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	0020670	A. BUILDING: _____ B. WING _____	C 09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS ADULT FAMILY HOMES LLC (THE)	5657 N ACADIA DRIVE APPLETON, WI 54913

(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 09/03/2025 with additional inforamtion gathered through 09/08/2025, Surveyor conducted a complaint investigation at The Gardens Adult Family Home. As a result three deficiencies were identified. The complaint was substantiated. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and staff interviews, the provider did not ensure a significant change in 1 of 1 resident's condition was reported within 24 hours to the Department. On 07/21/2025, Resident 1 was known to have ingested another resident's morning medications. Following the incident the resident was confused, light-headed, tired and dizzy. On 07/22/2025, Resident 1 was brought to the ED, hospitalized for 29 days and discharged on hospice services. The provider did not submit a self-report when Resident 1 experienced this significant change in	M 134		

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

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M 134	Continued From page 1 status. Findings include: On 09/03/2024, Surveyor reviewed Resident 1's closed medical record which indicated, the resident was admitted to the facility on 03/28/2025 with diagnoses of diabetes mellitus, hypertension and chronic diastolic heart failure. On 09/04/2025, Surveyor requested to review the most recent ISP (Individual Service Plan) for Resident 1. The ISP dated 09/03/2025 indicated, Resident 1 required as needed assistance with bathing, dressing, toileting, eating, mobility and walking. On 09/03/2025, Surveyor reviewed a report for Resident 1, which was completed and provided by Licensee G. The report was titled "[Resident 1], July 21, 2025, Medication Administration Incident Report" and indicated the following: "On July 22, 2025 at 12:09 PM, I received a phone call from [Case Manager K] at Community Care...During that call, [Case Manager K] asked me if I knew what happened with [Resident 1's] medications yesterday. I responded that I was not aware of any issues but would follow up immediately. Immediately following that discussion, I spoke with [Licensee F] and [Registered Nurse E]. [Registered Nurse E] had already informed [Licensee F] of the potential medication administration mix-up from yesterday. [Registered Nurse E] explained to me [Caregiver A] was working first shift in [Resident 1's] home and at approximately 9 AM on July 21, 2025, [Registered Nurse E] was informed [Resident 1] "accidentally took" some of [Resident 2's] meds... Review of Resident 1's ED visit report dated 07/22/2025 indicated, "CHIEF COMPLAINT: Fall	M 134		

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M 134	Continued From page 2	M 134		

and Medication Error...HISTORY OF PRESENT ILLNESS: [Resident 1] here with "family friends"..."they were told by resident's family doctor to bring [her/him] in." Per report, [Resident 1] is currently at an assisted living facility. Has had multiple recurrent falls with unclear pattern of injuries. Yesterday [Resident 1] was accidentally given other resident's medications, including multiple anti-hypertensive medications, and "has been more confused since." [Resident 1] with history of dementia and unfortunately unable to provide any coherent history. Per clinic evaluation notes from earlier today: "I called and spoke to [Family Member C]...Family found out today, that yesterday, the resident had accidentally been given another residents medications the morning of 07/21/2025...[Family Member C] also updates me that the facility told [her/him] that the resident has experienced 3 falls over the course of the last week. The most recent of which was yesterday and today. [Family Member C] reports [Resident 1] was more confused over the last 24-48 hours. [Resident 1] is current on antiplatelet therapy with aspirin and plavix, concerned about a bleed to the brain. [S/he] had requested CBC collected, does show some drop in Hg to 9.9 (compared to 11.5 in March 2025). Discussed concern that perhaps resident is having a bleed into the brain. Urinalysis has some trace abnormalities, but does not overwhelmingly seem concerning for infection at this time. Family friend was planning to bring resident to ED in the morning per [Family Member C] report. I advised [Family Member C] that resident be seen in ED ASAP. Discussed potential for hemodynamic instability, cardiotoxicity and occult intracranial bleed given residents confusion and other history as noted above." ...Physical Exam: ...Chest: Chest wall: tenderness present...Musculoskeletal: General:

