Wisconsin Department of Health Services

| 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 _____ | R 03/03/2026 |

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

| (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 |
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| {M 000} | INITIAL COMMENTS<br><br>On 03/03/2026, Surveyors conducted a verification visit at Deelynn Home Care LLC. As a result, 3 deficiencies were identified. Three of 3 were repeat violations (see Statement of Deficiency E1HH11, dated 08/12/2025).<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed.<br><br>Census: 4 | {M 000} | | |
| {M 406} | 88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 2 residents' Individual Service Plans (ISPs) were signed by responsible parties and managed care organization (MCO) care management teams indicating involvement with the development of the plans. Resident 1's and Resident 4's ISPs were not signed by people involved with developing the ISPs.<br><br>This is a repeat deficiency. See Statement of | {M 406} | | |

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

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| {M 406} | Continued From page 1<br>Deficiency E1HH11, dated 08/12/2025.<br><br>Findings include:<br><br>On 03/03/2026, Surveyors reviewed resident records and identified the following:<br><br>-Resident 1 was admitted to the home on 01/03/2011. Resident 1 had a guardian appointed on 01/11/2023 and an MCO care management team. Resident 1's ISP, dated 10/01/2025, did not contain signatures of Resident 1's guardian, Licensee A, or Resident 1's MCO care management team.<br><br>-Resident 4 was admitted to the home on 04/18/2022. Resident 4 was his/her own person. Resident 4 had an MCO care management team. Resident 4's ISP, dated 10/02/2025, was not signed by Resident 4, Licensee A, or Resident 4's MCO care management team.<br><br>On 03/03/2026, at approximately 10:15 AM, Surveyors interviewed Licensee A. Licensee A confirmed the ISPs were not signed. Licensee A reported the last time Resident 1's guardian was in the home, they did not sign the ISP, so Licensee A recently called the guardian to inform them they needed to sign it. They had not been to the facility since the reminder. Licensee A reported s/he did not know the MCO care management teams should sign the ISPs but would have them sign as soon as they come back for their scheduled visits. Licensee A reported s/he did not know s/he needed to physically sign the ISPs but would ensure they were signed in the future. Licensee A confirmed s/he develops the ISPs with the assistance of the facility contracted nurse, guardians, residents, and their MCOs. | {M 406} | | |

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| {M 464} | 88.07(3)(d) MEDICATION- WRITTEN ORDER<br><br>Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file.<br><br>This Rule is not met as evidenced by:<br>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 identifying who could administer medication to the resident and what medication, dosage, and circumstances each medication was to be administered.<br><br>This is a repeat deficiency. See Statement of Deficiency E1HH11, dated 08/12/2025.<br><br>Findings include:<br><br>On 03/03/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 01/03/2011. | {M 464} | | |

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| {M 464} | Continued From page 3<br><br>Resident 1's record included the Medication Administration Records (MARs). The MARs indicated Resident 1 was prescribed and administered the following medications: chlorpromazine 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 2 mg tab, Dissolve 1 tablet by mouth 3 times a day in the morning, noon, and evening. The MARs were initialed by care staff indicating care staff administered the medication. Resident 1's record did not contain written physician's orders or a physician's order identifying who could administer medications to Resident 1.<br><br>On 03/03/2026, 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. Licensee A confirmed s/he did not get Resident 1's order to administer medication to Resident 1 from his/her physician. Licensee A reported it was an oversight, and s/he would obtain the order as soon as s/he can. Licensee A confirmed Resident 1 received prescription medications and Resident 1's record did not contain physician's orders prescribing the medications. Licensee A reported s/he would contact Resident 1's physician or their contracted pharmacy to ensure the record contains the required physician's orders. | {M 464} | | |

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| {M 582} | Continued From page 4 | {M 582} | | |
| {M 582} | 88.10(3)(q) Medications<br><br>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.<br><br>This Rule is not met as evidenced by:<br>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 received their 4 PM medication (risperidone 2 milligrams (mg)) at 4:00 PM along with scheduled 8:00 PM medication (risperidone 2 mg).<br><br>This is a repeat deficiency. See Statement of Deficiency E1HH11, dated 08/12/2025.<br><br>Findings include:<br><br>On 03/03/2026, Surveyor reviewed Resident 1's record. -Resident 1 was admitted to the home on 01/03/2011. Resident 1's February Medication Administration Records (MARs) identified Resident 1 received his/her 4:00 PM and 8:00 PM medication on 17 days out of the 26 possible days recorded. On all of these 17 days, the 4:00 PM dose of risperidone was administered along with the 8:00 PM dose, effectively double dosing | {M 582} | | |

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| {M 582} | Continued From page 5<br>the resident.<br><br>On 03/03/2026 at 10:00 AM, Surveyor interviewed Licensee A. Licensee A stated that s/he was responsible for administering medications to Resident 1. Licensee A stated s/he comes in 2 times a day to administer medications. Surveyor asked Licensee A what time that usually is. Licensee A stated, "whatever time is on the MARs is when I give them." Licensee A confirmed that MARs show both the 4:00 PM and 8:00 PM doses being administered at 8:00 PM. Licensee A stated s/he will contact Resident 1's doctor to work something out. Licensee A reported s/he discussed this with the physician, but was unable to locate the information. Licensee A confirmed they did not have physician's orders in the home.<br><br>Cross Reference: M0464 88.02(3)(d) - Medication Written Order | {M 582} | | |