STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017574	A. BUILDING: _____ B. WING _____	R-C 10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT CARE	**9035 N 97TH ST MILWAUKEE, WI 53224**

(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
{N 000}	Initial Comments On 10/21/2025, Surveyor completed a verification visit and 3 complaint investigations at Bright Care. Statement of Deficiency (SOD) FQ9916 was corrected. Four new deficiencies were identified, 2 of the 4 were repeat violations (see SOD FQ9915, dated 09/18/2024). Two complaints were unsubstantiated, and 1 complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 23	{N 000}		
N 191	83.13(3)(d) Posting activity schedule. The CBRF shall post all of the following: Activity schedule as required under s. DHS 83.38(1)(c). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure an activity schedule was posted in the facility. This is a repeat deficiency. See statement of deficiency (SOD) FQ9915, dated 09/18/2024. Findings include: On 09/10/2025, at 9:05 AM, Surveyor toured the facility and did not observe an activity schedule posted. On 09/10/2025, at approximately 9:20 AM, Surveyor interviewed Resident 12. Resident 12 reported s/he was unaware of an activity schedule posted anywhere in the facility and had	N 191		

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

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N 191	Continued From page 1 not been given an activity schedule. On 09/10/2025, at approximately 2:00 PM, Surveyor interviewed Director of Operations A and the following was reported: Director of Operations A searched for the activity schedule behind a full-size refrigerator/freezer within the activities room. S/He pulled out an activity schedule dated March 2025, which was not posted for residents to view. S/He thought the most recent schedule was posted, but confirmed it was not. S/He confirmed the code requirement and stated, "We are doing our best." The facility has continued to pay for a subscription service to an activities calendar program, but did not have a staff member working to maintain monthly activity calendars. Cross Reference: DHS N0427 83.38(1)(c) - Leisure Time Activities	N 191		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 13) reviewed received their prescribed medications in the dosage and at intervals prescribed by the practitioner.	N 352		

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N 352	Continued From page 2 Resident 13 missed 24 doses of brimonidine eye drops and 24 doses of dorzolamide/timolol eye drops. Resident 13 did not have blood sugars (BS) checked and was not administered insulin lispro on 47 occasions. Resident 13 missed 2 doses of insulin lispro, when BS checks indicated it should have been administered. Resident 13 was administered insulin lispro on 14 occasions, when BS checks indicated it should have been held. Resident 13 was administered insulin lispro without BS checks on 10 occasions. Resident 13 missed a total of 99 doses over a 40-day period, from 08/01/2025 - 09/09/2025. Findings include: On 08/12/2025, the Department received a complaint a resident was not receiving their prescribed medications, and they were not being refilled timely. On 09/10/2025, at 9:05 AM, Surveyor conducted an onsite visit at the facility and reviewed resident records, and the following was identified: Resident 13 Resident 13's individual service plan (ISP) documented Resident 13 was admitted to the facility on 01/27/2022, with diagnoses including diabetes mellitus type 2 (DM2), partial blindness, and an artificial left eye. Resident 13 required medications to be administered by staff. Resident 13's assessment, dated 04/25/2025, documented s/he required assistance from staff with diabetes management, to include blood sugars (BS) taken 4 times per day (before meals and at bedtime). S/He required assistance from	N 352		

