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M 000	INITIAL COMMENTS On 07/24/2023, Surveyor completed a standard survey and verification visit at Madison Creative Care LLC, an AFH located in Madison. Twelve deficiencies were identified. Six deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) SPZV11, 09/08/2021 and SOD SPZV12, dated 04/08/2022 and SOD SPZV13, dated 10/17/2022. The complaint was unsubstantiated. Census: 2	M 000		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a	M 114		

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

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M 114	Continued From page 1	M 114		

dependent population, the funds or property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a criminal records check was completed for 1 of 3 service providers reviewed.

Caregiver B did not have a completed background information disclosure (BID) at the time of hire.

Findings include:

On 07/12/2023 at approximately 10:00 a.m., Surveyor requested employee records from Resident Coordinator A, including the background checks completed upon hire.

On 07/12/2023 at approximately 10:15 a.m., Surveyor reviewed Caregiver B's record. Caregiver B's record documented s/he was hired on 07/10/2022. Caregiver B's Background Information Disclosure (BID), Department of Justice check (DOJ) and the Integrated Background Information System check (IBIS) were all dated 01/08/2023, nearly 6 months after

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M 114	Continued From page 2 his/her hire. Surveyor asked Resident Coordinator A if background checks were completed at the time of hire. Resident Care Coordinator A stated s/he was unsure. Resident Care Coordinator A was given until the end of the day to provide follow up documentation. On 07/13/2023 at approximately 12:00 p.m., Surveyor received documentation of a DOJ and IBIS background check, dated 07/06/2022, for Caregiver B. Surveyor did not receive documentation of a BID check completed upon hire.	M 114		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure that the home and its operation complied with all laws governing the home and its operation. This is a repeat deficiency. See Statement of Deficiency (SOD) SPZV12, dated 04/08/2022 and SOD SPZV13, dated 10/17/2022. Findings include: On 07/13/2023, Surveyor completed a complaint investigation and standard survey. The following concerns were identified: Resident Care:	M 216		

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M 216	Continued From page 3 - One of 1 residents reviewed had not been screened for communicable disease, including tuberculosis, within 90 days prior to or 7 days after admission. *Repeat deficiency. - Two of 2 individual service plans (ISP) reviewed did not include the level of supervision the residents required. *SOD SPVZ11, dated 09/08/2021, and SPZV12, dated 04/08/2022, included a "Notice of Special Orders" which ordered the provider to ensure resident ISPs addressed supervision, including the level and frequency needed within the home. - Two of 2 ISPs reviewed had not been reviewed in greater than 6 months. *Repeat deficiency. SOD SPVZ11, dated 09/08/2021, and SPZV12, dated 04/08/2022, included a "Notice of Special Orders" which ordered the provider to review all ISPs and include a statement of agreement with the plan. - The health of 2 of 3 residents reviewed was not monitored with observations and changes documented. Resident 3's blood glucose readings were not recorded and Resident 2's sodium and fluid intake was not monitored as ordered. SOD SPZV13, dated 10/17/2022, included a "Notice of Special Orders" which ordered the provider to develop or review a written procedure to address how the facility would monitor and document changes in the residents physical or mental health. - The home's staff administered medication to Resident 1 without a physician order to administer medications. - The medication administration of 2 of 2 residents reviewed was not accurately documented. *Repeat deficiency. SOD SPZV13, dated 10/17/2022, included a "Notice of Special Orders" which ordered the provider to develop or review a written procedure to address how the	M 216		

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M 216	Continued From page 4 facility will document medication administration. Employees: - The provider did not have a complete background check on file for 1 of 3 caregivers reviewed. Environment: - The home was not well kept. There were holes in the wall, soiled laundry piled up in the laundry room, dryer lint covering the floor and part of the laundry room wall, the shower had hardened soap on the surface, food was not stored in a secured manner and Resident 2's bedroom had a soiled incontinence pad with bugs on it. *Repeat deficiency. SOD SPZV12, dated 04/08/2022, included a "Notice of Special Orders" which ordered the provider to ensure housekeeping was scheduled and completed "as needed" to maintain a safe, clean, homelike environment. - Resident Care Coordinator A was unsure the last time the home's furnace had been inspected. - Resident 1's bedroom windows were covered with plexiglass, preventing ventilation. - The home's fire extinguishers had not been inspected in greater than a year. On 07/12/2023 at approximately 10:30 a.m., Surveyor reviewed resident care, employee and environmental concerns with Resident Care Coordinator A. Resident Care Coordinator A stated s/he had recently taken over management of the home, so some concerns were from before s/he started and other concerns s/he would address with staff. Cross Reference: M0114 DHS 88.03(3)(b) Criminal Records Check	M 216		

