STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013489	A. BUILDING: _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
505 PINE CONE PLACE	505 PINE CONE PLACE HOLMEN, WI 54636

(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 03/26/2025, Surveyor conducted a standard survey at 505 Pine Cone Place. Data collection continued through 04/09/2025. Twelve deficiencies were identified. Two of the 12 were repeat violations. See Statement of Deficiency (SOD) 526711, dated 03/12/2021, SOD 526712, dated 02/01/2022, and SOD 526713, dated 09/08/2022. Census: 3	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a report was submitted to the department within 24 hours when Resident 3's whereabouts were unknown. Findings include: On 03/26/2025, at approximately 11:20 AM, Surveyor interviewed Caregiver A and Program	M 134		

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

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M 134	Continued From page 1 Director (PD) B. Surveyor asked if there had been any incidents within the last 6 months. Caregiver A stated Resident 3 had left the home sometime during the winter months. Surveyor asked if the provider considered the incident an elopement. Caregiver A requested an explanation of what an elopement was, and Surveyor explained. Caregiver A stated they would have considered the incident an elopement. Caregiver A stated the Mag (Magnetic) Lock located on the outdoor exit was demagnetized from the cold weather and still needed repair. PD B stated s/he was not aware if the incident was reported to the department. Surveyor requested a copy of the incident report related to Resident 3's elopement and evidence it was reported to the department. On 03/27/2025, at 8:45 AM, Surveyor requested records for Resident 3 from PD B via email. At 5:05 PM, Surveyor received an email from PD B, including records for Resident 3. The following was included: -Resident 3 was admitted on 09/27/2010 and had a guardian. Resident 3 was diagnosed with Autism. Resident 3's Individual Service Plan (ISP,) signed 11/09/2024, identified the following behavioral challenges: Aggression to Staff, Self Harm or SIB (Self Injurious Behavior,) Aggressive to Peers, Verbal Aggression, Property Destruction, and Elopement Risk. -A staff observation note, dated 01/05/2025 at 7:15 PM: "[Resident 3] did elope once once [sic] ..." The note indicated an incident report was filled out. -An incident report, dated 01/05/2025, related to Resident 3's elopement. It stated Resident 3 went	M 134		

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M 134	Continued From page 2 outside the back sliding door to the deck and was able to exit the yard due to "the magnetic lock gate not working." It stated Resident 3 went next door to another facility that was licensed by the department. Resident 3 went inside and took a puzzle from another person being served. Staff from that home knocked on the provider's door and alerted that Resident 3 was at the other home. Resident 3 was back in the home within a few minutes of when s/he originally went outside to the deck. The report indicated maintenance would be at the home on 01/08/2025 to assess the magnetic lock on the fence. On 04/01/2025, at 4:30 PM, Surveyor reviewed the provider's department file. Surveyor did not locate any reports related to Resident 3's elopement. On 04/09/2025, at 10:00 AM, Surveyor interviewed PD B via phone. PD B stated s/he asked the provider's quality assurance staff if the elopement was reported, and the staff indicated it was not. PD B stated the staff admitted to having to remind him/herself to get certain reports submitted especially if they were higher than a level 2. PD B stated they considered an elopement a level 3.	M 134		
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 observation, record review, and	M 216		

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M 216	Continued From page 3	M 216		

interview, the licensee did not ensure the home and its operation complied with Wis. Admin. Code Ch. 88 and all other laws governing the home and its operation.

Findings include:

The provider is licensed on 09/09/2010, to provide care to up to 3 residents within the client group developmentally disabled.

On 03/26/2025, Surveyor conducted a standard licensure survey. Surveyor collected information through 04/09/2025.

