveyor's observation. Licensee A stated s/he believed it was a documentation error and that Resident 2 received the medication because staff would have left any medications not administered in the medication supply and Licensee A did not see any extras. Resident 2 stated s/he would reeducate staff regarding medication administration and documentation. | M 466 | | |