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N 352	Continued From page 3 staff with all eyesight/vison needs and was "to receive complete care from staff and to retain as much of vision as possible." Surveyor reviewed Resident 13's physician's orders and identified the following: - Brimonidine solution (SOL) 0.2% ophthalmic (OP) (eye), instill 1 drop into left eye every 12 hours. Start Date: 05/04/2025. End Date: 09/06/2025. - Dorzolamide/timolol OP SOL (Cosopt 2%-0.5% OP SOL), 1 drop into the left eye every 12 hours. Start Date: 05/04/2025. End Date: 09/06/2025. - Insulin lispro kwikpen (Humalog) 100 units / milliliter (mL), inject subcutaneously (SubQ) with breakfast: for blood glucose (BG) 0-70 = 0 units, 71-90 = 12 units, 91-130 = 20 units, 131-150 = 21 units, 151-200 = 22 units, 201-250 = 23 units, 251-300 = 24 units, 301-350 = 25 units, 351-400 = 26 units, 401-450 = 27 units, greater than 450 = 28 units. Start Date: 05/04/2025. End Date: 09/06/2025. - Insulin lispro kwikpen (Humalog) 100 units / milliliter (mL), inject subcutaneously (SubQ) with lunch: for BG 0-70 = 0 units, 71-90 = 10 units, 91-130 = 18 units, 131-150 = 19 units, 151-200 = 20 units, 201-250 = 21 units, 251-300 = 22 units, 301-350 = 23 units, 351-400 = 24 units, 401-450 = 25 units, greater than 450 = 26 units. Start Date: 05/04/2025. End Date: 09/06/2025. - Insulin lispro kwikpen (Humalog) 100 units / milliliter (mL), inject subcutaneously (SubQ) with supper: for BG 0-70 = 0 units, 71-90 = 8 units, 91-130 = 14 units, 131-150 = 15 units, 151-200 = 16 units, 201-250 = 17 units, 251-300 = 18 units,	N 352		

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N 352	Continued From page 4 301-350 = 19 units, 351-400 = 20 units, 401-450 = 21 units, greater than 450 = 22 units. Start Date: 05/04/2025. End Date: 09/06/2025. - Insulin lispro kwikpen (Humalog) 100 units / milliliter (mL), inject subcutaneously (SubQ) at bedtime: for BG 0-250 = 0 units, 251-300 = 1 unit, 301-350 = 2 units, 351-400 = 3 units, 401-450 = 4 units, greater than 450 = 5 units. Start Date: 05/04/2025. End Date: 09/06/2025. Surveyor reviewed Resident 13's medication administration records (MAR) for August - September 2025, and the following was identified: The MAR documented brimonidine OP SOL on line 6 and dorzolamide/timolol OP SOL on line 7; both were scheduled daily for 8:00 AM and 8:00 PM. Blank boxes on the MAR indicated Resident 13 did not receive the prescribed medications. The following were the dates/times administration was not recorded and Resident 13 missed her/his doses of brimonidine OP SOL and dorzolamide/timolol OP SOL: August 2025: 1. 08/03/2025 at 8:00 PM 2. 08/05/2025 at 8:00 PM 3. 08/06/2025 at 8:00 PM 4. 08/07/2025 at 8:00 PM 5. 08/09/2025 at 8:00 PM 6. 08/10/2025 at 8:00 PM 7. 08/11/2025 at 8:00 AM 8. 08/12/2025 at 8:00 PM 9. 08/13/2025 at 8:00 PM 10. 08/15/2025 at 8:00 PM 11. 08/16/2025 at 8:00 PM 12. 08/17/2025 at 8:00 PM 13. 08/18/2025 at 8:00 AM and 8:00 PM	N 352		

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N 352	Continued From page 5 14. 08/19/2025 at 8:00 PM 15. 08/20/2025 at 8:00 PM 16. 08/21/2025 at 8:00 PM 17. 08/23/2025 at 8:00 PM 18. 08/26/2025 at 8:00 PM 19. 08/28/2025 at 8:00 PM September 2025: 1. 09/01/2025 at 8:00 AM and 8:00 PM 2. 09/02/2025 at 8:00 AM 3. 09/05/2025 at 8:00 PM There were no other notes recorded, or explanations for the missed doses. According to the National Library of Medicine: "Ophthalmic brimonidine is used to lower pressure in the eyes in patients who have glaucoma (high pressure in the eyes that may damage nerves and cause vision loss) and ocular hypertension (pressure in the eyes that is higher than normal but not high enough to cause vision loss). Brimonidine is in a class of drugs called alpha adrenergic agonists. Brimonidine works by decreasing the amount of fluid in the eyes." (medlineplus.gov, Brimonidine Ophthalmic, Retrieved on 10/22/2025). Resident 13's MAR documented BS checks 4 times per day, at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM, on line 12. The MAR documented the administration of insulin lispro on multiple lines for breakfast, lunch, dinner, and bedtime. The following were dates/times of which the administration of insulin lispro was incorrect: Insulin lispro kwikpen (Humalog) -	N 352		

