STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
{M 000}	INITIAL COMMENTS On 02/18/2025, with information gathered through 02/23/2025, Surveyor conducted a standard licensure survey and a verification visit at Good Hand Care AFH 2. Ten deficiencies were identified. Three of 10 deficiencies were repeat (see Statement of Deficiency (SOD) TK6V11). Under statutory provisions of Wis. Stat. Ch. 50 a $200 revisit fee is being assessed. Census: 4	{M 000}		
{M 218}	88.04(2)(b) AWAKE STAFF FOR CONTINUOUS CARE The licensee shall ensure that he or she or a service provider is present and awake at all times if any resident is in need of continuous care. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure that s/he or a service provider was present and always awake for residents that require continuous care. This is a repeat deficiency. See Statement of Deficiency (SOD) TK6V11, dated 08/28/2024. The home's designated exit doors were locked from the inside that required a key to disengage the deadbolt lock due to Resident 2 opening the doors and allowing visitors into the home after visiting hours. Findings include:	{M 218}		

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
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
{M 218}	Continued From page 1 The provider is licensed to care for up to 4 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and physically disabled. On 02/18/2025, at approximately 1:40 PM, Surveyor toured the home with Licensee A and observed the designated exit doors contained a deadbolt locking system that required a key to disengage. Surveyor noted the front exit door also had a door alarm installed. Licensee A explained that Resident 2 had a significant other and s/he would allow this individual to enter the home when staff and residents were sleeping. Licensee A stated, "It worried the other residents. So the doors locks were changed so that you would need a key to open them. The doors are only locked during sleep hours." Licensee A explained the home was staffed with sleep staff during the NOC shift. (Surveyor noted Licensee A had to obtain the key to open the door for Surveyor to view where the door exited to.) On 02/18/2025, Surveyor reviewed Resident 2's record. Resident 2 moved into the home 05/08/2024 and is his/her own person. Resident 2's "Individual Service Plan," dated 02/10/2025, documented: "Mobility - Resident needs monitoring / assistance with mobility." "Behavioral Intervention - No behavioral interventions." "Supervision: Resident requires 24 hour supervision (cannot be left alone)."	{M 218}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
{M 218}	Continued From page 2 On 02/21/2025, at approximately 3:40 PM, Surveyor interviewed Resident 4. Resident 4 did not express any concerns with visitors that had been in the home.	{M 218}		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record observation, record review and interview, the provider did not ensure that 1 of 1 service providers (Caregiver D) received training in medication administration prior to working independently. Findings include: The provider was licensed on 06/13/2023 to care for up to 4 residents in the client groups physically disabled, advanced aged, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, and developmentally disabled. On 02/18/2025, at approximately 12:00 PM,	M 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 244	Continued From page 3 Surveyor arrived at the home and was greeted by Caregiver D, who was working independently. On 02/18/2025, at approximately 12:30 PM, Licensee A arrived while Surveyor was reviewing Resident 3's medications. Surveyor asked Caregiver D why Resident 3 had not been administered his/her 8:00 AM medications. Licensee A translated to Caregiver D what Surveyor had asked, and Caregiver D stated Resident 3 had not gotten up for morning medications. On 02/18/2025, Surveyor reviewed Caregiver D's record. Caregiver D was hired in 11/2024. Caregiver D's record did not include training in medication administration. On 02/18/2025, at approximately 1:15 PM, Surveyor interviewed Licensee A. Surveyor asked if Caregiver D had received training in medication administration. Licensee A stated, "[Caregiver D] was working because I had gone to the grocery store." On 02/21/2025, at approximately 2:30 PM, Surveyor interviewed Licensee A. Surveyor asked if Caregiver D had any training records. Licensee A did not have a response. On 02/21/2025, at approximately 3:30 PM, Surveyor arrived at the home and Caregiver D was working independently.	M 244		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 246	Continued From page 4 (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on interview and record review, the licensee did not ensure 1 of 2 staff members (Licensee A) received at least 8 hours, per calendar year, of continuing education training related to the health, safety, welfare, rights, and treatment of residents every year, during the calendar year 2024. Findings include: The provider was licensed on 06/13/2023 to care for up to 4 residents in the client groups physically disabled, advanced aged, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, and developmentally disabled. On 02/18/2025, Surveyor reviewed Licensee A's training records. Licensee A's 2024 continuing education contained 8.5 hours of training but did not contain training related to medication administration, standard precautions, first aid, and fire safety. On 02/18/2025, at approximately 1:00 PM, Surveyor interviewed Licensee A. Licensee A	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 246	Continued From page 5 stated s/he was the primary caregiver for the home.	M 246		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the licensee did not ensure 2 of 2 fire extinguishers observed in the home were in readily usable condition and inspected annually by an authorized dealer or the local fire department. Findings include:	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 332	Continued From page 6 On 02/18/2025, at approximately 1:30 PM, Surveyor toured the home's physical environment with Licensee A. Surveyor observed a fire extinguisher in the kitchen, which was tagged 02/2023. Surveyor observed a fire extinguisher in the basement, where the laundry room was located, which was tagged 02/2023. Surveyor asked if the fire extinguishers had been inspected in 02/2024 or earlier. Licensee A stated s/he would have the fire extinguishers inspected by an authorized dealer.	M 332		
M 406	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Individual Service Plan (ISP) for 2 of 2 records reviewed were developed together with the placing agency, the person being admitted or person's guardian / designated representative and the provider. Resident 2's and Resident 3's ISP did not contain signatures from the placing agency, ensuring their agreement with the resident's ISP.	M 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 406	Continued From page 7 Findings include: On 02/18/2025, Surveyor reviewed Resident 2's and Resident 3's record. Resident 2 was admitted to the facility 05/08/2024. Resident 2 was placed in the home by a managed care organization (MCO) and was represented by Care Manager (CM) E. Resident 2's record contained an "Individual Service Plan," dated 09/09/2024 and 02/10/2025, which were not signed and dated by CM E. Resident 3 was admitted to the facility on 09/28/2024. Resident 3 was placed in the home by an MCO, and his/her representative is CM F. Resident 3's record contained an "Individual Service Plan," dated 10/02/2024 which was not signed and dated by CM F. On 02/21/2025, at approximately 2:30 PM, Surveyor interviewed Licensee A. Licensee A did not have a response when asked if the care managers had been asked to review Resident 2's and Resident 3's ISP and to sign the ISP to confirm understanding.	M 406		
{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.	{M 458}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
{M 458}	Continued From page 8	{M 458}		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure medications remained secured until time of administration for 4 of 4 residents (Resident 1, Resident 2, Resident 3, and Resident 4).