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M 134	Continued From page 3 Tenderness present. Skin: ...Findings: Bruising present. Neurological: Mental Status: S/he is alert. S/he is disorientated...Medical Decision Making and ED course: [Resident 1] from assisted living with question alter mental status, weakness, multiple falls with unclear injuries. Multiple diagnoses were considered in this resident, question metabolic vs infectious vs cardiovascular vs other etiologies. [S/he] is status post receiving multiple anti-hypertensive and other medications yesterday. History of dementia and question if mental status is actually at baseline. No focal deficits noted. Work up started...Will admit..." Review of Resident 1's Hospital History and Physical report dated 07/23/2025, indicated, "Chief Complaint: Resident presents with Fall, Medication Error...Principal Problem: Altered mental status, unspecified altered mental status type. Historian: [Resident 1]...brought to the ED from assisted living facility due to generalized weakness, multiple episodes of falls and accidental drug overdose. As reported by resident friends, resident her/himself and ED physician, [s/he] has been falling, fell 3 times this week, last fall was on Monday. Apparently, [s/he] was given another resident's medication on Monday, 07/21/2025. After taking medication resident was very dizzy, lightheaded and slept all day. [S/he] fell during [her/his] symptoms but no reported loss of consciousness. Today family called [her/his] primary care physician who requested resident be taken to the ED for further evaluation. No reported fever or chills, no nausea or vomiting. Resident was slightly confused on Monday and yesterday, early hours of the morning. [S/he] seemed to be in [her/his] baseline during my examination..."	M 134		

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M 134	Continued From page 4 Review of Resident 1's Hospital Discharge Summary report dated 08/11/2025 indicated, "...Admission date 07/22/2025, Discharge date 08/11/2025...Discharge Diagnoses: Principal Problem: Transient alteration of awareness...The following problems were addressed during the hospitalization, Transient alteration of awareness, secondary to the mediation error. Resident lives at the assisted living facility and was giving medications of the other resident. Having dizziness and lightheaded and fall. CT of head and max of neck was done no fracture was noted. Dizziness improved after the fluid. Elevated troponin secondary to the demand of ischemia...Resident is stable to discharge on hospice..." On 09/03/2025 at 11:00 a.m., Surveyor interviewed Registered Nurse E regarding the above incident with Resident 1. Registered Nurse E verified Resident 1 could make his/her needs known, could ambulate with a walker and transfer independently. Registered Nurse E verified Resident 1 received the wrong medications the morning of 07/21/2025. Registered Nurse E further verified following this incident family was concerned and brought Resident 1 to the ED on 07/22/2025 and Resident 1 was hospitalized. Surveyor then asked Registered Nurse E if the above incident was reported to the department. Registered Nurse E indicated s/he was not aware if a report was made to the department and stated, "The incident was reported to [Resident 1's] funding source...I assumed they would report to you." On 09/03/2025 at 12:00 PM, Surveyor asked Licensee G if s/he reported the above incident to the department. Licensee G verified s/he did not send any report to the department.	M 134		

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M 134	Continued From page 5 On 09/03/2025, Surveyor reviewed the facility's record. The department had no record of the medication error with Resident 1 and the need for ED treatment resulting in hospitalization. Cross Reference M0582 DHS 88.10(3)(q) Medications	M 134		
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. This Rule is not met as evidenced by: Based on observation and interviews, the provider did not ensure prescription medications for 3 of 4 residents were securely stored and kept in their original containers as received from the pharmacy. Caregiver H transferred Resident 2's, 3's, and 4's medications from the original pharmacy containers to small plastic medication cups, to be administered at a later time. Caregiver H did not ensure residents' medications were taken directly out of the original containers provided by the	M 458		

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pharmacy at the time of administration. Additionally, Resident 3's medications were not securely stored to prevent unauthorized access.

Findings include:

On 08/12/2025 the department received a complaint regarding concerns with medication administration.

On 09/03/2025 at 9:30 AM, Caregiver H verified staff managed and administered medications for Residents 2, 3 and 4.

