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M 000	INITIAL COMMENTS On 03/28/2025, Surveyor conducted three complaint investigations at Lexington. Data collection continued through 04/11/2025. Two of 3 complaints were substantiated. Four deficiencies were identified. Census: 4	M 000		
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 safe, clean and well-maintained. Findings include: On 01/31/2025, the Department received a complaint about the provider environment. On 03/28/2025 at approximately 9:00 AM, Surveyor interviewed Caregiver A and asked if there were any concerns with the home. Caregiver A stated the door trim for Resident 1 was in rough shape as a result of his/her wheelchair, and Resident 2 had electrical outlets that did not function or work.	M 276		

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

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M 276	Continued From page 1 On 03/28/2025 at approximately 9:05 AM, Surveyor toured the home and observed the following: -Back deck ramp observed to have several pieces of wood not secured to the walkway. The deck contained several boards that gave way or dipped when walked on. The boards were not even and created a trip hazard. Caregiver A confirmed that exit path was designated as the home's second exit and would be used to evacuate. -The front entrance ramp leading up to the door needed repair. The wooden walkway was not stable when the boards at the bottom of the walkway were loose. Surveyor stepped on a board and the opposite side popped up. The walkway also contained pieces of wood that were cracked and uneven. -Electrical outlets in Resident 2's room did not function. Caregiver A stated they had not been working since last summer, after a big storm, and management was aware. Caregiver A stated s/he was concerned there was a safety issue going on. -Resident 1's room door was not maintained and was not secured, creating a gap along the left side of the door. Surveyor could see into the room with the door closed. -The window blinds in the bathroom were broken, with pieces of the broken window blind on the floor and hanging from the window. Surveyor requested maintenance logs from 2024 - current from Caregiver A. On 03/28/2025, Area Director (AD) H sent an email to Surveyor	M 276		

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M 276	Continued From page 2 acknowledging the request with other requested items, but maintenance logs were not received. As of 04/11/2025, no additional information was received.	M 276		
M 444	88.07(2)(b)3 TRANSPORTATION TO MEDICAL Providing, arranging, transporting or accompanying a resident to medical or other appointments as part of the resident's individual service plan. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide, arrange, transport or accompany a resident to medical appointments. Findings include: On 03/28/2025 at 9:50 AM, Surveyor observed a calendar hanging on the wall in the staff office. The calendar showed multiple appointments crossed off with a note, "rescheduled". Surveyor interviewed Caregiver A and asked why appointments were rescheduled multiple times. Caregiver A stated, "Appointments are getting cancelled because staff are not available to take them. We are contracted with [MCO] that we (the company) will transport to appointments, but the residents aren't getting to their appointments. [Resident 1]'s annual urology appointment has been rescheduled 3 times now and was last missed on 03/21/2025 due to staffing and will need to be re-scheduled for the fourth time. [Resident 2] missed a bone density test yesterday because I had to take [Resident 1] to urgent care and there were no staff available so that will need to be rescheduled again for the fourth time. It was	M 444		

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M 444	Continued From page 3 scheduled 03/05/2025 and missed, then rescheduled to 03/14/2025 and missed, and rescheduled to 03/26/2025 and missed due to lack of staff and communication from the program director."	M 444		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 residents received the correct dosage at the correct time when the service provider administered prescription medications. Findings include: On 03/07/2025, the Department received a complaint regarding medication errors. On 03/28/2025 at approximately 8:30 AM, Surveyor asked Caregiver A if there were any concerns with medications. Caregiver A stated, "Yes, there was a 12-day period with 7 med (medication) errors by [Caregiver B] and [Caregiver F] who were previously suspended for	M 462		

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having too many errors and were supposedly re-trained by [Nurse C] remotely and then put back on meds to have more errors. [Caregiver B] is still passing meds and scheduled on evenings and night shift."

Caregiver A further stated, "I do the med audits, and I am the Lead, but my last day is coming up so I'm not sure who will catch these errors. There should be more training and priority made towards the staff making them. We've had two program managers left [sic] or stepped down back in December. Employees are frustrated."

Surveyor reviewed the following General Event Reports (GER) related to medication errors in the facility:

RESIDENT 1

Resident 1 had an admission date of 02/09/2024. Resident 1 had 4 GERs filed regarding medication errors:

12/19/2024 at 4:00 PM: Caregiver B did not administer Trospium Chloride and Gabapentin on 12/18. Nurse C documented, "All staff have been trained on proper med (medication) pass techniques, including opening MAR (medication administration record) to perform 3 checks of 5 rights of medication label against MAR entry. Last step in med pass is after observing individual ingest medication [sic] complete all needed documentation. Best practice is to do medication check to ensure documentation was saved & all meds are out of blister pack. It is each staff member's responsibility to pass medication as ordered, [sic] it is each individual's right to receive medication as ordered.

