STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016066	A. BUILDING: _____ B. WING _____	R 09/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY HOUSE 5 LLC	N62 W15681 SKYLINE DR MENOMONEE FALLS, WI 53051

(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 09/25/2025, with information gathered through 09/27/2025,Surveyor conducted a verification visit at Liberty House 5 LLC. Three deficiencies were identified. One of 3 deficiencies were a repeat violation (see Statement of Deficiency (SOD) VFPQ11). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
M 406	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Individual Service Plan (ISP) for 4 of 4 residents (Resident 1, Resident 2, Resident 3, Resident 4) records reviewed were developed together with the placing agency, the person being admitted or person's guardian / designated representative and the provider.	M 406		

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

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M 406	Continued From page 1 Findings include: On 09/25/2025, Surveyor reviewed Resident 1's, Resident 2's, Resident 3's and Resident 4's record. Resident 1 moved into the home 08/10/2023 and was represented by a managed care organization (MCO) Care Manager (CM). Resident 1's ISP, dated 06/11/2025, did not contain the MCO CM's signature. Resident 2 moved into the home 08/02/2021 and was represented by Guardian C and MCO CM F. Resident 2's ISP, dated 06/11/2025, did not contain Guardian C's or CM F's signature. Resident 3 moved into the home 08/02/2021 and was represented by a MCO CM. Resident 3's ISP, dated 06/11/2025, did not contain the MCO CM's signature. Resident 4 moved into the home 10/26/2018 and was represented by a MCO CM. Resident 4's ISP, dated 09/08/2025, did not contain the MCO CM's signature. On 09/25/2025, at approximately 10:15 AM, Surveyor interviewed Administrator B. Administrator B stated that s/he had not obtained guardian or MCO CM signatures and would obtain those during organized care conferences.	M 406		
M 408	88.06(3)(c) ASSESSMENT IDENTIFY NEEDS & ABILITIES The assessment shall identify the person's needs and abilities in at least the areas of activities of daily	M 408		

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M 408	Continued From page 2 living, medications, health, level of supervision required in the home and community, vocational, recreational, social and transportation. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not assess 1 of 1 resident to identify the needs and abilities in the areas of health. Resident 3 was not assessed to determine if s/he was capable of self-administering medications. Findings include: On 09/25/2025, at approximately 9:30 AM, Surveyor and Caregiver E observed Resident 3's medications in the med closet. Surveyor observed an empty box that was labeled, " Fluticasone Propionate 50 MCG/ACT (micrograms/actuations), Use 2 sprays in each nostril in the morning. Dispensed 01/30/2025." Surveyor asked Caregiver E where the bottle of Fluticasone was, since the box was empty. Caregiver E stated that Resident 3 stored the medication in his/her room. Caregiver E and Surveyor walked to Resident 3's room and asked Resident 3 if s/he could show Surveyor his/her bottle of Fluticasone. Resident 3 proceeded to look through different containers where s/he kept his/her over-the-counter medications but was not able to find the bottle of Fluticasone. On 09/25/2025, Surveyor reviewed Resident 3's	M 408		

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M 408	Continued From page 3	M 408		

record.

Resident 3 moved into the home 08/02/2021.

Resident 3's "Individual Service Plan," dated 06/11/2025, documented:
"Medications - See Attachment"

Resident 3's Medication Administration Records (MARs), dated 08/01/2025 to 09/25/2025, documented:
"Fluticasone Propionate (Flonase) - Scheduled at 8:00 AM"
The MARs documented that the medication had been administered as prescribed.

On 09/25/2025, at approximately 10:00 AM, Surveyor interviewed Administrator B, Caregiver C and Caregiver E. Surveyor asked for clarification if Resident 3 had been assessed to determine if s/he was able to self-administer medications and if staff observed him/her administering his/her Fluticasone when documenting it had been administered in the MAR. Administrator B stated that Resident 3 should not be self-administering his/her medications. Surveyor commented that the Fluticasone was dispensed 01/30/2025 and based on the prescription, was a 30 day supply. Surveyor asked for clarification regarding the last time the Fluticasone had been ordered. Surveyor did not receive a response.

"Each bottle contains a net fill weight of 16 g (grams) and will provide 120 actuations. Each actuation delivers 50 mcg (micrograms) of fluticasone propionate in 100 mg (milligram) of formulation through the nasal adapter. The correct amount of medication in each spray cannot be assured after 120 sprays even though

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M 408	Continued From page 4 the bottle is not completely empty." (Source: National Institute of Health website, Fluticasone Propionate, 12/2022, https://dailymed.nlm.nih.gov/dailymed/fda (retrieval date - July 24, 2024).)	M 408		
{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 observation, record review and interview, the provider did not ensure accurate records were kept of all prescription medications administered for 1 of 1 resident. This is a repeat deficiency. See Statement of Deficiency (SOD) VFPQ11, dated 06/08/2025. Resident 4's Medication Administration Record (MAR) documented med administration when the medication was not available. Findings include: On 09/25/2025, at approximately 9:20 AM, Surveyor and Caregiver E observed Resident 4's meds in the med cabinet. Surveyor observed a	{M 466}		

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{M 466}	Continued From page 5 blister card that stated, "Aripiprazole (antipsychotic medication) 10 MG (milligram) tablet - Take ½ tablet by mouth in the morning for 7 days. Dispensed Date: 09/17/2025." On the back of the blister card, the dates for administration had been written over each tablet bubble, with a start date of 09/19/2025. On 09/25/2025, Surveyor reviewed Resident 4's record. Resident 4 moved into the home 10/26/2018. Resident 4's MAR, dated 09/01/2025 to 09/25/2025, documented: "Aripiprazole 10 MG (Abilify 10 MG) - Scheduled at 8:00 AM" Documented as administered 09/18 to 09/25 - 8 days "Aripiprazole 10 MG (Abilify 10 MG) - Scheduled at 8:00 AM" Documented as administered 09/18, 09/22, 09/24, 09/25 On 09/25/2025, at approximately 10:00 AM, Surveyor interviewed Administrator B, Caregiver C and Caregiver E. Surveyor asked for clarification as to why the Aripiprazole had been listed twice on the MAR. Administrator B stated the order must have been placed twice on the MAR, but staff should have acknowledged that and not documented that the medication had been administered twice on specific dates. Administrator B informed staff that they had to verify the MAR with the medications that they were administering coincided with each other to avoid med errors.	{M 466}		