STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 09/09/2025, with information gathered through 10/06/2025, Surveyor conducted a complaint investigation at Midwest Adult Family Home. Six deficiencies were identified. Complaint was substantiated. Census: 2	M 000		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review and interview, Licensee A did not ensure that the home and its operation complied with all laws governing the home and its operation. Findings include: The provider was licensed, 04/01/2017, to provide cares for up to 4 residents in the client groups developmentally disabled, physically disabled, advanced aged, and emotionally disturbed/mental illness. From 04/03/2024 to 10/06/2025, Licensee A has received 31 deficiencies: SOD 503311, dated 10/06/2025 On 09/09/2025, with information gathered through 10/06/2025, Surveyor conducted a complaint investigation. As a result of the survey, 6 deficiencies, including this one, were identified:	M 216		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 216	Continued From page 1 M0216 88.04(2)(a) Responsibilities M0230 88.04(2)(f) Condition Which Represents Risk or Harm M0400 88.06(2)(c)7. Conditions of Transfer or Discharge M0448 88.07(2)(b)5. Monitoring Health N0556 88.10(3)(e) Self-Direction M0580 88.10(3)(p) Prompt and Adequate Treatment SOD I0YO13, dated 12/04/2024 From 12/03/2024 to 12/04/2024, Surveyor conducted a verification visit at Midwest Adult Family Home. Five deficiencies were identified. M0346 88.05(4)(d)2.b. Fire Evacuation Annual Evaluation M0380 88.06(2)(a) Admission - Health Exam M0384 88.06(2)(b) Service Agreement Except Respite M0464 88.07(3)(d) Medication - Written Order M0574 88.10(3)(n)1. Freedom From Seclusion and Restraints SOD I0YO12, dated 09/03/2024 On 09/03/2024, Surveyor conducted verification visits at Midwest Adult Family Home. Six deficiencies were identified. M0114 88.03(3)(b) Criminal Records Check M0246 88.04(5)(b) Training - 8 Hours Annually M0346 88.05(4)(d)2.b. Fire Evacuation Annual Evaluation M0420 88.06(3)(d)5. Signed Statement of Agreement M0510 88.09(1)(d)11. Resident Funds Z0012 50.065(2)(bm) Out of State Background Checks SOD 9G4G11, dated 08/08/2024 On 08/08/2024, Surveyor attempted to conduct a verification visit at Midwest Adult Family Home.	M 216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 216	Continued From page 2 Three deficiencies were identified. M0204 88.03(8)(a) Monitoring of Home M0230 88.04(2)(f) Condition Which Represents Risk or Harm M0458 88.07(3)(a) Prescription Medications SOD I0YO11, dated 04/04/2024 From 04/03/2024 to 04/04/2024, Surveyor conducted a standard survey at Midwest Adult Family Home. Eleven deficiencies were identified. M0114 88.03(3)(b) Criminal Records Check M0244 88.04(5)(a) Training - 15 Hours Within 6 Months M0246 88.04(5)(b) Training - 8 Hours Annually M0278 88.05(3)(b) Free of Hazards M0346 88.05(4)(d)2.b. Fire Evacuation Annual Evaluation M0420 88.06(3)(d)5. Signed Statement of Agreement M0448 88.07(2)(b)5. Monitoring Health M0458 88.07(3)(a) Prescription Medications M0466 88.07(3)(e)1. Medication - Record Keeping M0510 88.09(1)(d)11. Resident Funds M0582 88.10(3)(q) Medications On 10/06/2025 at 12:30 PM, Surveyor interviewed Licensee A. Licensee A stated s/he will focus on making corrections to his/her processes.	M 216		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a	M 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 230	Continued From page 3	M 230		

resident at substantial risk of harm.

This Rule is not met as evidenced by:
Based on interview and record review, the provider permitted an existence and continuation of a condition in the home which placed the health, safety, and welfare for residents at substantial risk of harm.

This is a repeat deficiency. See Statement of Deficiency (SOD) 9G4G11, dated 08/08/2024.

Resident 1 required dedicated staffing (1:1) which was not provided.
The provider's home was independently staffed by Caregiver D, who did not have access to resident records.

Findings include:

The provider was licensed, 04/01/2017, to provide cares for up to 4 residents in the client groups developmentally disabled, physically disabled, advanced aged, and emotionally disturbed/mental illness.

On 09/09/2025, at approximately 2:10 PM, Surveyor arrived at the home to conduct a complaint investigation. Caregiver D was the only staff member present. Licensee A was not present in the home.

Example 1: Resident 1

On 09/09/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home, 04/21/2017, with diagnoses including spastic quadriparesis,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 230	Continued From page 4	M 230		

scoliosis, cerebral palsy, epilepsy, dysphagia, and gastrointestinal tube present.

Resident 1's record contained an email, dated 07/02/2025, from Licensee A to Resident 1's managed care organization (MCO) Care Manager (CM) C, along with other MCO representatives which documented:
"The Dedicated Staffing issues is just one part of a complex scenario of [Resident 1's] daily cares. ... Yes, [Resident 1] has extreme anxiety, but [s/he] does not hit or throw objects at staff (unable to do so) that may warrant a close proximity watch at all times. [S/he] has [his/her] rights to privacy also. Again, I have been providing specialized and necessary daily 1:1 care ..."

