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 _____	R-C 02/05/2025

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 02/03/2025, Surveyor conducted a verification visit at Connie Home LLC 2. Additional information was received through 02/05/2025. Three (3) of 4 previous deficiencies were uncorrected. A total of 4 new deficiencies were identified. Census: 3 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{M 000}		
{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. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure Resident 3's individual service plan was reviewed and revised	{M 424}		

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

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{M 424}	Continued From page 1 to identify needs and services related to extended absences from the home, risk of abusive behavior towards residents and maintaining a clean/safe bedroom. This is a repeat deficiency, See Statement of Deficiency #1HC211, dated 09/09/2024. Findings include: On 02/03/2025 at 12:24 PM, Surveyor observed Resident 3's bedroom while accompanied by House Manager B. Surveyor observed the room was in disarray. The bed, desk, chair and most of the floor were overflowing with clothing, shoes, laundry baskets and other items. The walk in closet was so full it could not be entered. The only clear area of the floor was from the door to the foot of the bed, and that section of the carpeting was in need of vacuuming. Manager B confirmed Surveyor's observations and said Resident 3 "is a hoarder." At 12:27 PM, Surveyor interviewed Caregiver D and asked what assistance s/he provides to Resident 3 to keep his/her room clean. S/he replied, "Take a peek if [s/he] needs help. Make sure everything is off the floor. They're pretty independent here...I remind [him/her]... says [s/he] will take care of it [him/herself.]" Caregiver D stated Resident 3 was not home and s/he routinely leaves to spend time at the library and other community locations that provide services to homeless people. Caregiver D said Resident 3 normally returns around lunch to take medications then leaves again. S/he added, "Normally I tell [him/her] to try to be back by dinner or if [s/he] is not [s/he] will call and let us know." Caregiver D said there had been no concerns with that system. Surveyor observed	{M 424}		

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{M 424}	Continued From page 2 Resident 3 was not present for the lunch meal and as of 2:00 PM had not returned to the home. Surveyor reviewed portions of Resident 3's records on 02/03/2025 at 3:30 PM and noted the following. Observation notes 01/01/2025 - 02/03/2025: 01/01 - "finally came home this morning around 930am. Said [s/he] had spent a few days at a friend's house. Managers spoke with [Resident 3] about notifying someone before spending the night elsewhere." 01/06 - "came home for breakfast and left out again for an appointment around 930am...called in the afternoon to say...wouldn't be home until late." 01/07 - "When staff arrived (01/06 night shift) [Resident 3] wasn't here...never came in." 01/07 - "came home this morning around 830am to take [his/her] meds. Staff talked with [him/her] about getting permission to stay the night out and [s/he] said [s/he] would be better about calling...did leave back out around noon...hasn't been back since...did call and say [s/he] would come home around 8-830pm." 01/08 - "When staff arrived (01/07 night shift) [Resident 3] wasn't here [Resident 3] never came in." 01/08 - "...[Resident 3]...called to say [s/he] will be here about 8:30 (pm) [Resident 3] never came in." 01/09 - "OPD (Oshkosh Police Department) came looking for [Resident 3] the officer said [his/her] [family] was looking for [Resident 3], I informed the officer that [Resident 3] did called twice on yesterday [s/he] said if [s/he] shows for staff to contact OPD. 1215pm [Resident 3] returned back and the officer also talked with [him/her], [Resident 3] said [s/he] will be back	{M 424}		

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{M 424}	Continued From page 3	{M 424}		

tonight."
01/21 - "has been gone all day today and has not called the house at all either. Whenever [s/he] returns this evening thee [sic] is dinner ready for [him/her] in the refrigerator...came in about 10ish [s/he] ate [his/her] dinner went to [his/her] room for the rest of the night"
01/27 - "...came in around 7 30pm (night before, 01/26) and when came in [s/he] was drunk barely able to stand up crying to staff...was able to calm [him/her] down [s/he] ate [his/her] dinner and went to [his/her] room for the rest of the night"
01/30 - "ate breakfast and took [his/her] meds in the morning. [s/he] left...at around 930am and said [s/he] would be back later tonight...[s/he] came in about 2am [s/he] was so drunk [s/he] was barely was able to walk up the stairs [s/he] went right to sleep"