On 09/03/2025 at approximately 9:30 AM, Surveyor observed the medication area with Caregiver H. Surveyor observed cabinets containing keyed locks above the medication desk. Caregiver H unlocked the cabinets containing Resident 2's, 3's and 4's medications. Surveyor observed shelving units within the cabinets labeled with each resident's name. On the shelf near Resident 2's name was a small plastic med cup filled with approximately 16 loose pills, on the shelf near Resident 3's name was a small plastic med cup filled with approximately 13 loose pills and on the shelf near Resident 4's name was a small plastic cup filled with approximately 10 loose pills. Surveyor asked Caregiver H about the plastic med cups containing the loose medication. Caregiver H stated, "I pop out all the medications from the pharmacy blister packs into the containers ahead of time, and place them on the shelf for Residents 2, 3 and 4." Caregiver H verified the small plastic cups contained scheduled prescription medications for the 09/03/2025 morning med pass for Residents 2, 3 and 4. Surveyor then asked Caregiver H why residents' medications were removed ahead of time and not at the time

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M 458	Continued From page 7 they would be administered. Caregiver H stated, "I've been setting the meds up ahead of time and doing it this way since I started, it saves time...No one said I couldn't do it." On 09/03/2025 from 10:38 AM until 10:47 AM, Surveyor observed the med cabinet containing Resident 3's medication unlocked. At 10:48 AM, Surveyor pointed out to Caregiver H the med cabinet was unlocked. Caregiver H verified Resident 3's medications in the cabinet were not locked and stated, "I couldn't get the key to work." Surveyor then observed Caregiver H lock the medication cabinet containing Resident 3's meds with a key. On 09/03/2025 at approximately 11:30 AM, Surveyor shared the above observations with Registered Nurse E. Registered Nurse E stated, "That's against our policy. [Caregiver H] should wait for the resident to be up and then punch out the meds and administer them when the resident is ready." Registered Nurse E also verified s/he would expect staff to ensure all medications are locked in the cabinets.	M 458		
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		

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M 582	Continued From page 8	M 582		

This Rule is not met as evidenced by:
Based on record review and interviews, the Licensee did not allow each resident to receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician for 1 of 1 resident reviewed.

On 07/21/2025, Caregiver A placed Resident 2's morning medications in a medication cup and set the cup down on the dining room table between Resident 1 and Resident 2. After placing the medication cup down on the table Caregiver A left the area and did not witness Resident 2 take the medications. While Caregiver A was pre-occupied with another task, Resident 1 ingested Resident 2's morning medications. Following the incident the provider did not immediately notify or document communication with Resident 1's emergency contact, physician and/or other health care providers regarding the incident for potential interventions. Additionally, the provider did not document any increase health monitoring or add interventions to monitor Resident 1 for potential changes in condition. On 07/22/2025, Family Friend D noticed Resident 1 was not her/himself and brought Resident 1 to the ED (Emergency Department). Resident 1 was admitted to the hospital for twenty-nine days and was discharged on hospice services.

Findings include:

The Gardens Adult Family Home was issued a regular license on 12/17/2024 to care for 4 residents which has the client group consisting of Terminally Ill, Advanced Age, Irreversible Dementia/Alzheimer's disease, Developmentally Disabled, traumatic Brain Injury and Physically

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M 582	Continued From page 9 Disabled. On 08/12/2025 the department received a complaint regarding concerns with medication administration. Review of Resident 1's closed medical record indicated, the resident was admitted to the facility on 03/28/2025 with diagnoses of diabetes mellitus, hypertension and chronic diastolic heart failure. Resident 1 did not have an activated POA (Power of Attorney) and required staff to administer all his/her medications. On 09/04/2025, Surveyor requested to review the most recent ISP (Individual Service Plan) for Resident 1. The ISP dated 09/03/2025 indicated, Resident 1 required as needed assistance with bathing, dressing, toileting, eating, mobility and walking. Additionally, the ISP stated, "[Resident 1] is almost completely blind, needs a lot of light to be able to see. Staff should assist with ambulation and explaining to [her/him] where items are located." Review of Resident 1's "Resident Agreement" dated 03/12/2025 indicated, "...Please note that it is our policy when there is any cause for serious concern, management/staff will contact 911 emergency services with no regard for medical cost to resident and/or family. Our staff members are trained to make decisions based on the well-being of the resident and to always err on the side of caution...In the event of an emergency, staff should contact: [Family Member B and C]...All medications are administered as prescribed by Resident's attending doctors: The Gardens staff will monitor/administer medication to resident."	M 582		

