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P 000	Initial Comments On 10/27/25, an onsite visit was conducted at Madigan House, for the purpose of completing the state relicensure survey. It was determined that Madigan House is not in substantial compliance with 10/144, Chapter 113-Regulaitons Governing the Licensing and Functioning of Assistive Housing Programs- Level IV, Private Non-Medical institutions.	P 000		
P 345	7.7 Medications and Treatments Expired and discontinued medications. For medications administered by the assisted living program, residential care facility, or private non-medical institution, medications shall be removed from use and properly destroyed after the expiration date and when discontinued, according to procedures contained in Section 7.9. They shall be taken out of service and locked separately from other medications until reordered or destroyed. [III] This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure expired medications were removed from available supply in 1 of 1 medication storage observation (Medication Refrigerator). Finding: On 10/27/25 at 9:18 a.m., during an observation of medication storage, a surveyor and a Certified Residential Medication Aide (CRMA #3), observed and confirmed that 1 box labeled Bisacodyl Suppositories, 100 suppositories, 10	P 345		

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P 345	Continued From page 1 milligrams (mg) each, was on the shelf and available for use with an expiration date of 06/2025. This provision has not changed in the new rule, under Section 5.I, effective 9/18/25.	P 345		
P 365	7.15 Medications and Treatments First aid kit. A first aid kit containing supplies which may be necessary for the first aid treatment of minor injuries such as cuts, scrapes or first degree burns shall be included and available in the facility. All staff shall be instructed in the use of any item in the kit. This STANDARD is not met as evidenced by: Based on review of employee training records and interview, the facility failed to provide in-service training on the proper use of items in the First Aid Kit, in order to provide treatment for minor injuries of residents, for 3 of 5 employee files reviewed (Employee #1 [E1], E2, and E5). Findings: 1. On 10/27/25, a surveyor reviewed E1's employee file. E1's employee training records lacked evidence that E1 received training on use of the First Aid Kit. 2. On 10/27/25, a surveyor reviewed E2's employee file. E2's employee training records lacked evidence that E2 received training on use of the First Aid Kit.	P 365		

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P 365	Continued From page 2 3. On 10/27/25, a surveyor reviewed E2's employee file. E5's employee training records lacked evidence that E5 received training on use of the First Aid Kit. On 10/27/25 at 12:59 p.m., during an interview with 2 surveyors, the Residential Care Director stated the First Aid Kit training was provided to CRMA (Certified Residential Medication Aide) staff, but she could not find evidence that the Patient Support Specialist (PSS) staff received the First Aid Kit training. At this time, 2 surveyors confirmed that there is no evidence that E1, E2, and E5 received First Aid Kit training. This provision has changed in the new rule effective 9/18/2025. See new provisions of the rule Section 5.Q.1, Section R.1, and Section 9.B.4.d.	P 365		
P 437	11.1.1.6 Administrative and Resident Records Dentist's name, address and telephone number; This STANDARD is not met as evidenced by: Based on record reviews and an interview, the facility failed to ensure that a resident's choice of dentist was identified on the resident's identification and summary sheet for 2 of 5 sampled residents (Resident #4 and #5). Findings: 1. On 10/27/25, a surveyor reviewed Resident #4's identification and summary sheet (face sheet). The resident's choice of a dentist was not identified on the resident's identification and summary sheet.	P 437		

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P 437	Continued From page 3 2. On 10/27/25, a surveyor reviewed Resident #5's identification and summary sheet (face sheet). The resident's choice of a dentist was not identified on the resident's identification and summary sheet. On 10/27/25 at 2:53 p.m. the above findings were confirmed with the Residential Care Director when she provided the face sheets to this surveyor and they did not identify the residents choice of a dentist. This provision has not changed in the new rule effective 9/18/25. See the provisions of the new rule Section 8.A.1.f	P 437		
P 465	11.1.6.10 Administrative and Resident Records Documented proof of guardianship, conservatorship, representative payee, power of attorney or other legal representative, if such a relationship exists; and This STANDARD is not met as evidenced by: Based on a record review and an interview, the clinical record for 1 of 5 sampled residents (Resident #3) lacked documented proof of the legal representative. Finding: On 10/27/25 during a clinical record review for Resident #3 it was observed that his/her identification and summary sheet (face sheet) form identified the resident's son as the Power of Attorney. The clinical record lacked documented proof that the resident's son was the Power of Attorney.	P 465		