On 09/09/2025, at approximately 2:15 PM, Surveyor interviewed Caregiver E. Surveyor asked if s/he had provided cares to Resident 1. Caregiver E stated s/he had been with the provider for awhile and had provided cares for Resident 1, but s/he was not Caregiver E's dedicated staff. Caregiver E explained that if Resident 1 could not see a staff member, s/he would immediately start to scream.

On 09/16/2025, at approximately 8:45 AM, Surveyor interviewed MCO CM C. Surveyor asked for clarification on Resident 1's requirement of 1:1 (one-to-one) dedicated staffing. CM C explained that the MCO had determined that Licensee A was not providing 1:1 dedicated staffing for Resident 1, meaning Resident 1 has his/her own staff member 24/7 (24 hours a day/7 days a week). Licensee A had informed CM C that s/he did not have the staff to provide that kind of supervision and Resident 1 did not need someone watching him/her sleep.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 230	Continued From page 5	M 230		

CM C stated that the level of care that was being paid for was not provided, so the reimbursement rate was lowered. Licensee A then issued a 30-day notice to Resident 1.

On 09/16/2025, at approximately 4:00 PM, Surveyor interviewed Licensee A. Surveyor asked for clarification regarding staffing levels provided to Resident 1. Licensee A stated Resident 1 lived in his/her home for 8 years and s/he was provided the best of care. Licensee A explained that s/he is a registered nurse and understands the cares Resident 1 requires. Surveyor asked for clarification regarding CM C's observation when s/he was in the home, there was only one staff member present for 2 residents. Licensee A stated CM C was not observant, that s/he had been in the home, but at that moment s/he was not next to Resident 1.

On 09/16/2025, Surveyor reviewed Resident 1's record.

Resident 1's "Behavior Support Plan (BSP)," dated 03/03/2025, unsigned, documented:
"Home Environment - 24/7, Awake Staff, Staffing Ratio (1 to 1 and with two staff when available), Line of sight at all times"
"Staffing Supervision - [Fe/male] staff, 1 to 1 and with two staff when available"

Resident 1's "Individual Service Plan (ISP)," dated 04/31/2025, documented:
"Lives in a State Licensed Adult Family Home with 2 other [residents]. Supervision of at least one staff working 24 hour/day, 7 days per week to assist with all resident ADLS (activities of daily living)."

The BSP and the ISP did not correlate the staffing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 230	Continued From page 6	M 230		

ratio requirement.

On 10/05/2025, Surveyor reviewed Resident 1's MCO documentation that was provided by his/her MCO provider, which documented:
05/27/2025 - AFH (adult family home) is being paid for DS (dedicated staffing), Care team did an unannounced visit, and member was not receiving DS at any time during the duration of visit. Provider opened the door to IDT (interdisciplinary team), leaving member unattended in the kitchen. CM/RN (registered nurse) entered AFH, and member was in the kitchen with another resident and one staff member who turned his/her back to member in order to feed the other resident.

On 10/05/2025, Surveyor reviewed the provider's May 2025 staff schedule, which documented:
05/27 - 12:00 AM - 9:00 AM, 9:00 AM - 1:00 PM, 1:00 PM - 8:00 PM, 8:00 PM - 12:00 AM
Documented that 2 staff members were scheduled for each shift, but based on MCO observation and documentation, the staffing level was not provided.

On 10/06/2025 at 12:30 PM, Surveyor interviewed Licensee A. Licensee A stated s/he is always in the home and stated the MCO is now deciding to enforce this rule. Licensee A stated, "The MCO have never observed [Resident 1's] cares, how my staff perform [Resident 1's] cares. [S/he] has only been to the hospital 2 times in the eight years [s/he] has lived in this home. There were always 2 staff available in the home because I live in the home."

Example 2: Resident Records

On 09/09/2025, Surveyor requested resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 230	Continued From page 7	M 230		

records from Caregiver D. Caregiver D stated s/he was unable to provide Surveyor with any resident records, including full names, and stated all records were kept locked downstairs. Surveyor asked Caregiver D to contact Licensee A or another staff member who could provide assistance. Caregiver D contacted Licensee A via telephone. Surveyor spoke with Licensee A who stated s/he would contact Manager B.

On 09/09/2025, at approximately 2:25 PM, Manager B arrived at the home and explained that all the records were locked downstairs, and staff did not have access to them. Surveyor requested resident records and Manager B stated s/he would attempt to locate the documents. Surveyor asked for clarification as to why staff did not have access to basic resident information. Manager B stated the records have always been locked in the office, downstairs.

