STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011268	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN MANOR II	3430 LARRY COURT PLOVER, WI 54467

(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 10/16/2025, Surveyor completed an abbreviated survey at Evergreen Manor II. Additional information was gathered through 10/22/2025. As a result of the survey, four (4) new deficiencies were identified. Census: 3	M 000		
M 276	88.05(3)(a) Homelike 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, record review and interview, the provider did not ensure the living environment was safe, clean, comfortable and homelike. Findings include: This facility is licensed to serve up to 4 residents within one of the following client groups: developmentally disabled, emotionally disturbed/mental illness. On 10/16/2025 from approximately 9:33 A.M. to 11:30 A.M., Surveyor conducted an environmental tour of the facility with House Manager B.	M 276		

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

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M 276	Continued From page 1 The following was observed: Basement: -- An unsealed bag of Splenda, one bag of all-purpose flour, one bag of hotdog buns, four bags of chips, one box of lasagna noodles, and one box of angel hair noodles. Surveyor observed an active mouse trap on the same counter surface as the aforementioned food items. -- In the small hallway leading to the basement office, one ceiling tile was missing, exposing wooden beams and a dark open space above. Adjacent ceiling tiles display brown discoloration and what appeared to resemble water damage. -- A couch located in the basement living room with a broken arm rest. Empty Resident Room: -- A wooden nightstand with the finish worn away in irregular patched exposing lighter-colored wood beneath on the top surface. -- A dark stained wooden dresser with multiple scratches on the top surface, front, and side of the dresser. The finish appeared worn in several areas, revealing lighter wood tones beneath. -- A thick layer of dust on the metal vent located on the wall. Flooring: -- A tear in the carpet located on the edge of the bottom stair leading to the basement living room. The tear was approximately three and a half inches long by one and a half inches wide. -- Multiple dark stains measuring approximately five inches to one foot in diameter, located on the basement carpet in the immediate vicinity of the laundry room door and living room entryway. -- Two areas of the kitchen floor directly in front of the refrigerator where the top layer of the flooring appeared to be scrapped off revealing an area	M 276		

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M 276	Continued From page 2 approximately seven inches long by one and a half inches wide exposing the cement subflooring. House Manager B informed Surveyor that the damaged flooring extends under the refrigerator and is approximately 12 inches long. S/he expressed difficulties cleaning the floor due to the damaged area. -- A gap in the dining room floor, expanding the length of the patio door and extended approximately two inches out, which exposed what appeared to be old flooring underneath the current flooring. -- Approximately eight gouges in the dining room floor exposing the cement subfloor ranging in diameter from one to two and a half inches long. Kitchen: -- Dirt and dust were scattered alongside the edges of the floor and on the ceiling fan. -- Dust accumulation on the majority of cabinet and drawer surfaces. House Manager B acknowledged the dirty cabinets and stated, "we do not clean those. We should." -- An area approximately six inches long and four inches high where paint was missing on the sideboard of the kitchen island. -- Two locking mechanisms attached to the kitchen refrigerator and freezer consisting of padlocks and metal clasps. House Manager B acknowledges that the refrigerator and freezer had the means to be locked, they do not lock them currently but had in the past due to a previous resident, "stealing food." Living Room, Entrance Hallway and Upstairs Hallway: -- Dust accumulation located on the surface of the brown leather furniture pieces. -- A rusty and dented metal grate located under the large bay window.	M 276		

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M 276	Continued From page 3 -- An old doorbell attached to the wall across from the stairway with a missing cover and exposed wires hanging out of the fixture. -- Cobwebs approximately 3 feet long lined the joint of the wall and ceiling directly above the stairway leading to the bedrooms. House Manager B acknowledged and stated, "I don't come up here much." Resident 3's Room: -- One dresser with the finish worn away in irregular patched exposing lighter-colored wood beneath on the top surface. -- Dust accumulation located on the ceiling fan and surface of the windowsill located directly above Resident 3's bed. Resident 2's Room: -- A hole in the ceiling approximately four inches long by three inches wide. -- Dust accumulation located on the ceiling fan, curtains, and smoke detector. -- A broken window screen located above Resident 2's bed. -- A wooden nightstand with the finish worn away in irregular patched exposing lighter-colored wood beneath on the top surface. -- A bent curtain rod located above window next to Resident 2's bed. Resident 1's Room and Private Bathroom: -- Dust accumulation located on the ceiling fan, curtain rod, dresser, light switch, perimeter of bathroom floor, bathroom vent, perimeter of closet ceiling, and on the carpet extending approximately 3 inches from the wall located near the bathroom door. -- A rusty shower rod. -- A puddle of what appeared to be urine, approximately 10 inch in diameter, located on the	M 276		

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floor in front of the toilet.

