STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018707	A. BUILDING: _____ B. WING _____	08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON CARE NETWORK MAPLE VALLEY	3010 MAPLE VALLEY DRIVE MADISON, WI 53719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	INITIAL COMMENTS From 08/25/2026 to 08/26/2026, Surveyor conducted a standard survey at Horizon Care Network Maple Valley, an AFH in Madison. Five deficiencies were identified. Two deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) RIX111, dated 04/15/2024. Census: 4	M 000		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents reviewed were evaluated annually for evacuation time, using the department's form. Resident 1 and Resident 2 had not had their ability to evacuate the home, using the department's form, assessed since 2024. This is a repeat deficiency. See Statement of Deficiency (SOD) RIX111, dated 04/15/2024. Findings include:	M 344		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018707	A. BUILDING: _____ B. WING _____	08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON CARE NETWORK MAPLE VALLEY	3010 MAPLE VALLEY DRIVE MADISON, WI 53719

(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 344	Continued From page 1 On 08/25/2026 at approximately 11:00 a.m., Surveyor reviewed resident records provided by Licensee A, which documented the following: - Resident 1 admitted to the provider's home on 04/15/2022. Resident 1's evacuation assessment was dated 06/23/2024. - Resident 2 was admitted to the provider's home on 07/01/2022. Resident 2's evacuation assessment was dated 06/11/2024. On 08/25/2026 at approximately 11:30 a.m., Surveyor interviewed Licensee A and asked if s/he had updated evacuation assessments, using the department's form, for Resident 1 and Resident 2. Licensee A replied, "No," and stated the provider completed routine fire drills but did not complete the evacuation assessment using the department's form annually.	M 344		
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: Based on record review and interview, the provider did not ensure an accurate record was maintained for all prescription medications	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018707	A. BUILDING: _____ B. WING _____	08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON CARE NETWORK MAPLE VALLEY	3010 MAPLE VALLEY DRIVE MADISON, WI 53719

(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 2 administered to 1 of 2 residents reviewed. Resident 1's record documented daily administration of Florajen capsules from 08/01/2026 to 08/24/2026, which were not administered. This is a repeat deficiency. See Statement of Deficiency (SOD) RIX111, dated 04/15/2024. Findings include: On 08/25/2026 at approximately 9:15 a.m., Surveyor reviewed Resident 1's medication administration record (MAR), dated 07/01/2026 to 08/25/2026, and Resident 1's medication supply. Surveyor observed a Florajen punch card containing 25 of 25 capsules, which was filled 07/07/2026. Surveyor noted the MAR, dated 07/01/2026 to 08/25/2026, documented daily administration of the Florajen from 08/01/2026 to 08/24/2026. On 08/25/2026, while reviewing the medication supply and MAR, Surveyor interviewed Caregiver B. Caregiver B stated s/he did not believe Resident 1 had been receiving the Florajen. Caregiver B stated s/he was not responsible for Resident 1's morning medication administration that morning. On 08/25/2026 at approximately 11:30 a.m., Surveyor interviewed Licensee A regarding Resident 1's Florajen administration. Licensee A stated the Florajen had not been administered and staff should not have documented the medication as administered. Licensee A stated s/he thought the Florajen was prescribed PRN. Licensee A stated s/he would complete training regarding documentation with staff.	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018707	A. BUILDING: _____ B. WING _____	08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON CARE NETWORK MAPLE VALLEY	3010 MAPLE VALLEY DRIVE MADISON, WI 53719

(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 3 Cross Reference: M0582 DHS 88.10(3)(q) Medications	M 466		
M 510	88.09(1)(d)11 RESIDENT FUNDS Records maintained by the licensee of the resident's finances, including written authorization from the resident of resident's guardian to control the resident's funds. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure records of 2 of 2 resident finances were maintained. The provider did not maintain a record of funds for Resident 1 and Resident 2. Findings include: On 08/25/2026 at approximately 11:00 a.m., Surveyor reviewed resident records provided by Licensee A, which documented the following: - Resident 1 admitted to the provider's home on 04/15/2022. Documentation indicated the provider had authorization to assist with management of Resident 1's funds. Documentation did not include a record of funds. - Resident 2 was admitted to the provider's home on 07/01/2022. Documentation indicated the provider had authorization to assist with management of Resident 2's funds. Documentation did not include a record of funds. On 08/25/2026 at approximately 11:30 a.m., Surveyor interviewed Licensee A and asked if	M 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018707	A. BUILDING: _____ B. WING _____	08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON CARE NETWORK MAPLE VALLEY	3010 MAPLE VALLEY DRIVE MADISON, WI 53719