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M 582	Continued From page 10 On 09/03/2025, Surveyor reviewed a report for Resident 1, which was completed and provided by Licensee G. The report was titled "[Resident 1], July 21, 2025, Medication Administration Incident Report" and indicated the following: "On July 22, 2025 at 12:09 PM, I received a phone call from [Case Manager K] at Community Care...During that call, [Case Manager K] asked me if I knew what happened with [Resident 1's] medications yesterday. I responded that I was not aware of any issues but would follow up immediately. Immediately following that discussion, I spoke with [Licensee F] and [Registered Nurse E]. [Registered Nurse E] had already informed [Licensee F] of the potential medication administration mix-up from yesterday. [Registered Nurse E] explained to me [Caregiver A] was working first shift in [Resident 1's] home and at approximately 9 AM on July 21, 2025, [Registered Nurse E] was informed [Resident 1] "accidentally took" some of [Resident 2's] meds. At approximately 4:30 PM, I drove to the Acadia Home and met with [Registered Nurse E]. Together, [Licensee G] and [Registered Nurse E] discovered: [Caregiver A] was at the computer desk, popping the meds out of [Resident 2's] cards and putting them into a clear plastic med cup. At 8:48 AM, [Caregiver A] turns around and reaches around the right side of [Resident 2] and presumably sets the med cup in front of [Resident 2]. [Caregiver A] then goes downstairs to use the bathroom, returning to the kitchen at 8:51 AM. [Caregiver A] sits down at the med desk and immediately turns around with a puzzled face. [Caregiver A] asks [Resident 1] something to the effect of "what meds are you taking?" [Resident 1] responds back and says something to the effect of "I am taking my meds, that you put down in front of me..." [Caregiver A] responds again with "I put them down in front of [Resident 2], not	M 582		

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M 582	Continued From page 11 you..." [Resident 1] says "I thought something was off; I don't take any blue pills..." [Caregiver A] immediately gets up and goes next door to get [House Manager I] to help with the situation, who then calls [Registered Nurse E] ... At 7:26 AM on July 23, I called [Case Manager K] and left a voicemail to report our findings. I told [Case Manager K] in our voicemail how sorry I was for our staff to make this mistake, and that I was also sorry I didn't know about it until the day after it happened...On August 6, ...The hospital has been recommending hospice care for [Resident 1]...On August 8, I interviewed [House Manager I] at approximately 7:30 AM. [House Manager I] was working next door on July 21. I asked [her/him] to tell me exactly what [s/he] saw that morning. [House Manager I] told me [Caregiver A] came next door a little before 9 AM, and told [her/him] "I don't know what to do, I think [Resident 1] took some of [Resident 2's] meds..." [House Manger I] went next door with [Caregiver A] and saw that there were at least three pills remaining in the med cup (all green in color). [House Manager I] immediately called [Registered Nurse E] to let [her/him] know what took place and connected by message with [her/him] at approximately 9:15 AM and then spoke with [her/him] on the phone around 10:30 AM. On August 9, I interviewed [Resident 2]. I asked [Resident 2] to tell me what took place. [Resident 2] told me [s/he] remembers [Caregiver A] putting the med cup down in the space between [her/him] and [Resident 1] on the table and saying, "Here are your meds." [Resident 2] believes that [Resident 1] said something like "Those are my meds" and [Resident 2] handed the cup to [her/him]..." Following this incident the facility: *Conducted a refresher training on med administration with staff	M 582		

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*Held individual conversations between the nurse and staff to follow up on refresher training
*Implemented a medication administration reminder sheet placed in all med cupboards
*Held an all staff meeting focused on medication administration on 09/05/2025

On 09/04/2025, Surveyor reviewed Resident 2's medication list, which included the following fifteen AM medications:

~Bupropion HCL XL 300 mg (milligrams) tablet (an anti-depressant medication)
~Calcium 600 mg plus Vit. D 400 IU tablet
~Carvedilol 25 mg tablet (used to treat heart failure and hypertension)
~Certa-Vite tablet
~Clonidine HCL 0.3 mg tablet (used to treat hypertension)
~Ferrous Sulfate 325 mg tablet (used to treat iron deficiency anemia)
~Furosemide 40 mg tablet (a diuretic)
~Glucosamine/Chondroitin 500/400 mg tablet (used as a supplement to relieve joint pain)
~Hydralazine 100 mg tablet (used to treat hypertension)
~Januvia 25 mg tablet (used to treat type 2 diabetes)
~Levothyroxine 200 mcg (microgram) tablet (used to treat low thyroid activity)
~Senna Laxative 17.2 mg (used to treat constipation)
~Sertraline HCL 175 mg (an anti-depressant medication)
~Vitamin C 500 mg tablet
~Vitamin D3 5000 IU tablet

On 09/03/2025, Surveyor requested all incident/fall reports for Resident 1 during the month of July 2025. The only incident report

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provided revealed the following:

*07/11/2025- Fall-Unwitnessed in resident bathroom. "Resident stated s/he lost balance while stepping backward, fell and hit part of the wall by the shower. Swelling noted to back of neck."