This is a repeat deficiency. See Statement of Deficiency (SOD) TK6V11, dated 08/28/2024.

Findings include:

The licensee can serve up to 4 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and physically disabled.

On 02/18/2025, at approximately 12:00 PM, Surveyor arrived onsite to conduct a standard licensure survey and a verification visit. Surveyor was greeted by Caregiver D. Surveyor walked to the medication closet which was unlocked. Surveyor observed Resident 1's, Resident 2's, Resident 3's, and Resident 4's medications sitting in unsecured plastic bins. Surveyor noted Caregiver D was not in the process of administering medications prior to Surveyors arrival.

On 02/21/2025, at approximately 3:30 PM, Surveyor arrived onsite and noticed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
{M 458}	Continued From page 9 medication closet was locked. Surveyor asked Caregiver D to unlock the medication closet. Caregiver D picked up the keys sitting on the counter next to the medication closet and unlocked the cabinet.	{M 458}		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 2 residents (Resident 3 and Resident 4) received prescribed medications in the proper dosage. Findings include: Example 1: Resident 3 On 02/18/2025, at approximately 12:30 PM, Surveyor and Licensee A observed Resident 3's medication. Resident 3's medications were dispensed into a 7-day weekly organizer. Surveyor opened the compartments of the 7-day organizer and observed: MORN (8:00 AM) - 9 tablets, 3 capsules EVE (5:00 PM) - 3 tablets, 1 capsule	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 462	Continued From page 10	M 462		

BED (8:00 PM) - 6 tablets

On 02/18/2025, Surveyor reviewed Resident 3's record.

Resident 3 moved into the home, 09/28/2024, with diagnoses including diabetes, hypothyroidism/hyperthyroidism, congestive heart failure (CHF), hypertension (high blood pressure), cerebral vascular accident (stroke), and cognitive impairment.