On 09/16/2025, at approximately 2:30 PM, Surveyor arrived at the home to follow up on the complaint investigation. Caregiver D was the only caregiver present. Surveyor requested resident records from Caregiver D. Caregiver D stated s/he was unable to provide Surveyor with any resident records, including full names, and stated all records were kept locked downstairs. Surveyor asked Caregiver D to contact Licensee A or another staff member who could provide assistance. Caregiver D contacted Licensee A via telephone who stated s/he would return to the home in approximately 1 hour, s/he was currently at a medical appointment for him/herself and unavailable. Surveyor expressed concern that Caregiver D did not have access to resident records, including their full names. Licensee A confirmed all resident records were kept locked downstairs and did not believe records needed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 230	Continued From page 8 be available to Caregiver D. Surveyor shared concern that Caregiver D would not be able to provide resident information in the event of an emergency. Licensee A did not respond to Surveyor's concern. Caregiver D was responsible for the care of 2 residents at the home, but did not have access to resident information, including their full names, diagnoses or care needs. Licensee A was outside the home and unavailable from at least 2:30 PM to 3:30 PM. On 10/06/2025 at 12:30 PM, Surveyor interviewed Licensee A. Surveyor asked for clarification as to why staff do not have access to the resident records. Licensee A stated that staff members cannot always be trusted with the resident records. Licensee A stated, "The records are not locked up, they are just downstairs in a secure area." Licensee A stated, "I can move the records upstairs, to a location where they can be locked, and the key can be placed somewhere that I can ensure the records are safe." Cross Reference: M0400 88.06(2)(c)7. Conditions of Transfer or Discharge	M 230		
M 400	88.06(2)(c)7 CONDITIONS OF TRANSFER OR DISCHARGE Conditions for transfer or discharge and the assistance a licensee will provide in relocating a resident. This Rule is not met as evidenced by:	M 400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 400	Continued From page 9	M 400		

Based on record review and interview, information in the service agreement concerning conditions for transfer or discharge of a resident did not specify the assistance a licensee will provide in relocating 1 of 1 resident reviewed.

A 30-day written notice of involuntary discharge was issued to Resident 1, dated 07/31/2025. The written service agreement did not specify the assistance the licensee would provide in relocating Resident 1.

Findings include:

On 09/09/2025, at approximately 2:10 PM, Surveyor arrived at the home and was informed by Caregiver E that Resident 1 no longer resided in the home.

On 09/09/2025, at approximately 2:45 PM, Surveyor interviewed Manager B. Surveyor asked for clarification as to why Resident 1 no longer resided in the home. Manager B stated s/he had been given a 30-day notice. Manager B explained there had been concerns regarding the level of care Resident 1 required.

On 09/09/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home, 04/21/2017, with diagnoses including spastic quadriparesis, scoliosis, cerebral palsy, epilepsy, dysphagia, and gastrointestinal tube present.

Resident 1's record contained an email, dated 07/02/2025, from Licensee A to Resident 1's managed care organization (MCO) Care Manager (CM) C, along with other MCO representatives, which documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 400	Continued From page 10	M 400		

"I am writing in response to the reduction in rate for [Resident 1] effective 06/20/2025. The decision to remove Dedicated Staffing for [Resident 1] jeopardizes [his/her] health and safety, as providing the level of care that [s/he] requires is not possible without 1:1 care and specialized training. ... The Dedicated Staffing issues is just one part of a complex scenario of [Resident 1's] daily cares. ... Yes, [Resident 1] has extreme anxiety, but [s/he] does not hit or throw objects at staff (unable to do so) that may warrant a close proximity watch at all times. [S/he] has [his/her] rights to privacy also. Again, I have been providing specialized and necessary daily 1:1 care ...

On 09/16/2025, at approximately 8:45 AM, Surveyor interviewed Resident 1's MCO CM C. Surveyor asked for clarification regarding Resident 1's 30-day notice. CM C explained that the MCO had determined that Licensee A was not providing 1:1 (one-to-one) dedicated staffing for Resident 1. Licensee A stated s/he did not have the staff to provide that kind of supervision and Resident 1 did not need someone watching him/her sleep. CM C stated that the level of care that was being paid for was not provided, so the reimbursement rate was lowered. Licensee A then issued a 30-day notice and was adamant that Resident 1 had to be out by 08/31/2025. Licensee A stated, "[Licensee A] would call us, threatening us, that [Resident 1] HAD to be out by 08/31/2025. It came to the point, all staff at the [MCO] were attempting to find an emergency placement, as we feared for [Resident 1's] well-being." CM C stated Licensee A did not assist Guardian D or his/her care team in any way with finding new placement for Resident 1.

On 09/16/2025, Surveyor reviewed Resident 1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 400	Continued From page 11	M 400		

30-day notice that Manager B had forwarded, which documented:
"I am writing to formally give my 30-day notice, starting August 1st, 2025, and ending August 31st, 2025, regarding the care of [Resident 1]. Our home has provided Dedicated Care to [him/her] for over eight years. However, I now feel that I am continually being asked to justify the quality of care that has been consistently provided by myself and my team. The revised reduced rate is inadequate to fully care for [Resident 1] due to inflation, staff hire and maintaining the home to support [Resident 1's] care, etc."

The 30-day notice did not specify the assistance the licensee would provide in relocating Resident 1 due to an unvoluntary discharge.