Individual Service Plan (ISP) - signed/dated 12/13/2024 (date of admission):
"Elopement Risk...has a history of elopement...is able to come and go as [s/he] pleases but at times [s/he] will stay out all night and not return home until the next morning...will stay out with the homeless population as these are the people [s/he] chooses to associate with. Provide supervision and redirection to avoid and prevent elopement. Provide checks throughout day/night and document whereabouts. If elopement occurs, following proper elopement procedures."
(Surveyor note: no procedure was identified)
"Leisure Time...Independent...prefers to spend [his/her] time out of the house at parks and salvation army. When [s/he] is out of the house [s/he] admits to drinking alcohol to the point of getting drunk and then will not return to the house." (Surveyor note: no intervention was identified)
"Housekeeping - ...is able to clean on [his/her]

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{M 424}	Continued From page 4	{M 424}		

own but needs assistance and reminders to do this task daily to ensure [s/he] has a room that is safe and clean...does have hording tenancies and will bring home broken items [s/he] has found while out in the community...Provide assistance with...all room care needs." (Surveyor note: type of assistance was not identified)
"Aggressive/Combative (and) Destructive/Abusive - ...has a tendency to get aggressive when [s/he] drinks alcohol, mainly towards the people [s/he] hangs around with in the park...prefers to hang out with the homeless population which [s/he] has had quite a few physical and verbal altercations with where the police have been contacted...has a hard time with anyone telling [him/her] what to do...leaves the group home and will be gone for days...will ask people for money...likes to go to stores and get things [s/he] does not need...at times can get aggressive when [s/he] does not get [his/her] way or when staff asks [him/her] to do a task [s/he] does not wish to do...Provide supervision and monitoring to help manage/redirect aggressive or combative behavior..."

Surveyor interviewed Guardian G on 02/04/2025 at 3:22 PM. S/he confirmed Resident 3's tendency to leave the home without communicating his/her whereabouts or anticipated return. Guardian G said Resident 3 is independent in many ways but makes risky decisions while in the community. Guardian G further explained Resident 3 collects more personal items than s/he needs or can store creating an environment in his/her bedroom with the potential for health and safety concerns. Guardian G also stated Resident 3 was recently moved to this home from a different home run by the same provider, after an allegation s/he sexually assaulted a resident at the other home.

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{M 424}	Continued From page 5 Guardian G said the provider could make improvements with identifying and implementing plans to maintain his/her room, respond to absences and ensure s/he is not engaging in abusive behavior towards other residents. Surveyor interviewed Assistant Business Manager C on 02/05/2025 at 9:35 AM. S/he verified the sexual abuse concerns, the condition of Resident 3's room and the risks associated with extended absences. Assistant Business Manager C agreed the ISP did not identify the needs or specific services related to the areas of concern and stated s/he would work with the guardian and care team to develop plans and update the ISP accordingly.	{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 record review and interview, the provider did not ensure Resident 1 received assistance to take all medications in the correct dosages and the correct times and did not ensure effective communication with his/her physician.	{M 462}		

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{M 462}	Continued From page 6 This is a repeat deficiency, See Statement of Deficiency #1HC211, dated 09/09/2024. Findings include: Surveyor reviewed portions of Resident 1's facility file on 02/03/2025 and 02/04/2025 to include the current individual service plan (ISP) signed 12/13/2024 and the January 2025 medication administration record (MAR). Resident 1 was admitted on 01/19/2024 and had a legal guardian. The ISP documented Resident 1's need for staff assistance with medication administration and management (with the exception of self-administered blood sugar checks and insulin injections.) The MAR documented a prescription for Advair 250/50 inhaler; "1 puff by mouth twice daily for moderate asthma." The MAR documented it was only administered 4 out of 62 doses. Reasons for not administering the medications were documented 56 times: 14 times - refused 42 times - reasons included; doesn't need, not needed, doesn't take, as needed, not needed today, not available and doesn't take this medication According to the manufacturer, "ADVAIR DISKUS 250/50 is a twice-daily prescription medicine used long term to treat chronic obstructive pulmonary disease (COPD), including chronic bronchitis, emphysema, or both, for better breathing and fewer flare-ups...ADVAIR is not used to relieve sudden breathing problems from asthma or COPD and won't replace a rescue inhaler." Source: https://www.advair.com, retrieval date 2/12/2025	{M 462}		