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N 352	Continued From page 6 August 2025: 08/01/2025 - 7:51 PM (bedtime): BS was recorded as 145. The MAR was initialed by staff and time stamped 19:50 on 2 separate lines of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 08/02/2025 - 7:32 PM (bedtime): BS was recorded as 145. The MAR was initialed by staff and time stamped 19:32 on 2 separate lines of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 08/03/2025 - 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/04/2025 - 7:44 PM (bedtime): BS was recorded as 163. The MAR was initialed by staff and time stamped 18:20 on 2 separate lines of the MAR, which indicated the medication was administered. The	N 352		

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N 352	Continued From page 7 sliding scale indicated the medication was to be held. 08/05/2025 - 9:32 AM (breakfast): BS was recorded as 273. The MAR was documented "VIT," with staff initials and time stamped 9:38 on 5 separate lines of the MAR, which indicated the medication was held. The sliding scale indicated Resident 13 should have received 24 units of insulin. 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/06/2025 - 12:00 PM (lunch): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro	N 352		

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N 352	Continued From page 8 or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/07/2025 - 9:27/9:28 AM (breakfast): Resident 13's BS was recorded twice as 125 and 295. The MAR was documented "VIT," with staff initials and time stamped 9:29 on 5 separate lines of the MAR, which indicated the medication was held. The sliding scale indicated Resident 13 should have received 20 units or 24 units of insulin. 12:00 PM (lunch): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/08/2025 - 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose.	N 352		

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N 352	Continued From page 9 7:29 PM (bedtime): BS was recorded as 213. The MAR was initialed by staff and time stamped 19:22 and 20:22 on 2 separate lines of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 08/09/2025 - 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/10/2025 - 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/11/2025 - 8:00 AM (breakfast): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes	N 352		

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N 352	Continued From page 10 indicating a BS was recorded, or an explanation for the missed dose. 12:00 PM (lunch): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 7:42 PM (bedtime): BS was recorded as 231. The MAR was initialed by staff and time stamped 18:39 on 2 separate lines of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 08/12/2025 - 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/13/2025 - 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro	N 352		

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N 352	Continued From page 11 or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/14/2025 - 12:00 PM (lunch): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): BS was recorded as 122. The MAR was initialed by staff and time stamped 19:59 on 2 separate lines of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 08/15/2025 - 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/16/2025 - 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose.	N 352		

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N 352	Continued From page 12 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/17/2025 - 12:00 PM (lunch): BS was not documented. Lines 22-25 were initialed by staff and time stamped 11:12, which indicated the medication was administered. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/18/2025 - 8:00 AM (breakfast): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 12:00 PM (lunch): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose.	N 352		

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N 352	Continued From page 13 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/19/2025 - 12:00 PM (lunch): BS was not documented. Lines 22-25 were initialed by staff and time stamped 10:08/10:09, which indicated the medication was administered. 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/20/2025 - 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/21/2025 -	N 352		

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N 352	Continued From page 14 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/22/2025 - 7:47 PM (bedtime): BS was recorded as 166. The MAR was initialed by staff and time stamped 19:44 on 2 separate lines of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 08/23/2025 - 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/24/2025 - 7:53 PM (bedtime): BS was recorded as 165. The MAR was initialed by staff and time stamped 19:52 on 2 separate lines of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 08/25/2025 -	N 352		

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N 352	Continued From page 15 7:38 PM (bedtime): BS was recorded as 134. The MAR was initialed by staff and time stamped 19:38 on line 27 of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 08/26/2025 - 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/27/2025 - 7:36 PM (bedtime): BS was recorded as 190. The MAR was initialed by staff and time stamped 19:35 on line 27 of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 08/28/2025 - 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 08/29/2025 - 4:00 PM (dinner): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): No BS was recorded. The	N 352		

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N 352	Continued From page 16 MAR was initialed by staff and time stamped 21:13/21:14 on 2 separate lines of the MAR, which indicated the medication was administered. 08/30/2025 - 4:00 PM (dinner): No BS was recorded. The MAR was initialed by staff and time stamped 16:13 on lines 17-21 and 26 of the MAR, which indicated the medication was administered. 8:00 PM (bedtime): No BS was recorded. The MAR was initialed by staff and time stamped 19:15/19:16 on 2 separate lines of the MAR, which indicated the medication was administered. 08/31/2025 - 8:00 PM (bedtime): No BS was recorded. The MAR was initialed by staff and time stamped 20:08 on 2 separate lines of the MAR, which indicated the medication was administered. September 2025: 09/01/2025 - 8:00 AM (breakfast): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 09/02/2025 -	N 352		

