STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014876	A. BUILDING: _____ B. WING _____	R-C 05/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS OF LIFE LLC III	3509 S GREEN BAY ROAD RACINE, WI 53406

(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 05/08/2026, Surveyor completed a verification visit and complaint survey. As a result, 3 deficiencies were identified. One of 3 deficiencies is a repeat deficiency. (See Statement of Deficiency 953D12, dated 01/05/2026) One of 1 complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
M 450	88.07(2)(b)6 NOTIFICATION OF CHANGES Notifying the placing agency, if any, the guardian, if any, of any significant changes in the resident's medical condition, including any life-threatening, disabling or serious illness, any illness lasting more than 3 days, an injury sustained by the resident, medical treatment needed by the resident or the resident's absence from the home for more than 24 hours. This Rule is not met as evidenced by: Based on record review and interview, 1 (Resident 3) of 1 resident's placing agency, primary care physician, and/or legal guardian did not receive notification of a significant change in the resident's medical condition.	M 450		

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

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M 450	Continued From page 1 Resident 3's primary care physician, placing agency, and legal guardian were not notified after Resident 3 was administered another resident's medication. Resident 3 was allergic to the medication that was administered and experienced significant change in their medical condition. Findings include: On 04/10/2026, the department received a complaint about a medication error. On 05/07/2026 at approximately 11:30 AM, Surveyor reviewed Resident 3's record. Resident 3 moved into the home on 11/06/2024. Resident 3's individualized service plan (ISP) with a review date of 05/06/2026 indicated Resident 3 relied on staff to manage and administer her/his medications. Resident 3's record identified Resident 3 was allergic to Tylenol. Within Resident 3's record was an incident report, dated "3/26" and completed by Resident Coordinator C. The incident report stated the following: "[Resident 3] stated [she/he] was given Tylenol that made [her/him] sick or something that made [her/him] sick over the weekend. [She/He] had been throwing up didn't feel well ..." No documentation was located that stated Resident 3's placing agency, primary care physician and legal guardian was notified of the medication error. On 05/07/2026 at approximately 11:01 AM, Surveyor interviewed Licensee A and Resident Coordinator C. Licensee A denied any knowledge of Resident 3 being administered another resident's Tylenol. Resident Coordinator C reported informing Resident 3's placing agency,	M 450		

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M 450	Continued From page 2 primary care physician, and legal guardian of the medication error. On 05/07/2026 at approximately 1:44 PM, Surveyor interviewed Case Manager D. Case Manager D denied being notified of the medication error. On 05/07/2026 at approximately 1:54 PM, Surveyor interviewed Legal Guardian G. Legal Guardian G reported Resident 3 contacted her/him about the medication error. Legal Guardian G immediately contacted Resident Coordinator C, who denied a medication error occurred. On 05/07/2026 at approximately 2:02 PM, Surveyor interviewed Nurse H. Nurse H denied Resident 3's primary care physician was notified of the medication error.	M 450		
{M 570}	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by:	{M 570}		

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{M 570}	Continued From page 3 Based on observation, and interview, the provider did not ensure 3 (Resident 1, Resident 2, and Resident 3) of 3 residents were safeguarded from environmental hazards. The hot water coming from the bathroom faucet was 126.5° Fahrenheit (F). This is a repeat deficiency. See Statement of Deficiency (SOD) 953D12, dated 01/05/2026. Findings include: This facility was licensed on 12/10/2013 to serve up to 4 ambulatory residents in the client groups of advanced age, developmentally disabled, emotionally disturbed/mental illness, correctional clients, terminally ill, irreversible dementia/Alzheimer's, traumatic brain injury, physically disabled and alcohol/drug dependent. On 05/07/2026, at approximately 12:14 PM, Surveyor tested the hot water temperature from the resident bathroom sink faucet. The hot water was 126.5° F. On 05/07/2026 at approximately 12:15 PM, Surveyor interviewed Licensee A. Licensee A reported testing the water temperature monthly. Licensee A stated he/she last tested the water in April 2026, and the water temperature read 110° F. Surveyor inquired if Licensee A had the facility thermometer that was used to take the water temperature in April 2026. Licensee A confirmed. Surveyor asked for Licensee A to test the water with the Surveyor observing, using the same facility thermometer that was used in April 2026. At 12:16 PM, Licensee A tested the hot water temperature from the resident bathroom sink faucet, using the same facility thermometer that was used in April 2026. The hot water was 120°	{M 570}		

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{M 570}	Continued From page 4 F. Licensee A acknowledged the temperature was still too high. Licensee A stated he/she would turn the water temperature down. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017.)	{M 570}		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, 2 (Resident 1 and Resident 3) of 2 residents	M 582		