Shared Residents Bathroom Upstairs:

On 10/16/2025 at approximately 10:30 A.M., Resident 2 told House Manager B, "[House Manager B], tell them about the mold in the bathroom upstairs."

On 10/26/2025 at 11:02 A.M., while on tour of the facility with House Manager B, Surveyor observed a dark black substance in irregular shaped clusters on the ceiling above the shower which extended approximately six feet out from the edge of the ceiling to the center of the bathroom ceiling. Additional dark black substance was observed above the bathroom door, above the bathroom mirror, and on all the plastic shower rings attached to the shower curtain. House Manager B stated, "the vent does not work right" and stated that maintenance had been notified in the past and was onsite "two years ago and looked at it."

Outdoor Patio and Deck:

At approximately 10:04 A.M., Surveyor observed a second story deck located on the back of the facility. Surveyor observed eight wooden support posts holding up the deck. One support post had a crack in the wood and an additional wooden post attached to it that was lighter in color. Another support beam located near the corner of the home appeared at an angle that was not consistent with the other support posts. House Manager B stated that no one goes on the deck, but Resident 3 sits under the deck daily to smoke. Surveyor observed a black chair on the ground located directly under the deck. Surveyor observed an additional first story deck off of the

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dining room that had 3 wooden support posts that extended approximately 2 inches off of the cement slab, suspended approximately 6 inches off the ground below.

On 10/16/2025 at 10:25 A.M., House Manager B provided Surveyor with a document titled, "Daily Chores Schedule for 2nd, 3rd and weekend shifts." The document contained a list of cleaning tasks and a space for staff to initial after completing each task. The document was dated 05/22/2025. House Manager B acknowledged the most recent documented cleaning tasks were completed over 4 months prior and when asked how s/he knows if cleaning tasks are being competed s/he stated, "I don't know without documentation."

On 10/16/2025 at 12:15 P.M., Surveyor interviewed Resident 1. S/he expressed difficulty utilizing a vacuum and moving items to dust. S/he stated, " ...staff make me clean ...we switch off every day who cleans the kitchen and common areas ...Staff don't do much cleaning. They say it is my job. I don't do it either so it doesn't get done ..."

On 10/16/2025 at 2:42 P.M. Surveyor interviewed Caregiver C. Surveyor inquired about the black substance on the resident bathroom ceiling and Caregiver C replied, "I typically don't go in there." At 2:49 P.M. Caregiver C accompanied Surveyor to observe the resident bathroom upstairs and stated, "I see the spots ...I don't think the rings are washed at all..it is gross" and stated it is likely "mold."

On 10/17/2025 at 10:44 A.M., Administrator A sent an email correspondence to Surveyor which read in part, "...I assure you that we immediately

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M 276	Continued From page 6 acted on the concerns as we began to get those areas cleaned thoroughly. This morning I spoke to our account manager and gave him a run down of what you shared with me. He will share the immediate concerns with our maintenance staff so those areas that you mentioned are addressed and changed to assure resident safety..."	M 276		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure Resident 1's individual service plan (ISP) was updated with a description of the services the provider would offer to meet Resident 1's needs related to diabetes management.	M 424		

