STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014191	A. BUILDING: _____ B. WING _____	R-C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNX	6188 N 122ND ST MILWAUKEE, WI 53225

(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
{N 000}	Initial Comments On 07/07/2026, Surveyor completed a verification visit and 2 complaint investigations. As a result, 2 deficiencies were identified. Two of 2 complaints were unsubstantiated. Two of 2 deficiencies were repeat violations. (See Statement of Deficiency M7KB11, dated 02/17/2026). Under statutory provisions of Wis. Stat. C. 50, a $200 revisit fee is being assessed. Census: 5	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all medications were administered at the dose prescribed for 1 (Resident 3) of 3 residents reviewed. Resident 3 had a physician's order to receive 1 tablet of acetaminophen 325 milligrams (MG) every 4 hours as needed for pain. Resident 3 was administered acetaminophen within 4 hours after receiving the previous dose on 3 occasions in April 2026. This is a repeat deficiency. See Statement of	{N 352}		

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

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{N 352}	Continued From page 1 Deficiency M7KB11, dated 02/17/2026. Findings include: On 07/07/2026 at approximately 12:30 PM, Surveyor toured the medication cabinet. Lead Direct Support Professional (DSP) E denied any residents within the community based residential facility (CBRF) self-administered their medication. On 07/07/2026, Surveyor reviewed Resident 3's record. Resident 3 was admitted into the facility on 01/02/2014. Resident 3's individual service plan (ISP), dated 02/20/2026, indicated staff administered Resident 3's medications. Resident 3 had a physician order with a start date of 10/12/2018 for 1 tablet of acetaminophen 325 MG to be taken by mouth every 4 hours as needed for pain. Instructions on Resident 3's April 2026 medication administration record (MAR) stated, "Take this product by mouth as directed, Do not take more acetaminophen than recommended." Resident 3's medication administration record (MAR) for April 2026 indicated Resident 3 was administered acetaminophen on 04/11/2026 at 1:07 AM and 4:00 AM. The two doses were taken within 2 hours and 53 minutes of one another and not every 4 hours as indicated in the physician order. On 04/15/2026, Resident 3 was administered acetaminophen at 2:56 AM and 6:23 AM. The two doses were administered within 3 hours and 27 minutes of one another and not every 4 hours as indicated in the physician order. On 04/21/2026, Resident 3 was administered acetaminophen at 3:43 AM and 7:17 AM. The two doses were taken within 3 hours and 34 minutes of one another and not every 4 hours as indicated on the physician order. On 07/07/2026 at approximately 3:30 PM,	{N 352}		

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{N 352}	Continued From page 2 Surveyor interviewed Program Director A and Program Director B. Program Director B acknowledged the above doses were administered too early and not according to the physician's order. Program Director B stated Lead Direct Support Professional was recently rehired and will start looking over MARs. One thing Lead Direct Support Professional will be looking at is ensuring medications are being administered as ordered.	{N 352}		
{N 415}	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have documentation of the time of medication administration, the person administering the medication or treatment and the name, dosage, date and time of medication taken or treatments performed and initialed in the medication administration record (MAR) for 2 (Resident 3 and Resident 4) of 3 residents reviewed.	{N 415}		

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{N 415}	Continued From page 3 The provider did not accurately document when Resident 3's medication was administered. No staff initial was observed for a total of 93 administered doses of prescribed medications in April 2026, 10 administered doses of prescribed medications in May 2026, 27 administered doses in June 2026, and 13 administered doses in July 2026. The provider did not accurately document when Resident 4's medication was administered. No staff initial was observed for a total of 10 administered doses of prescribed medications in May 2026, 47 administered doses in June 2026, and 6 administered doses in July 2026. This is a repeat deficiency. See Statement of Deficiency M7KB11, dated 02/17/2026. Findings include: On 07/07/2026, Surveyor reviewed resident records. The following was identified: Resident 3 was admitted on 01/02/2014. Resident 3's April 2026 MAR indicated the following orders, and prescribed medications were not documented as administered: -Atorvastatin 20 mg tablet 1 time daily at 7:00 AM. Two doses were not documented as administered. -Bupropion hydrochloride (Hcl) extended release (XL) 75 mg tablet 1 time daily at 7:00 AM. One dose was not documented as given. -Bupropion Hcl XL 150 mg tablet 1 time daily at 8:00 AM. Seven doses were not documented as given. -Buspirone 15 mg tablet 2 times daily at 7:00 AM and 4:00 PM. A total of 10 doses were not	{N 415}		