Resident 3's February 2025 Medication Administration Record (MAR) documented:

-8:00 AM medications, one tablet/capsule each: Amiloride 5 MG (milligram) (water pill), Duloxetine 60 MG (psychotropic medication), Eliquis 5 MG (blood thinner), Famotidine 20 MG (stomach acid reducer), Gabapentin 600 MG (seizure medication), Magnesium Oxide (400 MG), Metamucil (capsule) (fiber supplement), Metoprolol Tartrate 50 MG (high blood pressure medication), Omeprazole 20 MG (heartburn medication) and Rosuvastatin 40 MG (cholesterol medication).
Surveyor noted there were 10 medications listed versus the 12 that were in Resident 3's 'morn' compartment in the pill organizer. Surveyor verified the ten prescribed medications were dispensed in the organizer. Surveyor determined 2 tablets of Methylphenidate were included in the 8AM med pass. (Each pill was stamped with a different identifier - One was a white circular pill stamped with a 20 on one side and a M in a square on the other. One was a light-yellow circular pill stamped with a K and 102). This medication was not listed on the MAR.

-2:00 PM medications: One tablet Gabapentin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 462	Continued From page 11 (600 MG) Surveyor noted there was 1 medication listed versus the 4 that were in Resident 3's 'eve' compartment in the pill organizer. Surveyor determined the additional medications were Omeprazole 20 MG, Metoprolol Tartrate 50 MG, and 1 tablet of Methylphenidate. -8:00 PM medications, one tablet/capsule each: Eliquis (5 MG), Famotidine 20 MG, Gabapentin 600 MG, Metoprolol Tartrate 50 MG, Montelukast (10 MG), Myrbetriq (50 MG), and Omeprazole 20 MG. Surveyor noted there were 8 medications listed versus the 6 that were in Resident 3's 'bed' compartment in the pill organizer. Surveyor determined the medications not included were Omeprazole and Metoprolol Tartrate and a tablet of Methylphenidate, which was not listed on the MAR, was added. On 02/18/2025, at approximately 12:45 PM, Surveyor interviewed Licensee A. Surveyor commented that the medications dispensed did not match what was documented on the MAR. Licensee A did not have a response. Surveyor requested Resident 3's physician orders. On 02/19/2025, Surveyor reviewed Resident 3's physician orders, dated 10/02/2024, submitted by Licensee A. The physician orders matched what was listed on Resident 3's MAR and identified specific time of administration for the following medications: Magnesium Oxide, Psyllium (Metamucil), Duloxetine, Amiloride - 8am Gabapentin - 8am, 4pm, 8pm Metoprolol Tartrate, Omeprazole - 8am, 8pm Myrbetriq, Montelukast, Rosuvastatin - 8pm	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 462	Continued From page 12	M 462		

There was an order for Fluticasone Propionate and Salmeterol that was not listed on the MAR. There was no order for the Methylphenidate and 4 tablets were administered daily.

On 02/23/2025 at 12:32 PM, Surveyor emailed Licensee A and stated the physician orders provided did not include Methylphenidate.

On 02/23/2025 at 1:29 PM, Licensee A emailed Surveyor a screenshot picture from Resident 3's "My Chart" that documented:
Methylphenidate 20 MG - Take 1 tab by mouth 2 times daily morning and noon.
Surveyor noted the medication was administered as 2 tablets at 8:00 AM, 1 tablet at 2:00 PM, and 1 tablet at 8:00 PM.

Example 2: Resident 4

On 02/18/2025, at approximately 12:55 PM, Surveyor and Licensee A observed Resident 4's medication. Resident 4's medications were dispensed into a 7-day weekly organizer.
Surveyor opened the compartments of the 7-day organizer and observed:
MORN (8:00 AM) - 5 tablets, 2 capsule
MIDDAY (Noon) - 3 tablets
EVE (5:00 PM) - 3 tablets
BED (8:00 PM) - 3 tablets

On 02/18/2025, Surveyor reviewed Resident 4's record.

Resident 4 moved into the home 09/21/2024.

