STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410009	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	349 W 11TH ST FOND DU LAC, WI 54935

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N 000	Initial Comments On 05/23/2025 to 06/04/2025, Surveyor conducted a complaint investigation and standard survey at Franklin House. Four deficiencies were identified. The complaint was unsubstantiated. Census: 9	N 000		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by:	N 406		

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

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N 406	Continued From page 1 Based on observation and interview, the provider did not ensure medications that had been changed, discontinued, or expired were removed from the medication cart and disposed of within 30 days. Findings include: On 05/23/2025 at 9:07 AM, Surveyor toured the provider's medication cart with Manager A. The following was observed: -Resident 3's blister card of Acetaminophen 325 mg PRN (as needed) with a dispensed date of 07/17/2024, contained 58 tablets. -Resident 3's blister card of Acetaminophen 625 mg tablet PRN with a dispensed date of 07/06/2024, contained 2 tablets. -Resident 3's blister card of Melatonin 1 mg tablet PRN, with a dispensed date of 09/12/2024, contained 55 tablets. -Resident 4's blister card of Acetaminophen 500 mg tablet PRN, with a dispensed date of 07/15/2024, contained 07/15/2024. -Resident 5's blister card of Risperidone 1 mg tablet PRN, with a dispensed date of 07/22/2024, contained 56 tablets On 05/23/2025 at 915 AM, Surveyor interviewed Manager A regarding the number of medications retained beyond 30 days for the above residents. Manager A stated s/he was responsible for auditing the med cart for any expired medications. Manager A acknowledged the above medications should have been destroyed within 30 days.	N 406		

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N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (who required) quarterly psychotropic medication reviews was completed in 2024 and 2025. Findings include: On 05/23/2025, Surveyor reviewed Resident 1's record and identified the following: Resident 1 admitted to the facility on 10/24/2024. Resident 1's individual service plan (ISP) dated 02/2025 indicated staff administer his/her medications. Resident 1's physician orders included the following: Amantadine 100mg tablet to be taken twice daily with a start date of 11/01/2024 (schizoaffective disorder/depression), Fluphenazine 5mg to be taken once daily with a start date of 12/09/2024 (schizoaffective disorder), Lorazepam 0.5mg to be taken 3 times daily with a start date of 10/31/2024 (schizoaffective disorder), and Venlafaxine	N 407		

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N 407	Continued From page 3 150mg to be taken once daily with a start date of 12/02/2024 (schizoaffective disorder, depressive type). Resident 1's record did not contain a psychotropic medication review for the 4th quarter of 2024 and 1st quarter of 2025, completed by a pharmacist, practitioner, or registered nurse as needed, for the desired response and possible side effects of scheduled psychotropic medications. On 05/23/2025 at 12:00 PM, Surveyor interviewed Manager A and Manager B. Surveyor reviewed a quarterly psych evaluation dated 05/22/2025 completed by Manager A. Surveyor asked Manager A if s/he was one of the above clinicians to be able to complete assessment. Manager A stated s/he was not and did not know a licensed clinician had to complete quarterly psychotropic medication reviews. Manager A reported the facility did not currently have a nurse, but was actively looking.	N 407		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by:	N 426		

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N 426	Continued From page 4 Based on record review and interview, the provider did not ensure services were adequate to meet the need of the resident in the area of supervision for Resident 2. Between 04/14/2025-05/22/2025, staff documented Resident 2 had 6 occurrences of wandering behaviors including wandering dangerously close to train tracks (next door to the facility) and leaving the facility on 05/18/2025 without notifying staff. Findings include: The facility is licensed as a semi-ambulatory CBRF able to serve up to 12 residents within the client groups of irreversible dementia/Alzheimer's, developmentally disabled, emotionally disturbed/mental illness, and advanced age. On 05/23/2025, Surveyor conducted a standard survey and identified the following: On 05/23/2025 at 11:10 AM, Surveyor interviewed Manager A regarding Resident 2's wandering behavior. Manager A reported Resident 2 admitted on 04/14/2025 and within days, we started seeing wandering behavior including on 04/17, I [Manager A] went outside for something and saw Resident 2 within inches of a moving train. Manager A reported s/he redirected Resident 2 back to the facility and told him/her about the expectation related to leaving the facility and telling staff. Manager A reported Resident 2's ISP was updated to include staff supervision when outside. Surveyor asked about staffing levels. Manager A reported there is usually 1 staff each shift, with a manager at the facility during the day. While Surveyor was reviewing records, observed Resident 2 continue	N 426		

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to exit in/out the back door of the facility to walk up and down the provider's ramp. Manager A and Manager B were present in the provider's sunroom and were talking/reminding Resident 2 to stay close to the facility.

On 06/03/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 04/14/2025 with a diagnosis of intellectual disability. Resident 2 had a guardian. Resident 2's facesheet had the following key indicators: "Wander Risk-Resident is to be supervised when going outside. [S/he] has been wandering into people's yards and dangerously close to the train tracks."

Resident 2's individual service plan (ISP) dated 05/02/2025 documented: "Behaviors: [Resident 2] is in love with the train and has been found dangerously close to it outside. [Resident 2] is to be supervised by staff at all times when [s/he] is outside. [Resident 2] will ask staff to go with [him/her] outside if [s/he] wants to spend time outside. Staff will monitor [Resident 2's] whereabouts. [Resident 2] will ask staff if [s/he] wants to spend time outside."

The ISP did not address Resident 2's need for 2 staff due to his/her wander risk.