On 09/16/2025, Surveyor reviewed Resident 1's service agreement, provided by Licensee A, which documented:

Resident 1's service agreement, dated 04/21/2017, unsigned, documented:
"Conditions for the transfer or discharge and termination of payment: If a resident needs to be transferred or relocated to Adult Family Home, arrangements for the residents to move will be made with their family, guardian, or social worker."

On 09/29/2025, at approximately 1:00 PM, Surveyor interviewed Resident 1's Guardian D. Surveyor asked for clarification on Resident 1's 30-day notice. Guardian D explained that the MCO had found out that Licensee A was not ensuring Resident 1 received the level of care that Licensee A was being reimbursed for. Licensee A's reimbursement rate was reduced,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 400	Continued From page 12	M 400		

and Resident 1 was then given a 30-day notice. Guardian D stated, "It was so stressful. [Licensee A] would call and tell me I had better have [Resident 1] out of the home by 08/31/2025. CM C and I would express to each other our concerns regarding Licensee A and how his/her anger would be portrayed on [Resident 1]." Guardian D stated Licensee A did not assist him/her with finding placement for Resident 1.

On 10/06/2025 at 8:55 AM. Surveyor interviewed Resident 1's MCO RN (registered nurse) G. Surveyor asked for clarification if there were concerns with Resident 1's discharge plan from Midwest Adult Family Home. RN G stated Licensee A was not cooperative with ensuring a safe discharge plan for Resident 2. Licensee A had misused Medicaid funds and was upset that Resident 1's rate had been decreased, due to the misuse of funds. RN G explained that Resident 1 required a high level of complex care, and we wanted to ensure the new provider was trained on his/her cares (baclofen pump, g-tube feeding, cecostomy (bowel movement system). Licensee A, who was a RN and had been providing the cares, was asked to train the staff at the new provider home and s/he was not flexible with his/her schedule. RN G stated, "[Licensee A] made sure everyone involved understood that [Resident 1] must be out of [his/her] home by 08/31/2025 but did not make it easy to ensure [Resident 1's] cares were going to be met."

On 10/06/2025 at 12:30 PM, Surveyor interviewed Licensee A. Surveyor discussed the requirements by the provider when they issue a 30-day notice. Licensee A stated, "I was stressed that I would not be able to provide cares for [Resident 1] in a safe manner, due to [his/her] funding being cut. I was never asked to provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 400	Continued From page 13 training to any other staff members, I ensured my staff were trained properly, very well. Then, [Guardian D] took [Resident 1] out a week before [his/her] contract ended. It is not right that the MCO and Guardian D are allowed to make these type of accusations against me."	M 400		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 1 resident was monitored, and observed changes in his/her health were documented. Resident 1 was diagnosed with an ear infection and possible ear drum rupture and the provider did not document this change of condition in his/her record. Resident 1 was diagnosed with sepsis/cellulitis on 04/20/2025 and 08/05/2025, which required hospitalization, and his/her change of condition was not documented in his/her record. Findings include: On 08/28/2025, the Department received a concern that resident medical concerns were not properly assessed, documented and treated. Example 1: Ear Infection	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 448	Continued From page 14	M 448		

On 09/09/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home, 04/21/2017, with diagnoses including spastic quadriparesis, scoliosis, cerebral palsy, epilepsy, dysphagia, and gastrointestinal tube present. Resident 1 was represented by Guardian D and managed care organization (MCO) Care Manager (CM) C.

On 09/09/2025, at approximately 2:45 PM, Surveyor interviewed Manager B. Surveyor reviewed Resident 1's July 2025 MAR with Manager B and asked why Resident 1 had been prescribed an antibiotic on 07/06/2025. Manager B stated s/he would need to review his/her documentation, but believed it was for an ear infection. Surveyor requested Resident 1's documentation where his/her signs and symptoms of a potential ear infection would be documented.

Resident 1's "Individual Service Plan," dated 04/31/2025, unsigned, documented:
"Unable to verbally express pain to staff. [S/he] may use nonverbal indicates such as moans, groans, cries, screams, or touching the affected area. Staff to use PRN (as needed) pain reliever as treatment. See MAR (Medication Administration Record)."
"Had a large wax in [his/her] R (right) ear resulting in an ear infection. [S/he] was taken to [urgent care] on 07/06/2025. The infection was treated with a 7-day antibiotic. Cefdinir 250 MG (milligram) suspension for 7 days and liquid Ibuprofen as needed for discomfort."

On 09/09/2025, at approximately 3:00 PM, Manager B provided Surveyor with Resident 1's daily note, which documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 448	Continued From page 15	M 448		

07/05/2025 - Skin Condition: Skin looked Good; Mood: Scream
Manager B stated s/he was unable to locate any other daily notes covering 07/01/2025 to 07/06/2025. Surveyor asked if s/he had any documentation showing that the provider notified Resident 1's care team when s/he showed signs and symptoms of an ear infection.

