STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018206	A. BUILDING: _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONNIE HOME LLC 2	1128 HIGH AVE OSHKOSH, WI 54901

(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 09/03/2024, with information gathered through 09/09/2024, Surveyor conducted a complaint investigation at Connie Home LLC 2. Four deficiencies were identified. Complaint was unsubstantiated. Census: 3	M 000		
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's physical environment was safe, well maintained, and appropriate to provide a homelike environment to residents. Findings include: On 09/03/2024, at approximately 11:20 AM, Surveyor toured the home and observed the following in the upstairs resident bathroom: -The bathtub had what appeared to be dried on soap scum. There was what appeared to be adhesive on the rim of the tub that had black and brown substance stuck to it. -The bathroom vanity had a light fixture above it that held 4 lightbulbs. The light fixture did not contain any lightbulbs.	M 276		

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

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M 276	Continued From page 1 -The plaster on the wall was cracking and peeling. The walls had cobwebs and what appeared to be dust hanging from the walls. -The bathroom ceiling vent was covered in a layer of dust. The dust was thick enough that Surveyor could not see the vent area where the area should flow through. Surveyor observed throughout the home that the wall plaster was cracking and peeling, with dust and cobwebs hanging on the walls and ceilings. On 09/03/2024, at approximately 11:35 AM, Surveyor interviewed Co-Owner A, House Manager B, Assistant Business Administrator (ABA) C, and Caregiver D. House Manager B acknowledged the home was in need of repair.	M 276		
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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M 424	Continued From page 2 This Rule is not met as evidenced by: Based on interview and record review, the provider did not review and/or obtain signatures of the appropriate parties to indicate agreement with 1 of 1 resident (Resident 1) Individual Service Plan (ISP). The provider did not update 1 of 1 resident's (Resident 1) ISP regarding his/her behaviors. Findings include: On 05/02/2024, the Department received a concern regarding special diets. On 09/06/2024, Surveyor requested and reviewed Resident 1's MCO documentation, dated 01/01/2024 to 09/05/2024, which documented: "03/27/2024: IDT (interdisciplinary team) were notified by [House Manager] with [Provider] that they are having an issue with [Resident 1's Family Member] sending [him/her] food via [food vendor] that is not following [his/her] diabetic diet. [Resident 1] has since been having high blood sugars and they are concerned that with how high they become that [s/he] will end up back in the hospital. [S/He] has been reaching 350 & higher. Management has discussed this with [Resident 1's Family Member] a few times because of how high they are getting and yet [s/he] continues to send inappropriate food: soda, chips and other unhealthy foods. [Resident 1] has also been keeping them in [his/her] room which is against a house rule of no snacks being kept in resident bedrooms on the second floor as they should be stored in the kitchen. They are going to see if they could ask [him/her] to bring the food downstairs. Last night [House Manager] got a phone call from staff saying [s/he] was at 400 so [s/he] called the	M 424		

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M 424	Continued From page 3 RN (registered nurse) and the RN said push lots of water. This was effective in bringing [his/her] blood sugars down. The facility purchases food that adheres to [his/her] diabetic diet. [House Manager] also states that they are still having issues of [him/her] not communicating with staff that [s/he] is still hungry during meals and wants another helping. They have asked [him/her] numerous times to communicate with staff as they won't know that [s/he] wants a second portion. [House Manager] set up a meeting with LCI (MCO) IDT, GDN (guardian) to discuss concerns for 4/3 at 1PM. [House Manager] to invite [Resident 1's Family Member] to discuss concerns as well." "06/19/2024: IDT, GDN, [Resident 1], and Management staff from [Provider] met to discuss a few concerns including communication, inappropriateness of calls from [Resident 1's Family Member], and visitation. IDT and GDN were updated that [Resident 1] and [his/her Family Member] have been calling [his/her] physician to talk about how often [his/her] blood sugars can be taken but what the physician says verbally it doesn't get communicated to the facility management, nor are orders updated. In example, according to [Resident 1], [his/her] Physician verbally told [him/her] [s/he] can check [his/her] blood sugars as often as [s/he'd] like; however orders were written as 4 times daily so the pharmacy would only supply enough strips for the orders. Facility has since followed up and obtained new orders for up to 8 times a day. GDN educated [Resident 1] that the doctor should not be discussing that with [his/her Family Member] as [s/he] is not [his/her] guardian. GDN also educated [Resident 1] that a doctor needs to have written orders for the facility to follow. GDN stated that [s/he] would speak with [his/her]	M 424		