Resident 2's progress notes documented:

"-04/17/2025 written by [Manager A]: Resident decided to go outside and I just so happened to go outside myself, only to find resident standing within inches of the train tracks as a train was coming by. I ran to [him/her] and told [him/her] to back away. [S/he] replied "What? I can't watch the train?" I said "you are more than welcome to watch the train but not this close! That is

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N 426	Continued From page 6	N 426		

extremely dangerous." [S/he] said "Why?" I told [him/her] "you could get very hurt by being that close to the train." [S/he] said okay and I redirected [him/her] to help me fill up the bird feeder and put corn out for the squirrels ....RESIDENT IS NOT TO BE OUTSIDE BY [HIM/HERSLEF]!! STAFF NEEDS TO SUPERVISE [HIM/HER] IF [S/HE] WANTS TO WALK AROUND OUTSIDE!!! I did tell [him/her] that [s/he] is welcome to be outside but to please tell staff if you want go out there.

-04/18/2025 written by [Manager A]: [Resident 2] continues to go outside without asking staff to go with [him/her]. Staff and I have reminded [him/her] today. [Resident 2] was with staff outside earlier and started walking to someone else's yard in the back. I asked [him/her] what [s/he] was doing and [s/he] said "going over there.!" I said "[Resident 2] that is someone else's yard!" and [s/he] said "oh it is?" and walked back over by staff.

-05/03/2025 written by [Manager A]: Resident was about to leave the facility to go to church with a friend. I saw [him/her] getting into the car and then get out and come back in and I asked [him/her] "are you going somewhere?" [S/he] said "Yeah." Okay, well it is not acceptable for you to leave the facility without letting staff know. I would of thought you just walked off the property and called someone for help." [S/he] said "well, I am just going to church?" I said "I do not care where you are going, you just need to tell someone and not just hop in a car and leave!" [S/he] said "Okay" and left.

-05/07/2025: Resident was trying to leave the house shortly after staff go to work. Resident seemed very upset, when staff asked [him/her]

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what was wrong, [s/he] said "everyone hates me here" and explained how [s/he] had gotten angry earlier.

-05/18/2025: Had a good day but went out to church without saying anything.

-05/22/2025: Had a good day but tried to walk out by [him/herself]."

On 06/03/2025 at 9:53 AM, Surveyor sent the following email to Manager A and Administrator C: " .....Third, after reviewing [Resident 2's] record more, I do have an additional concern regarding [his/her] supervision. 4/17-found outside next to the train, 4/18-continues to go outside without telling staff, 5/3-about to leave the facility for church without letting staff know, 5/7-resident was trying to leave the house shortly after staff got to work, 5/18-goes to church without telling staff. I saw [his/her] ISP was updated to include [s/he] will be supervised by staff at all times if outside. 5/18, how was [s/he] able to leave the facility, if supervised per the ISP? Also, if staff is assisting another resident, how do you ensure [Resident 2] does not leave the facility?"

On 06/03/2025 at 10:30 AM, Administrator C sent the following email: "Good Morning,
Thank you for taking the time to work with the staff in my absence. I wanted to touch on your concerns. I personally take care of all assessments for new residents. [Resident 2] referral came in as they were shutting down an AFH but for some reason reached out to us. To me that was a red flag but I figured we would take a look. The guardian involved is one that we work with all the time with multiple other residents. After about 3 different visits and not seeing nor being told that we had a wandering

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issue.....You can kind of see that once we admitted her we have to come up with a plan to deal with this. When I reached out, (Disturbed) to the guardian and asked why this wasn't disclosed [s/he] apparently was unaware. It sounded like [Resident 2] went in a cab whenever [s/he] wanted. The communication after admission with the closing facility was lacking. Staffing the [provider name] during the day with more than two people is new, and has been something we have implemented now due to this. I understand your concerns with our charting notes, and it has been my concern as well. [S/he] is very redirectable and calm when approached appropriately. We will continue to two staff [provider name] to ensure resident safety until we can appropriately navigate this process."

A review of the provider's staff schedule from 04/14/2025-05/31/2025 shows only 1 staff working each shift (1st, 2nd, 3rd) besides (05/05 & 05/06 training taking place).

On 06/04/2025 at 9:30 AM, Surveyor interviewed Manager A regarding the staff schedules submitted for review. Manager A confirmed s/he worked Monday-Friday during business hours. Surveyor questioned why only 1 staff was on their schedule/shift on the weekends when management was not present. Manager A reported currently, weekends are hard to fill and was only staffed with 1 person during the day, but someone was on call and s/he lived close to the facility for additional support. Manager A stated s/he will continue to work with Administrator C on ways to ensure 2 staff are present and other interventions to keep Resident 2 safe.

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N 538	Continued From page 9	N 538		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the fire detection system was tested annually by certified or trained and qualified personnel. The providers fire detection system had not been tested in 2023 and 2024. Findings include: On 05/23/2025, Surveyor reviewed safety records and identified the following: There was no evidence the fire detection system inspection was completed in 2023 and 2024. On 05/23/2025 at 12:00 PM, Surveyor interviewed Manager A and Manager B. Manager A reported their fire safety company had been to the facility in 2025 but was unsure about the other years. Both staff requested additional time to gather inspections reports and talk with Administrator C who was on vacation. Surveyor noted any inspections reports would need to be submitted no later than 05/27/2025. On 05/28/2025 at 12:28 PM, Surveyor received the following email from Manager B: " .... [Manager A] has spent the past 2 days looking for our 2023 state book and unfortunately we are unable to locate it .....[Manager A] did send over	N 538		

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N 538	Continued From page 10 the 2024 inspection, it was done in 2025 due to Ahern being behind and short staffed."	N 538		