The provider was issued 12 deficiencies. Two of 12 were repeat deficiencies. The following deficiencies were identified:

88.03(5)(e)1 Significant Change to the Resident
88.04(2)(a) Responsibilities
88.04(5)(b) Training - 8 Hours Annually
88.05(2) Access To Home And Within The Home
88.05(3)(a) Home Environment
88.05(4)(b)2 Smoke Detectors - Testing And Maintenance
88.05(4)(d)2.b Fire Evacuation Annual Evaluation
88.07(3)(a) Prescription Medications
88.07(3)(d) Medication - Written Order
88.07(3)(e)1 Medication - Record Keeping
88.10(3)(e) Self-Direction
88.10(3)(L) Safe Physical Environment

On 04/02/2025, at 4:02 PM, Surveyor received an email from Program Director (PD) B regarding Surveyor's documentation request. PD B stated within the email, in part, "I am sorry that this is coming in almost an hour past the deadline...I unfortunately struggled with finding information and have included others from my team...I had

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M 216	Continued From page 4 help from [Supervisor D] today but we both struggled with locating trainings to print a report for you...We also struggled with the schedule request. The homes are supposed to keep the copies of past schedule in a file on site but we did not find them anywhere on site..." On 04/09/2025, at 10:00 AM, Surveyor interviewed PD B regarding the deficiencies identified during the survey. PD B stated s/he was pulling his/her hair out to obtain the records that Surveyor requested. PD B stated Program Supervisor (PS) C was unable to find some of the records. PD B stated that when s/he transferred in September, the concerns related to the residents' shared bathroom being kept locked from the outside and the water being turned off in the shared bathroom sink was not brought to his/her attention. PD B stated the safety binder was "all out of whack" and many of the requested documents could not be located. PD B stated s/he could not provide evidence that staff were receiving annual Resident Rights training as required. PD B stated s/he recently implemented a task list to keep staff accountable for housekeeping duties. PD B stated some staff were more accountable than others as it related to housekeeping tasks. The licensee did not ensure the home and its operation complied with all laws governing the home.	M 216		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing	M 246		

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M 246	Continued From page 5 agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all employees received 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents annually for 2 of 2 employees reviewed who required continuing education. Findings include: On 03/26/2025, Surveyor requested employee records for Program Supervisor (PS) C and Caregiver D from Program Director (PD) B. On 03/31/2025, Surveyor reviewed employee records received via email from PD B. PS C had a hire date of 09/13/2011. PS C had no training hours for calendar year 2023. PS C's record did not contain evidence that Resident Rights training was completed in 2023. Caregiver D had a hire date of 08/30/2017. Caregiver D had 5.25 hours of training for calendar year 2023. Caregiver D's record did not contain evidence that Resident Rights training was completed in 2023 and 2024. On 04/02/2025, Surveyor emailed PD B and asked if there was additional training	M 246		

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M 246	Continued From page 6 documentation for PS C and Caregiver D. At 4:02 PM, PD B stated via email, "We found that [PS C] did rights training twice in 2024 but did not find anything for 2023. [Caregiver D] we did not fifind [sic] any rights training completed for 2023 or 2024. [Caregiver D] will be instructed to complete this by end of week and I will send once [s/he] has record of completion in place. Also maybe someone better at pulling info from the Relias program will be able to find something we did not." On 04/09/2025, at 10:00 AM, Surveyor interviewed PD B via phone. PD B stated s/he had not found evidence of any additional trainings for PS C or Caregiver D.	M 246		
M 260	88.05(2) ACCESS TO HOME AND WITHIN THE HOME RESIDENT ACCESS TO THE HOME AND WITHIN THE HOME. An adult family home shall be physically accessible to all residents of the home. Residents shall be able to easily enter and exit the home, to easily get to their sleeping rooms, a bathroom, the kitchen and all common living areas in the home, and to easily move about in the home. Additional accessibility features shall be provided as follows, if needed to accommodate the physical limitations of the resident or if specified in the resident's individual service plan:	M 260		

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M 260	Continued From page 7	M 260		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 3 of 3 residents were able to easily enter or exit a shared bathroom on the main floor. The door to the bathroom was kept locked to manage resident behaviors and fluid restrictions.

Findings include:

The provider is licensed to care for 3 adults in the client group of: developmentally disabled.