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N 352	Continued From page 17 8:00 AM (breakfast): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 12:00 PM (lunch): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 7:19 PM (bedtime): BS was recorded as 184. The MAR was initialed by staff and time stamped 19:17 on line 27 of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 09/03/2025 - 4:00 PM (dinner): No BS was recorded. The MAR was initialed by staff and time stamped 18:34 on line 17-21 and 26 of the MAR, which indicated the medication was administered. 8:00 PM (bedtime): No BS was recorded. The MAR was initialed by staff and time stamped 19:42 on line 27 of the MAR, which indicated the medication was administered. 09/04/2025 - 8:12 PM (bedtime): BS was recorded as 231. The MAR was initialed by staff and time stamped 19:59 on line 27, 39, and 42 of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held.	N 352		

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N 352	Continued From page 18 09/05/2025 - 12:00 PM (lunch): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 8:00 PM (bedtime): Blank boxes indicated Resident 13 did not receive her/his insulin lispro or have a BS recorded. There were no notes indicating a BS was recorded, or an explanation for the missed dose. 09/06/2025 - 7:12 PM (bedtime): BS was recorded as 123. The MAR was initialed by staff and time stamped 19:11 on lines 39 and 42 of the MAR, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 09/07/2025 - 7:34 PM (bedtime): BS was recorded as 179. Lines 39 and 42 were initialed by staff and time stamped 19:34, which indicated the medication was administered. The sliding scale indicated the medication was to be held. 09/08/2025 - 8:00 PM (bedtime): No BS was recorded. Lines 39 and 42 were initialed by staff and time stamped 21:34, which indicated the medication was administered. 09/09/2025 -	N 352		

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N 352	Continued From page 19 8:00 PM (bedtime): No BS was recorded. Lines 39 and 42 were initialed by staff and time stamped 20:53, which indicated the medication was administered. On 09/10/2025, at 10:30 AM, Surveyor interviewed Daily Operations Manager (DOM) N and the following was reported: Surveyor inquired about insulin administration for Resident 13. DOM N reported Resident 13 requested insulin be administered before meals. When s/he administered medications s/he checked blood sugars before meals and administered the insulin lispro according to Resident 13's sliding scale. Blank boxes on the MAR were undocumented and missed medications. Resident 13's eyedrops were not charted. DOM N could not confirm if caregivers were administering medications if the MAR was not documented. DOM N reported Resident 13 went "a few days" without eyedrops sometime at the end of August and beginning of September. The facility was waiting on an order from the pharmacy to be filled. On 09/10/2025, at 1:44 PM, Surveyor interviewed Director of Operations (DOO) A and the following was reported: Resident 13 ran out of her/his prescription eye drops on a Friday and the pharmacy did not do anything over the weekend. Resident 13 missed doses of medications during that time. DOO A switched pharmacies the facility was utilizing due to their lack of filling prescriptions timely and support when refills were needed, which led to residents missing medications. DOO A reported the switch to a different pharmacy should correct the problems with medication availability for	N 352		

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N 352	Continued From page 20 residents.	N 352		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a daily activity program was provided to meet the interests and capabilities of the residents. The provider did not provide activities for the residents. This had the potential to affect 23 of 23 residents. This is a repeat deficiency. See statement of deficiency (SOD) FQ9915, dated 09/18/2024. Findings include: The facility was licensed as a Community Based Residential Facility (CBRF) class CNA (non-ambulatory), serving up to 28 residents, in the client groups irreversible dementia/Alzheimer's, physically disabled,	N 427		

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advanced age, emotionally disturbed/mental illness, and developmentally disabled.

On 09/10/2025, at approximately 9:20 AM, Surveyor was touring the facility and observed 4-5 residents sitting in a living area watching television (TV). Amongst those residents was Resident 12. Surveyor interviewed her/him. Surveyor inquired how things were going for Resident 12, and s/he stated, "This is all we do all day, every day." S/He reported the facility does not provide any activities. Resident 12 reported s/he wanted options and opportunities to do other things outside of watching TV all day. S/He reported none of the staff try to engage residents in activities and they did not have any schedule of activities s/he was aware of.