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{N 415}	Continued From page 4	{N 415}		

documented as given.
-Desvenlafaxine extended release (ER) 100 mg tablets 1 time daily at 7:00 AM. One dose was not documented as given.
-Eliquis 5 mg tablets 2 times daily at 8:00 AM and 8:00 PM. Forty-two doses were not documented as given.
-Ferrous sulfate 325 mg take 1 tablet every other day. One dose was not documented as given.
-Fluticasone 50 mcg spray 1 time daily at 7:00 AM. One dose was not documented as given.
-Lithium carbonate 150 mg capsule 2 times daily at 7:00 AM and 7:00 PM. A total of 6 doses were not documented as given.
-Loratadine 10 mg tablet 1 time daily at 7:00 AM. Three doses were not documented as given.
-Losartan potassium 25 mg tablet 1 time daily at 7:00 AM. One dose was not documented as given.
-Melatonin 10 mg capsule 1 time daily at 7:00 AM. Two doses were not documented as given.
-Multivitamin Take 1 tablet daily at 8:00 AM. Seven doses were not documented as given.
-Omeprazole delayed release (DR) 20 mg capsule 1 time daily at 7:00 AM. One dose was not documented as given.
-Quetiapine 50 mg tablet 2 times daily at 7:00 AM and 7:00 PM. A total of 8 doses were not documented as given.

Resident 3's May 2026 MAR indicated the following orders, and prescribed medications were not documented as administered:
-Buspirone 15 mg tablet 2 times daily at 7:00 AM and 8:00 PM. A total of 3 doses were not documented as given.
- Desvenlafaxine ER 100 mg tablets 1 time daily at 7:00 AM. One dose was not documented as given.
-Folic acid 1 tablet daily at 7:00 AM. One does

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{N 415}	Continued From page 5	{N 415}		

was not documented as given.
-Lithium carbonate 150 mg capsule 2 times daily at 7:00 AM and 7:00 PM. One dose was not documented as given.
-Losartan potassium 25 mg tablet 1 time daily at 7:00 AM. One dose was not documented as given.
-Omeprazole DR 20 mg capsule 1 time daily at 7:00 AM. One dose was not documented as given.
-Quetiapine 50 mg tablet 2 times daily at 7:00 AM and 7:00 PM. A total of 2 doses were not documented as given.
Resident 3's June 2026 MAR indicated the following orders, and prescribed medications were not documented as administered:
-Bupropion Hcl XL 75 mg tablet 1 time daily at 7:00 AM. Four doses were not documented as given.
- Bupropion Hcl XL 150 mg tablet 1 time daily at 8:00 AM. Three doses were not documented as given.
-Buspirone 15 mg tablet 2 times daily at 7:00 AM and 8:00 PM. A total of 2 doses were not documented as given.
-Cephalexin 500 mg tablets 4 times daily at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Four doses were not administered as given.
-Desvenlafaxine ER 100 mg tablets 1 time daily at 7:00 AM. One dose was not documented as given.
-Eliquis 5 mg tablets 2 times daily at 8:00 AM and 8:00 PM. Five doses were not documented as given.
-Folic acid 1 tablet daily at 7:00 AM. One does was not documented as given.
-Lithium carbonate 150 mg capsule 2 times daily at 7:00 AM and 7:00 PM. One dose was not documented as given.
-Losartan potassium 25 mg tablet 1 time daily at

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{N 415}	Continued From page 6 7:00 AM. One dose was not documented as given. -Multivitamin Take 1 tablet daily at 8:00 AM. Three doses were not documented as given. -Omeprazole DR 20 mg capsule 1 time daily at 7:00 AM. One dose was not documented as given. -Quetiapine 50 mg tablet 2 times daily at 7:00 AM and 7:00 PM. One dose not documented as given. Resident 3's July 2026 MAR indicated the following orders, and prescribed medications were not documented as administered between July 1, 2026 to July 7, 2026. -Atorvastatin 20 mg tablet 1 time daily at 7:00 PM. One dose was not documented as administered. -Bupropion Hcl XL 75 mg tablet 1 time daily at 7:00 AM. Two doses were not documented as given. -Bupropion Hcl XL 150 mg tablet 1 time daily at 8:00 AM. Two doses were not documented as given. -Buspirone 15 mg tablet 2 times daily at 7:00 AM and 4:00 PM. One dose was not documented as given. -Eliquis 5 mg tablets 2 times daily at 8:00 AM and 8:00 PM. Two doses were not documented as given. -Lithium carbonate 150 mg capsule 2 times daily at 7:00 AM and 7:00 PM. One dose was not documented as given. -Melatonin 10 mg capsule 1 time daily at 7:00 PM. One dose was not documented as given. -Multivitamin Take 1 tablet daily at 8:00 AM. Two doses were not documented as given. -Quetiapine 50 mg tablet 2 times daily at 7:00 AM and 7:00 PM. One dose was not documented as given Resident 4 was admitted on 05/18/2026.	{N 415}		