On 03/26/2025, at approximately 11:30 AM, Surveyor observed Resident 2 inform Caregiver A that Resident 2 needed to use the bathroom. Caregiver A gave Resident 2 a collection of keys that were hanging on a lanyard. Resident 2 walked to the shared bathroom and unlocked the bathroom door using the keys that Caregiver A provided. Surveyor asked Caregiver A why the bathroom door was locked. Caregiver A stated the bathroom was usually locked because residents would spend hours in the bathroom and flush toilets. Caregiver A stated Resident 2 was on a fluid restriction and had a history of excessively drinking water. Program Director (PD) B observed the transfer of keys to Resident 2 and advised Caregiver A s/he should be unlocking the door for Resident 2.

On 04/09/2025, at 10:00 AM, Surveyor interviewed PD B via phone. Surveyor shared concerns related to the shared bathroom door being locked and asked if the provider had a waiver for that. PD B stated s/he was not aware if a waiver was submitted to the department. PD B stated his/her observation on the day of survey was the first time s/he knew the bathroom door

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M 260	Continued From page 8 was being locked. PD B stated the bathroom door should be unlocked at all times. PD B stated it should be unlocked, especially for those that can go in there by themselves. Cross Reference N0556 DHS 88.10(3)(e) Self-Direction	M 260		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was clean and well-maintained. Findings include: The provider is licensed to care for 3 residents in the client group developmentally disabled. On 03/26/2025, from approximately 11:00 AM to 2:00 PM, Surveyor observed the following: Laundry Room -The right-side door was missing a panel near the bottom. Resident 1's Bedroom (Lower Level of Home) - Window blinds were missing sections. His/her bedroom floor contained dust, dirt, and debris.	M 276		

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M 276	Continued From page 9 Resident 1's Bathroom (Lower Level of Home) - A ceiling vent above the shower had dark spots on it and appeared to have thick areas of dust accumulation. -The toilet had a brown ring around the base and appeared to have a small amount of water leaking from the bottom. Living Room Outside of Resident 1's Bedroom (Lower Level of Home) -A mounted wall cabinet was missing a door panel. Living Room (Main Floor) -The medication cabinet door near the main floor living room had two holes in it. One of the holes was approximately 3 inches wide and 5 inches long. The other hole was approximately 3 inches wide and 3 inches long. Dining Area (Main Floor) -The window blinds were broken off in large sections. Backyard -There appeared to be a worn and discarded incontinence product lying on the grass. At approximately 11:55 AM, Surveyor shared some of the above observations with Caregiver A. When asked about the holes in the medication cabinet door, Caregiver A stated Resident 1 punched the door. Caregiver A stated Resident 1 had a tendency to break stuff. On 04/09/2025, at 10:00 AM, Surveyor interviewed Program Director (PD) B. Surveyor shared concerns related to the above observations. PD B stated a task list was recently	M 276		

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M 276	Continued From page 10 put into place because the home was having issues related to housekeeping tasks. PD B stated there were times when 1 staff was doing all the cleaning and the other was not. PD B stated the task list should be marked as tasks were completed. PD B stated staff should be checking the yard as often as possible because a resident had a history of throwing his/her briefs over the railing.	M 276		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure smoke detectors were tested monthly. This is a repeat deficiency. See Statement of Deficiency (SOD) 526711, dated 03/12/2021, SOD 526712, dated 02/01/2022, and SOD 526713, dated 09/08/2022. Findings include: On 03/26/2025, at approximately 11:15 AM, Surveyor requested to review smoke detector tests completed in 2023 and 2024. Caregiver A	M 336		

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M 336	Continued From page 11	M 336		

provided a red safety binder and indicated the smoke detector tests should be in the binder. Surveyor did not observe documentation pertaining to smoke detector tests completed in the binder. There was a policy with a section titled, "H.15. Fire Equipment Maintenance," that stated, in part, "Smoke alarms are checked monthly when running fire drills. These checks are documented on the Fire Drill report."

At 4:20 PM, Surveyor requested all smoke detector tests completed in 2023 and 2024 via email from Program Director (PD) B.

