STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019003	A. BUILDING: _____ B. WING _____	C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS HOME	**308 MEMPHIS AVE MADISON, WI 53714**

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M 000	INITIAL COMMENTS From 06/10/2026 through 06/23/2026, Surveyor conducted a complaint investigation at Memphis Home, an AFH in Madison. Eight deficiencies were identified. Three of the 8 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) MLCI11, dated 01/15/2025. Complaint was substantiated. Census: 3	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 interview, the provider did not report to the Department within 24 hours, when 1 of 1 resident's eloped. On 06/05/2026, Resident 3 eloped and was missing from the home requiring law enforcement involvement to locate and hospitalization.	M 134		

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

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M 134	Continued From page 1 Findings include: On 06/10/2026, Surveyor arrived at the facility to conduct a complaint investigation alleging the facility did not meet the ambulation needs of Resident 3. On 06/10/2026, at approximately 9:00 AM, Surveyor interviewed Caregiver A. Caregiver A stated that Resident 3 was currently in the hospital but would be returning home in the next couple days. Caregiver A stated that Resident 3 had eloped out of his/her bedroom window and was missing from the home for over a day. Caregiver A stated that Resident 3 was found at a coffee shop and was transported to the hospital. Caregiver A stated that s/he had spoken to the hospital the day before and was told that Resident 3 was having some medication changes. On 06/10/2026, at 10:45 AM, Surveyor received an email from APS Worker C. APS Worker C reported that Resident 3 "eloped from the facility on the evening of 6/5/2026. A silver alert was issued, [s/he] was found at a coffee shop in downtown Madison on 6/6/2026 and was admitted to the [hospital] with acute kidney injury, fractured ribs and pneumonia. [S/he] reported falling several times overnight. [S/he] will not be returning to the facility." On 06/11/2026, at 10:39 AM, Surveyor received an email from Licensee B. The email was sent to Resident 3's guardian and indicated that Resident 3 had eloped from the facility on 06/06/2026. The email stated the following: -June 6 at 6:35 AM "We would like to provide an update regarding an incident that occurred late	M 134		

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M 134	Continued From page 2 this afternoon involving [Resident 3]. [Resident 3] broke the window in [his/her] bedroom and subsequently eloped and left [facility]. Law enforcement was contacted immediately and is currently assisting with locating [him/her]. At this time, [Resident 3] has not been found, and the search remains ongoing. We will continue to provide updates as additional information becomes available." -June 8 at 4:45 PM "[Resident 3] was located at a coffee shop in the downtown Madison area. Law enforcement transported [Resident 3] to the [hospital] for evaluation. As of yesterday, [facility] team spoke with [hospital] and was informed that [Resident 3] is expected to remain hospitalized as an inpatient for at least two more days. We will continue to monitor the situation and keep you informed of any significant updates." A review of department records noted as of 06/15/2026, the department did not receive any report related to Resident 3's elopement on 06/05/2026. On 06/23/2026 at 1:00 PM, Surveyor interviewed Licensee B via phone regarding Resident 3's elopement on 06/05/2026. Licensee B confirmed Resident 3 eloped from the home, and it required law enforcement. Licensee B stated that s/he was unaware of that and would let the department know of changes going forward.	M 134		
M 260	88.05(2) ACCESS TO HOME AND WITHIN THE HOME RESIDENT ACCESS TO THE HOME AND WITHIN THE HOME. An adult family home shall	M 260		

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M 260	Continued From page 3 be physically accessible to all residents of the home. Residents shall be able to easily enter and exit the home, to easily get to their sleeping rooms, a bathroom, the kitchen and all common living areas in the home, and to easily move about in the home. Additional accessibility features shall be provided as follows, if needed to accommodate the physical limitations of the resident or if specified in the resident's individual service plan: This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure residents were able to easily enter and exit the home. Findings include: The Adult Family Home (AFH) is licensed to serve up to 4 ambulatory individuals with a primary diagnosis that include: correctional clients, emotionally disturbed/mental illness, traumatic brain injury, alcohol/drug dependent, advanced aged, and developmentally disabled. On 06/10/2026, at approximately 10:00 AM, Surveyor conducted a tour and observed Resident 1 walking to the bathroom. Surveyor noted Resident 1 walked with the assistance of a walker. Surveyor noted the front of the home had a step down with wide uneven steppingstones to exit the front of the home so Resident 1 could not easily exit the home.	M 260		