(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 510	Continued From page 4 s/he had a record of Resident 1 and Resident 2's funds. Licensee A confirmed staff assisted Resident 2 with management of his/her debit card and staff assisted Resident 1 with management of ~$100 cash. Surveyor asked if Licensee A had receipts of purchases and/or a tracker to maintain record of resident funds. Licensee A replied, "No," and stated a tracker was something s/he could implement.	M 510		
M 530	88.09(2)(a)8 TRAINING DOCUMENTATION Documentation of successful completion of the training requirements under HSS 88.04(5). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure training documents were maintained for 2 of 3 employees reviewed. The provider did not maintain records of Caregiver B and Caregiver C's records. Findings include: On 08/25/2026 at approximately 11:00 a.m., Surveyor reviewed employee records provided by Licensee A, which documented the following: - Caregiver B was hired on 09/12/2024. Caregiver B's record included documentation of 15 hours of training completed in December 2025. The record did not include documentation of any training completed within the first 6 months of hire. - Caregiver C was hired in December 2024. Caregiver C's record did not include documentation of training.	M 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018707	A. BUILDING: _____ B. WING _____	08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON CARE NETWORK MAPLE VALLEY	3010 MAPLE VALLEY DRIVE MADISON, WI 53719

(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 530	Continued From page 5 On 08/25/2026, while reviewing employee records, Surveyor requested documentation of trainings completed within the first 6 months of hire for Caregiver B and Caregiver C from Licensee A. Licensee A stated s/he completed training with staff while shadowing, but did not document the training. Licensee A stated staff also completed trainings through an online program. Licensee A logged on to the provider's online training program and noted s/he did not have access to documentation of trainings completed in the years prior. Licensee A stated s/he usually printed documentation of trainings, but was unable to locate the documents and would reach out to the training company if unable to locate documentation. On 08/26/2026 at approximately 11:45 a.m., Surveyor received an email from Licensee A indicating the company was unable to access prior trainings at this time due to a recent software change.	M 530		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency.	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018707	A. BUILDING: _____ B. WING _____	08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON CARE NETWORK MAPLE VALLEY	3010 MAPLE VALLEY DRIVE MADISON, WI 53719

(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 582	Continued From page 6 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 2 residents reviewed received all medication as prescribed. Resident 1 did not receive his/her Florajen as prescribed. Findings include: On 08/25/2026 at approximately 9:15 a.m., Surveyor reviewed Resident 1's medication administration record (MAR), dated 07/01/2026 to 08/25/2026, and Resident 1's medication supply. The MAR, dated 07/01/2026 to 07/31/2026, did not list Florajen. The MAR, dated 08/01/2026 to 08/24/2026, documented daily administration of Florajen. Surveyor observed a Florajen punch card containing 25 of 25 capsules, which was filled 07/07/2026. On 08/25/2026, while reviewing the medication supply and MAR, Surveyor interviewed Caregiver B. Caregiver B stated s/he did not believe Resident 1 had been receiving the Florajen. Caregiver B stated s/he was not responsible for Resident 1's morning medication administration that morning. On 08/25/2026 at approximately 11:15 a.m., Surveyor reviewed an After Visit Summary, dated 07/07/2026, that indicated Resident 1 was seen for diarrhea, presumed to be of infectious origin, and prescribed a probiotic to take 1 time daily (Florajen). On 08/25/2026 at approximately 11:30 a.m., Surveyor interviewed Licensee A regarding Resident 1's Florajen administration. Licensee A	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018707	A. BUILDING: _____ B. WING _____	08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON CARE NETWORK MAPLE VALLEY	3010 MAPLE VALLEY DRIVE MADISON, WI 53719

(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 582	Continued From page 7 stated Florajen was never administered to Resident 1. Licensee A stated s/he thought the Florajen was prescribed as a PRN medication because Resident 1 had a history of constipation. Licensee A stated s/he would reach out to Resident 1's physician for clarification. Cross Reference: M0466 DHS 88.07(3)(e)1. Medication - Record Keeping	M 582		