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P 465	Continued From page 4 On 10/27/25 at 2:45 p.m. during an interview with the Residential Care Director the surveyor confirmed that Resident #3's clinical record lacked the documented proof that the son is Resident #3's Power of Attorney. This provision has not changed in the new rule effective 9/18/25. See the provisions of the new rule Section 8.A.5.a	P 465		
P 466	11.1.7 Administrative and Resident Records Incident reports. An incident report shall be completed for any resident who has sustained or caused a fall, injury or accident in the facility, while being transported by the facility, or in an activity supervised by facility staff, who unsafely wanders from the facility, who is involved in an altercation with another resident, who has a medication reaction, or when an error is made in the documentation or administration of medication. The report shall describe the incident and indicate the extent of the injury or reaction and necessary treatment. The dispensing pharmacy shall be consulted regarding incidents involving medications, in order to assist in assessing adverse drug reaction, drug-drug interaction, drug-food interaction and allergies/sensitivities. If, in the opinion of the administrator or person in charge, the incident is not serious enough to call an examining duly authorized licensed practitioner, an incident report shall still be recorded in the resident's record. The administrator shall initial the record within seventy-two (72) hours. If examination and treatment by a duly authorized licensed practitioner is necessary as a result of an incident, the facility shall notify the guardian or	P 466		

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conservator as soon as possible, within seventy-two (72) hours.

This STANDARD is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure that incident reports were filed in the individualized clinical records for 3 of 5 sampled residents (Resident #3, #4 and #5).

Findings:

1. On 10/27/25 During a resident record review, the surveyor asked the Residential Care Director (RCD) about incidents involving Resident #3, the RCD and the Registered Nurse (RN) provided the surveyor with incident reports that were in a binder that is kept in the chart room. There were no incident reports in the resident's clinical record.

2. On 10/27/25 During a resident record review, the surveyor asked the RCD about incidents involving Resident #4, the RCD and the RN provided the surveyor with incident reports that were in a binder that is kept in the chart room. There were no incident reports in the resident's clinical record.

3. On 10/27/25 During a resident record review, the surveyor asked the RCD about incidents involving Resident #5, the RCD and the RN provided the surveyor with incident reports that were in a binder that is kept in the chart room. There were no incident reports in the resident's clinical record.

On 10/27/25 at 3:00 p.m. during an interview with the RCD and the RN, they stated that the incident reports were put in the binder so they were all together and in the same location making it

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P 466	Continued From page 6 easier to find when needed. The surveyor confirmed that the incident reports for these residents were not in their clinical records. This provision has not changed in the rule effective 9/18/25. See new provisions of the rule Section 8.A.6	P 466		
P 494	12.3 Standards for Resident Care Service plan: A service plan shall be developed and implemented within thirty (30) calendar days of admission for each resident based upon the findings of the resident assessment instrument (RAI). The plan shall address those areas in which the resident needs encouragement, assistance or an intervention strategy. The resident, his/her legal representative (if applicable) and others chosen by the resident shall be actively involved in the development of the service plan, unless he/she is unable or unwilling to participate. There shall be documentation in the resident's record identifying who participated in the development of the service plan. The service plan shall describe strategies and approaches to meet the resident's needs, names of who will arrange and/or deliver services, when and how often services will be provided and goals to improve or maintain the resident's level of functioning. Residents shall be encouraged to be as independent as possible in their functioning, including ADLs and IADL's if they choose, unless contraindicated by the resident's duly authorized licensed practitioner. The service plan shall be modified, as necessary, based upon identified changes. Residents shall never be required to perform activities specified in the residential service plan or any other activities and cannot be used to replace paid	P 494		

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P 494	Continued From page 7 staff. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the resident records contained documentation identifying who participated in the development of the service plans and that the resident and/or his/her legal representatives were actively involved in the service planning process for 5 of 5 sampled residents (#1,#2,#3,#4 and #5). In addition, the facility failed to develop a service plan to address a resident's needs in the areas of Cirrhosis and/or Chronic Pain (Resident #2 [R2]). Findings: Resident 1's clinical record indicated that a service plan was developed upon admission. The resident's clinical record lacked evidence identifying who participated in the development of the service plan. The resident's clinical record also lacked evidence that the resident and/or legal resident representative were actively involved in the development of the service plan process and review, or that the resident / legal representative was unable or unwilling to participate. Resident 2's clinical record indicated that a service plan was developed upon admission. The service plan does not describe intervention strategies and/or approaches to meet the resident's needs, identify who will arrange and/or deliver services, when and how often services will	P 494		

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be provided, and/or goals to improve or maintain the resident's level of functioning related to an active diagnosis of Chronic Pain and/or Cirrhosis. The resident's clinical record also lacked evidence identifying who participated in the development of the service plan, that the resident and/or legal representative were actively involved in the development of the service plan process and review, or that the resident / legal representative was unable or unwilling to participate.

Resident 3's clinical record indicated that a service plan was developed upon admission. The resident's clinical record lacked evidence identifying who participated in the development of the service plan. The resident's clinical record also lacked evidence that the resident and/or his/her representative were actively involved in the service planning process and review.