No additional falls/incident reports were documented or provided. On 09/03/2025, Licensee G indicated, "We track all incident and fall reports through ECP...We know of one more fall which happened the morning of 07/21/25 before breakfast...[Caregiver A] did not fill out a fall report, [s/he] verbally told us it happened."

On 09/03/2025, Surveyor reviewed all of Resident 1's observations notes for July 2025. The only observation note recorded was on 07/11/2025 regarding the above fall. No additional observations were documented after 07/11/2025.

**Surveyor noted the resident was known to have ingested another resident's morning medications on 07/21/2025 and no documentation was located within the medical record staff communicated with the resident's emergency contact(s), medical provider or other health care providers. Additionally, no documentation or interventions were located within the medical record to show staff were monitoring Resident 1's health for potential changes in condition following the incident. The only documented monitoring was vital signs taken at 1:21 PM, 2:15 PM, 4:48 PM and 6:46 PM on 07/21/2025, however no vitals were completed after 6:46 PM on 07/21/2025.

Review of Resident 1's ED visit report dated 07/22/2025 indicated, "CHIEF COMPLAINT: Fall

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M 582	Continued From page 14 and Medication Error...HISTORY OF PRESENT ILLNESS: [Resident 1] here with "family friends" ..."they were told by resident's family doctor to bring [her/him] in." Per report, [Resident 1] is currently at an assisted living facility. Has had multiple recurrent falls with unclear pattern of injuries. Yesterday [Resident 1] was accidentally given other resident's medications, including multiple anti-hypertensive medications, and "has been more confused since." [Resident 1] with history of dementia and unfortunately unable to provide any coherent history. Per clinic evaluation notes from earlier today: "I called and spoke to [Family Member C]...Family found out today, that yesterday, the resident had accidentally been given another residents medications the morning of 07/21/2025...[Family Member C] also updates me that the facility told [her/him] that the resident has experienced 3 falls over the course of the last week. The most recent of which was yesterday and today. [Family Member C] reports [Resident 1] was more confused over the last 24-48 hours. [Resident 1] is current on antiplatelet therapy with aspirin and plavix, concerned about a bleed to the brain. [S/he] had requested CBC collected, does show some drop in Hg to 9.9 (compared to 11.5 in March 2025). Discussed concern that perhaps resident is having a bleed into the brain. Urinalysis has some trace abnormalities, but does not overwhelmingly seem concerning for infection at this time. Family friend was planning to bring resident to ED in the morning per [Family Member C] report. I advised [Family Member C] that resident be seen in ED ASAP. Discussed potential for hemodynamic instability, cardiotoxicity and occult intracranial bleed given residents confusion and other history as noted above." ...Physical Exam: ...Chest: Chest wall: tenderness present...Musculoskeletal: General:	M 582		

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M 582	Continued From page 15 Tenderness present. Skin: ...Findings: Bruising present. Neurological: Mental Status: S/he is alert. S/he is disorientated...Medical Decision Making and ED course: [Resident 1] from assisted living with question alter mental status, weakness, multiple falls with unclear injuries. Multiple diagnoses were considered in this resident, question metabolic vs infectious vs cardiovascular vs other etiologies. [S/he] is status post receiving multiple anti-hypertensive and other medications yesterday. History of dementia and question if mental status is actually at baseline. No focal deficits noted. Work up started...Will admit..." The Hospital History and Physical report dated 07/23/2025, indicated, "Chief Complaint: Resident presents with Fall, Medication Error...Principal Problem: Altered mental status, unspecified altered mental status type. Historian: [Resident 1]...brought to the ED from assisted living facility due to generalized weakness, multiple episodes of falls and accidental drug overdose. As reported by resident friends, resident her/himself and ED physician, [s/he] has been falling, fell 3 times this week, last fall was on Monday. Apparently, [s/he] was given another resident's medication on Monday, 07/21/2025. After taking medication resident was very dizzy, lightheaded and slept all day. [S/he] fell during [her/his] symptoms but no reported loss of consciousness. Today family called [her/his] primary care physician who requested resident be taken to the ED for further evaluation. No reported fever or chills, no nausea or vomiting. Resident was slightly confused on Monday and yesterday, early hours of the morning. [S/he] seemed to be in [her/his] baseline during my examination..." Review of Resident 1's Hospital Discharge Summary report dated 08/11/2025 indicated,	M 582		

