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M 000	INITIAL COMMENTS On 01/22/2025, Surveyor conducted 1 complaint investigation at Gods Care. Five deficiencies were identified. The complaint was substantiated. Census: 3	M 000		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a new resident received a health examination by a physician to identify health problems within 90 days prior to or 7 days after admission. Resident 1 did not have a health examination completed by a physician that included a physical exam and medication orders until 11/05/2024, 15 days after admission.	M 380		

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

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M 380	Continued From page 1 Findings include: On 01/22/2025 at 11:01 AM, Surveyor requested Resident 1's record including Admission MD health exam from Licensee A. Resident 1 was admitted on 10/21/2024 and discharged on 11/13/2024. Diagnoses included Alzheimer's dementia with behavior disturbance. On 01/24/2025 at 8:40 AM, Surveyor received (via email from Licensee A) an unsigned medical clearance dated 09/24/2024 to transfer from a correctional facility to a skilled nursing stabilization unit and a competency evaluation (to determine need for guardianship) dated 09/11/2024. Neither the medical clearance nor competency evaluation included insight into Resident 1's physical condition(s), listed medications or included physician orders. On 01/24/2025 at 3:59 PM, Surveyor discussed concern regarding no admission health exam with Licensee A who stated s/he thought the physician would not see Resident 1 before the guardianship was finalized. Cross Reference: M0582 DHS 88.10(3)(q) Medications	M 380		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the	M 424		

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M 424	Continued From page 2	M 424		

resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure each resident's individual service plan (ISP) was reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding. The review is to determine continued appropriateness of the plan and to update the plan as necessary.

Resident 2's ISP was not reviewed with the resident, his/her guardian, or placing agency for 1 of 2 residents reviewed.

Findings include:

01/24/2025 at 12:02 PM, Surveyor received Resident 2's record via email from Licensee A.

Resident 2 was admitted 01/08/2024.

The record contained an ISP dated 08/01/2024. Under signatures section, Resident 2's name, the case manager's name and Licensee A's name were typed in and there were no signatures

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M 424	Continued From page 3 verifying Resident 2 and the case manager participated in the ISP review. On 01/24/2025 at 3:59 PM, Surveyor discussed concern regarding Resident 2's ISP review with Licensee A who stated the case manager was not yet available to sign it.	M 424		
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 medication administration was recorded accurately. Staff documented administration of Resident 1's prescribed medication on the medication administration record (MAR) with heart symbols instead of their initials. Findings include: On 01/23/2025 at 12:30 PM, Surveyor received Resident 1's record from Licensee A via email. Resident 1 was admitted on 10/21/2024 and discharged on 11/13/2024. Diagnoses included	M 466		

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M 466	Continued From page 4 Alzheimer's dementia with behavior disturbance. Resident 1's medication administration record identified staff administered lisinopril 5mg 1 tablet once daily, divalproex sodium delayed release 125 mg tablet 1 tablet twice daily, and quetiapine fumarate 25 mg ½ (12.5 mg) tablet twice daily. MAR dated 10/21/2024- 11/13/2024: From 10/21/2024-11/13/2024, staff documented medication administration with heart symbols, except on 11/05/2024 at 8:00 PM, 11/06/2024 at 8:00 AM and 8:00 PM and 11/07/2024 at 8:00 AM when there was no documentation of medication administration or reason why medications were not administered. On 01/24/2025 at 3:59 PM, Surveyor discussed concern regarding medication documentation with Licensee A who stated s/he would ensure the MARs are completed thoroughly and accurately. Cross Reference: M0582 DHS 88.10(3)(q) Medications	M 466		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact	M 556		

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M 556	Continued From page 5 any agency needed to arrange it. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the resident right to freedom of choice and self-direction. Four of 4 residents residing in the home did not have independent access to the kitchen refrigerator when it was locked due to Resident 2's behavior. Neither Resident 2's individual service plan (ISP) nor the home's program statement specifically identified the restriction. Findings include: The facility is licensed as an adult family home able to serve up to 4 ambulatory residents within the client groups of traumatic brain injury, developmentally disabled, terminally ill, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, and advanced age. On 01/22/2025 at 8:41 AM, Surveyor observed the kitchen refrigerator. The top freezer and bottom refrigerator doors were locked with padlocks. On 01/22/2025 at 8:52 AM, Caregiver D demonstrated to Surveyor how staff unlocked the padlocks with keys stored in a kitchen drawer. On 01/22/2025 at 8:52 AM, Surveyor interviewed Caregiver D and Caregiver E. Caregiver D stated the refrigerator had been locked a couple of weeks prior to 01/22/2025 and all 4 residents had to request staff unlock it. Caregiver D stated the locks were initiated due to Resident 2's behaviors because s/he was up frequently during the night	M 556		

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M 556	Continued From page 6	M 556		

and ate raw eggs. Caregiver D stated night shift staff remained awake during the night. When Surveyor asked for Resident 2's ISP, Caregiver E stated the ISPs were with Licensee A. Caregiver E when s/he started, Licensee A reviewed the ISPs with him/her.

