STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010246	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE ASSISTED LIVING APARTMENTS	121 S FIFTH STREET EVANSVILLE, WI 53536

(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
U 000	INITIAL COMMENTS On 04/28/2025, with information gathered through 04/29/2025, Surveyor conducted a standard licensure survey at Kelly House Assisted Living Apartments. One deficiency was identified. Census: 7	U 000		
U 118	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure medication administration and medication management, were provided in a safe manner consistent with standards of practice for 3 of 3 tenants. Tenant 1's medications were dispensed into a pill organizer that was not labeled with his/her name or medication name, dose and instructions for	U 118		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010246	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE ASSISTED LIVING APARTMENTS	121 S FIFTH STREET EVANSVILLE, WI 53536

(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
U 118	Continued From page 1	U 118		

use.
Tenant 2's expired Latanoprost (eye drops) and Refresh eye drops were administered after expiration dates.
Tenant 3's medications that were no longer utilized, were not disposed of and/or stored away from his/her current medications.

Findings include:

Medication management, as defined in Wisconsin State Legislature 89.13(22), means oversight by a nurse, pharmacist or other health care professional to minimize risks associated with use of medications. Medication management includes proper storage of medications; preparation of a medication organization or reminder system; assessment of the effectiveness of medications; monitoring for side effects, negative reactions and drug interactions; and delegation and supervision of medication administration.

Example 1: Tenant 1

On 04/28/2025, at approximately 12:30 PM, Surveyor, Assistant Administrator A and Med Technician B observed Tenant 1's medications in the med cart. Tenant 1's medications had been dispensed into a weekly pill organizer. Assistant Administrator A stated that Tenant 1 had moved in on a temporary basis as s/he determined if s/he wanted to stay. Surveyor observed a piece of tape with the resident's name had been placed onto the pill organizer. Assistant Administrator A stated Tenant 1's medications had not been set up through the pharmacy to be packaged individually by date and time. Assistant Administrator A stated s/he was unsure if tenants residing in a residential-care apartment complex

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010246	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE ASSISTED LIVING APARTMENTS	121 S FIFTH STREET EVANSVILLE, WI 53536

(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
U 118	Continued From page 2 were required to have their medications labeled if dispensed into a pill organizer. On 04/28/2025, Surveyor reviewed Tenant 1's record. Tenant 1 moved into the apartment complex 02/03/2025. Tenant 1's April Medication Administration Record (MAR), dated 04/01/2025 to 04/28/2025, documented: Lisinopril 2.5 MG (milligram) - Take one tablet by mouth, Monday, Wednesday, Friday, weekly Metformin Hydrochloride 500 MG - Take one tablet by mouth 2 times daily with morning and evening meals Furosemide 20 MG - Take one tablet by mouth one time daily. Montelukast Sodium 10 MG - Take one tablet by mouth once daily at bedtime. Rosuvastatin Calcium 5 MG - Take one tablet by mouth one time daily. Example 2: Tenant 2 On 04/28/2025, at approximately 12:30 PM, Surveyor, Assistant Administrator A and Med Technician B observed Tenant 2's medications in the med cart. Surveyor observed an opened bottle of Latanoprost Ophthalmic Solution, with an open date of 10/26/2024 written onto the bottle. Surveyor observed an opened bottle of Refresh Liquidgel eye drops that had an expiration date of 10/2023. Med Technician B stated s/he did not realize eye drops expired after they were opened and missed the expiration date on the Refresh eye drops. Assistant Administrator A stated s/he would discuss this with staff.	U 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010246	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE ASSISTED LIVING APARTMENTS	121 S FIFTH STREET EVANSVILLE, WI 53536

(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
U 118	Continued From page 3 On 04/28/2025, Surveyor reviewed Tenant 2's record. Tenant 2 moved into the apartment complex 07/18/2023. Tenant 2's April MAR, dated 04/01/2025 to 04/28/2025, documented: "Refresh Liquidgel - Instill one drop in each eye two times daily. Scheduled at 12:00 PM and 8:00 PM. Start Date: 04/30/2024." The MAR documented the eyedrops had been administered 55 out of 56 opportunities. "Latanoprost 0.005% eye drops - Instill 1 drop into left eye every night at bedtime. Start Date: 07/25/2024." The MAR documented the eyedrops had been administered 27 out of 27 opportunities. "Unopened bottles should be stored in the refrigerator. Once opened, the bottle can be kept at room temperature for either 6 weeks (Xalatan) or 30 days (Iyuzeh). For Xelpros, the bottle should continue to be kept in the refrigerator, even after opening, until the expiration date on the bottle." (Source: MedlinePlus website, Latanoprost Ophthalmic, August 15, 2023, https://medlineplus.gov/druginfo/meds/a697003.html (retrieval date - April 29, 2025).) Example 3: Tenant 3 On 04/28/2025, at approximately 12:30 PM, Surveyor, Assistant Administrator A and Med Technician B observed Tenant 3's medications in the med cart. Surveyor observed a pill organizer that contained medications, with Tenant 3's name written on it. Assistant Administrator A stated those medications should have been destroyed. The medications were utilized when Tenant 3	U 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010246	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE ASSISTED LIVING APARTMENTS	121 S FIFTH STREET EVANSVILLE, WI 53536

(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
U 118	Continued From page 4 moved into the apartment complex until his/her medications were set up with the pharmacy. On 04/28/2025, Surveyor reviewed Tenant 3's record. Tenant 3 moved into the apartment complex 02/19/2025. Tenant 3's April MAR, dated 04/01/2025 to 04/28/2025, documented: Amlodipine Besylate (blood pressure medication) 2.5 MG - Give one tablet once a day for hypertension. Aspirin 325 MG - Give one capsule by mouth once daily Carvedilol (heart medication) 3.125 MG - Give one tablet twice daily with meals Mirtazapine (antidepressant) 30 MG - Give one tablet, once daily by mouth Multivitamin with Minerals - One tablet by mouth daily Olanzapine (psychotropic) 2.5 MG - Give one tablet at bedtime for agitation Propylthiouracil (thyroid medication) - Give one tablet by mouth once a day Sertraline Hydrochloride (antidepressant) 50 MG - Give one tablet by mouth once a day for anxiety associated with depression Tylenol Extra Strength 1000 MG - Give two 500 MNG tablets daily by mouth 3 times daily in the morning, afternoon and bedtime for pain	U 118		
U 172	89.27(1) SERVICE AGREEMENT REQUIREMENT. A residential care apartment complex shall enter into a mutually agreed-upon written service agreement with each of its tenants consistent with the comprehensive	U 172		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010246	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE ASSISTED LIVING APARTMENTS	121 S FIFTH STREET EVANSVILLE, WI 53536

(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
U 172	Continued From page 5 assessment under s. DHS 89.26. This Rule is not met as evidenced by: Based on record review and interview, 1 of 2 tenants (Tenant 1) reviewed did not have a mutually agreed-upon written service agreement upon admission. Findings include: On 04/28/2025, Surveyor reviewed Tenant 1's record. Tenant 1 moved in on 02/03/2025. Tenant 1's admission agreement was dated 04/25/2025. On 04/28/2025, at approximately 3:00 PM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A stated that Tenant 1 was originally a temporary placement but has informed staff that s/he was still thinking about whether or not s/he was going to move in permanently.	U 172		