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M 462	Continued From page 5 01/31/2025 at 9:00 PM: While completing narc (narcotic) count, AM staff noticed 8 PM Clonazepam from 01/29/2025 had not been administered and the pill was still in the pack. Nurse C documented, "All staff has been trained on proper med pass techniques. It is each staff member's responsibility to pass medications as they have been ordered. It is each individual's right to receive medication as ordered. 02/01/2025 at 5:00 PM: AM staff found envelope of NAC 600 MG Capsule marked as 1/31 in the bottom of medication drawer with 1 of 2 capsules still in it. Caregiver G was responsible for administering the medication and did not administer as ordered. Nurse C documented, "All staff has been trained on proper med pass techniques. It is each staff member's responsibility to pass medications as they have been ordered. It is each individual's right to receive medication as ordered." 03/25/2025 at 7:00 AM: Divalproex was initially on hold until after 7:30 AM blood draw, but resident was not taken to lab draw so all meds were given except Divalproex. RESIDENT 2 Resident 2 had an admission date of 02/09/2024. Resident 2 had 16 GERs (1 duplicate) filed regarding medication errors: 12/09/2024 at 4:14 PM: Resident 2's Gabapentin and Propranolol were not administered. Nurse C documented, "All staff have been trained on proper med pass techniques [sic] including opening the MAR & doing 3 checks. It is each staff member's responsibility to pass medications as ordered. It is each individual's right to receive	M 462		

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medication as ordered."

12/14/2024 at 8:00 PM: Medication from 12/13/2024 found still in medication bubble pack when staff was giving 8pm medications for 12/14/24. Notified on-call PD and put medication in black box. Nurse documented, "All staff have been trained on proper med pass techniques, including opening the MAR, doing 3 checks of medication label against the MAR entry, observe individual ingest medication [sic] then complete documentation. Best practice is for staff (co-staff if avail [available]) to med check after med pass is complete to ensure all meds have been passed & all documentation was saved properly. PD D documented, "So I will do a training with staff at he [sic] next staff meeting."

12/19/2024 at 8:00 PM: Caregiver B did not administer Buspirone HCL 30 MG Tablet, gave only 1 tablet of Divalproex instead of 3, did not give Gabapentin, gave 2 tablets of Trazodone 40 mg tablets instead of 1. Nurse C documented, "All staff have been trained on proper med pass techniques, including opening MAR to perform 3 checks of 5 rights of medication label against MAR entry. Last step in med pass is after observing individual ingest medication [sic] complete all needed documentation. Best practice is to do medication check to ensure documentation was saved & all meds are out of blister pack. It is each staff member's responsibility to pass medication as ordered, [sic] it is each individual's right to receive medication as ordered.

12/22/2024 at 4:00 PM: Caregiver B did not administer Resident 2's Gabapentin 300 mg capsules at 4:00 PM. Nurse C documented, "All staff have been trained on proper med pass

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techniques, including opening MAR to perform 3 checks of 5 rights of medication label against MAR entry. Last step in med pass is after observing individual ingest medication [sic] complete all needed documentation. Best practice is to do medication check to ensure documentation was saved & all meds are out of blister pack. It is each staff member's responsibility to pass medication as ordered, [sic] it is each individual's right to receive medication as ordered. Area Director (AD) E documented, "PD will provide additional administration training with staff at next staff meeting."

01/09/2024 at 8:07 PM: Caregiver B administered 1 of 3 tablets of Divalproex. Nurse C documented, "All staff have been trained on proper med pass techniques [sic] including opening the MAR, doing 3 checks of Medication label against MAR entry before passing medication to individual. Staff need to slow down and do 3 checks. After observing ingestion of medication [sic] staff are to complete documentation. AD E documented, "PD will provide additional medication administration training with staff at next staff meeting."

01/11/2025 at 8:17 PM: Divalproex medication not completely administered. Only 1 of 3 tablets given. Two tablets still in bubble pack 01/10/2025. Nurse C documented, "All staff have been trained in proper med pass techniques, including opening the MAR to do 3 checks of MAR entry against the medication label. It is each staff member's responsibility to pass medications as ordered during their shift. It is each individual's right to received [sic] medication as ordered. Staff must slow down and do their checks completely."

02/19/2025 at 8:00 PM: Caregiver B did not

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administer Gabapentin. Nurse C documented, "All staff have been trained on proper med pass techniques. It is each staff member's responsibility to pass medication at time ordered on the MAR during their shift. It is each individual's right to receive medications as ordered."