On 03/27/2025, at 5:04 PM, Surveyor received an email from PD B. PD B stated in the email s/he attached what fire drills s/he could find. The email included the following:

-Fire Drill forms that included a subsection titled, "Smoke Detectors/Fire Extinguishers." The forms indicated smoke detectors were checked on 03/07/2024, 05/06/2024, 07/11/2024, and an illegible date.

On 04/09/2025, at 10:00 AM, Surveyor interviewed PD B by phone. When asked if PD B had found any additional smoke detector tests, PD B stated s/he had not. PD B stated that when s/he reviewed the safety binder, it was all out of whack. PD B stated s/he would go back to the home and send any additional documentation found by the end of the day.

As of 04/10/2025, Surveyor had not received any additional documentation from PD B.

The provider did not ensure smoke detectors were tested monthly in 2023 and 2024.

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M 336	Continued From page 12 Cross Reference N0346 DHS 88.05(4)(d)2.b Fire Evacuation Annual Evaluation Cross Reference N0570 DHS 88.10(3)(L) Safe Physical Environment	M 336		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents sampled (Resident 1, Resident 2, and Resident 3), were evaluated annually for evacuation capabilities. Findings include: On 03/26/2025, at approximately 12:30 PM, Surveyor reviewed resident records. -Resident 1 was admitted on 04/03/2006. Resident 1's record did not contain evidence of an evacuation assessment for calendar year 2023 and 2024, using the Department's form. -Resident 2 was admitted on 09/01/2014. Resident 2's record did not contain evidence of an evacuation assessment for calendar year 2023 and 2024, using the Department's form. -Resident 3 was admitted on 09/27/2010.	M 346		

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M 346	Continued From page 13 Resident 3's record did not contain evidence of an evacuation assessment for calendar year 2023 and 2024, using the Department's form. On 03/27/2025 at 8:45 AM, Surveyor requested annual evacuation records for the calendar year of 2023 and 2024 from Program Director (PD) B via email. At 5:15 PM, Surveyor received an email from PD B with a subject line, "Missing Documentation." PD B stated within the email that the annual evacuation documentation for Resident 1, Resident 2, and Resident 3 was not located anywhere in the home or in any of the resident's binders. Cross Reference N0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing And Maintenance Cross Reference N0570 DHS 88.10(3)(L) Safe Physical Environment	M 346		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist.	M 458		

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M 458	Continued From page 14 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were securely stored to prevent unauthorized access. Findings include: The provider serves up to 3 residents within the following client group: developmentally disabled On 03/26/2025 at approximately 11:30 AM, Surveyor observed Resident 2 inform Caregiver A that Resident 2 needed to use the bathroom. Caregiver A gave Resident 2 a collection of keys that were hanging on a lanyard. Resident 2 was in possession of the keys while s/he was using the bathroom independently. Program Director (PD) B also observed the transfer of keys to Resident 2. PD B told Caregiver A that Caregiver A should go unlock the door for Resident 2 rather than give him/her the keys. Surveyor asked Caregiver A if the keys to the medication closet were included on the keys that were transferred to Resident 2. Caregiver A stated the same keys had the medication closet key on it. At approximately 12:09 PM, Surveyor asked Caregiver A about how the keys were managed among staff. Caregiver A stated s/he tried to keep an eye on the keys or carry them. Caregiver A stated the keys were often kept in a plastic storage bin on a shelf in the kitchen. Surveyor asked Caregiver A to identify the storage bin that was used to store the keys. Caregiver A identified a small white storage bin with six drawers. The storage bin was not locked and it was not kept in a locked cabinet. The keys would be accessible to anyone when kept in that location. Surveyor discussed concerns about the storage of the medication closet key.	M 458		