On 09/10/2025 at 10:20 AM, Manager B emailed Surveyor with an email that Licensee A had sent to Guardian D, CM C and MCO Registered Nurse (RN) G on 07/06/2025 at 8:55 PM. The email stated:
"[Resident 1] was picked up by [Guardian D] at 11 AM today 07/06/2025 for a family outing. On Friday 06/04 [sic: 07/04/2025] at 11 PM, night shift staff informed me that something like a very tiny object was seen in the inner canal of [Resident 1's] right ear, when they were performing [his/her] night routine care. I immediately checked on [Resident 1] and noted a wax-like blob in [his/her] right ear. I had Earvana Wax-R in [his/her] med cabinet (removes ear wax). I applied as instructed in [his/her] R (right) ear and drained it. A small blob of wax fell out of R ear with a slight bleed. Outer ear was cleaned with a Q-tip, a clean cotton ball applied at the tip of [his/her] ear canal to absorb any extra drainage. No bleeding through the night and no object was pushed down [his/her] ear canal. No fevers except for slight discomfort. Liquid Tylenol was given every 4 hrs (hours) for discomfort. I called [medical facility] On Call Physician, [Doctor I] to report the incident. [Resident 1] has a Hx (history) of ear infection and explained what happened to [Resident 1] on Friday night. [Doctor I] informed me that the clinic was closed, and if it is a problem with ear wax, then [s/he] may not have an ear infection, even though I reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 448	Continued From page 16	M 448		

[s/he] had a slight bleed. [Doctor I] suggested monitoring [Resident 1] for fevers and discomfort and administer PRN (as needed) Tylenol. If no improvement to call [Resident 1's] Primary [doctor name] to inform [him/her] on Monday 07/07/2025. I called [Resident 1's] [Guardian D] and informed [him/her] after getting off the phone with the on call physician on Saturday morning 07/07 [sic: 07/05]. [Resident 1's] parents had a previous plan of picking [him/her] up for a family outing on Sunday 07/06 for and suggested they would check on [him/her] when [s/he] picks [him/her] up. Parents took [Resident 1] to the [urgent care] today during their outing trip to be checked. [Guardian D] called and reported that [Resident 1] had a R (right) ear infection (Non recurrent acute suppurative otitis media of R ear with spontaneous rupture of tympanic membrane) Urgent Care MD (medical doctor) diagnosis. Cefdinir (antibiotic) 250 mg (milligram) suspension (liquid antibiotic) was prescribed for 7 days. Ibuprofen suspension as PRN for pain and discomfort. [Resident 1's] parents dropped [him/her] off at about 7 PM with medication instructions reviewed with [Guardian D]. I verbalized my appreciation for them taking [him/her] in. End of report."

On 09/10/2025, Surveyor reviewed Resident 1's July 2025 MAR, which documented:
Acetaminophen 500 MG Caplet - Sub (substitute) for: Tylenol extra strength - Take 1-2 tablets by G-Tube every 6 hours as needed for fever or pain.
The MAR did not document that PRN Tylenol had been administered and there was no physician order for Debrox.

On 09/29/2025 at 1:05 PM, Surveyor interviewed Guardian D. Surveyor asked for clarification on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 448	Continued From page 17	M 448		

when s/he had been informed that Resident 1 had a potential ear infection. Guardian D explained that s/he had called Licensee A on 07/05/2025 to inform him/her that s/he would be picking Resident 1 up on Sunday, 07/06/2025, for a family outing. During the phone call, Licensee A informed Guardian D that Resident 1 had a build-up of wax in his/her ear with minor blood. Guardian D stated s/he stopped at the home, 07/06/2025, to check on Resident 1. Guardian D stated, "I observed [Resident 1] and [s/he] is bent over and seriously grinding [his/her] teeth. That is a sure sign that [s/he] is in pain. There is blood in [his/her] ear. I asked [Licensee A] to take [Resident 1] to urgent care. [Licensee A] told me that [s/he] did not have the staffing to take [Resident 1] to urgent care. I was upset. I made changes in our family day, so that I could take [Resident 1] to urgent care where it was determined s/he had an ear infection and a possible perforation of the ear drum."

On 10/05/2025, Surveyor reviewed Resident 1's managed care organization (MCO) documentation that was provided by his/her MCO provider, which documented:
"07/11/2025 - Date of Incident, Becoming aware of incident 07/14/2025 - AFH (adult family home) called members Dr. Friday about members ear. Member had blood coming out of [his/her] ear, Stated by [Guardian D]. [Guardian D] called/or texted [Licensee A] stating [s/he] was coming to visit member. When [Guardian D] got there members ear did not look good. [Guardian D] took member to the ER (emergency room). Member ended up with ear drum issues, which did need medical attention. Substantiated for failure to initiate/provide services-documentation of health monitoring. ... Care note submitted do not reflect documentation of health monitoring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 448	Continued From page 18	M 448		

related to call to PCP (primary care physician)."
"07/24/2025 - ... The contact call was made on Saturday morning 07/05. OTC (over the counter) Debrox was instilled in JL's R (right) ear and the wax fell off. No sharp object was placed in [Resident 1's] ear. The bleeding was quite small and cleaned off. [Doctor name] eluded that unless [s/he] develops fevers or discomfort to call [his/her] primary [Doctor name] on Monday 07/07. If [s/he] has discomfort to give OTC Tylenol every 4 hrs. [Resident 1] showed no signs of discomfort until [his/her] parents took [him/her] out for a family outing on 07/05. We have been giving [him/her] OTC Tylenol as needed. [Guardian D] called to inform me they were taking [him/her] into the Urgent Care."

