STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013415	A. BUILDING: _____ B. WING _____	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT ADULT FAMILY HOME	1442 ENDL BLVD FORT ATKINSON, WI 53538

(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 07/24/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a standard licensing survey at Walnut Adult Family Home, an adult family home (AFH) located in Fort Atkinson, WI. As a result of the survey, 3 deficiencies were identified. Census: 4	M 000		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a service agreement was signed by Resident 1's legal guardian. Findings include: On 07/24/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/01/2023 with diagnoses including autism spectrum disorder, anxiety disorder, and	M 384		

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

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M 384	Continued From page 1 obsessive-compulsive disorder. Resident 1 was documented as having a legal guardian, which was active at the time of his/her admission. Within Resident 1's record, Surveyor reviewed a service agreement. At the end of the service agreement, there was a signature line for "Resident or Legal Representative." On the line, the annotation of "Refused to sign" with a date of "8/23/23" was handwritten. There were no other signatures on the agreement. At approximately 11:30 a.m., Surveyor interviewed House Manager A regarding Resident 1's service agreement. House Manager A reported s/he was unsure why it indicated that there was a refusal to sign it. House Manager A reported that s/he had not been involved in that and s/he didn't know who wrote that.	M 384		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications 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 that a record was kept of all the prescription medications administered by	M 466		

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M 466	Continued From page 2	M 466		

staff showing the date and time the medication was taken.

Resident 2 was prescribed 3 medications that were scheduled to be administered by staff at 4:00 p.m. - 2 that were directed as such within their prescription instructions and 1 that was scheduled at that time by the provider. Resident 2 had a job, his/her attendance at which was tracked in the provider's electronic record system, which blocked his/her 4:00 p.m. medication administration time in his/her medication administration record (MAR). As a result, on 14 days between 06/01/2025 - 07/24/2025, there was no record of Resident 2 receiving his/her 4:00 p.m. medications. Per report, staff administered these medications to him/her when s/he returned to the home from work.

Findings include:

On 07/24/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/01/2021 with diagnoses including autism spectrum disorder. Resident 2's current individual service plan (ISP), last signed as reviewed on 07/09/2025 (and prior to that, 12/02/2024), documented that Resident 2 required staff assistance for medication management and administration. Resident 2's prescriptions included the following 3 medications that were documented in his/her MARs as being scheduled for daily administration at 4:00 p.m.:

1. Hydroxyzine HCl 50 mg tablets with instructions to, "Take 1 tablet by mouth two times a day (7AM/4PM)."
2. Aripiprazole 20 mg tablets with instructions to, "Take 1/2 tablet (=10 mg) by mouth two times daily (7AM/4PM) for mood."

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M 466	Continued From page 3 3. Guanfacine HCl 1 mg tablets with instructions to, "Take 1 tablet by mouth two times a day for mood." In reviewing the MARs from 06/01/2025 - 07/24/2025, Surveyor observed the following 14 days in which the 4:00 p.m. entries for the above 3 medications were grayed out with the annotation "WK" indicating that Resident 2 was out at work during the administration time: 06/05/2025, 06/06/2025, 06/12/2025, 06/13/2025, 06/18/2025, 06/19/2025, 07/02/2025, 07/03/2025, 07/05/2025, 07/06/2025, 07/09/2025 - 07/11/2025, and 07/23/2025 There were no notes in the MAR to indicate whether Resident 2 received his/her 4:00 p.m. medications on those dates as scheduled. At approximately 12:00 p.m., Surveyor interviewed House Manager A about staff's management of Resident 2's 4:00 p.m. medications. House Manager A reported that Resident 2 typically returned home from work between 3:30 p.m. - 4:00 p.m. and staff administered his/her 4:00 p.m. medications upon his/her arrival home. Caregiver B, who was present in the room during the interview, reported that Resident 2 sometimes came home between 4:30 p.m. - 5:00 p.m. because s/he had to wait for a local taxi to take him/her home from work. Caregiver B reported that when Resident 2 was charted as being at work in the provider's electronic record system, it blocked staff from being able to document his/her 4:00 p.m. medication administration. House Manager A and Assistant Director C, who was present during the interview, were given a list of the above dates by Surveyor and asked if there was evidence of staff having documented administration of Resident	M 466		

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M 466	Continued From page 4 2's 4:00 p.m. medications on those days. Both confirmed they were unable to find any evidence. At approximately 12:45 p.m., Surveyor interviewed Assistant Director C. Assistant Director C reported s/he understood Surveyor's concern regarding the lack of documentation of staff's administration of Resident 2's 4:00 p.m. medications. Assistant Director C reported that management staff could look to change Resident 2's electronic record to allow staff to sign off on administration of these medications.	M 466		
M 510	88.09(1)(d)11 RESIDENT FUNDS Records maintained by the licensee of the resident's finances, including written authorization from the resident of resident's guardian to control the resident's funds. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a written authorization from Resident 1's legal guardian to control his/her funds was maintained as part of his/her record. Findings include: On 07/24/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/01/2023 with diagnoses including autism spectrum disorder, anxiety disorder, and obsessive-compulsive disorder. Resident 1 was documented as having a legal guardian, which was active at the time of his/her admission. Within Resident 1's record, Surveyor reviewed a	M 510		

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M 510	Continued From page 5 document titled "Consent for Financial Supervision" which outlined general terms for which a resident or his/her legal guardian could authorize the provider's staff to have varying levels of financial management of that resident's funds. The form was not filled out and at the bottom where a signature line was located, the annotation of "Refused to sign" with a date of "8/23/23" was handwritten. There were no other records for Resident 1 indicating that his/her guardian authorized the provider's staff to control Resident 1's funds. At approximately 11:30 a.m., Surveyor interviewed House Manager A regarding money management for Resident 1. House Manager A confirmed that staff held and managed a debit card for Resident 1 that s/he could use to make purchases and that also staff used to make purchases on his/her behalf for items s/he needed. House Manager A showed Surveyor how staff stored Resident 1's debit card and how they organized his/her purchase receipts, billing statements, and a ledger showing an approximate month-by-month tracking of the purchases made either by or for Resident 1. When asked about the unsigned document in Resident 1's record authorizing staff to manage Resident 1's funds, House Manager A reported s/he was unsure why it indicated that there was a refusal to sign it. House Manager A reported that s/he had not been involved in that and s/he didn't know who wrote that.	M 510		