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{M 462}	Continued From page 7 The MAR documented prescriptions for vitamin D3 50 mcg tab twice daily for vitamin D deficiency and vitamin C 500 mg tab once daily. 01/20 - 01/31 vitamin C was not administered 12 of 12 days with reasons to include "not available" and "out of stock" 01/21 - 01/31 vitamin D3 was not administered 8 of 11 days with reasons to include "not available" and "out of stock" Surveyor interviewed Caregiver D on 02/04/2025 15 10:38 AM. Caregiver D confirmed Resident 1 has prescribed Advair and it is available in the medication cart. Surveyor asked why it was only administered 4 times in January and Caregiver D replied, "[S/he] almost never uses it. It's like an as needed thing but the MAR still prompts us every morning." When asked about the vitamins Caregiver D said, "[Resident 1] hasn't been taking those...for a couple weeks...[House Manager B] said they had a problem getting it covered with insurance. I've been writing 'not available.'" Surveyor interviewed Pharmacist H on 02/04/2025 at 12:59 PM. S/he stated: Resident 1 has a current prescription for Advair scheduled twice daily. The medication is automatically refilled each month and the provider needs to request the refill when they need it. The last time the medication was filled was 06/14/2024. Resident 1 has current prescriptions for vitamins C and D3. On 12/19/2024 a 28 day supply of vitamin D3 was delivered and on 12/30/2024 a 22 day supply of vitamin C was delivered. The provider was informed of issues with insurance refill for the vitamins in December 2024 and again in January 2025.	{M 462}		

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{M 462}	Continued From page 8 On 02/04/2024, Surveyor sent an email to Assistant Business Administrator D and requested information about the 3 aforementioned prescriptions. Assistant Business Administrator D replied, "House Manager B called to address the Advair because [Resident 1] declines using it. We are requesting that it be used as a PRN (as needed) instead of a scheduled medication...Here is the request from pharmacy to MCO (managed care organization) for vitamins..." Attached to the email was correspondence dated 01/22/2025 addressed to the provider from the pharmacy. It read in part, "The patient listed above is enrolled with a Managed Care Organization (MCO), [the pharmacy] is providing a LIMITED supply of the OTC (over the counter) items listed below (Vitamin C & Vitamin D3) to allow time for the MCO to make a coverage determination. Any items NOT authorized by the MCO will be charged to the patient's account...This form is being faxed to the MCO as well as to the facility, As soon as a determination for coverage is received, pharmacy will continue to dispense the item(s)..." 02/04/2024 at 2:20 PM, Surveyor conducted an interview with Assistant Business Administrator D: S/he verified Surveyor's review of the record and acknowledged recent awareness of systems issues with medication administration and documentation. As a result of the concerns, two weeks ago management staff (including Assistant Business Administrator D) started daily monitoring of the MARs for all residents. During the daily monitoring they noticed Advair was not being administered twice daily, however	{M 462}		

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{M 462}	Continued From page 9 no steps were taken until 01/31/2025 after a meeting with the MCO. On that date, the provider contacted the physician to report Resident 1 was refusing the medication and to request it be changed to PRN instead of scheduled. Assistant Business Administrator D said they had not yet heard back from the physician. Surveyor reviewed with Assistant Business Administrator D the routine entries documenting reasons other than refusals, the interview with Caregiver D who said s/he thought it was a PRN medication and that the medication had not been refilled since June 2024. Surveyor also noted Advair is not typically prescribed PRN, according to the manufacturer. Assistant Business Administrator D said s/he would look into the issue and ensure the physician received accurate information to inform any potential changes to the medication. Surveyor asked about the availability of Resident 1's prescribed vitamins. Assistant Business Administrator D said the only documentation regarding this was the correspondence from the pharmacy to the provider informing them of the billing concern. Assistant Business Administrator D said s/he would check with House Manager B to see if s/he had taken any steps with the MCO or the pharmacy to try to resolve the issue, and if so would provide the information to Surveyor by the end of the day. No additional information was received.	{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	{M 464}		