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M 424	Continued From page 4	M 424		

doctor's office regarding not allowing communication with [Resident 1's Family Member]. Management also updated IDT and GDN that [Resident 1's Family Member] has been calling and has been very rude on the phone, especially when [s/he] wanted to do a visit outside the home with [Resident 1] and GDN had not been made aware to give consent. GDN educated [Resident 1] that [s/he] needs to give consent and that [his/her Family Member] can call [him/her] to schedule visits. GDN also stated [s/he] would speak with [Resident 1's Family Member] about scheduling visits through [him/her], and [s/he] will communicate approved visits to [Provider]. Discussed how staff try to encourage [Resident 1] to do activities but [s/he] declines because an outing was unable to happen back in March, so [s/he] decided [s/he] wouldn't go on any. Those present encouraged [Resident 1] to attend future outings, such as the picnic [Provider] is doing with all their homes. [Provider] management informed CM (care manager) and GDN that they will ask [Resident 1]preferences on food and most of the time [s/he] doesn't reply. Staff also try to engage with [him/her] and [s/he] chooses not to. [Resident 1] was encouraged if [s/he] has concerns regarding staff to bring concerns to management so they can address it."

"07/08/2024: CM received request from [Provider] for assistance creating a BSP (behavior support plan) for [Resident 1] as [s/he] continues to speak with [his/her Family Member] making accusations of what staff are doing or not doing regarding [his/her] blood sugars. They also report that [Resident 1] is not communicating with staff when they speak to [him/her], especially about [his/her] blood sugars, and continues to accuse the staff of ignoring [him/her]. [Provider]

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management also reports that [Resident 1] "nit-picks" [his/her] peers and staff to try to upset them and get a reaction. CM updated member assessment and MCP. CM completed referral request for BHS (behavioral health services) assistance in creating a BSP for member. CM updated provider and GDN on request for BHS assistance."

"07/19/2024: BHS reviewed provider ISP. Current ISP does not include any information related to [Resident 1] behavioral health needs or interventions - BHS suggests that commonly observed behaviors and effective support strategies/interventions be documented within the provider ISP in lieu of a BSP. BHS offered to meet with IDT and provider or to draft something that could be transferred into [Resident 1] ISP related to [his/her] behavioral health needs."

"07/30/2024: IDT and BHS met for meeting with provider, however provider did not attend."

On 09/06/2024, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home, 01/19/2024, and was represented by Guardian E and managed care organization (MCO) Care Manager (CM) F.

Resident 1's ISP, dated 07/01/2024, documented:
"Eating: Independent."
"Meal Preparation: Staff to prepare nutritious meals and snacks per diabetic diet."
"Cognition: Staff to assist with simple decisions as needed."
"Nutrition: Staff to assist with choosing diabetic friendly foods and provides a diabetic diet for meals."

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M 424	Continued From page 6 "Behaviors and Mental Health: Offensive or Violent Behaviors to Others - None; Mental Health Needs - None; Behavioral Support Plan - None." The ISP was not signed by Guardian E or CM F. The ISP did not identify care guidelines regarding concerns the provider had reported to the MCO CM. On 09/08/2024 at 7:13 AM, Surveyor emailed House Manager B informing him/her that Resident 1's ISP did not identify guidelines regarding his/her behaviors. As of 09/09/2024 at 1:00 PM, Surveyor did not receive a response.	M 424		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 2 of 3 residents received prescribed medications in the proper dosage and administration times. Resident 1's prescribed epinephrine (epi-pen	M 462		

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[emergency allergy medication]) and Saxenda (weight loss medication) were not available for administration.
Resident 1 did not receive correct dosages of insulin.
Resident 2's Vitamin D and Oxybutynin were not available for administration.

Findings include:

Example 1: Resident 1 - Unavailable Medications

On 09/03/2024, at approximately 10:50 AM, Surveyor interviewed Resident 1. Resident 1 expressed concerns that s/he is allergic to peanut butter and another resident in the home had placed peanut butter on his/her bedroom doorknob. Resident 1 stated, "If I had not been careful, I could have gone into an allergic reaction, and my epi-pen is not available."

On 09/03/2024, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home 01/19/2024.