On 10/06/2025, Surveyor reviewed Resident 1's urgent care office visit medical documentation, dated 07/06/2025, which stated:
"Concerns for possible perforated ear drum on R ear. Pt (patient) [parent] states pt lives in an adult home, yesterday they were cleaning the pt ears and noticed there was blood in [his/her] ears. Today [parent] looked in [his/her] ears again and it's full of blood. Patient is exhibiting symptoms of pain with teeth grinding."
"Temperature slightly elevated on exam today. Physical exam revealing acute otitis media of the right ear. No obvious perforation on exam today but it is possible there was a perforation. Patient has had reaction to penicillins in the past. We will treat with doxycycline. Liquid antibiotic is provided to be administered through G-tube twice a day. Ibuprofen as needed for pain."

On 10/06/2025 at 12:30 PM, Surveyor interviewed Licensee A. Surveyor reviewed the MAR with Licensee A and stated the PRN medications were not documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 448	Continued From page 19	M 448		

administered as stated by him/her while Resident 1 was being monitored for his/her potential ear infection. Licensee A stated there was no proof at that time that Resident 1 had an ear infection and Licensee A did not have a response regarding why the PRN medications were not documented on the MAR. Licensee A stated the ear wax removal medication is a 'house' medication and there isn't a specific physician order for it. Surveyor asked if there were concerns regarding resident's receiving prompt medical treatment due to a staffing shortage. Licensee A stated, "I always make sure [Resident 1] receives medical care. I have sat in the hospital with [him/her] for hours, for various treatments."

Example 2: Resident 1 - Sepsis/Cellulitis

On 09/16/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home, 04/21/2017, with diagnoses including spastic quadriparesis, scoliosis, cerebral palsy, epilepsy, dysphagia, and gastrointestinal tube present. Resident 1 was represented by Guardian D and MCO CM C.

Resident 1's "Individual Service Plan," dated 04/31/2025, documented:
Was admitted to the hospital from April 20 to April 22, 2025, for cellulitis of the left leg resulting from an infection associated with loss of [his/her] great toe. [S/he] was sent home with Cephalexin antibiotics for 7 days.

Resident 1's April 2025 daily notes, dated a week prior to his/her 04/20/2025 hospitalization, documented:
04/12/2025 - Behaviors: Calm
04/13/2025 - Behaviors: Calm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 448	Continued From page 20 04/14/2025 - Behaviors: Fine 04/15/2025 - Behaviors: Calm/ Good 04/16/2025 - Behaviors: Calm 04/17/2025 - Behaviors: Getting anxious and always want to see staff around him/her 04/18/2025 - Behaviors: Fine 04/19/2025 - Behaviors: S/he always wants to see staff around. Was doing good but s/he has a red swollen foot 04/20/2025 - Hospitalized On 09/16/2025, Surveyor reviewed Resident 1's MCO documentation provided by his/her MCO provider, which stated: 04/21/2025 - Member was admitted in hospital on 04/20/2025 for cellulitis. 08/05/2025 - Resident 1 is in the hospital with a leg that is red and swollen. It looks pretty bad. 08/06/2025 - The member is currently hospitalized for sepsis. 08/08/2025 - The member is currently hospitalized for right leg swelling, redness. Rn received phone call form hospital discharge planner. Member is transitioning to oral antibiotics and is ready for discharge. Was told that [Licensee A] could not take [Resident 1] today because of staffing issues. On 09/29/2025 at 1:05 PM, Surveyor interviewed Guardian D. Surveyor asked if s/he had concerns regarding Resident 1's care that s/he received from the provider. Guardian D stated Resident 1 had been hospitalized twice this year for sepsis and cellulitis, in April and in August. On 10/05/2025, Surveyor reviewed Resident 1's "Inpatient Discharge Summary," dated 08/09/2025, which documented: Admission Date: 08/05/2025, Discharge Date: 08/09/2025	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 448	Continued From page 21	M 448		

Sepsis due to right lower extremity cellulitis; Possible urinary tract infection ... Of note, pt was recently admitted from 4/20/2025 to 4/22/2025 for LLE (left lower extremity) cellulitis which responded well to empiric ceftriaxone and eventually cephalexin course. ... RLE (right lower extremity) diffusely erythematous (widespread redness of the skin) and tender based on pt making sounds on exam. ... [S/he] is accompanied by [his/her] caregiver, who reports that redness began this morning. No recent falls or trauma. Pt appears to be at [his/her] baseline mental status and is not indicating that [s/he] is in pain. No fevers prior to arrival. ... Over the past several days, the patient has again developed progressively worsening LLE redness and pain, ultimately prompting transfer to the ED (emergency department).