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M 458	Continued From page 15 On 04/09/2025, at 10:00 AM, Surveyor interviewed PD B via phone. Surveyor shared concerns related to how the keys were being stored and managed. PD B stated s/he sent out a group chat to staff regarding the incident. PD B stated Resident 2 should definitely not be in possession of the keys. PD B stated a staff member replied and indicated s/he was trained that way. PD B stated the concerns would be addressed with staff. The keys to the provider's medications were accessible to anyone in the home.	M 458		
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 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 ensure 2 of 3 residents (Resident 1 and Resident 2) reviewed, had a written order from his/her prescribing physician specifying who by name or position was permitted to administer the medication, under what circumstances, and in	M 464		

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M 464	Continued From page 16 what dosage the medication was to be administered. Findings include: On 03/26/2025 at approximately 12:30 PM, Surveyor reviewed resident records. -Resident 1 was admitted on 04/03/2006 and had a guardian. Resident 1's Individual Service Plan (ISP), dated 02/25/2025, indicated staff completed tasks related to medication management and administration. Resident 1's record did not include a written physician order permitting staff to administer medications. -Resident 2 was admitted on 09/01/2014 and had a guardian. Resident 2's ISP, dated 01/08/2025, indicated staff completed tasks related to medication management and administration. Resident 2's record did not include a written physician order permitting staff to administer medications. On 03/27/2025, at 8:45 AM, Surveyor requested documentation via email to reflect the written physician's orders permitting staff to administer medications from Program Director (PD) B. At 5:15 PM, Surveyor received an email from PD B with a subject line, "Missing Documentation." PD B stated within the email that the written authorizations for staff to dispense medications to Resident 1 and Resident 2 could not be found.	M 464		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications	M 466		

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M 466	Continued From page 17 controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the medication administration record (MAR), for 3 of 3 residents reviewed, showed the administration of the medication. Resident 1's MAR, from 01/01/2025 - 03/31/2025, contained 20 blank entries. Resident 2's MAR, from 01/01/2025 - 03/31/2025, contained 30 blank entries. Resident 3's MAR, from 01/01/2025 - 03/31/2025, contained 30 blank entries. Findings include: On 03/27/2025, Surveyor requested MARs for Resident 1, Resident 2, and Resident 3 from Program Director (PD) B via email. On 04/02/2025, Surveyor received an email from PD B with resident MARs included. Resident 1's January 2025 MAR included the following blank entries for his/her prescribed medications:	M 466		

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M 466	Continued From page 18 Clomipramine 50 MG Capsule 01/18/2025 8:00 PM 01/19/2025 8:00 PM Divalproex SOD DR 500 MG Tab 01/18/2025 8:00 PM 01/19/2025 8:00 PM Melatonin 3 MG Tablet 01/18/2025 8:00 PM 01/19/2025 8:00 PM Risperidone 1 MG Tablet 01/18/2025 8:00 PM 01/19/2025 8:00 PM Clonazepam 2 MG Tablet 01/18/2025 8:00 PM 01/19/2025 8:00 PM Resident 1's March 2025 MAR included the following blank entries for his/her prescribed medications: Clomipramine 50 MG Capsule 03/05/2025 8:00 PM Divalproex SOD DR 500 MG Tab 03/05/2025 8:00 PM 03/31/2025 8:00 AM Therapeutic-M Tablet 03/31/2025 8:00 AM Melatonin 3 MG Tablet 03/05/2005 8:00 PM Risperidone 1 MG Tablet 03/05/2025 8:00 PM 03/31/2025 8:00 AM Sertraline HCL 50 MG Tablet 03/31/2025 8:00 AM Clonazepam 2 MG Tablet 03/05/2025 8:00 PM 03/31/2025 8:00 AM Resident 2's January 2025 MAR included the following blank entry for his/her prescribed	M 466		