Resident 4's February 2025 MAR documented:

-8:00 AM medications, one tablet/capsule each: Fluoxetine 10 MG, Famotidine 20 MG,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 462	Continued From page 13 Armodafinil 150 MG, Iron 45 MG, Aspirin 81 MG, Senna - S, Baclofen 20 MG Surveyor noted there were 7 medications listed versus the 8 that were in Resident 4's 'morn' compartment in the pill organizer. Surveyor verified the 7 prescribed medications were dispensed in the organizer, but the Baclofen had been cut in half, so only 10 MG were administered. Surveyor determined 1 tablet of Docusate was included in the 8AM med pass. -Noon medications, one tablet/capsule each: Senna - S, Baclofen 20 MG, Vitamin B Complex Surveyor noted the medications in the 'Noon' compartment consisted of the Baclofen tablet being cut in half, so only 10 MG were administered. The Vitamin B Complex had originally been prepacked by the pharmacy to be dispensed at 8:00 AM. The Senna-S capsule was not dispensed to be administered. A Docusate tablet was dispensed for administration. -5:00 PM medications, one tablet/capsule each: Senna - S, Baclofen 20 MG, Multivitamin Surveyor noted the medications in the 'Eve' compartment consisted of the Baclofen tablet being cut in half, so only 10 MG were administered. The Senna-S capsule was not dispensed to be administered. A Docusate tablet was dispensed for administration. -8:00 PM medications, one tablet/capsule each: Senna - S, Baclofen 20 MG, Magnesium 500 MG, Trazodone 50 MG - 2 tablets, Melatonin 3 MG - 2 tablets Surveyor noted there were 5 medications listed versus the 3 that were in Resident 4's 'Bedtime' compartment in the pill organizer. Surveyor determined the medications not included were Trazadone and Melatonin. An additional tablet of	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 462	Continued From page 14 Docusate was also in the organizer that was not scheduled for 8:00 PM. Surveyor noted the blister card of Trazadone documented, "Take 2 tablets (100 MG) by mouth at bedtime as needed." The MAR documented the Trazadone as a scheduled medication and administered daily. Surveyor noted the Docusate was prepackaged by the pharmacy and labeled to be administered 4 times daily (8:00 AM, 12:00 PM, 5:00 PM, 8:00 PM). On 02/18/2025, at approximately 12:45 PM, Surveyor interviewed Licensee A. Surveyor commented that the medications dispensed did not match what was documented on the MAR. Licensee A did not have a response. Surveyor requested Resident 3's physician orders. On 02/21/2025, at approximately 3:15 PM, Surveyor was onsite at the home with Licensee A and asked Licensee A to assist with determining what medications were dispensed at what time and to assist in identifying the medications. Licensee A stated Co-Owner B, who is a registered nurse, dispensed the medications into the weekly pill organizers. On 02/22/2025, Surveyor reviewed Resident 4's physician orders, dated March 2025, provided by Licensee A. The physician orders did not match Resident 4's February 2025 MAR. Cross Reference: M0466 DHS 88.07(3)(e)1. Medication - Record Keeping	M 462		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 464	Continued From page 15	M 464		

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 observation, record review and interview, the provider did not obtain a written order from the physician who prescribed the medications, specifying who by name or position was permitted to administer the medication for 2 of 2 residents reviewed.

Resident 3's record did not contain a written order for Resident 1 to administer his/her own medication.
Resident 3's and Resident 4's record did not contain a written order for staff to administer medication.

Findings include:

Example 1: Resident 3

On 02/18/2025, at approximately 12:30 PM, Surveyor and Licensee A reviewed Resident 3's medications. Resident 3's medication bin contained an unopened box that stated, "Fluticasone Propionate and Salmeterol - Inhale 1 puff twice daily." Licensee A stated s/he would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 464	Continued From page 16	M 464		

check with Resident 3 to see if s/he had the inhaler in his/her room. Licensee A returned with an inhaler that had 44 remaining doses.

On 02/18/2025, Surveyor and Licensee A reviewed Resident 3's record.

Resident 3 moved into the home 09/28/2024.

Resident 3's February 2025 Medication Administration Record (MAR), dated 02/01/2025 to 02/18/2025, documented the following medications had been administered:
Amiloride, Duloxetine, Eliquis, Famotidine, Gabapentin, Magnesium Oxide, Metamucil, Metoprolol Tartrate, Montelukast, Myrbetriq, Omeprazole, Rosuvastatin.
The MAR did not document Fluticasone Propionate and Salmeterol.
Surveyor asked Licensee A if s/he had a written order from Resident 3's physician stating that the provider was authorized to administer his/her medications and that s/he was able to self-administer the Fluticasone. Licensee A stated s/he did not have that kind of documentation.

Surveyor also noticed an albuterol inhaler and a bottle of methylphenidate in Resident 3's medication bin, the medications were not listed on the MAR.

Surveyor requested Licensee A send Resident 3's current physician orders to Surveyor, since they were not in the record.