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M 424	Continued From page 7 Findings include: This facility is licensed to serve up to 4 residents within one of the following client groups: developmentally disabled, emotionally disturbed/mental illness. On 10/26/2025 at 8:48, House Manager B volunteered to Surveyor that Resident 1's blood glucose was 79 mg/dL earlier and, "dips down into 50's and feels funny." House Manager B said s/he has Resident 1 test him/herself and described administering either glucose chews or glucose gel if Resident 1 is hypoglycemic (low blood glucose). House Manager B said s/he offered Resident 1 cheese "as a stabilizer" and that Resident 1 has had a "couple" of low blood glucose readings and receives a cheese stick, milk, and peanut butter sandwich if hypoglycemic. House Manager B stated s/he would fax Resident 1's Medical Provider on Monday if Resident 1 "still dips low." When asked what would be considered a low/high blood glucose reading for Resident 1 Caregiver A responded, "75 to 100 is perfect for me." On 10/26/2025 at 11:32 A.M., Surveyor observed Resident 1 test his/her blood glucose. Resident 1 acknowledged his/her blood glucose was 60 mg/dL. On 10/26/2025 at 11:33 A.M. and 12:15 P.M., Surveyor interviewed Resident 1. S/he described feeling "hot and sweaty" when s/he is hypoglycemic (low blood sugar) and will walk if s/he is hyperglycemic (high blood glucose) but stated, "sometimes I am too dizzy to walk." Resident 1 stated that House Manager B usually provides him/her food when s/he is hypoglycemic and said, "don't know how to cook ...I never	M 424		

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cook." During the interview with Resident 1, House Manager B yelled while in an adjacent room that Resident 1's blood glucose was 79 mg/dL earlier and stated, "that's why I told [him/her] [s/he] shouldn't walk."

On 10/26/2025 at 11:39 A.M., Surveyor interviewed House Manager B. S/he stated Resident 1 was administered two glucose chews and that s/he will re-check Resident 1 blood glucose "before I leave at 2pm ...then I will know [s/he] is going in the right direction."

On 10/16/2025 at 4:41 P.M., Surveyor observed Resident 1 checking his/her blood glucose which was 206 mg/dL. House Manager B stated that if Resident 1's blood glucose is "over 200 (mg/dL) I consider that high." House Manager B stated Resident 1's blood glucose was "around 150 (mg/dL)" approximately 40 minutes earlier.

On 10/16/2025 at 4:44 P.M., House Manager B provided Surveyor with Resident 1's medication administration record (MAR) which read in part, "Blood Glucose Protocol ...If blood glucose is less than 80 Treat [sic] with 15 grams of carbohydrate and Re-check in 15-20 minutes. Repeat protocol if still hypoglycemic ...If blood glucose is less than 50 Treat [sic] with 30 grams of fast acting carbohydrates and Re-check in 15-20 minutes. Repeat protocol if still hypoglycemic ...In case of hypoglycemic and patient is unable to take oral fasting glucose call 911 ...Notify [Health Care Provider D] if patient is hypoglycemic more than 2 times within a week or if hospitalized related to hypoglycemic ...Notify [Health Care Provider D] or seek medical attention if the office is closed if the patient has 2 blood glucose tests greater than 400 in a row (at least 4 hours apart) without symptoms. If patient has blood glucose greater

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than 300 and symptoms seek medical treatment ..." The protocol prompts for a fax to be sent to the provider earlier with "any concerns or significant blood glucose."

On 10/16/2025 at 4:25 P.M., Surveyor reviewed Resident 1's Daily Progress Notes and noted the following entries:

-- " ...10/1/2025 (6am-2pm) ...[Resident 1] then came down and did [his/her] blood glucose 59 ... [Resident 1] then was in and out of [his/her] room. [Resident 1] had breakfast and am medications. [Resident 1] walked for 30 minutes. [Resident 1] then went to [his/her] room ..."

-- " ...10/6/2025 (10pm-6am) ...[Resident 1] was in [his/her] room when staff arrived. [Resident 1] appeared to be asleep at all check ins [sic]. At 10:40 [Resident 1] came down saying [s/he] was sweating and we tested blood glucose, it was at 39 so I gave [him/her] two glucose chews. We retested at 11:30 it was 55. The rest of the night was uneventful ..."

-- " ...10/9/2025 (6am-2pm) ...[Resident 1] walked 15 minutes then came down and said [s/he] needed to test cause [s/he] was sweaty. [Resident 1] tested and was 71. [Resident 1] was advised no more walking until supper time. [Resident 1] then went to [his/her] room. [Resident 1] did [his/her] chores for the day ..."