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M 582	Continued From page 16 "...Admission date 07/22/2025, Discharge date 08/11/2025...Discharge Diagnoses: Principal Problem: Transient alteration of awareness...The following problems were addressed during the hospitalization, Transient alteration of awareness, secondary to the mediation error. Resident lives at the assisted living facility and was giving medications of the other resident. Having dizziness and lightheaded and fall. CT of head and max of neck was done no fracture was noted. Dizziness improved after the fluid. Elevated troponin secondary to the demand of ischemia...Resident is stable to discharge on hospice..." INTERVIEWS: On 09/05/2025 at 12:35 PM, Surveyor interviewed Caregiver A regarding the incident with Resident 1. Caregiver A indicated s/he prepared all of Resident 2's morning medications in a plastic med cup and set them down on the dining room table next to Resident 2. Caregiver A verified both Resident 1 and Resident 2 were sitting at the dining table when s/he placed the plastic med cup down. Caregiver A further verified after placing the medication cup down in front of Resident 2 s/he left the area and did not witness Resident 2 take the medications. Caregiver A stated, "I was in a rush to do something else ...It's my fault for not watching [Resident 2] take [her/his] meds." Surveyor asked if Resident 1 ingested Resident 2's medications, Caregiver A stated, "Yes. [Resident 1] took the majority of [Resident 2's] meds. There were over ten different pills in the med cup and [Resident 1] took all of them except for two little green pills." Surveyor then asked Caregiver A what s/he did following this incident. Caregiver A stated, "I immediately tried to contact	M 582		

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[Registered Nurse E], but I couldn't get a hold of [her/him], so I went next door to get [House Manager I]. [House Manager I] was able to get a hold of [Registered Nurse E]. [Registered Nurse E] directed [House Manger I] and I to monitor [Resident 1]." Surveyor questioned Caregiver A if Resident 1's physician and emergency contact(s) were notified, Caregiver A stated, "No". Surveyor asked if the pharmacist or poison control was contacted following the incident. Caregiver A stated, "No." Surveyor then asked Caregiver A what Resident 1's condition was following the incident. Caregiver A stated, "[Resident 1] felt a little lightheaded and kept saying [s/he] was really tried and groggy...[Resident 1] seemed a little off. I took [Resident 1's] vitals, and [s/he] had a low blood pressure. I told the next shift what happened and to keep a close eye on [her/him]." Surveyor then asked Caregiver A if s/he documented the incident or any of the above information. Caregiver A verified s/he did not document the medication error incident or any observations notes following the incident.

On 09/08/2025 at 1:45 PM, Surveyor interviewed Caregiver J regarding Resident 1. Caregiver J verified s/he worked on 07/22/2025 from 7 AM until 3 PM. Caregiver J stated when s/he arrived the staff member who was leaving did not report any medication error with Resident 1 nor was there any documentation an incident occurred. Caregiver J stated, "The only reason I found out about the medication error with [Resident 1] was from [Resident 2]...I went to get [Resident 2] ready for the day and [Resident 2] told me [s/he] was worried about [Resident 1], because [Resident 1] took [her/his] meds the day before. [Resident 2] was adamant about me checking on [Resident 1], so I went to go check on [Resident 1] and s/he appeared fine. About 10 minutes