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M 260	Continued From page 4 On 06/10/2026, at approximately 10:30 AM, Surveyor interviewed Caregiver A. Caregiver A stated that Resident 1 did use the walker for mobility. Caregiver A stated staff assist Resident 1 with exiting the home. On 06/10/2026, Surveyor reviewed the Department file and reviewed the program statement on file. The program statement documented: "Our home is not wheelchair accessible. We have one short step at the primary entrance and a secondary entrance near the kitchen." Surveyor noted that all exits out of the home have at least 1 or more steps. Surveyor reviewed the facility application and noted the license was issued for ambulatory residents. On 06/23/2026, at approximately 1:00 PM, Surveyor interviewed Licensee B. Licensee B stated that Resident 1 did not come to the facility with a walker. Surveyor stated that using the walker was in the individual service plan (ISP) for Resident 1. Licensee B stated that s/he had installed a ramp for the entrance door and would look into non-ambulatory requirements.	M 260		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment.	M 276		

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M 276	Continued From page 5 This Rule is not met as evidenced by: Based on interview and observation, the provider did not maintain a safe, clean, and homelike environment. Findings include: On 06/10/2026, Surveyor toured the facility and observed the following: Outside of home -Yard was not mowed -Garbage/furniture on the side of the home Family Room -Several broken blinds Hallway outside Resident 3's room: -Broken blinds Resident 3's bedroom: -Torn window screens -Broken closet doors -No dresser for clothing -Sagging low mattress On 06/23/2026 at 1:00 PM, Surveyor conducted an exit conference and shared findings with Licensee B. Licensee B stated that s/he had been fixing items in the home. Licensee B stated that Resident 3 had moved out. Licensee B said that there was a resident in the home that damaged the blinds and the facility was in the process of putting up new blinds.	M 276		
M 440	88.07(2)(b)1 SUPERVISNG & ASSISTING WITH ADLS	M 440		

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M 440	Continued From page 6 Supervising or assisting a resident with or teaching a resident about activities of daily living. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide Resident 3 with proper supervision appropriate to his/her needs. Resident 3 eloped from the home and was missing for up to 1 day without shelter and medications. Findings include: On 05/08/2026, The Department received a complaint that a resident had eloped, and law enforcement were involved. On 06/10/2026 at 9:00 AM, Surveyor reviewed Resident 3's medical record. Resident 3 was admitted 04/22/2026 with diagnoses that include but not limited to: dementia with psychotic disturbance and unspecified psychosis. On 06/10/2026, at approximately 9:00 AM, Surveyor interviewed Caregiver A. Caregiver A stated that Resident 3 was currently in the hospital but would be returning home in the next couple days. Caregiver A stated that Resident 3 had eloped out of his/her bedroom window and was missing from the home for over a day. Caregiver A stated that Resident 3 was found at a coffee shop and was transported to the hospital. Caregiver A stated that s/he had spoken to the hospital the day before and was told that Resident 3 was having some medication changes.	M 440		