Surveyor was onsite from 9:05 AM until approximately 3:00 PM and did not observe any residents engaged in activities, or any staff attempting to conduct activities.

On 09/10/2025, at approximately 2:00 PM, Surveyor interviewed Director of Operations A and the following was reported:

The facility did not have an activities director, and they were "doing our best." S/He confirmed the code requirement. Director of Operations A reported s/he would continue the search for an activities director and work to provide scheduled activities for the residents.

The National Institute of Aging stated:

"Engaging in social and productive activities you enjoy, such as taking an art class, joining a hiking club, or becoming a volunteer in your community, may help to maintain your well-being and

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independence as you age. An active lifestyle is more than just getting your daily steps in. It includes doing activities that are meaningful to you and benefit your mind, spirit, and body. Research has shown that older adults with an active lifestyle:

- Are less likely to develop certain diseases. Participating in hobbies and other social activities may lower risk for developing some health problems, including dementia, heart disease, stroke, and some types of cancer.

- Have a longer lifespan. Studies looking at people's outlooks and how long they live show that happiness, life satisfaction, and a sense of purpose are all linked to living longer. Doing things that you enjoy may help cultivate those positive feelings.

- Are happier and less depressed. Studies suggest that older adults who participate in activities they find meaningful, such as volunteering in their communities or being physically active, say they feel happier and healthier.

- Are better prepared to cope. When people feel happier and healthier, they are more likely to be resilient, which is our ability to bounce back and recover from difficult situations. Positive emotions, optimism, physical and mental health, and a sense of purpose are all associated with resilience.

- May be able to improve their thinking abilities. Research suggests that participating in certain activities, such as those that are mentally stimulating or involve physical activity, may have a positive effect on memory - and the more

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N 427	Continued From page 23 variety the better. Other studies are providing new information about ways that creative activities, such as music or dance, can help older adults with memory problems or dementia." (Source: National Institute of Aging, Participating in Activities You Enjoy as You Age, https://www.nia.nih.gov/health/healthy-aging/participating-activities-you-enjoy-you-age (retrieval date: October 21, 2025).) Cross Reference: DHS N0191 83.13(3)(d) - Posting Activity Schedule	N 427		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 452		

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did not ensure food was stored and served under sanitary conditions. Insects were observed throughout the pantry in cups used to trap them. Food items were expired or beyond the best by dates and not labeled with a date of opening.

Findings include:

On 09/10/2025, at 12:50 PM, Surveyor toured the kitchen at the facility, and the following was observed:

- The pantry shelves contained 3 small plastic cups filled with a yellowish/brown liquid, consistent with apple cider vinegar. The cups and the areas around the cups had multiple small black flying insects. Pantry food items were stored on the shelves with dead and active insects. Multiple insects were flying around the pantry.

- The kitchen refrigerators contained the following items:
1. An open container of shredded parmesan cheese, labeled use by 11/19/2023.
2. An open container of grated parmesan cheese dated 11/29/2023.
3. An open jar of Italian dressing not dated or labeled.
4. An open container of garlic parmesan sauce, labeled best by 09/09/2024. The sauce was leaking and covered the outside of the container.
5. An open jar of ranch dressing, which contained a handwritten label "05-20."

- The vent fan over the stove was covered in dust and grease.

On 09/10/2025, at 12:50 PM, Surveyor interviewed Chef AA and Director of Operations

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N 452	Continued From page 25 (DOO) A. DOO A confirmed the cups in the pantry were apple cider vinegar, used to trap drain flies. DOO A was unsure why the cups were placed in the pantry, as s/he had hired an exterminator to treat the facility on a regular basis. Surveyor inquired about the food items in the refrigerator. Chef AA reported the jar of ranch dressing was opened on May 20th but could not provide a year. Chef AA looked at the jar and stated, "I'll just throw it away." Chef AA reported s/he dated the food items when they were received at the facility and dated them again upon opening. Chef AA did not provide information on the items beyond the use/best by dates. DOO A threw all of the above items away and asked Cheff AA to check the food stock for other items that needed discarding.	N 452		