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later [Resident 1] was pressing [her/his] call light repeatedly. When I walked into [Resident 1's] room [s/he] was on the floor sitting on [her/his] buttocks with [her/his] legs in front of [her/him] next to the chair. [Resident 1] said [s/he] didn't hit [her/his] head but felt dizzy and light-headed. I then helped [Resident 1] up and brought [her/him] to the dining room. While walking with [Resident 1] to the dining room [s/he] was very unsteady on [her/his] feet and needed to hang onto me. After the fall, around 8 AM, I called [Family Member B] to let [her/him] know about [Resident 1's] fall. [Family Member B] informed me [Resident 1] told family [s/he] took the wrong meds and couldn't feel [her/his] legs the night before...Throughout the shift [Resident 1] seemed very unsteady and stated [s/he] felt dizzy and light-headed." Surveyor asked if [s/he] notified anyone else. Caregiver J stated, "I tried calling [Registered Nurse E] to let [her/him] know about the fall, but there was no answer...[Registered Nurse E and House Manger I] showed up at the home around 11 AM to check on [Resident 1]...Around 2:30 PM [Family Friend D] came to the house to pick [Resident 1] up and bring [her/him] in to get checked out because [Family Member B] called [Family Friend D]...I provided [Family Friend D] with a list of [Resident 2's] morning medications." Surveyor then asked Caregiver J if s/he documented any of the above observations. Caregiver J indicated s/he could not recall.

On 09/03/2025 at 9:47 AM, Surveyor interviewed Resident 2. Resident 2 stated, "The morning of 07/21/2025, [Caregiver A] was working alone and [Resident 1] and I were sitting at the kitchen table for breakfast. [Caregiver A] set a cup full of medications down between [Resident 1] and me. [Caregiver A] went downstairs and didn't watch anyone take the meds. [Resident 1] reached for

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the pills and took them...[Caregiver A] shouldn't left the pills on the table. After this happened [Caregiver A] went to get [House Manger I] next door, and [House Manger I] came over and then called [Registered Nurse E]. They decided to keep an eye on [Resident 1]...During the lunch meal [Resident 1] said [s/he] was dizzy, had a headache and couldn't see straight...[Resident 1] didn't eat much during dinner."

On 09/03/2025 at 1:45 PM, Surveyor interviewed Resident 3. Resident 3 indicated s/he was aware Resident 1 received Resident 2's meds on 07/21/2025 and stated, "I was told by staff and [Resident 1], that [Resident 1] fell several times on 07/21/2025 after [s/he] took the wrong meds. During the morning on 07/22/2025, I noticed [Resident 1] was not [her/himself]..."

On 09/03/2025 at 2:45 PM, Surveyor spoke with Family Member B and C via phone regarding Resident 1. Family Member B and C indicated on 07/21/2025 during the breakfast meal Resident 1 took Resident 2's morning medications in error. Family Member B and C indicated neither Resident 1's physician or emergency contact(s) were notified of the med error until the following day (07/22/2025), when they (Family B and C) called the facility and Caregiver J confirmed Resident 1 received Resident 2's medications. Caregiver J told Family B and C, Resident 1 was confused and had a fall. Family Member B and C indicated after they confirmed the med error occurred, they asked Family Friend D to check on Resident 1 and bring Resident 1 to the doctor's office. Family Member C stated, "The doctor told us to take [Resident 1] to the ED immediately since the medications [Resident 1] received were considered a poisonous emergency...We had [Family Friend D] bring [Resident 1] to the ED and

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[Resident 1] was admitted to the hospital." Family B and C indicated since this incident Resident 1's quality of life has deteriorated.

On 09/04/2025 at 12:25 PM, Surveyor interviewed Family Friend D regarding Resident 1. Family Friend D indicated s/he visits Resident 1 at least weekly and sometimes more. Family Friend D stated, "On 07/22/2025, I received a call from [Family Member B] that [Resident 1] received the wrong medications, couldn't feel [her/his] legs and fell. After the call my significant other and I went to the home to check on [Resident 1]. [Resident 1] was confused, and an appointment was made to get blood work. We took [Resident 1] to get the blood work and noticed [Resident 1] was not [her/himself]. I called [Family Member B] right away and told [Family Member B], [Resident 1] was not right. [Family Member B] called [Resident 1's] physician and the physician told [Family Member B] to take [Resident 1] to the ED. My significant other and I then took [Resident 1] to the ED. When we arrived at the ED, I noticed a big bruise on [Resident 1's] hip. We were told by [Caregiver J], [Resident 1] had a few falls after the med mix-up."