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M 440	Continued From page 7 On 06/10/2026, at 10:45 AM, Surveyor received an email from APS Worker C. APS Worker C reported that Resident 3 "eloped from the facility on the evening of 6/5/2026. A silver alert was issued, [s/he] was found at a coffee shop in downtown Madison on 6/6/2026 and was admitted to the [hospital] with acute kidney injury, fractured ribs and pneumonia. [S/he] reported falling several times overnight. [S/he] will not be returning to the facility." On 06/11/2026, at 10:39 AM, Surveyor reviewed Resident 3's individual service plan (ISP). Resident 3's ISP indicates that Resident 3 needs 24 hour supervision due to confusion, poor judgement, legal blindness and behavioral risk. On 06/11/2026, at 10:39 AM, Surveyor received an email from Licensee B. The email was sent to Resident 3's guardian and indicated that Resident 3 had eloped from the facility on 06/06/2026. The email stated the following: -June 6 at 6:35 AM "We would like to provide an update regarding an incident that occurred late this afternoon involving [Resident 3]. [Resident 3] broke the window in [his/her] bedroom and subsequently eloped and left [facility]. Law enforcement was contacted immediately and is currently assisting with locating [him/her]. At this time, [Resident 3] has not been found, and the search remains ongoing. We will continue to provide updates as additional information becomes available." -June 8 at 4:45 PM "[Resident 3] was located at a coffee shop in the downtown Madison area. Law enforcement transported [Resident 3] to the [hospital] for evaluation. As of yesterday, [facility] team spoke with	M 440		

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M 440	Continued From page 8 [hospital] and was informed that [Resident 3] is expected to remain hospitalized as an inpatient for at least two more days. We will continue to monitor the situation and keep you informed of any significant updates." On 06/23/2026 at 1:00 PM, Surveyor interviewed Licensee B via phone regarding Resident 3's elopement on 05/06/2026 and 06/05/2026. Licensee B confirmed Resident 3 eloped from the home, and it required law enforcement. Licensee B stated that s/he had been trying to get additional resources to provide the proper supervision for Resident 3.	M 440		
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 staff interview, the provider did not ensure medications were securely stored or disposed of according to standards of practice. The provider did not ensure Resident 3's medications were securely stored and remain in the original container.	M 458		

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M 458	Continued From page 9	M 458		

Resident 3's discontinued medications were not disposed of according to standards of practice.

This is a repeat violation from Statement of Deficiency (SOD) MLCI11, dated 01/15/2025.

Findings include:

On 06/10/2026 at 9:00 AM, Surveyor observed a large pill container in the medication closet. The container was not labeled and had several pills dispensed in the sections of the container. Surveyor observed discontinued medications stored in the medication room on a desk.

Example 1-Resident 3

On 06/10/2026 at approximately 9:00 AM, Surveyor observed a pill container in the medication closet. The pill container was not labeled with any Resident name or identification. The pill container was separated by days of the week, morning, noon, evening and bedtime. Surveyor observed several pills in the pill container.

On 06/10/2026 at approximately 9:15 AM, Surveyor interviewed Caregiver A. Caregiver A stated the s/he was unsure who those pills belonged but believed they were Resident 3's. Caregiver A stated that the pill container had been in the medication closet for over a month and s/he did not believe that staff were using that container.

Example 2-Resident 3

On 06/10/2026, Surveyor reviewed Resident 3's medical record. Surveyor observed the following discontinued medications for Resident 3:

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M 458	Continued From page 10 -One medication card with 52.5 pills of Quetiapine 50 mg with a dispensed date of 07/15/2025. Surveyor noted that Resident 3 was not on that dosage of Quetiapine, as of 06/10/2026. On 06/10/2026, at approximately 9:15 AM, Surveyor interviewed Caregiver A. Caregiver A stated that Resident 3 was not using the medications that were stacked on the desk. Caregiver A stated that the medications came from Resident 3's previous facility. On 06/23/2023 at approximately 1:00 PM, Licensee B stated he/she was unaware of the expired or discontinued medications. Licensee B stated he/she will monitor the medication cabinet.	M 458		
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 from the resident's physician permitting the provider's staff	M 464		

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M 464	Continued From page 11	M 464		

to administer medications was received before administering medications for 1 of 3 residents reviewed. The provider did not have a written order to administer medications to Resident 2.

This is a repeat violation, see Statement of Deficiency (SOD) MLCI11, dated 01/15/2025.