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M 216	Continued From page 5 M0276 DHS 88.05(3)(a) Home Environment M0290 DHS 88.05(3)(e)2.b Inspection - Gas Furnace M0298 DHS 88.05(3)(g) Windows And Ventilation M0332 DHS 88.05(4)(a) Fire Safety - Fire Extinguishers M0380 DHS88.06(2)(a) Admission - Health Exam M0414 DHS 88.06(3)(d)2. Level Of Supervision M0424 DHS 88.06(3)(f) Review Of ISP M0448 DHS 88.07(2)(b)5. Monitoring Health M0464 DHS 88.07(3)(d) Medication - Written Order M0466 DHS 88.07(3)(e)1. Medication - Record Keeping	M 216		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was safe, clean and well-maintained to provide a homelike environment. This is a repeat deficiency. See Statement of Deficiency (SOD) SPZV11, dated 09/08/2021 and SOD SPZV12, dated 04/08/2022. Findings include: On 07/12/2023 at approximately 8:30 a.m.,	M 276		

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M 276	Continued From page 6 Surveyor toured the provider's home with Caregiver C. Surveyor observed the following: - There were 2 holes in the wall upon entry from the home's garage (Photo 1). Caregiver C stated the holes had just occurred from Resident 1 slamming the door. Resident 1 discharged 06/27/2023. - Soiled laundry was piled up on the floor in the home's laundry room (Photo 2). Caregiver C stated s/he was in the middle of doing laundry. - Dryer lint was covering the floor and several feet up the wall behind the home's laundry appliances (Photo 3). Caregiver C stated, "It's clean." - A shower had hardened soap on the floor (Photo 4). Resident Care Coordinator A stated Surveyor toured the home before caregivers were able to clean for the day. - Resident 2's bedroom had a soiled incontinent pad on a recliner with bugs settled on the pad and flying around the room (Photo 5). Caregiver C denied seeing any bugs. - Herbs were stored unsealed in the home's refrigerator. Caregiver C replied, "It's okay," when Surveyor shared concern that food was not properly sealed. On 07/12/2023 at approximately 11:30 a.m., Surveyor shared cleanliness concerns with Resident Care Coordinator A. Resident Care Coordinator A stated staff had not had time to complete cleaning tasks yet.	M 276		
M 290	88.05(3)(e)2.b INSPECTIONS-GAS FURNACE A gas furnace shall be inspected and serviced every 3 years by a heating contractor or local utility company.	M 290		

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M 290	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the gas furnace was inspected and serviced every 3 years by a heating contractor or local utility company. Findings include: On 07/12/2023 at approximately 10:30 a.m., Surveyor requested documentation from Resident Care Coordinator A of the most recent furnace inspection. Resident Care Coordinator A stated s/he was unsure of the last furnace inspection because s/he had recently taken over management of the home. Resident Care Coordinator A asked what the requirement was for furnace inspections and stated s/he would schedule an inspection for that week. Resident Care Coordinator A was given until 07/13/2023 to provide follow up documentation. No documentation of a furnace inspection was received.	M 290		
M 298	88.05(3)(g) WINDOWS AND VENTILATION The home shall have ventilation for health and comfort. There shall be at least one window which is capable of being opened to the outside in each resident sleeping room and each common room used by residents. Windows used for ventilation shall be screened during appropriate seasons of the year. This Rule is not met as evidenced by: Based on observation and interview, the provider	M 298		