02/22/2025: Staff was passing 8:00 PM medications and saw the medication (Trazodone) had already been removed for that date. Nurse C documented, "All staff have been trained on proper med pass techniques. During 3 checks staff must ensure correct date/time is used. It is each staff member's responsibility to pass medications as ordered during their shift. It is each individual's right to receive medications as ordered. Caregiver A documented, "I had done a med audit on 2/19 during the AM shift (thus the GER on 2/19 for an error on 2/17). On the 19th [sic] this med had not been missed therefore leaving the med error occurring on 2/19, 2/20, or 2/21. PD D documented, "Staff had notified me on the 17th and told me of the error and staff told me that [s/he] was going to the GER the next day stating [s/he] was tired from working [his/her] double shift. So, the staff need to be really checking and going over meds and asking a coworker [sic] if available to look at the med as well and if that is not an option maybe call on-call or supervisor and video chatting to show what they believe is wrong with the med pack."

02/28/2025 at 8:00 PM: Caregiver F did not administer Famotidine [sic] was still in pill pack, and Fluticasone spray not administered. Nurse C documented, "All staff have been trained on proper med pass techniques. It is each staff member's responsibility to pass medication as ordered (on time) during their shift. It is each

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individual's right to receive medications as ordered.

03/02/2025 at 8:00 PM: Dose of Famotidine was missed on 02/27 and 02/26 (may have been delivered too late. Noted on 03/02 during med audit, both 26th and 27th doses were punched out but doses from 28th and 1st are in pill pack. Staff to remove 28th and 1st and remind evening shift staff to use correct dates. Nurse C documented, "All staff have been trained on proper med pass techniques [sic] including doing 3 checks during med pass. Staff need to slow down [sic] and double/triple check correct date is being used.

03/03/2025 at 8:00 PM: Charting error- 8:00 PM Buspirone not passed on 03/02/25. Notified on-call PD and put medication in the black box. Nurse C documented, "All staff have been trained on proper med pass techniques. It is each staff member's responsibility to pass medication as ordered (on time) during their shift. It is each individual's right to receive medications as ordered."

03/04/2025 at 8:00 PM: On 03/01 staff reported an extra dose had been given and requested PD order [sic] an extra dose to replace it. Upon doing a med audit, staff noticed there was no longer a missing dose, and an extra dose was not delivered. Med was not given between 3/1 and 3/3.

03/08/2025 at 4:00 PM: Buspirone still in pill pack. Nurse C documented, "All staff have been trained on proper med pass techniques. It is each staff member's responsibility to pass medications as ordered (on time) during their shift. It is each individual's right to receive medications as

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ordered."

03/18/2025 at 4:00 PM: Charting error- Staff did not chart medication was given. Nurse C documented, "Documentation error. Staff must complete documentation as soon as individual has ingested their medication so on [sic] coming staff know what's been given."

03/21/2025 at 8:00 PM: Caregiver B did not administer 8pm Trazadone dose as it was still in pill pack for 03/20 but marked as administered on the MAR. GER report further documented, "Remove the staff member from the med pass and have them retrain with the RN (registered nurse) of [company name]."

RESIDENT 3

Resident 3 had an admission date of 02/08/2024. Resident 3 had 6 GERs filed related to medication errors:

12/14/2024 at 8:00 PM: Risperidone still in medication bubble pack for date 12/13. Nurse C documented, "All staff have been trained on proper med pass techniques, including opening the MAR, doing 3 checks of medication label against the MAR entry, observe individual ingest medication [sic] then complete documentation. Best practice is for staff (co-staff if avail) to med check after med pass is complete to ensure all meds have been passed & all documentation was saved properly."

12/19/2024 at 8:00 PM: Caregiver B did not administer full dose of Tacrolimus. Nurse C documented, "All staff have been trained on proper med pass techniques, including opening MAR to perform 3 checks of 5 rights of

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medication label against MAR entry. Last step in med pass is after observing individual ingest medication [sic] complete all needed documentation. Best practice is to do medication check to ensure documentation was saved & all meds are out of blister pack. It is each staff member's responsibility to pass medication as ordered, [sic] it is each individual's right to receive medication as ordered."

01/01/2025: 1 of 3 1mg capsules was found loose in the drawer and not administered. Nurse C documented, "Staff need to slow down, not smash blister packs together, & double check correct number of pills in cup."

01/11/2025: An extra dose of Melatonin was given at some point. Discovered on 01/11. Nurse C documented, "All staff have been trained in proper med pass techniques, including opening the MAR and do 3 checks of MAR entry against the medication label. It is each staff member's responsibility to pass medications as ordered during their shift. It is each individual's right to received [sic] medication as ordered. Staff must slow down and do their checks completely." AD E documented, " ...additional training needs to occur on medication administration by PD."