01/24/2025 at 12:02 PM, Surveyor received Resident 2's record via email from Licensee A.

Resident 2 was admitted 01/08/2024. Diagnoses included schizoaffective disorder bipolar type.

The record contained a managed care organization's Behavioral Support Plan (BSP) dated 07/30/2024 and facility ISP dated 08/01/2024. Neither the BSP nor ISP addressed eating unsafe foods or restricting access to refrigerator.

On 01/24/2025, Surveyor reviewed the Program Statement dated 8/1/23 on file with the Department. The Program Statement did not address food restrictions.

On 01/24/2025 at 3:59 PM, Surveyor discussed concern of locks on refrigerator with Licensee A who stated locks were initiated prior to 12/27/2024 to prevent him/her from eating prior to colonoscopy. Licensee A stated they would remove the locks after rescheduled colonoscopy in March 2025, then stated they would remove the locks on 01/24/2025 and reinstate the locks prior to March 2025 colonoscopy. Licensee A verbalized an understanding that locking the refrigerator was a violation of the resident's right to freedom of choice.

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M 582	Continued From page 7	M 582		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident right to receive all medications in the dosage and at the intervals prescribed by the resident's physician. On 11/05/2024 Resident 1's medication ran out and s/he did not receive medications on 11/05/2024 PM, 11/06/2024 AM and PM, and 11/07/2024 AM. Findings include: On 11/12/2024, the Department received a complaint regarding medication administration. On 01/22/2025, Surveyor received Resident 1's record from Licensee A via email. Resident 1 was admitted on 10/21/2024 and discharged on 11/13/2024. Diagnoses included Alzheimer's dementia with behavior disturbance. A health examination (due within 90 days prior to or 7 days after admission) consisted of an unsigned medical clearance dated 09/24/2024 to transfer from a correctional facility to a skilled nursing stabilization unit and a competency	M 582		

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M 582	Continued From page 8	M 582		

evaluation for guardianship dated 09/11/2024. Neither the medical clearance nor competency evaluation included insight into Resident 1's physical conditions, listed medications or included physician orders.

Resident Summary dated 10/21/2024 identified 2 family medicine practitioners and 1 internal medicine physician as Resident 1's health care providers.

Resident 1's record did not contain physician orders for medications identified on his/her medication administration record (MAR) dated 10/21/2024-11/13/2024 including lisinopril 5mg 1 tablet once daily, divalproex sodium delayed release 125 mg tablet 1 tablet twice daily, and quetiapine fumarate 25 mg ½ (12.5 mg) tablet twice daily.

MAR dated 10/21/2024- 11/13/2024:
From 10/21/2024-11/13/2024, staff documented medication administration except on 11/05/2024 at 8:00 PM, 11/06/2024 at 8:00 AM and 8:00 PM and 11/07/2024 at 8:00 AM, when there was no documentation of medication administration or reason why medications were not administered.

On 01/23/2025 at 5:02 PM, Surveyor interviewed Pharmacy Tech B who stated the pharmacy was not notified of Resident 1's admission to God's Care until 11/05/2025 when they received electronic physician orders for lisinopril, divalproex, and quetiapine, and then the pharmacy had to contact the physician to obtain demographic information including Resident 1's birth date, address, etc. Pharmacy Tech B stated typically facilities notified the pharmacy in writing of new admissions including demographics at time of admission. Pharmacy Tech B stated this

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M 582	Continued From page 9 was not the first time Gods Care had not notified them of a new admission. On 01/24/2025 at 3:59 PM, Surveyor discussed concern regarding medication administration with Licensee A who stated s/he created the MAR based on medications Resident 1 brought with him/her on admission. Licensee A stated at time of Resident 1's admission, s/he knew Resident 1's medications were limited, and an appointment was needed for refills. Licensee A stated upon Resident 1's admission the guardianship hearing had not yet been scheduled and s/he thought the physician would refuse to schedule an appointment until the guardianship was finalized so Family Member B could make Resident 1's health care decisions. Licensee A stated s/he texted Family Member B for the guardianship hearing date, but Family Member B did not answer, and told Family Member B Resident 1's medications would run out. Licensee A stated s/he informed pharmacy Resident 1 was being admitted but did not ask pharmacy to fill the medications because Resident 1 needed a primary care physician. Licensee A stated Family Member B scheduled the 11/05/2025 MD appointment and on 11/06/2024 s/he called the pharmacy, but pharmacy did not know anything about Resident 1. Cross Reference: M0466 DHS 88.07(3)(e)1 Medication- Record Keeping M0380 DHS 88.06(2)(a) Admission-Health Exam	M 582		