On 10/05/2025, Surveyor reviewed Resident 1's "After Hospital Care Plan," dated 04/20/2025 to 04/22/2025, which documented:
[Resident 1] presented to the emergency department today for LLE redness and swelling. Parents report that has been going on for 2 days. They note that they are concerned that patient did not get medical care for the past 2 days because the facility was understaffed and did not have appropriate staff to accompany [Resident 1] to the hospital. ... Skin: LLE with erythema and warmth to medial aspect of thigh and entire lower leg, missing left great toenail. Toenail has come off recently with increased swelling and redness to LLE. ... [Resident 1] developed a L medial thigh rash 2 days ago. Staff at [his/her] group home sought medical advice and were told to give cetirizine and apply a topical hydrocortisone. Unfortunately, the rash kept spreading down the leg. [Resident 1's] parents visited [him/her] today and noted that the rash had significantly spread

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 448	Continued From page 22 and that it looked like cellulitis, so they brought [him/her] into the ED. [Parent] thinks the infection may have made its way up from an injured L big toenail that fell off recently. ... [Parent] requested that [Resident 1] be seen in the ED due to the cellulitis but staff/owner of group home commented that it was not a good time to bring [him/her] to the ED because they were understaffed for Easter. [Parent] had to bring [Resident 1] in via their own van, which due to logistical issues, took several hours to accomplish. ... Cephalexin 250 MG (milligram) - Take 10 ML (milliliter) by mouth 4 times daily for 3 days. Purpose: INFECTION. Start Date: 04/23/2025. On 10/06/2025 at 12:30 PM, Surveyor interviewed Licensee A. Surveyor asked for clarification on how staff were trained to document resident's change of condition. Licensee A stated staff communicated directly to him/her as s/he is a registered nurse. Surveyor asked if these concerns and/or observations were documented in the resident's record. Surveyor reviewed the medical documentation with Licensee A and stated that there had been concerns that Resident 1 did not receive prompt medical attention due to staffing concerns and that in August, Resident 1 had displayed signs and symptoms of cellulitis for a couple of days, but there was no documentation in his/her record that these symptoms had been monitored until the day before his/her hospitalization. Licensee A stated s/he could have done a better job at documentation and would work on that going forward.	M 448		
M 556	88.10(3)(e) Self-Direction	M 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 556	Continued From page 23	M 556		

Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure the right to freedom of choice for 2 of 2 residents in the home.

Resident 2 and Resident 3, who previously had private rooms, were moved to a shared room.

Findings include:

The provider was licensed, 04/01/2017, to provide cares for up to 4 residents in the client groups developmentally disabled, physically disabled, advanced aged, and emotionally disturbed/mental illness.

On 09/09/2025, at approximately 2:20 PM, Surveyor toured the home. Surveyor observed 2 vacant resident rooms, where flooring technicians were replacing the flooring. Resident 2, who as napping, and Resident 3, who was out of the home, were in a shared room.

On 09/09/2025, at approximately 2:30 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 556	Continued From page 24 Surveyor interviewed Caregiver E. Surveyor asked which room Resident 1 had resided in. Caregiver E stated Resident 1 had been in the larger room, due to him/her being nonambulatory. When Resident 1 moved out, about two weeks ago, Resident 2 and Resident 3 were moved into the larger room. On 10/06/2025 at 8:27 AM, Surveyor interviewed Resident 2's managed care organization (MCO) Care Manager (CM) F. Surveyor asked if s/he was aware that Resident 2 was moved from his/her private room to a shared room. CM F stated s/he had visited with Resident 2 on 09/26/2025 and stayed in the common area and was not aware that Resident 2 had been moved to a different room. CM F stated s/he would need to review the MCO contract to determine if Resident 2's rate was for a private room. CM F stated Resident 2 is non-verbal and one would have to watch for physical signs to determine if s/he was upset with the change. On 10/06/2025 at 12:30 PM, Surveyor interviewed Licensee A. Surveyor asked if Resident 2's and Resident 3's representatives were informed that they had been moved from private rooms to a shared room. Licensee A stated s/he had not contacted any resident representatives as s/he did not believe it would be a concern.	M 556		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs.	M 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 580	Continued From page 25	M 580		

This Rule is not met as evidenced by:
Based on record review and interview, 1 of 1 resident did not receive prompt and adequate treatment when experiencing a medical emergency.

Staff did not document that Resident 2 was showing signs and symptoms of a urinary tract infection (UTI). Licensee A informed Resident 2's managed care organization (MCO) Care Manager (CM) F on 07/08/2025 that Resident 2 showed signs and symptoms of a UTI on 07/04/2025 which was confirmed on 07/06/2025 and Cephalexin (antibiotic) was prescribed and started that evening.

Findings include:

The provider was licensed, 04/01/2017, to provide cares for up to 4 residents in the client groups developmentally disabled, physically disabled, advanced aged, and emotionally disturbed/mental illness.

On 08/28/2025, the Department received a concern that residents medical concerns were not properly assessed, documented and treatment provided.

On 09/09/2025, Surveyor reviewed Resident 2's record.