01/14/2025: Resident's medications were given to another resident (Resident 4) on 01/08. Staff then had to administer medications dated for 01/09. Staff sent PD a communication on the 9th requesting extra doses be ordered from pharmacy so there was not a missing dose. On the 14th, staff did a med audit and discovered all meds were back on track by date even though the missing doses were not delivered from pharmacy. Somewhere between the 9th and 13th, the missing doses were not given (Prazosin,

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M 462	Continued From page 12 Risperidone, and Melatonin). 03/04/2025 at 8:00 AM: Omission-Caregiver B did not administer 8 PM dose on 3/3 of Mycophenolate. Nurse C documented, "All staff have been trained on proper med pass techniques, including opening the MAR & doing 3 checks of med label against MAR entry ..." RESIDENT 4 Resident 4 had an admission date of 09/01/2023. Resident 4 had 9 GERs filed regarding medication errors: 12/24/2024 at 8:03 PM: Caregiver B responsible when the bubble pack with 2 of the 3 pills had the 23rd and 24th punched out for Resident 2. AD E documented, "PD will provide additional medication administration training with staff at next staff meeting. 01/08/2025 at 7:01 PM: Caregiver B administered Resident 3's medications (Olanzapine 10mg tablet) to Resident 4. 01/08/2025 at 8:00 PM: Caregiver B administered Resident 4's two Atorvastatin meds instead of one. Resident 4 was not given Perdiem Overnight Relief tablet, olanzapine, or buspirone at 8:00 PM. Above reports were reviewed by Nurse C. Nurse C documented, "All staff have been trained on proper med pass techniques [sic] including opening the MAR, doing 3 checks of Medication [sic] label against MAR entry (checking right person, drug, dose, date/time, route) before passing medication to individual. Staff need to slow down and do 3 checks. After observing	M 462		

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ingestion of medication [sic] staff are to complete documentation. Reports were also reviewed and approved by PD D and AD E.

01/12/2025 report date for unknown time of error: An extra dose of Resident 4's Atorvastatin was given between the 9th and 10th. Nurse documented, "All staff have been trained in proper med pass techniques, including opening the MAR to do 3 checks of MAR entry against the medication label. It is each staff member's responsibility to pass medications as ordered during their shift. It is each individual's right to receive medication as ordered. Staff must slow down and do their checks completely. Be sure to know the date." AD E documented, "PD will provide additional medication administration training with staff at next staff meeting." PD D documented, "Staff has had additional training at this program and PD will be doing another administration training at February meeting."

01/14/2025 at 8:00 PM: Overnight shift staff was completing narcotic count and found medication was written down by Caregiver F on the sheet as given and was checked off in the MAR but it was still in the bubble pack. Notified on-call and administered the medication. Nurse C Reviewed the error and documented, "Narc (narcotic) count should be counted with 2 staff at shift change."

01/30/2025 at 9:00 PM: Omission- While completing narcotic count, AM staff noticed Lorazepam from 01/29/2025 had not been administered and the pill was still in the pack. Nurse C documented, "All staff have been trained on proper med pass techniques. It is each staff member's responsibility to pass medications as they have been ordered. It is each individual's right to receive medication as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019854	A. BUILDING: _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON	710 E LEXINGTON BLVD EAU CLAIRE, WI 54701

(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 462	Continued From page 14 03/01/2025 at 8:00 PM: Staff was changing resident's bedding and found Olanzapine and Divalproex (2 pills) in the middle of bed. Nurse C documented, "Staff need to observe individual ingest the medication during med pass. Always [sic] if individual is able med pass should not happen in bed. 03/08/2025: Omission at unknown time- Staff was putting laundry away and found ½ tablet Olanzapine on the floor. Nurse C documented, "Staff need to observe individual ingest medication." 03/14/2025 at 8:00 PM: Caregiver F signed out medications on the MAR and the narcotic sheet for the 8:00 PM dose on 03/13/2025, but the medication (Lorazepam) was still in the pill pack and not given. Scheduled medication Clotrimazole was marked as given on the MAR but was not on-site. Nurse C reviewed the report and documented, "All staff have been trained on proper med pass techniques including 3 checks. The last step in med pass is to complete documentation after observing ingestion of medication. Thirty-four medication errors were reported between 12/18/2024 and the date of survey. Nurse C followed up and reviewed each GER and indicated staff were trained, however, errors continued to occur. Staff was not removed from medication administration until 03/21/2025.	M 462		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when	M 570		

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M 570	Continued From page 15	M 570		

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 ensure a safe environment. The dryer vent did not consist of rigid metal.

Findings include:

"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.

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

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M 570	Continued From page 16 the past should no longer be used. They should be noted as a potential fire hazard if observed during an inspection." (Retrieved on 04/02/2025 from the International Association of Certified Home Inspectors web page at https://www.nachi.org/dryer-vent-safety.htm). On 03/28/2025 at approximately 9:00 AM, Surveyor toured the home and observed a flexible dryer vent in use. Caregiver A informed Surveyor at the time of observation that the dryer vent had recently been replaced when they remodeled the kitchen and was unable to provide additional documentation related to the rating for the vent in use.	M 570		