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{N 415}	Continued From page 7 Resident 4's May 2026 MAR indicated the following orders, and prescribed medications were not documented as administered between 05/19/2026-05/31/2026: -Propranolol 80 mg tablet daily at 7:00 AM. Two doses were not documented as given. -Quetiapine fumarate 200 mg tablets 3 times a day at 7:00 AM, 12:00 PM, and 8:00 PM. Four doses were not documented as given. -Reguloid powder 3 grams 3 times a day at 7:00 AM, 12:00 PM, and 8:00 PM. Two doses were not documented as given. -Tamsulosin HCL 0.4 mg capsules daily. Two doses were not documented as given. Resident 4's June 2026 MAR indicated the following orders, and prescribed medications were not documented as given: -Acetaminophen 500 mg tablets 3 times daily at 8:00 AM, 2:00 PM, and 8:00 PM. A total of 11 doses were not documented as given. -Divalproex sodium DR 250 mg tablets two times daily at 7:00 AM and 8:00 PM. Five doses were not documented as given. -Docusate sodium 100 mg tablets daily. Two doses were not documented as given. -Escitalopram 20 mg tablets daily. Two doses were not documented as given. -Lacosamide 150 mg tablets 2 times a day at 7:00 AM and 7:00 PM. Four doses were not documented as given. -Levothyroxine 125 micrograms (MCG) tablets daily. One dose was not documented as given. -Memantine HCL 10 mg tablets 2 times a day at 7:00 AM and 7:00 PM. Two doses were not documented as given. -Polyethylene glycol 3350 powder 17 grams 1 time a day. Two doses were not administered as given. -Propranolol 80 mg tablet daily at 7:00 AM. One dose was not documented as given.	{N 415}		

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{N 415}	Continued From page 8 -Quetiapine fumarate 200 mg tablets 3 times a day at 8:00 AM, 4:00 PM, and 8:00 PM. Five doses were not documented as given. -Reguloid powder 3 grams 3 times a day at 7:00 AM, 4:30 PM, and 8:00 PM. Five doses were not documented as given. -Risperidone 2 mg tablet 2 times a day at 8:00 AM and 8:00 PM. Five doses were not documented as given. -Tamsulosin HCL 0.4 mg capsules daily. One dose was not documented as given. -Trazadone 100 mg tablet daily. One dose was not documented as given. Resident 4's July 2026 MAR indicated the following orders, and prescribed medications were not documented as administered between July 1, 2026 to July 7, 2026: -Acetaminophen 500 mg tablets 3 times daily at 8:00 AM, 2:00 PM, and 8:00 PM. A total of 3 doses were not documented as given. -Lacosamide 150 mg tablets 2 times a day at 7:00 AM and 7:00 PM. One dose was not documented as given. -Polyethylene glycol 3350 powder 17 grams 1 time a day. One dose not administered as given. -Reguloid powder 3 grams 3 times a day at 7:00 AM, 4:30 PM, and 8:00 PM. One dose was not documented as given. On 07/07/2026 at approximately 1:00 PM, Surveyor interviewed Resident 2. Resident 2 confirmed receiving his/her medications. Resident 2 stated, "they are strict here about giving everyone their medicine." On 07/07/2026 at 3:30 PM, Surveyor interviewed Program Director A and Program Director B. Program Director B acknowledged the blank spaces within the MARs. Program Director B	{N 415}		

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{N 415}	Continued From page 9 stated it was found that the administration of medication the caregivers signed off on while using Therap's (electronic medical record platform) cell phone application did not carry over into the desktop version of the Therap application. Because of this, the MARs appear to be incomplete. Since the discovery, caregivers were educated to not use Therap's cell phone application to document the administration of medication. Program Director B reported Lead Direct Support Professional was recently rehired and will be responsible for auditing MARs to ensure completeness.	{N 415}		