Resident 4's clinical record indicated that a service plan was developed upon admission. The resident's clinical record lacked evidence identifying who participated in the development of the service plan. The resident's clinical record also lacked evidence that the resident and/or his/her representative were actively involved in the service planning process and review.

Resident 5's clinical record indicated that a service plan was developed upon admission. The resident's clinical record lacked evidence identifying who participated in the development of the service plan. The resident's clinical record also lacked evidence that the resident and/or his/her representative were actively involved in the service planning process and review.

On 10/27/25 at 2:38 p.m. during an interview two

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P 494	Continued From page 9 surveyors discussed the above findings with the Residential Care Director and the Registered Nurse. This provision has not changed in the new rule effective 9/18/25. See the provisions of the new rule Section 13.C.	P 494		
P 540	13.10 Staffing The pharmacists consultant services. Each facility of more than ten (10) beds shall retain the services of a pharmacist consultant no less than quarterly to: This STANDARD is not met as evidenced by: Based on record reviews and interviews, there was no evidence the Pharmacist visited quarterly and reviewed written policies and procedures for pharmaceutical services, reviewed medication areas for labeling, storage, temperature, expired medications, locked compartment, access to keys and availability and completeness of a first aid kit, reviewed staff performance in carrying out pharmaceutical policies and procedures, and/or reviewed medication records and initial and date the records when reviewed for 3 of 5 resident records reviewed (Resident #1 [R1], R4, and R5). Findings: 1. On 10/27/25, review of R1's clinical record indicated that the Pharmacy Consultant last reviewed and signed the resident's record on 5/9/25. The clinical record lacked evidence that the R1's Medication Regiment Review was completed a minimum of quarterly.	P 540		

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P 540	Continued From page 10 On 10/27/25 at 4:00 p.m., during an interview with the Residential Care Director (RCD) and 2 surveyors, R1's clinical record was reviewed. At this time a surveyor confirmed that the last Pharmacy Consultant visit documented in R1's clinical record was 5/9/25, that the next review was due in August of 2025, and that the clinical record lacks evidence that the R1's clinical record was reviewed by the Pharmacy consultant from 8/2025 through present. 2. On 10/27/25, review of R4's clinical record indicated that the Pharmacy Consultant last reviewed and signed the resident's record on 5/9/25. The clinical record lacked evidence that the R4's Medication Regiment Review was completed a minimum of quarterly. 3. On 10/27/25, review of R5's clinical record indicated that the Pharmacy Consultant last reviewed and signed the resident's record on 5/9/25. The clinical record lacked evidence that the R5's Medication Regiment Review was completed a minimum of quarterly. On 10/27/25 at 5:30p, during an interview with 2 surveyors, the RCD, and a Registered Nurse (RN), the RCD and the RN stated they were unable to find evidence that the Pharmacy Consultant reviewed all resident records during the last quarterly visit, and the Pharmacy Consultant was unable to send them the information at this time. At this time a surveyor confirmed the facility lacked evidence that the Pharmacy Consultant provided services no less than quarterly to review policies and procedures, monitor for expired medications, and / or review, initial, and date resident records when reviewed. This provision has not changed in the new rule	P 540		

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P 540	Continued From page 11 effective 9/18/25. See the provisions of the new rule Section 14.D.	P 540		
P 618	15.16 Sanitation/dietary services Testing of chemical sanitizers. When chemical sanitizing solutions are used for either manual or mechanical sanitization, an approved test kit shall be used to measure the residual of the sanitizing solution. This STANDARD is not met as evidenced by: Based on observation and interviews the facility failed to ensure they were testing the chemical sanitizer solution for sanitization in their low temperature warewasher (dishwasher). Finding: On 10/27/25 at 10:30 a.m. during an observation of the use of the warewasher the surveyor interviewed the staff about testing the sanitizer solution used for sanitation of the dishes. She stated she is a new staff and could not tell this surveyor when or how the warewasher chemical testing was done. The administrator came into the kitchen area and was then asked how and when the chemical testing was done and he was not able to tell this surveyor when and how the sanitizing levels were monitored. At 10:52 a.m. during a second interview with the Administrator, the surveyor confirmed that the sanitizing levels were not being tested in the warewasher. He asked the surveyor to review online information on the Hobart warewasher and it was noted that the manufacturer recommended	P 618		

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P 618	Continued From page 12 a monthly testing of the chemicals used for sanitation the recommendation was for the chemicals to be 50 to 100 PPM (parts per million). The facility could not provide evidence that any chemical testing was completed. This provision has not changed in the new rule effective 9/18/25. See the provisions of the new rule Section 10.K.2.a	P 618		