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M 466	Continued From page 19 medication: Divalproex SOD ER 250 MG Tab 01/18/2025 8:00 PM 01/19/2025 8:00 PM Fluvoxamine Maleate 100 MG Tab 01/18/2025 8:00 PM 01/19/2025 8:00 PM Haloperidol 5 MG Tablet 01/18/2025 8:00 PM 01/19/2025 8:00 PM Lorazepam 1 MG Tablet 01/18/2025 8:00 PM 01/19/2025 8:00 PM Propranolol 10 MG Tablet 01/18/2025 8:00 PM 01/19/2025 8:00 PM Risperidone .5 MG Tablet 01/18/2025 8:00 PM 01/19/2025 8:00 PM Resident 2's March 2025 MAR included the following blank entry for his/her prescribed medication: Divalproex SOD ER 250 MG Tab 03/05/2025 8:00 PM 03/24/2025 8:00 PM 03/31/2025 8:00 AM Fluvoxamine Maleate 100 MG Tab 03/05/2025 8:00 PM 03/24/2025 8:00 PM 03/31/2025 8:00 AM Haloperidol 5 MG Tablet 03/05/2025 8:00 PM 03/24/2025 8:00 PM 03/31/2025 8:00 AM Lorazepam 1 MG Tablet 03/05/2025 8:00 PM 03/24/2025 8:00 PM	M 466		

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M 466	Continued From page 20 03/31/2025 8:00 PM Propranolol 10 MG Tablet 03/05/2025 8:00 PM 03/24/2025 8:00 PM 03/31/2025 8:00 AM Risperidone .5 MG Tablet 03/05/2025 9:00 PM 03/31/2025 8:00 AM 03/24/2025 9:00 PM Resident 3's January 2025 MAR included the following blank entry for his/her prescribed medication: Quetiapine Fumarate 200 MG Tab 01/18/2025 8:00 PM 01/19/2025 8:00 PM Melatonin 5 MG Tablet 01/18/2025 8:00 PM 01/19/2025 8:00 PM Docusate Sodium 100 MG 01/18/2025 8:00 PM 01/19/2025 8:00 PM Fluphenazine 5 MG Tablet 01/18/2025 8:00 PM 01/19/2025 8:00 PM Benztropine Mes .5 MG Tab 01/18/2025 8:00 PM 01/19/2025 8:00 PM Lorazepam 2 MG Tablet 01/17/2025 4:00 PM 01/18/2025 8:00 PM 01/19/2025 8:00 PM 01/29/2025 4:00 PM Zolpidem Tartrate 10 MG Tablet 01/18/2025 8:00 PM 01/19/2025 8:00 PM Resident 3's March 2025 MAR included the following blank entry for his/her prescribed	M 466		

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M 466	Continued From page 21 medication: Quetiapine Fumarate 200 MG Tab 03/05/2025 8:00 PM Sertraline HCL 50 MG Tablet 03/31/2025 8:00 AM Olanzapine 10 MG Tablet 03/31/2025 8:00 AM Polyethylene Glycol 3350 Powd 03/31/2025 8:00 AM Melatonin 5 MG Tablet 03/05/2025 8:00 PM Docusate Sodium 100 MG 03/05/2025 8:00 PM 03/31/2025 8:00 AM Fluphenazine 5 MG Tablet 03/05/2025 8:00 PM Benztropine Mes .5 MG Tab 03/05/2025 8:00 PM 03/31/2025 8:00 AM Lorazepam 2 MG Tablet 03/05/2025 8:00 PM 03/31/2025 8:00 AM Zolpidem Tartrate 10 MG Tablet 03/05/2025 8:00 PM Vitamin D3 2,000 Unit Softgel 03/31/2025 8:00 AM On 04/09/2025, at 10:00 AM, Surveyor interviewed PD B via phone. Surveyor asked if MAR audits were completed and how often they were completed. PD B stated s/he could not remember if the quality assurance manager or the nurse was responsible for completing MAR audits. PD B stated s/he would ask another member of his/her team. When asked about the blank spaces on the MAR, PD B stated it was possible that paper MARs were completed on the corresponding dates. Surveyor requested copies of paper MARs, if found, by the end of the day.	M 466		

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M 466	Continued From page 22 As of 04/10/2025, Surveyor had not received any additional documentation from PD B.	M 466		
M 556	88.10(3)(e) Self-Direction 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, record review, and interview, the provider did not ensure the resident right to self-direction was respected or promoted for 3 of 3 residents in the home. Residents' access to the backyard was limited due to staff placing a piece of wood on the patio door track to prevent from opening. Residents' access to running water was limited when the shared bathroom's water supply was turned off to address a resident's fluid restriction. Findings include: The provider is licensed to care for 3 adults in the client group of developmentally disabled. Example 1	M 556		