-- " ...10/10/2025 (6am-2pm) ...[Resident 1] came down and did [his/her] blood sugar 77 ...[Resident 1] then was in and out of his room. [Resident 1] had breakfast and am medications. [Resident 1] walked 30 minutes. [Resident 1] was in and out of [his/her] room. [Resident 1] came down and did [his/her] blood sugar 74. [Resident 1] went up and

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was waiting for lunch. [Resident 1] said he was staring to feel funny and went back down and retested 59. Staff handed [Resident 1] 2 chews and faxed the doctor. Dr faxed back and lowered his insulin to 44 units a day. [Resident 1] went up and had lunch, [Resident 1] did not walk. [Resident 1] then went to [his/her] room. [Resident 1] did [his/her] chores for the day ..."

-- " ...10/11/2025 (6am-2pm) ...[Resident 1] came down and did [his/her] blood sugar 53. [Resident 1] went up and had lunch. [Resident 1] did not walked [sic] 30 minutes due to blood sugar being low. [Resident 1] then went to [his/her] room. [Resident 1] did his chores for the day ..."

On 10/16/2025 at 4:07 P.M., Surveyor reviewed Resident 1's most recent ISP dated 02/02/2025 which read in part, " ...NURSING PROCEDURES: Check insulin unit daily. [Resident 1] checks [his/her] blood sugar 4-6 times daily and as needed due to blood sugar hypoglycemia. Staff to see the draw up of [his/her] insulin ..."

Surveyor noted the ISP did not:

-- Identify Resident 1's history of hypoglycemia and hyperglycemia.
-- Specify parameters for hypoglycemia and hyperglycemia including signs and symptoms to identify when Resident 1's blood glucose is too high or too low.
-- Identify specific, individualized interventions for when Resident 1's blood glucose is hyperglycemic or hypoglycemic including when Resident 1's blood glucose should be re-checked, what interventions to try to help lower/raise Resident 1's blood glucose, and when to contact the doctor.

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M 424	Continued From page 11 Please note: On 10/16/2025 at 4:37 P.M., House Manager B informed Surveyor that the date listed on the current ISP was mistakenly imputed as 02/02/2025 and should be 08/12/2025. On 10/16/2025 at 4:55 P.M., Surveyor interviewed Administrator A. S/he acknowledged that needs and interventions regarding diabetes management should be in Resident 1's ISP, that they were not, and stated, "that is somewhat concerning." On 10/22/2025, House Manager B emailed an updated ISP to Surveyor which included additional needs and interventions regarding Resident 1's diabetes management.	M 424		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not keep all prescription medications in the original container as received from the pharmacy	M 458		

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and store as specified by the pharmacist. Staff repackaged Resident 1's, Resident 2's, and Resident 3's daily medication in containers without the pharmacy label and without the physician order.

Findings include:

This facility is licensed to serve up to 4 residents within one of the following client groups: developmentally disabled, emotionally disturbed/mental illness.

On 10/16/25 at 11:44 AM Surveyor and House Manager B reviewed Resident 1's MAR/TAR (Medication Administration Record/Treatment Administration Record), noting the charting for 10/12/25 indicates a medication, omeprazole, was omitted or not signed out. House Manager B stated, "He received it, but I forgot to sign it out."

On 10/16/25 at 11:57 AM, Surveyor observed small plastic storage containers in the facility's locked kitchen cabinet. Each storage container contained medications and had a taped label on the cover. Surveyor reviewed the labels noting they had Resident 1's, Resident 2's, or Resident 3's name on them and a time. Surveyor observed some of the times were in the future, including 4:30 PM and 8:00 PM.