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M 582	Continued From page 5 reviewed did not receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1 missed a total of 233 doses of prescribed medications between 03/01/2026 to 05/06/2026. Resident 3 missed a total of 61 doses of prescribed medications between 03/01/2026 to 05/06/2026. Resident 3 was administered another resident's medication. Findings include: On 04/10/2026, the department received a complaint alleging medication errors. Example 1: On 05/07/2026 at approximately 11:00 AM, Surveyor reviewed resident records. The following was identified: Resident 1 was admitted to the home on 05/28/2024. Resident 1 was diagnosed with adjustment disorder with depressed mood, depression, agitation, anxiety, bipolar 1, cardiac failure, catatonic disorder, dysphagia, fibromyalgia, encephalopathy, chronic pain, developmental scholastic skills disorder, hallucinations, manic episode, dysuria, and paranoid personality disorder. Resident 1's individual service plan, with a review date of 11/08/2025 indicated staff manage and administer Resident 1's medication. Resident 1 had a physician order for the following scheduled medications:	M 582		

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M 582	Continued From page 6	M 582		

Risperidone 0.5 milligrams (MG), take 1 tablet by mouth every night at bedtime
Lithium extended release (ER) 300 MG, take 2 tablets by mouth every night at bedtime
Divalproex ER 500 MG, take 1 tablet by mouth 2 times a day
Senna tablet, take 1 tablet by mouth 2 times a day
Trihexyphenidyl 5 MG, take 1 tablet by mouth 3 times a day with food
Simethicone 80 mf chloride (CH), take 1 tablet by mouth 4 times a day
Quetiapine 100 MG, take 1 tablet by mouth at bedtime
Clonazepam 1 MG tablet, take 1 tablet by mouth at bedtime
Propranolol long acting (LA) 60 MG, take 1 capsule by mouth every morning
Docusate Sodium 100, take 1 capsule by mouth every morning
Pantoprazole 40 MG, take 1 tablet by mouth every morning
Amlodipine 5 MG, take 1 tablet by mouth every morning
Gabapentin 100 MG, take 2 capsules by mouth 2 times a day
Benztropine 0.5 MG, take 1 tablet by mouth 2 times a day

Resident 1's May 2026 medication administration record (MAR) indicated Resident 1 was not administered her/his risperidone on 1 occasion, lithium on 1 occasion, divalproex on 1 occasion, senna on 1 occasion, trihexyphenidyl on 4 occasions, simethicone on 2 occasions, quetiapine on 1 occasion, and clonazepam on 1 occasion between 5/1/2026-5/06/2026.

Resident 1's April 2026 MAR indicated Resident 1 was not administered her/his senna on 4

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M 582	Continued From page 7	M 582		

occasions, benztropine on 1 occasion, quetiapine on 1 occasion, clonazepam on 2 occasions, simethicone on 18 occasions, risperidone on 3 occasions, lithium on 3 occasions, propranolol on 2 occasions, docusate sodium on 2 occasions, pantoprazole on 2 occasions, amlodipine on 2 occasions, divalproex on 5 occasions, and gabapentin on 3 occasions.

Resident 1's March 2026 MAR indicated Resident 1 was not administered her/his propranolol on 6 occasions, docusate sodium on 6 occasions, pantoprazole on 6 occasions, amlodipine on 6 occasions, divalproex on 12 occasions, gabapentin on 12 occasions, risperidone on 32 occasions, senna on 12 occasions, lithium on 12 occasions, benztropine on 14 occasions, trihexyphenidyl on 20 occasions, quetiapine on 5 occasions, clonazepam on 8 occasions, and simethicone on 22 occasions.

Resident 3 was admitted to the home on 11/06/2024. Resident 3 was diagnosed with Alzheimer disease, anemia, anxiety, depression, cerebral infarction, dementia, glaucoma, hepatitis C, and cognitive impairment. Resident 3's individual service plan, with a review date of 05/06/2026 indicated staff manage and administer Resident 3's medication. Resident 3 had a physician order for the following scheduled medications:

Lisinopril 10 milligram (MG) tabets, take 1 tablet by mouth in the morning
Memantine 5 MG, take 1 tablet by mouth 2 times a day
Travatan Z-Pak (Z) 0.004% solution, instill 1 drop in both eyes at night
Atorvastatin 10 MG tablet, take 1 tablet by mouth at night

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M 582	Continued From page 8 Clonidine 0.1 M tablet, take 1 tablet by mouth 2 times a day Clopidogrel 75 MG, take 1 tablet by mouth in the morning Famotidine 20 MG tablet, take 1 table by mouth 2 times a day Ferrous Sulfate 325 MG tablet, take 1 tablet by mouth in the morning with meal Folic Acid 1 MG tablet, take 1 tablet by mouth in the morning Tramadol 50 MG tablet, take 1 tablet by mouth 2 times a day Resident 3's May 2026 medication administration record (MAR) indicated Resident 3 was not administered her/his lisinopril on 2 occasions, Memantine on 3 occasions, travatan on 1 occasion, atorvastatin on 1 occasion, clonidine on 3 occasions, clopidogrel on 2 occasions, famotidine on 3 occasions, ferrous sulfate on 2 occasions, folic acid on 2 occasions, and tramadol on 3 occasions between 05/01/2026 to 05/06/2026. Resident 3's April 2026 MAR indicated Resident 3 was not administered her/his Memantine on 1 occasion, travatan on 1 occasion, atorvastatin on 1 occasion, clonidine on 4 occasions, clopidogrel on 2 occasions, famotidine on 3 occasions, ferrous sulfate on 2 occasions, folic acid on 2 occasions, and tramadol on 8 occasions. Resident 3's March MAR indicated Resident 3 was not administered her/his tramadol on 3 occasions, atorvastatin on 2 occasions, clonidine on 2 occasions, clopidogrel on 1 occasion, famotidine on 2 occasions, ferrous sulfate on 1 occasion, folic acid on 1 occasion, Memantine on 2 occasions, and travatan on 1 occasion.	M 582		

