STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012789	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEELYNN HOME CARE LLC	4143 N 42ND ST MILWAUKEE, WI 53209

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M 000	INITIAL COMMENTS On 08/06/2025 with information gathered through 08/12/2025, Surveyor completed a standard survey at Deelynn Home Care LLC. Seven deficiencies were identified. Census : 4	M 000		
M 204	88.03(8)(a) MONITORING OF HOME The licensee shall comply with all department and licensing agency request for information about residents, services or operation of the home. This Rule is not met as evidenced by: Based on record review and interview, the provider did not comply with Department requests for information during the survey process. Findings include: On 08/06/2025, at 2:30 PM, Surveyor spoke with Executive Director A while at the facility. Surveyor requested the complete resident record for Resident 1 and Resident 2. Licensee A reported s/he would send the information via email by 4:30 PM on 08/06/2025. As of 08/11/2025, Surveyor did not receive any documentation. On 08/12/2025, at 9:40 AM, Surveyor arrived onsite to review the documentation s/he did not receive via email. On 08/12/2025, at 9:45 AM, Surveyor interviewed	M 204		

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

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M 204	Continued From page 1 Licensee A. Licensee A reported s/he sent photos to Surveyor of the requested documentation. Surveyor informed Licensee A nothing had been received. Surveyor requested to review the documentation in the facility. Licensee A led Surveyor to the facility office on the 2nd floor of the facility. Surveyor reviewed documentation and asked questions regarding the processes. At 10:20 AM, Licensee A reported s/he was done complying with the survey process and asked for Surveyor to leave the facility. Licensee A confirmed s/he was not going to allow the survey to continue.	M 204		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure smoke detectors were located on the ceiling in 5 of 5 required areas. The smoke	M 334		

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M 334	Continued From page 2 detectors in all 4 resident bedrooms and the living room were located on the wall and not the ceiling. Findings include: On 08/06/2025 at 10:00 AM, Surveyor toured the facility with Licensee A. Surveyor observed the smoke detectors in the 4 resident bedrooms as well as the smoke detector in the living room were mounted at the top of the wall and not on the ceiling. On 08/06/2025 at approximately 11:00 AM, Surveyor interviewed Licensee A regarding the placement of the smoke detectors. Licensee A stated that smoke rises so the placement of the smoke detectors was fine. Surveyor informed licensee that the regulations state that smoke detectors need to be mounted on the ceiling in living rooms and bedrooms. Licensee A stated, "...I will get them moved."	M 334		
M 406	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This Rule is not met as evidenced by:	M 406		

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M 406	Continued From page 3 Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1's) guardian was involved with the development of his/her individual service plan (ISP). Findings include: On 08/12/2025 at approximately 10:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 01/11/2011. Resident 1's current ISP was dated for 6/1/2025 with only signatures of the Licensee A and Resident 1. There was no signature of Resident 1's guardian on the ISP. On 08/12/2025 at approximately 10:00 AM, Surveyor interviewed Licensee A. Licensee A stated Resident 1 had a corporate court appointed guardian. Surveyor asked why the only signatures on the ISP were the licensee's and the resident's. Licensee A stated s/he signed for the resident as s/he was not able to sign for him/herself. Surveyor asked if the guardian was involved in creating the ISP. Licensee A stated the guardian has not been involved with the ISP or signed the ISP in the last 3 years.	M 406		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted	M 464		

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M 464	Continued From page 4 to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a written order from the physician who prescribed the medication specifying who by name or position was permitted to administer the medication, under what circumstances, and in what dosage the medication was to be administered for 1 of 1 resident. Resident 1 required staff of the adult family home to administer medication and there were no physician's orders in the record. Findings include: On 08/12/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 01/03/2011. Resident 1's record included the Medication Administration Records (MARs). The MARs indicated Resident 1 was prescribed and administered the following medications: chlopromazine hydrochloride (HCL) 50 milligrams (mg), 4 tablets in the morning and 3 tablets at bedtime; diphenhydramine 25 mg, 1 capsule by mouth 2 times a day; fexofenadine HCL 180 mg tablet, 1 tablet by mouth in the morning; metformin HCL extended release (ER) 500 mg tab, 1 tablet by mouth 2 times a day in the morning and evening; multivitamin tablet 1 tablet by mouth in the morning (this order was duplicated; and risperidone orally disintegrating tablet (ODT) *bulk* 2 mg tab rapdis, Dissolve 1 tablet by mouth 3 times a day in the morning	M 464		