On 02/19/2025 at 10:43 AM, Licensee A emailed Resident 3's physician orders, dated 10/02/2024, to Surveyor. The physician orders did not include the methylphenidate but did include the albuterol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 464	Continued From page 17 inhaler and the fluticasone which were not listed on the MAR. Example 2: Resident 4 On 02/18/2025, at approximately 12:30 PM, Surveyor and Licensee A reviewed Resident 4's medications and his/her record. Resident 4 moved into the home 09/21/2024. Resident 4's February 2025 MAR, dated 02/01/2025 to 02/18/2025, documented the following medications had been administered: Fluoxetine, Famotidine, Armodafinil, Iron, Aspirin, Senna-S, Baclofen, Vitamin B Complex, Multivitamin, Magnesium, Trazodone, Melatonin, Sumatriptan, Ondansetron, and Ibuprofen. Surveyor asked Licensee A if s/he had a written order from Resident 4's physician stating that the provider was authorized to administer his/her medications. Licensee A stated s/he did not have that kind of documentation. Cross Reference: M0462 DHS 88.07(3)(c) Medication Assistance	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	{M 466}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
{M 466}	Continued From page 18 shall be kept in a locked place. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure accurate records were kept of all prescription medications administered for 2 of 2 residents. This is a repeat deficiency. See Statement of Deficiency (SOD) TK6V11, dated 08/28/2024. Resident 4's February 2025 Medication Administration Record (MAR) was missing documentation of medication administration of his/her as-needed (PRN) Sumatriptan. Findings include: On 02/18/2025, at approximately 12:55 PM, Surveyor and Licensee A observed Resident 4's open box of Sumatriptan, with a dispensed date of 02/11/2025. The label read: Take 1 tablet by mouth at onset of headache. May repeat after 2 hours as needed. Max 4 tablets daily. There were 6 of 9 tablets remaining. On 02/18/2025, Surveyor reviewed Resident 4's February 2025 MAR which documented: 2/14 - 3:00 PM The MAR documentation did not correlate with the number of tablets remaining in the box of Sumatriptan.	{M 466}		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a	M 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 474	Continued From page 19 sanitary manner. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that food was stored in a safe and sanitary manner. The provider did not implement a system to identify when opened food was to be discarded for the prevention of food borne illnesses. Findings include: The provider is licensed to care for up to 4 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's, and physically disabled. On 02/18/2025, at approximately 1:20 PM, Surveyor and Licensee A observed the refrigerator and noted: -A 5.25 ounce box of plant-based bacon strips which stated to keep frozen until ready to use. -A 10 ounce box of plant-based corn dogs which stated to keep frozen until ready to use. -A clear plastic container that contained 2 boiled eggs which was not dated. -(4) glass bowls of what appeared to be leftovers that were not labeled or dated. -A black plastic container with a clear plastic lid with what appeared to be leftovers that was not labeled or dated. -A clear plastic container with a blue lid which contained 2 pieces of leftover pizza. -A 12 ounce opened jar of turkey flavored gravy	M 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 474	Continued From page 20	M 474		

that was not dated.
-A 12 ounce opened jar of roasted garlic & rosemary gravy that was not dated.
-A clear plastic container, covered with saran wrap, that contained a yellow substance was not labeled or dated.
-A 45 ounce opened jar of spaghetti sauce that was dated 11/24/2024.

According to the 2017 FDA (US Food and Drug Administration) Food Code, refrigerated, ready to eat (RTE), Time/Temperature Controlled for Safety (TCS) food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of seven days. The day of preparation shall be counted as Day 1. Refrigerated, RTE/TCS food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed or discarded.

The "Servsafe Coursebook - 7th Edition, documented ready-to-eat TCS food (foods that need time and temperature control for safety) can be stored for only seven days if it is held at 41 degrees Fahrenheit or lower." TCS foods includes milk and dairy products, eggs, meat (beef, pork, and lamb), poultry, fish, shellfish and crustaceans, baked potatoes, tofu or other soy protein, sprouts and sprout seeds, sliced melons, cut tomatoes, cut leafy greens, untreated garlic-and-oil mixtures, and cooked rice, beans, and vegetables.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019548	A. BUILDING: _____ B. WING _____	R-C 02/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HAND CARE AFH 2	1308 MATHYS RD MONONA, 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
M 474	Continued From page 21 Licensee A stated s/he understood that food products need to be labeled and dated when opened.	M 474		