Resident 1's July, August, and September 2024 Medication Administration Record (MAR) documented:
"Epinephrine - use as directed as needed for allergic reaction (food allergy). Start Date: 01/19/2024."
"Allergies: Nut - Unspecified, tree and shrub pollen."

"Saxenda - Inject 0.6 MG (milligrams) Sub-Q (subcutaneous) daily for 1 week, then 1.2 MG daily for 1 week, then inject 1.8 MG daily.
The medication had not been documented as administered.

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M 462	Continued From page 8 On 09/03/2024, at approximately 11:30 AM, Surveyor observed Resident 1's medications. Resident 1's Epinephrine and Saxenda were not available. On 09/03/2024, at approximately 11:35 AM, Surveyor interviewed Co-Owner A, House Manager B, Assistant Business Administrator (ABA) C, and Caregiver D. House Manager B and ABA C stated that there were potential concerns with Resident 1's insurance and they would follow up on the prescribed medications. Example 2: Resident 1 - Doses of Insulin On 09/03/2024, Surveyor reviewed Resident 1's record. Resident 1 moved into the home, 01/19/2024, with diagnosis including diabetes. Resident 1's August 2024 MAR documented: "Novolog Flexpen 100 Unit/ML (milliliter) - Prime with 2 units. Inject 6 units with breakfast and dinner in addition to sliding scale: 70 - 149 = 0 units; 150 - 169 = 1 unit; 170 - 189 = 2 units; 190 - 209 = 3 units; 210-229 = 4 units; 230 - 249 = 5 units; 250 - 269 = 6 units; 270 - 289 = 7 units, 290 and above call MD (medical doctor)." 08/07 4:00 PM - 174 Blood Sugar (BS) - 7 units (should have been 8 total units) 08/10 4:00 PM - 150 BS - 6 units (should have been 7 total units) 08/12 4:00 PM - 202 BS - 7 units (should have been 9 total units) 08/18 4:00 PM - 235 BS - 8 units (should have been 11 total units) 08/26 4:00 PM - 150 BS - 6 units (should have been 7 total units)	M 462		

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M 462	Continued From page 9 08/29 4:00 PM - 239 BS - 8 units (should have been 11 total units) On 09/03/2024, at approximately 11:35 AM, Surveyor interviewed Co-Owner A, House Manager B, Assistant Business Administrator (ABA) C, and Caregiver D. Co-Owner A stated s/he has discussed proper medication administration and documentation with staff several times but s/he would re-educate again. Example 3: Resident 2 On 09/03/2024, Surveyor reviewed Resident 2's record. Resident 2 moved into the home 04/26/2024. Resident 2's August 2024 MAR documented: "Vitamin D - take 1 capsule by mouth weekly on Wednesday. Start Date: 04/25/2024." The medication was not documented as administered. "Oxybutynin - Take 2 tablets (10 MG) by mouth nightly at bedtime." The medication was not documented as administered. On 09/03/2024, at approximately 10:30 AM, Surveyor observed Resident 2's medications. Surveyor did not observe Resident 2's Vitamin D or Oxybutynin. On 09/03/2024, at approximately 11:35 AM, Surveyor interviewed Co-Owner A, House Manager B, Assistant Business Administrator (ABA) C, and Caregiver D. House Manager B and ABA C stated that there were potential concerns with Resident 2's insurance and they	M 462		

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M 462	Continued From page 10 would follow up on the prescribed medications.	M 462		
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 obtain a written order from the physician who prescribed medications for 1 of 1 resident (Resident 1). Findings include: On 09/03/2024, at approximately 10:50 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he took his/her own blood sugar (BS) levels. On 09/03/2024, at approximately 11:15 AM, Surveyor interviewed Caregiver D. Caregiver D stated staff wrote down the BS numbers that Resident 1 reported. Resident 1 moved into the home, 01/19/2024, with diagnosis including diabetes.	M 464		

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M 464	Continued From page 11 Resident 1's "Individual Support Plan," dated 07/01/2024, documented: "Medication Management: Requires physical assistance - [Provider] will manage all medications for [Resident 1] and following physician orders." "Diabetes: Staff will assist with glucometer, blood sugar checks, and insulin highs and lows." On 09/03/2024, at approximately 11:35 AM, Surveyor interviewed Co-Owner A, House Manager B, Assistant Business Administrator (ABA) C, and Caregiver D. House Manager B could not confirm if the provider had a written order for Resident 1 to self-administer his blood sugar levels.	M 464		