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M 556	Continued From page 23 On 03/26/2025, at approximately 11:45 AM, Surveyor toured the home with Caregiver A. The shared bathroom on the main level of the home was locked. Caregiver A unlocked the door and Surveyor attempted to turn on the water supply at the sink. Caregiver A stated there was no running water at the sink unless staff flipped a switch that was located in a locked cabinet to the left of the sink. Caregiver A stated the short valve was the cold water and the long valve was the hot water. Caregiver A stated the water supply was always off at the sink unless staff turned it on. When asked why that practice was implemented, Caregiver A stated residents were "liquid obsessed." Caregiver A stated Resident 2 was on a fluid restriction and had a history of excessively drinking water. At approximately 12:20 PM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 04/03/2006 and had a legal guardian. Resident 2 was diagnosed with Autism. Resident 2's Individual Support Plan (ISP,) dated 02/25/2025, included a "Client Rights" section that indicated Resident 2 was limited to 60 fluid ounces per day due to kidney failure. Resident 2's Behavior Support Plan (BSP), reviewed on 03/31/2023, included a section titled, "Home Modifications." Under that section, it read, in part, "Due to doctor ordered fluid restrictions, water sources are locked in [Resident 2's] home. This includes the bathroom, kitchen faucet, and refrigerator. [Resident 2] will communicate when [s/he] would like something to drink, by asking for a cup, a drink, or [his/her] soda." Under a "Client Rights Considerations" section, it read, in part, "[Resident 2] has limited access to fluids in [his/her] home, [sic] the bathroom and laundry room water sources are locked. Staff will provide	M 556		

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M 556	Continued From page 24 access to the bathroom when [s/he] needs to use it, but monitor to ensure [Resident 2] isn't drinking water from the faucets...Prior to the fluid restriction [Resident 2] historically had issues with polydipsia (excessive water drinking) that REM was able to help curb with actively ignoring the behavior and always having a drinking cup accessible for [Resident 2.] This rights limitation is being following [sic] by [Medical Provider] and will be reviewed yearly..." On 04/09/2025, at 10:00 AM, Surveyor interviewed Program Director (PD) B via phone. PD B stated s/he did not know staff were turning the water off at the bathroom sink. PD B stated that when s/he transferred to the home in September, it was not brought to his/her attention. PD B stated s/he would ask his/her team about it. PD B stated s/he was not aware if a waiver was submitted regarding the water supply. Example 2 On 03/26/2025, at approximately 1:20 PM, Surveyor attempted to open a patio door, which was a second exit on the main level of the home. The patio door led to an outdoor deck and a fenced in backyard. Surveyor could not get the door open without assistance. Caregiver A approached the door and removed a small piece of wood that had been lodged at the bottom to prevent opening. Surveyor observed a white door alarm attached on the upper part of the patio door that did not alarm when opened. Caregiver A stated the alarm was not active and it would be dinging all the time with residents going in and out. Surveyor observed the parameter of the outdoor fence line and noticed the exit door appeared to be blocked.	M 556		