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M 298	Continued From page 8 did not ensure that 1 of 3 bedrooms had a window capable of being opened to the outside. Findings include: On 07/12/2023 at approximately 8:30 a.m., Surveyor toured the provider's home with Caregiver C. Surveyor observed 2 of 2 windows in a room previously occupied by Resident 1 had a wood frame and plexiglass covering the window. The covering had a paddle lock on it, requiring a key to open the window (Photo 6 and Photo 7). On 07/12/2023 at approximately 10:30 a.m., Surveyor asked Resident Care Coordinator A if the windows in the room previously occupied by Resident 1 were covered with the plexiglass while Resident 1 resided at the facility. Resident Care Coordinator A replied, "Yes. We had that installed the day prior to [him/her] coming due to past behaviors." Surveyor shared concern that the windows did not have the ability to ventilate from the inside and asked Resident Care Coordinator A if the provider requested a waiver from the department. Resident Care Coordinator A replied, "No. We didn't."	M 298		
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	M 332		

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M 332	Continued From page 9 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 provider did not ensure the home's fire extinguishers were inspected annually. The home's fire extinguishers had not been inspected in greater than a year. Findings include: On 07/12/2023 at approximately 10:00 a.m., Surveyor toured the home. Surveyor observed the fire extinguisher on the main level and in the basement had not been inspected since January 2022. On 07/12/2023 at approximately 10:30 a.m., Surveyor reviewed concern with Resident Care Coordinator A that the home's fire extinguishers had not been inspected in greater than 1 year. Resident Care Coordinator A replied, "Do they have to be inspected every year?"	M 332		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM	M 380		

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M 380	Continued From page 10 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 1 of 1 residents reviewed were screened for communicable disease, including tuberculosis, within 90 days prior to admission or 7 days after admission. Resident 1 did not have a communicable disease screen completed within 90 days prior to admission or 7 days after admission. This is a repeat deficiency. See Statement of Deficiency (SOD) SPZV11, 09/08/2021 and SOD SPZV12, dated 04/08/2022. Findings include: On 07/12/2023 at approximately 10:00 a.m., Surveyor reviewed resident records, which concluded the following: - Resident 1 admitted to the provider's home on 06/08/2023. Resident 1's record did not contain a communicable disease screen, including tuberculosis test.	M 380		

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M 380	Continued From page 11 On 07/12/2023 at approximately 11:30 a.m., Surveyor reviewed concern with Resident Care Coordinator A that Resident 1 did not have tuberculosis tests within 90 days prior to admission or 7 days after admission. Resident Care Coordinator A stated s/he thought Resident 1 had a tuberculosis test prior to admission and s/he would follow up with Surveyor on documentation. Resident Care Coordinator A was given until 07/13/2023 to provide follow up documentation. No documentation of tuberculosis tests was received.	M 380		
M 414	88.06(3)(d)2 LEVEL OF SUPERVISION Identification of the level of supervision required in the home and community. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 individual service plans (ISP) reviewed contained the level of supervision required in the home and community. Resident 2's ISP did not document his/her need for 1:1 dedicated staffing. Resident 3's ISP did not include his/her need for 24 hour supervision. Findings include: On 07/12/2023 at approximately 10:00 a.m., Surveyor reviewed resident records. Example 1 - Resident 2:	M 414		

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Resident 2 admitted to the provider's home on 09/22/2021. Resident 2's managed care organization plan stated s/he required 130 hours/week of 1:1 staffing. Surveyor reviewed Resident 2's ISP, completed and followed by the home's staff. The ISP stated "24-hour supervision semi awake/sleep staff and line of sight in the community."

On 07/12/2023 at approximately 11:30 a.m., Surveyor reviewed concern with Resident Care Coordinator A that Resident 2's ISP did not include Resident 2's need for 1:1 dedicated staffing. Resident Care Coordinator A stated staff provide 1:1 supervision but stay in the home's living room during sleep hours and complete checks every 15 minutes.

On 07/19/2023 at approximately 2:30 p.m., Surveyor interviewed Nurse D, a nurse with Resident 2's managed care organization (MCO). Nurse D stated the home was contracted with the MCO to provide dedicated 1:1 staffing 130 hours/week, which included all hours Resident 2 was at the home since Resident 2 went to work the remainder of the hours. Nurse D provided a document titled "Residential Services" that indicated the expectation of dedicated 1:1 staffing was staff must be at minimum within line-of-sight of the member receiving the dedicated staffing at all times.

Example 2 - Resident 3:

Resident 3 admitted to the provider's home on 10/03/2021. Resident 3's ISP, dated 08/08/2022, did not indicate s/he required dedicated 1:1 staffing.