Resident 2 moved into the home, 10/15/2020, with diagnoses including schizophrenia, major neurocognitive disorder (nonverbal at baseline), and a history of UTIs.
Resident 2 was represented by Guardian H and managed care organization (MCO) Care Manager (CM) F and MCO Registered Nurse (RN) G.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 580	Continued From page 26	M 580		

Resident 2's July 2025 Medication Administration Record (MAR) documented:
Cephalexin Cap (capsule) 500 MG (milligram) - Start Date: 07/07/2025 - Take 1 capsule by mouth twice daily for 7 days.

On 09/09/2025, at approximately 2:45 PM, Surveyor interviewed Manager B. Surveyor reviewed Resident 2's July 2025 MAR with him/her and asked why Resident 2 had been prescribed an antibiotic. Manager B stated s/he would need to review his/her documentation, but believed it was for a UTI. Surveyor requested Resident 2's documentation where his/her signs and symptoms of a potential UTI would be documented.

Manager B provided Surveyor with Resident 2's daily notes, which documented:
07/01/2025 - Bowel and Bladder: Yes, BM (bowel movement), Mood: Good
07/02/2025 - Bowel and Bladder: No BM, Mood: Good
07/03/2025 - Bowel and Bladder: Yes BM, Mood: Good
07/11/2025 - Bowel and Bladder: No BM, Mood: Good
Manager B provided Surveyor with Resident 2's behavior notes, which documented:
07/01/2025 - Behaviors: S/he is fine, S/he is okay
07/02/2025 - Behaviors: Calm and peaceful, S/he is fine
07/03/2025 - Behaviors: S/he is ok, S/he is fine
07/04/2025 - Behaviors: S/he is fine, S/he is fine

Surveyor reviewed the documentation with Manager B and commented that the notes did not document any concerns of a potential UTI. Manager B stated s/he was unable to locate any other documentation where signs and symptoms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 580	Continued From page 27	M 580		

would have been documented. Manager B stated s/he would review proper documentation with staff. Surveyor asked Manager B if s/he had any documentation where s/he notified Guardian H, CM F and/or RN G that Resident 2 was diagnosed with a UTI. Manager B stated s/he would look through his/her email correspondence and forward that documentation to Surveyor.

On 09/10/2025 at 10:16 AM, Manager B emailed Surveyor with an email that Licensee A had emailed CM F and RN G on 07/08/2025 at 10:30 AM. The email stated:
"Staff informed me that [Resident 2's] urine output had a strong odor on Friday 07/04 which I confirmed. It also looked cloudy when I inspected it. I sent a [medical record system] message to [Resident 2's primary care physician] to inform [him/her] and requested a UA (urinalysis) order for [Resident 2]. UA was sent into the lab early afternoon on Sunday 07/05. Results revealed a positive UA for bacteria. I saw the results in [Resident 2's] [medical record system] on Sunday 07/05 late evening. [Clinic] RN called on Monday 07/07 to inform [Guardian H) and myself about [Resident 2's] positive UA and told me Cephalexin has been sent to [his/her] pharmacy to be administered BID (twice a day) for 7 days. First dose was started last evening."

On 10/06/2025 at 8:55 AM, Surveyor interviewed RN G. Surveyor asked for clarification on when Resident 2 should have been provided medical attention when s/he showed signs and symptoms of a potential UTI. RN G stated that based on Resident 2's history of UTI's, s/he should have been taken to an urgent care facility so that a UA could have been obtained immediately, and an antibiotic could have been prescribed if positive for a UTI. RN G stated UTI's are painful, and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 580	Continued From page 28	M 580		

goal is to seek relief for the resident as soon as possible. Resident 2 could have potentially started on the Cephalexin 07/04/2025 versus 07/07/2025, evening.

On 10/06/2025 at 12:30 PM, Surveyor interviewed Licensee A. Surveyor asked for clarification on how Resident 2's physician had been informed that s/he was showing signs and symptoms of a potential UTI. Licensee A stated s/he had sent a message through the [medical record system] requesting a UA. Surveyor asked for clarification if this was the most efficient way to have Resident 2, who has a history of UTIs, to be evaluated. Licensee A stated when s/he evaluated Resident 2, s/he could not confirm if s/he had a UTI, so s/he was not rushing the process. Surveyor reviewed medical documentation with Licensee A regarding a previous change of condition regarding Resident 2. The documentation stated:
"Date of Admission: 03/07/2025. Chief Complaint: Concern for UTI ... Even when the patient is doing well, [s/he] would not be able to give a history per the caretaker (Licensee A). Over the last week [s/he] ... maybe a change in the color of [his/her] urine."
Surveyor asked for clarification why there was a potential delay in Resident 2 receiving medical attention when his/her urine was changing colors, which are typical signs of a UTI, and s/he has a history of UTIs. Licensee A stated s/he was a nurse and knew what was best for Resident 2. Surveyor stated concerns had been expressed during the survey process that residents do not receive medical assistance during a change of condition due to a lack of staff who can provide transportation. Licensee A stated residents and their representatives had to understand that s/he cannot always respond immediately when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016671	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST ADULT FAMILY HOME	5202 PRAIRIE ROSE ROAD MADISON, WI 53704

(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 580	Continued From page 29 transportation is needed. Licensee A stated s/he could have handled the situation differently and that going forward, s/he will rethink his/her decisions.	M 580		