Findings include:

On 06/10/2026 at approximately 9:15 AM, Surveyor interviewed Caregiver A regarding administering medication. Caregiver A stated that s/he did administer medications for Resident 2.

On 06/11/2026 approximately 10:39 AM, Surveyor reviewed files received from Licensee B for Resident 2 records. Resident 2 record did not indicate written orders from the resident's physician permitting provider's staff to administer medications.

On 06/11/2026 at approximately 10:39 AM, Surveyor received resident records for Resident 2 from Licensee B. The resident records indicated the following:

- Resident 2 was admitted to the provider's home on 05/14/2026. Resident 2's record indicated the provider's staff administered Resident 2's medication. Resident 2's record did not include a physician order to administer medications.

On 06/23/2026 at approximately 1:00 PM, Surveyor shared concern with Licensee B regarding no physician order permitting the provider's staff to administer medications to Resident 2. Licensee B stated that s/he would get Resident 2's paperwork in the facility.

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M 482	Continued From page 12	M 482		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain complete records for 2 of 3 residents reviewed. There were not complete records for Resident 2 and Resident 3 in the facility. This is a repeat violation from Statement of Deficiency (SOD) MLCI11, dated 01/15/2025. Findings include: On 06/10/2026 at approximately 9:00 AM., Surveyor reviewed resident records provided by Caregiver A. The records included the following: -Resident 2 had a Medication Administration Record (MAR). There were no other records for Resident 2 in the facility. -Resident 3 had a Medication Administration Record (MAR). There were no other records for Resident 3 in the facility. On 06/10/2026 at approximately 9:00 AM, Surveyor interviewed Caregiver A. Caregiver A stated that the manager had most of the records with him/her.	M 482		

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M 482	Continued From page 13 On 06/10/2026 at 9:15 AM, Surveyor phoned Licensee B and left a message and emailed. On 06/10/2026 at 9:25 AM, Surveyor talked with Licensee B on the phone and requested resident records. Licensee B stated that s/he would email the files to Surveyor as all the records were on his/her computer. On 06/11/2026 at 10:40 AM, Surveyor received resident records for Resident 2 and Resident 3 from Licensee B. On 06/23/2026 at approximately 1:00 PM, Surveyor shared concern with Licensee B regarding incomplete records and records not being available in the home for Resident 2 and Resident 3. Licensee B stated that s/he would get the records into the home for Resident 2.	M 482		
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 observation, record review and interview, the provider did not ensure 1 of 2	M 582		

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M 582	Continued From page 14 residents reviewed received all medications as prescribed. Resident 1 did not receive his/her Nystatin cream as prescribed. Findings include: On 06/10/2026 at approximately 9:30 AM, Surveyor reviewed resident records and the provider's medication storage. Records documented Resident 1 was admitted to the provider's facility on 08/18/2025 and the provider's staff was responsible for his/her medication administration. Resident 1's physician order included an order for Nystatin Cream 100000 (Start Date: 12/30/2025) - Apply topically 3 times a day. Surveyor's review of the provider's medication storage and noted that there were 11 tubes of this medication. Surveyor asked Caregiver A why Resident 1 had so many tubes of cream. Caregiver A did not know why there were 11 tubes available of the cream. On 06/10/2026 at approximately 9:35 AM, Surveyor reviewed the Medication Administration Record (MAR), dated 06/01/2026 through 06/10/2026. The nystatin cream 100000 was scheduled for 8:00 AM, 12:00 PM, and 5:00 PM. The MAR indicated that Resident 1 did not receive his/her Nystatin cream from 06/01/2026 through 06/10/2026 at any administration. On 06/23/2023 at approximately 1:00 PM, Licensee B stated he/she stated that Resident 1 refused medications and that was why there was so many tubes. Licensee B acknowledged that the medication should get a new order. Licensee B stated he/she will monitor the medication cabinet.	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019003	A. BUILDING: _____ B. WING _____	C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS HOME	**308 MEMPHIS AVE MADISON, WI 53714**

(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