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M 582	Continued From page 9 On 05/07/2026 at approximately 10:30 AM, Surveyor interviewed Resident 3. Resident 3 confirmed she/he does not receive all their prescribed medication(s) each day. Resident 3 disclosed her/his tramadol is often not within the facility, due to waiting on the pharmacy to drop the medication off. On 05/07/2026 at approximately 11:01 AM, Surveyor interviewed Licensee A and Resident Coordinator C. Licensee A reported if a medication is not within the facility, staff are to write "D" for did not dispense. The staff would then need to complete a "Medication Error Reporting" form to provide a reason as to why the medication was not dispensed. The form would then be stored within the resident's file. Licensee A acknowledged Resident 1's and Resident 3's file did not contain a "Medication Error Reporting" form regarding medications that were labeled as "D." Licensee A confirmed the above medication errors had no documentation that indicated the medications were administered or not dispensed. Resident Coordinator C disclosed if a medication is scheduled, the pharmacy typically delivers the medication on a routine basis. If the medication is found to need a prescription prior to the refill being complete, the pharmacy would contact the facility and inform staff of a possible delay. The pharmacy would then work with the physician to obtain a prescription. Resident Coordinator C denied receiving a phone call regarding Resident 1's and Resident 3's scheduled medications about a possible delay due to needing a new prescription. On 05/07/2026 at 4:00 PM, Surveyor interviewed Pharmacist E. Pharmacist E confirmed there were no delays or lapses in delivering Resident	M 582		

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M 582	Continued From page 10 3's scheduled medications in March 2026, April 2026, and May 2026. Pharmacist E reported Resident 3's scheduled medications are on "auto fill" and are delivered monthly. On 05/07/2026 at 4:13 PM, Surveyor interviewed Pharmacist F. Pharmacist F denied any delays or lapses in delivering Resident 1's scheduled medications. Pharmacist F reported in March 2026; Resident 1 needed a new prescription for simethicone. Pharmacist reported 120 tablets were delivered on 02/26/2026, which would have lasted through the month of March 2026. To ensure there was no lapse for Resident 1's simethicone, the pharmacy delivered 83 tablets, instead of the usual 120 tablets on 03/31/2026. On 03/16/2026, Resident Coordinator C was informed that Resident 1 needed to see her/his physician before the physician would send a new prescription for simethicone. Pharmacist F reported the 83 tablets dispensed on 03/31/2026 would have lasted Resident 1 until 04/25/2026. A new prescription was received, and 120 pills were delivered on 04/21/2026, which is prior to Resident 1 running out of the 83 tablets that were delivered on 03/31/2026. Example 2: On 05/07/2026 at approximately 11:30 AM, Surveyor reviewed Resident 3's record. Resident 3 moved into the home on 11/06/2024. Resident 3's individualized service plan (ISP) with a review date of 05/06/2026 indicated Resident 3 relied on staff to manage and administer her/his medications. Resident 3's record identified Resident 3 was allergic to Tylenol. Within Resident 3's record was an incident report, dated "3/26" and completed by Resident Coordinator C. The incident report stated the following:	M 582		

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M 582	Continued From page 11 "[Resident 3] stated [she/he] was given Tylenol that made [her/him] sick or something that made [her/him] sick over the weekend. [She/He] had been throwing up didn't feel well ..." On 05/07/2026 at approximately 10:30 AM, Surveyor interviewed Resident 3. Resident 3 confirmed receiving another resident's Tylenol. Resident 3 reported the Tylenol was in a clear medication cup, intermingled with her/his scheduled nighttime medications. Resident 3 took one of the Tylenol tablets before asking the caregiver what the tablets were. Resident 3 was informed it was Tylenol, and Resident 3 informed the caregiver that she/he was allergic to Tylenol. Resident 3 removed the 2 remaining Tylenol tablets, and saved them to show Resident Coordinator the next day. Resident 3 reported vomiting the same night the Tylenol was administered. Resident 3 stated the vomiting lasted 2 days. On 05/07/2026 at approximately 11:01 AM, Surveyor interviewed Licensee A and Resident Coordinator C. Licensee A denied any knowledge of Resident 3 being administered another resident's Tylenol. Resident Coordinator C acknowledged being informed by Resident 3 about the medication error. Resident Coordinator C confirmed the caregiver did receive a write-up, which should be in the caregiver's file. Licensee A confirmed all employee write-ups are to be placed within the employee file. Licensee A reported he/she audited employee files at the end of each month. Licensee A confirmed he/she audited employee files at the end of March and April, but denied seeing the write-up.	M 582		