On 09/03/2025 at 11:00 AM, Surveyor interviewed Registered Nurse E regarding Resident 1. Registered Nurse E verified Resident 1 received the wrong medications on 07/21/2025 and stated, "[Resident 1] and [Resident 2] were sitting at the dining table for breakfast. [Caregiver A] prepared [Resident 2's] medications in a med cup and set the cup down on the table in front of [Resident 2] and immediately walked downstairs. [Caregiver A] was gone for 3 minutes and noticed the pill cup was in front of [Resident 1] and [Resident 1] had taken some of the medications." Surveyor asked

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Registered Nurse E if s/he was notified by Caregiver A following this incident. Registered Nurse E stated, "I was not notified until an hour after the incident. I missed a call and then was sent a message from [House Manager I] around 10:30 AM via "Sling" (the company's private message system). The message indicated [Resident 1] got some of [Resident 2's] meds and asking me what to do with [Resident 1's] AM medications." Surveyor then asked what directions s/he gave [House Manager I]. Registered Nurse E stated, "I told [House Manager I] to hold off on given any medications until I could get to there...I couldn't look into anything and was unable to get to the home until 1 PM-1:30 PM, because I was at an appointment with another resident...When I arrived at the home around 1 PM-1:30 PM, I assessed [Resident 1], did vitals and [Resident 1] seemed fine." Surveyor then asked if Resident 1's physician was notified of the medication error. Registered Nurse E stated, "I called [Resident 1's] physician office between 1:30 PM and 2 PM and the receptionist said [s/he] would have the RN (Registered Nurse) call back, but I never received a call back." Surveyor questioned Registered Nurse E if s/he re-attempted to call back Resident 1's physician's office after no call back or attempted to notify any other health care providers regarding the medication error. Registered Nurse E confirmed s/he nor staff notified Resident 1's physician or any other health care providers regarding the medication error. Surveyor then asked if Resident 1's emergency contact(s) listed on the "Resident Agreement" were contacted following this incident. Registered Nurse E indicated s/he did not notify Resident 1's emergency contact(s) because "[Resident 1] already contacted family and made them aware." Registered Nurse E stated, "Staff

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were directed to continued to monitor [Resident 1]...On 07/22/2025, [Resident 1's] family friends were here and expressed concerns. The family friends took [Resident 1] to the ED, and [s/he] was admitted to the hospital...I went to the hospital multiple times to visit [Resident 1] during the first few weeks...The hospital was encouraging family to put [Resident 1] on hospice." Surveyor then asked Registered Nurse E if s/he was informed of any falls for Resident 1. Registered Nurse E stated, "[Resident 1] had a fall in [her/his] bathroom on 07/11/2025, with no major injuries and another one on 07/21/2025. I was told by [Caregiver A], during the morning on 07/21/2025, [Resident 1] slipped on [her/his] robe and fell. I was not informed of [Resident 1's] 07/21/2025 fall, nor was the 07/21/2025 fall documented." Surveyor then asked if s/he directed staff to increase health monitoring and document on Resident 1 after the medication error. Registered Nurse E stated, "I verbally told staff to monitor [Resident 1] and keep an eye on [her/him]." Registered Nurse E verified there was no evidence of increased health monitoring or documentation for Resident 1 following the medication error.

On 09/03/2025 at 10:25 AM, Surveyor interviewed Licensee F regarding the medication incident with Resident 1. Licensee F verified Resident 1 received Resident 2's morning medications on 07/21/2025. Licensee F stated, "The staff set the meds down on the table and went to the bathroom and returned three minutes later. When staff returned [Resident 1] had already taken the meds. Our policy is not to leave the resident until all meds are consumed...We terminated the employee the next day and [Licensee G] documented everything, did the audit, all the reviews and

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M 582	Continued From page 23 talked to employees." On 09/04/2025 at 9:51 AM, Surveyor asked Licensee G if all documentation including the investigation regarding the medication error incident for Resident 1 on 07/21/2025 was provided. On 09/04/2025 at 10:44 AM, Licensee G confirmed all documentation, and information was provided to Surveyor. In conclusion, Resident 1 was known to have ingested another resident's morning medications on 07/21/2025 and the facility did not communicate with the resident's emergency contact(s), medical provider or other health care providers. Additionally, no documentation or interventions were recorded to show staff were monitoring Resident 1's health for potential changes in condition following the incident. On 07/22/2025, Resident 1 was brought to the ED, hospitalized for 29 days and discharged on hospice services. Cross Reference M0134 DHS 88.03(5)(e)1- Significant Change to the resident M0458 DHS 88.07(3)(a) Prescription Medications	M 582		