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M 556	Continued From page 25 At approximately 1:25 PM, Surveyor asked Caregiver A to tour the backyard and demonstrate how staff and residents would exit the enclosed backyard. Caregiver A stated s/he had not attempted to go out through that exit. Caregiver A stated s/he did not know the position of the latch which was located on the opposite side of the exit door. Caregiver A attempted to open the door by reaching over the top of the fence but was not successful. Caregiver A stated the exit usually had a Mag (Magnetic) Lock on it but that lock needed repair. Caregiver A stated a barrel latch was put on until the Mag Lock was repaired. Resident 2's BSP, dated 03/31/2023, stated, in part, "[Resident 2's] target behaviors include Verbal Aggression, Physical Aggression, Self-Injurious Behavior (SIB) and Elopement..." Under a section titled, "Criteria/Procedure for using Mag Lock's on Exit Doors," it read, in part, "The fence gate will have mag locks that are always kept magnetically locked...The mag locks NEED to be engaged at all times...The sliding glass door to the back yard will not have a locking mechanism on it, should [Resident 2] want to go outside...The mag locking system for the front, garage, and fence doors are all hard wired into the fire system of the home. In the event of a fire, the mag locks would automatically disengage, allowing for safe evacuation from the home..." On 04/09/2025, at 10:00 AM, Surveyor interviewed PD B. When asked about the patio door, PD B stated they would use the piece of wood when they left the home. PD B stated staff should not be using it when they are in the house with the residents. PD B stated staff should be watching the residents and not be stopping them. PD B stated Resident 3 liked to go outside and	M 556		

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M 556	Continued From page 26 get fresh air. Surveyor shared concerns about the door with the barrel latch on the fence outside. PD B stated there was another opening on the fence that was used by maintenance that could be used in an emergency. Cross Reference N0260 DHS 88.05(2) Access To Home And Within The Home	M 556		
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: Based on observation and interview, the provider did not safeguard residents who cannot fully guard themselves from environmental hazards. The provider did not ensure that all fire extinguishers were mounted and readily accessible. Two of 2 fire extinguishers were located behind locked doors. One of 2 fire extinguishers was not mounted. The provider did not ensure the dryer vent was made of rigid venting material.	M 570		

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M 570	Continued From page 27 This is a repeat deficiency. See SOD 526711, dated 3/12/2021 and SOD 526712, dated 02/01/2022. Findings include: This provider is licensed to serve up to 3 residents in the client group developmentally disabled. Example 1 On 03/26/2025, at approximately 11:50 AM, Surveyor toured the lower level of the home with Caregiver A. Surveyor observed a locked door with a sign posted on it that read, "Fire Extinguisher." Caregiver A unlocked the door and indicated the fire extinguisher was mounted on the wall to the immediate right of the doorway. Surveyor observed the mounted fire extinguisher. At 11:53 AM, Surveyor asked Caregiver A where the main level fire extinguisher was located. Caregiver A stated, "I'm pretty sure it's in the med (medication) cabinet." Surveyor observed Caregiver A unlock the medication cabinet and the fire extinguisher sitting on the floor between a file cabinet and a storage organizer. Example 2 "House fires caused by dryers are more common than many people realize, based on statistics from the National Fire Protection Agency and the Consumer Product Safety Commission, which cite that around 15,000 fires each year can be attributed to improper lint cleanup and maintenance of the home's clothes dryer. Fortunately, these fires are very easy to prevent.	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013489	A. BUILDING: _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
505 PINE CONE PLACE	505 PINE CONE PLACE HOLMEN, WI 54636

(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 570	Continued From page 28 The recommendations outlined below reflect International Residential Code (IRC) SECTION M1502 CLOTHES DRYER EXHAUST guidelines: M1502.5 Duct construction. Exhaust ducts shall be constructed of minimum 0.016-inch-thick (0.4 mm) rigid metal ducts, having smooth interior surfaces, with joints running in the direction of air flow. Exhaust ducts shall not be connected with sheet-metal screws or fastening means which extend into the duct. This means that the flexible, ribbed vents used in the past should no longer be used. They should be noted as a potential fire hazard if observed during an inspection." (Retrieved on 04/09/2025 from the International Association of Certified Home Inspectors web page at https://www.nachi.org/dryer-vent-safety.htm). On 03/26/2025, at approximately 1:35 PM, Surveyor observed the provider's dryer vent with Caregiver A. It was not made of rigid venting material. It appeared to be flexible, accordion style venting. Caregiver A stated the previous venting had leaked and the venting was recently replaced. The provider did not safeguard residents who cannot fully guard themselves from environmental hazards. Cross Reference N0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing And Maintenance Cross Reference N0346 DHS 88.05(4)(d)2.b Fire Evacuation Annual Evaluation	M 570		