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M 464	Continued From page 5 noon and evening. The MARs were initialed by care staff indicating care staff administered the medication. There were no written medication orders for Resident 1, nor were there any orders that stated the employees of the facility could administer medication. On 08/06/2025 at 10:30 AM, Surveyor interviewed Caregiver B. Caregiver B stated his/her duties included administering medications to all residents. On 08/12/2025 at approximately 10:00 AM, Licensee A confirmed medications were administered by care staff. Licensee A confirmed s/he provided all records for each resident.	M 464		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 resident (Resident 1 and Resident 2) records were maintained in a secure location within the home. Neither resident's records were kept at the facility. Findings include:	M 482		

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M 482	Continued From page 6 On 08/06/2025 at approximately 11:00 PM, Surveyor requested the resident records to review. Licensee A stated that residents' records were not kept in the facility since there were issues with theft. Surveyor informed Licensee A it was a state regulation to keep records in the facility. Licensee A stated they were aware of the regulation but would not be keeping records in the facility. On 08/12/2025 at 9:40 AM, Surveyor interviewed Caregiver B. Caregiver B confirmed that there were no resident records kept in the facility, Surveyor asked Caregiver B how they know what cares the residents needed. Caregiver B shrugged and stated they just knew the residents.	M 482		
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, the provider did not ensure residents received their medication according to physician's orders as indicated on the medication administration records (MARs) for 1 of 1 resident. Resident 1	M 582		

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M 582	Continued From page 7 received their noon medication (risperidone 2 milligrams (mg)) at 4:00 PM along with scheduled 4:00 PM medication (risperidone 2 mg). Findings include: On 08/12/2025 at approximately 10:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 01/03/2011. Resident 1's MARs identified Resident 1 was prescribed risperidone 2 mg tabs scheduled to be administered 3 times a day (in the morning, at noon, and in the evening). The evening medications were scheduled at 4:00 PM. The noon dose for risperidone was already signed out at 10:00 AM. On 08/12/2025 at approximately 10:10 AM, Surveyor interviewed Licensee A regarding the noon medication being signed out at 10:00 AM. Licensee A stated that the noon medication was signed out early but the medication was not administered until Resident 1 returned from their day program. Surveyor asked Licensee A what time Resident 1 usually returned, and what time the noon medication was administered. Licensee A stated Resident 1 usually returned between 3:00 PM and 3:30 PM and the medication was given as they return. Licensee A confirmed the noon risperidone 2 mg tab was given along with the evening risperidone 2 mg tab. Survey asked Licensee A if they knew that was going against the doctors order. Licensee A reported providing Resident 1 with 2 tabs of risperidone 2 mg when s/he got home from the day program worked well for their schedule and stated, "It helps control his/her behaviors."	M 582		

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Z 023	Continued From page 8	Z 023		
Z 023	50.065(4m) (b) intro CAREGIVER HIRING AND CONTRACTING PROCESS Notwithstanding s.111.335, and except as provided in sub. (5), an entity may not hire or contract with a caregiver or permit to reside at the entity a nonclient resident if the entity knows or should have known any of the following: 1. That the person was convicted of a serious crime. 3. That a unit of government or a state agency, as defined in s. 16.61 (2) (d), has made a finding that the person has abused or neglected any client or misappropriated the property of any client. 4. That a determination has been made under s. 48.981 (3) (c) 4. that the person has abused or neglected a child. 5. That, in the case of a position for which the person must be credentialed by the Department of Safety and Professional Services, the person's credential is not current, or is limited so as to restrict the person from providing adequate care to the client. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure every reasonable effort was made to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction related to a conviction of s. 940.19(1),	Z 023		

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Z 023	Continued From page 9 for 1 of 1 caregiver (Caregiver C). Findings include: On 08/06/2025 at approximately 2:00 PM, Surveyor reviewed Caregiver C's record received from Licensee A. Surveyor identified the following: -The Department of Justice (DOJ) report showed: "Date of offense: 04/12/2021 ...940.19 - Battery." On 08/06/2025 at approximately 2:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed s/he provided the complete record for Caregiver C. On 08/12/2025, at 10:20 AM, Surveyor interviewed Licensee A. Surveyor attempted to interview Licensee A further regarding if a judgement of conviction was sought by Licensee A, but the Licensee A did not wish to continue with the survey process. Licensee A reported s/he was not going to continue the survey.	Z 023		