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{M 464}	Continued From page 10 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 observation and interview, the provider did not obtain written orders from the physician for Resident 1's prescribed medications, specifying who by name or position is permitted to administer medications and in what dosages. This is a repeat deficiency. See Statement of Deficiency #1HC211, dated 09/09/2024. Findings include: On 02/03/2025, Surveyor reviewed Resident 1's current individual service plan (ISP), signed and dated 12/13/2024. The ISP indicated Resident 1 needed staff assistance with medication administration, except for insulin which s/he could do independently. Surveyor reviewed Resident 1's January 2025 medication administration record (MAR) and noted staff charted administration of 6 scheduled medications and 3 vitamins. Resident 1's record did not contain physician's orders for the medications including the dosages or to permit the provider to administer the medications. On 02/04/2025 at 12:45 PM, Surveyor conducted an interview with Assistant Business Administrator C. S/he said the provider did not maintain physician's orders for medications or	{M 464}		

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{M 464}	Continued From page 11 orders to permit the provider to administer medications. Assistant Business Administrator C said their process for all residents is to rely on the pharmacy to enter medications and dosages into the electronic MAR. Assistant Business Administrator C said s/he was previously unaware of the requirement to have physician's orders for medications, including orders to permit the provider to administer medications.	{M 464}		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure caregivers accurately document administration of Resident 1's sliding scale insulin. At times, caregivers documented administration of the medication when it was not given. When caregivers did administer the medication, they did not document the number of units that were given. Findings include: On 02/03/2025 at 1:21 PM, Surveyor interviewed Resident 1. S/he told Surveyor receives insulin on	M 466		

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M 466	Continued From page 12	M 466		

a sliding scale, and explained the amount s/he gets depends on his/her blood sugar levels. Surveyor observed Resident 1's medications were controlled by the provider and kept in a secured location with only staff having access to them. Surveyor also observed charting of medication administration was completed by caregivers in an electronic medication administration record (MAR.)

Surveyor reviewed portions of Resident 1's facility file on 02/03/2025 and 02/04/2025. Resident 1's current individual service plan read in part, "...is diabetic and follows sliding scale insulin. See MAR's and follow MD orders appropriately."

The January 2025 MAR included scheduled insulin and sliding scale insulin. The sliding scale insulin was prescribed as follows:
Novolog flexpen - sliding scale 1 unit per 75 over 150
Scheduled on the MAR at 8:00 AM, 12:00 PM and 4:00 PM daily

The MAR also documented daily blood sugar values. Thirteen (13) times the values were greater than 225 mg/dl and warranted additional insulin in accordance with the sliding scale:
01/03 - 269 mg/dl and 239 mg/dl
01/05 - 253 mg/dl
01/07 - 248 mg/dl and 291 mg/dl
01/07 - 330 mg/dl and 246 mg/dl
01/14 - 245 mg/dl
01/23 - 261 mg/dl
01/25 - 241 mg/dl
01/28 - 260 mg/dl
01/29 - 265 mg/dl
01/31 - 230 mg/dl

Surveyor noted almost every day, 3 times a day

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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 466	Continued From page 13 (90 out of 93 times), caregivers documented initials/times on the MAR indicating the sliding scale insulin was administered. This included dates when the blood sugar values were less than 225 mg/dl as well as the aforementioned times when it was over 225 mg/dl. The MAR did not document how many units of insulin were administered for any of the entries. On 02/04/2025 at 10:38 AM, Surveyor interviewed Caregiver D. S/he confirmed Resident 1 is prescribed insulin based on a sliding scale. Caregiver D said there were times during January when s/he administered an extra unit of insulin based on values over 225 mg/dl. S/he also said there is no mechanism in the electronic MAR, or anywhere else, to document how many units were administered. Caregiver D explained the prompt for the sliding scale insulin comes up 3 times daily in the electronic MAR, and s/he always clicks the prompt even if the additional insulin was not administered. On 02/04/2025 at 2:20 PM, Surveyor interviewed Assistant Business Administrator C. S/he confirmed Surveyors review of the MAR and acknowledged caregivers were not accurately documenting when they were administering the sliding scale insulin or how much additional insulin was given.	M 466		