On 07/12/2023 at approximately 10:15 a.m.,

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M 414	Continued From page 13 Resident Care Coordinator A informed Surveyor that Resident 3 required 1:1 staffing. Surveyor re-reviewed Resident 3's ISP and behavioral support plan and was unable to locate the need for 1:1 staffing. On 07/18/2023 at 8:10 a.m., Surveyor interviewed Care Manager E with Resident 3's MCO. Care Manager E stated Resident 3 was at the "enhancement rate" indicating that s/he required dedicated 1:1 staffing. Resident 2's ISP did not include his/her need for 130 hours/week of 1:1 dedicated staffing and Resident 3's ISP did not include his/her need for 1:1 dedicated staffing 24 hours/day.	M 414		
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 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.	M 424		

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(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 424	Continued From page 14 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents had their individual service plan (ISP) reviewed at least once every 6 months by the licensee, the legal representative and the placing agency. Resident 2 and Resident 3's ISPs had not been reviewed in greater than 6 months. This is a repeat deficiency. See Statement of Deficiency (SOD) SPZV11, dated 09/08/2021, SOD SPZV12, dated 04/08/2022 and SOD SPZV13, dated 10/17/2022. Findings include: On 07/12/2023 at approximately 10:00 a.m., Surveyor reviewed resident records, which documented the following: - Resident 2 was admitted to the provider's home on 09/22/2021. Resident 2 had a legal guardian. Resident 2's ISP was dated 01/07/2023, indicating the ISP was due for review. The ISP was not signed by his/her guardian. Resident Care Coordinator A stated s/he was unsure if the ISP had been reviewed with Resident 2's guardian since s/he recently took over management of the home. - Resident 3 was admitted to the provider's home on 08/08/2022. Resident 3 had a legal guardian. Resident 3's ISP was dated 08/08/2022, indicating it was nearly 1 year overdue for a review. Resident Care Coordinator A stated s/he was unsure if there was a more recent ISP since s/he recently took over management of the home. The provider did not ensure Resident 2 and Resident 3's ISPs were reviewed at least once	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017592	A. BUILDING: _____ B. WING _____	C 07/24/2023

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M 424	Continued From page 15 every 6 months.	M 424		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the health of 2 of 3 residents reviewed was monitored, with observations and changes documented. This is a repeat deficiency. See Statement of Deficiency (SOD) SPZV13, dated 10/17/2022. Findings include: On 07/12/2023 at approximately 10:00 a.m., Surveyor reviewed resident records and noted the following concerns: - Resident 3 admitted to the provider's home on 10/03/2023 with diagnosis of diabetes. Resident 3's physician orders included "Test blood glucose twice daily (Start Date: 08/06/2021)." Surveyor was unable to locate blood glucose readings in Resident 3's record. Surveyor requested blood glucose readings from Resident Care Coordinator A, who responded, "Staff take the blood sugars, but don't write them down." - Resident 2 admitted to the provider's home on 09/22/2021 with congestive heart failure. Resident 2's managed care organization plan stated s/he had a sodium restriction of 2000	M 448		

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M 448	Continued From page 16 mg/day and a fluid restriction of 2000 ml/day. Surveyor reviewed Resident 2's record and was unable to find documentation of sodium and fluid intake monitoring. Surveyor asked Resident Care Coordinator A if the home's staff monitor Resident 2's sodium and fluid intake. Resident Care Coordinator A replied, "No. [S/he] doesn't even drink that much." *On 07/19/2023 at approximately 2:30 p.m., Surveyor received a physician order from Nurse D with Resident 2's managed care organization, dated 11/15/2022, for Resident 2's sodium and fluid restricted diet. The facility did not document Resident 3's blood sugars and did not monitor the fluid and sodium intake of Resident 2.	M 448		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER 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 record review and interview, the provider did not ensure a written order to administer medications was received prior to administering medications to 1 of 3 residents reviewed. The provider's staff administered	M 464		