On 10/16/25 at 12:00 PM Surveyor interviewed House Manager B. House Manager B indicated s/he removes residents' daily medications from the original pharmacy packaging for all three upcoming shifts and places them in small plastic storage containers. House Manager B indicated s/he brings the repackaged medications up to the kitchen and stores them in a locked cabinet for easier access throughout the 3 shifts. House

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M 458	Continued From page 13 Manager B indicated there is no label on the container with what the medications are, what dose they are, what the pharmacy label reads, or what the resident's physician order consists of. House Manager B indicated this is a daily practice in this facility and sometimes the caregiver who administers the medications is a different caregiver than the one who repackages the medications. Surveyor asked House Manager B how the next caregiver will ensure the medication is the correct drug, going to the correct resident, correct dose, and the correct time when it is administered. House Manager B indicated s/he was unsure. House Manager B indicated the facility had a recent incident where a medication error occurred due to staff administering the repackaged medication and then also punching out the medication to be given resulting in double dosing a resident. On 10/16/25 at 2:42 PM Surveyor interviewed Caregiver C. Caregiver C indicated the medications are usually removed from the pharmacy cards and put into the small containers stored in the kitchen cabinet before s/he arrives. Caregiver C indicated s/he administers the repackaged medications to the residents at the times on the containers. Caregiver C indicated s/he does not look at physician orders, pharmacy labels, or the residents' MAR (Medication Administration Record) prior to administering the medications, because this was already done by another caregiver. On 10/16/25 at 4:55 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was unaware that the medications needed to stay in the pill bottles with the medication labels on them. Administrator A indicated s/he was also unaware that one Caregiver would remove the medications	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011268	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 458	Continued From page 14 from the pharmacy packaging for 3 shifts and then another Caregiver would administer the medications. Administrator A indicated his/her expectation is that a caregiver will remove medications from the pharmacy packaging while reviewing the pharmacy label, the physician order, and signing out the resident's MAR at the time the medication is going to be administered. Administrator A indicated a caregiver should only administer medications that they, themselves, have prepared and stated, "Our consultant will do another training on this."	M 458		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure medications were administered in the dosage and intervals prescribed by the resident's physician for Resident 1. Resident 1's Mucinex pharmacy label and Resident 1' s MAR (Medication Administration Record) did not reflect each other.	M 582		

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M 582	Continued From page 15 Resident 1's Acetaminophen pharmacy label, Resident 1's physician order, and Resident 1's MAR did not match each other. House Manager B indicated s/he would use Resident 1's pharmacy label to know what dose to give Resident 1. Findings Include: This facility is licensed to serve up to 4 residents within one of the following client groups: developmentally disabled, emotionally disturbed/mental illness. On 10/16/25 at 11:44 AM Surveyor completed Medication Storage task and observed the following: -Resident 1's as needed Acetaminophen pharmacy packaged card was labeled, in part: 500mg take one to two every 8 hours as needed ... -Resident 1's MAR, for 10/1/25-10/31/25, includes, in part: take two tabs by mouth every 8 hours as needed ... (It is important to note the discrepancy in Resident 1's MAR and Resident 1's pharmacy label.) -Resident 1's current Physician Order, includes: Mucinex DM (dextromethorphan- an antitussive or cough suppressant) ER (extended release) 60 MG tab take one tab two times daily as needed ... -Resident 1's as needed Mucinex pharmacy packaged card was labeled, in part: Mucinex DM (dextromethorphan- an antitussive or cough suppressant) ER (extended release) 60 MG tab take two tab daily by mouth as needed for	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 582	Continued From page 16 cough/congestion ... -Resident 1's MAR, for 10/1/25-10/31/25, includes in part: Mucinex DM ER 60 MG take one tab daily as needed for cough ... (It is important to note the discrepancies in Resident 1's physician order, pharmacy label, and Resident 1's MAR.) On 10/16/25 at 11:48 AM House Manager B stated, "When we asked for a refill, they changed the order and we did not catch it." House Manager B indicated Resident 1's orders, Resident 1's MAR, and Resident 1's pharmacy labels should all match and if they don't, s/he would use the pharmacy label to know which dose to give Resident 1. Surveyor asked if House Manager B could call Resident 1's Medical Doctor to clarify the order. House Manager B indicated s/he should call Resident 1's Medical Doctor to clarify the orders for Resident 1's Acetaminophen and Mucinex. On 10/16/25 at 4:55 PM Surveyor interviewed Administrator A. Administrator A indicated Resident 1's orders, Resident 1's MAR, and Resident 1's pharmacy labels should match each other and if they don't the caregivers should call Resident 1's Medical Doctor to get the orders clarified and communicate with the pharmacy to be sure the labels are correct. Administrator A stated, "I want to blame the pharmacy, but it is our job to double check when they come in."	M 582		