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M 464	Continued From page 17 medications to Resident 1 from 06/08/2023 to 06/27/2023 without a physician order. Findings include: On 07/12/2023 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 06/08/2023 and discharged on 06/27/2023. Resident 1's record did not include a physician order to administer medications. Resident 1's medication administration record (MAR), dated 06/08/2023 to 06/27/2023, indicated the home's staff administered the following medications: Escitalopram 5 mg, Multivitamin, Pantoprazole 40 mg, Senna-Docusate 8.6-50 mg, Aripiprazole 20 mg, Aspirin 81 mg, Carbamazepine 100 mg, Cetirizine 10 mg and Escitalopram 10 mg. Resident Care Coordinator A confirmed the home's staff was responsible for medication administration, but the home did not have an order to administer medications because Resident 1 discharged prior to his/her primary care appointment to obtain the order.	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 shall be kept in a locked place.	M 466		

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M 466	Continued From page 18	M 466		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a record of all prescription medications controlled, dispensed and administered were recorded for 1 of 3 residents reviewed. Resident 3's medication administration record (MAR) did not include all medication administrations and recorded administration that did not occur.

This is a repeat deficiency. See Statement of Deficiency (SOD) SPZV12, dated 04/08/2022 and SOD SPZV13, dated 10/17/2022.

Findings include:

On 07/12/2023 at approximately 10:00 a.m., Surveyor reviewed Resident 3's record. Resident 3 admitted to the provider's home on 10/03/2023 with diagnosis of diabetes. Resident 3's MAR did not document administration of his/her medications on the following dates:

- Basaglar 100 unit/ml - Inject 30 units daily at 8:00 a.m. (Start Date: 08/29/2022): 07/12/2023
- Olanzapine 5 mg - Take 1 tablet daily at 8:00 a.m. (Start Date: 02/02/2023): 07/12/2023
- Olanzapine 7.5 mg - Take 1 tablet daily at 8:00 p.m. (Start Date: 02/02/2023): 07/11/2023
- Oxybutynin 15 mg - Take 1 tablet daily at 8:00 p.m. (Start Date: 11/29/2023): 07/11/2023
- Propranolol 80 mg - Take 1 capsule daily at 8:00 a.m. (Start Date: 02/02/2023): 07/12/2023
- Propranolol 80 mg - Take 1 capsule daily at 4:00 p.m. (Start Date: 02/02/2023): 07/11/2023
- Propranolol 80 mg - Take 1 capsule daily at 8:00 p.m. (Start Date: 02/02/2023): 07/11/2023
- Sertraline 50 mg - Take 1 tablet daily at 8:00 a.m. (Start Date: 02/02/2023): 07/12/2023

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M 466	Continued From page 19 - Simvastatin 40 mg - Take 1 tablet daily at 8:00 p.m. (Start Date: 07/11/2023): 07/11/2023 - Benztropine 1 mg - Take 1 tablet daily at 8:00 p.m. (Start Date: 02/02/2023): 07/11/2023 - Divalproex 500 mg - Take 4 tablets daily at 8:00 p.m. (Start Date: 02/02/2023): 07/11/2023 - Fenofibrate 67 mg - Take 1 tablet daily at 5:00 p.m. (Start Date: 02/02/2023): 07/11/2023 - Haloperidol 5 mg - Take 1 tablet daily at 8:00 a.m. (Start Date: 02/02/2023): 07/12/2023 - Haloperidol 5 mg - Take 1 tablet daily at 2:30 p.m. (Start Date: 02/02/2023): 07/11/2023 - Loratadine 10 mg - Take 1 tablet daily at 8:00 a.m. (Start Date: 11/29/2022): 07/12/2023 - Melatonin 5 mg - Take 1 tablet at 8:00 p.m. (Start Date: 11/04/2022): 07/11/2023 Resident 3 had an order for Trulicity 1.5mg/.5ml - Inject every 7 days at 8:00 a.m. (Start Date: 11/15/2021). Resident 3's MAR documented the medication as administered daily from 07/01/2023 - 07/11/2023. On 07/12/2023 at approximately 10:30 a.m., Surveyor reviewed concern of blank entries in Resident 3's MAR and Resident 3's Trulicity documented as administered daily, rather than weekly with Resident Care Coordinator A. Resident Care Coordinator A stated Caregiver B administered 07/11/2023 and 07/12/2023 medications, but hadn't documented the administration yet. Resident Care Coordinator A stated staff know to only give the Trulicity 1 time per week but documented daily administration in error. Resident Care Coordinator A stated s/he would retrain staff.	M 466		