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	0018569	A. BUILDING: _____ B. WING _____	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVERCREST	503 CLOVERCREST CT WATERTOWN, WI 53094

(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
N 000	Initial Comments On 07/30/2025, with information obtained through 08/15/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a standard licensing survey at Clovercrest, a community-based residential facility (CBRF) located in Watertown, WI. As a result of the survey, 12 deficiencies were identified. Two of the deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) 1BXT11, dated 10/28/2022. Census: 4	N 000		
N 205	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on observation, interview, and record review, the licensee permitted the existence or continuation of risk resulting from limited staff supervision and management of resident behaviors. For approximately 12 minutes on 07/30/2025, Resident 4's medications - all in liquid solutions - sat out on the kitchen counter. During this time, Caregiver C was with Resident 4 in his/her room and Caregiver B conducted other caregiving tasks, at times out of view of the kitchen counter.	N 205		

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

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Resident 2, who was at risk of ingesting non-food items and prior to this period had already approached the counter with the medications once before being redirected, was observed wandering in the area throughout this period. The medications that sat out included a thyroid medication and antiseizure medication.

Resident 1 was known to have behaviors of pulling others' hair. While Surveyor was onsite, Resident 1 was observed to pull the hair of staff and residents multiple times and place Resident 2 in a chokehold-type position twice. Nearly all the occasions required hands-on intervention by Coordinator A, who was not a caregiver and only onsite to assist with the survey, to break up. For most of the occasions, Caregiver D was either out of view or was within view and did not intervene. For one instance, Surveyor directed Caregiver D to intervene when Resident 1 approached Resident 4 and began pulling his/her hair. Despite Resident 1's continued behaviors, no steps were taken to escalate intervention techniques to prevent Resident 1's physical behaviors towards others or provide increased supervision of Resident 1. Caregiver D was scheduled to work the remainder of his/her second shift alone after Surveyor and Coordinator A left at the survey's onsite conclusion. Remaining tasks included evening feeding (of which, Resident 4 required a g-tube preparation and Resident 2 required supervision), resident evening/bedtime medication pass, and evening/bedtime cares (of which, all 3 other residents required total assistance) - all tasks that would require Caregiver D's attention and limit his/her ability to supervise Resident 1.

Resident 1 previously required redirection from staff to leave the areas where food was out -

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once after breakfast and once while dinner was being heated on the stove. Despite this, increased supervision was not provided to him/her during dinner preparation. On Resident 1's third attempt to get to the food on the stove, which was indicated as having hot burners, Coordinator A was attending to Resident 2 and Caregiver D was not in sight. Surveyor intervened by directing Coordinator A to the situation in order to prevent Resident 1 from touching the hot stove or accessing the food. Resident 1 was documented as being at high risk for choking and aspiration and had behaviors of taking food.

Findings include:

The provider is licensed to serve up to 6 nonambulatory residents within the client groups of traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, physically disabled, and alcohol/drug dependent.

On 07/30/2025, Surveyor conducted a survey. From approximately 9:07 a.m. - 12:25 p.m., and then 1:54 p.m. - 4:10 p.m., Surveyor observed the following:

Example 1 - Medications left out

On 07/30/2025, at approximately 9:07 a.m., Surveyor entered the home to conduct a survey. The home's common areas were observed to be "open concept" style with no separation between the living area, dining area, and kitchen. After Surveyor entered the home, Resident 1 was observed walking near the front door. At approximately 9:10 a.m., Resident 1 was observed attempting to walk out the front door. Caregiver B was observed redirecting Resident 1 back into the home.

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N 205	Continued From page 3 At approximately 9:10 a.m., Surveyor interviewed Caregiver C about staffing. Caregiver C reported that typically 2 staff worked the morning/day shift, 1-2 staff worked the afternoon/evening shift, and 1 staff worked the overnight (NOC) shift. Surveyor observed 2 staff - Caregivers B and C - working. At approximately 9:15 a.m., Surveyor observed Caregiver B preparing Resident 4's medications, which included dissolving tablets into water within medication cups, pouring capsule contents into water within a medication cup, preparing liquid medications and readying a water cup - all of which s/he placed on a plate on a counter between the kitchen and living areas. Surveyor observed Resident 1 approach the counter where Resident 4's medications were sitting out before s/he was redirected by Caregiver C. Shortly after this, Caregiver C went into Resident 4's room and closed the door. At approximately 9:30 a.m., Coordinator of Administrator Services (Coordinator) A arrived onsite to assist Surveyor with the survey. Coordinator A sat at the dining table where s/he was observed working on his/her laptop. At approximately 9:37 a.m., Surveyor observed the plate with medications still out. Resident 2 was observed wandering around the area, at times wandering near the counter. Resident 1 was observed sitting in a recliner in the living area. Caregiver B was observed by the laundry area that was just past the kitchen. While the laundry area was within view of the kitchen, Surveyor observed that at times Caregiver B had his/her back to the kitchen area while s/he worked in the laundry area. No one was observed	N 205		

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to redirect Resident 2 when s/he wandered near the kitchen counter with Resident 4's medications or move the medications to a location inaccessible to Resident 2.

At approximately 9:40 a.m., Surveyor observed Caregiver B rolling an IV pole out in the hallway towards Resident 4's room and then walk down the opposite hallway (which was out of sight from the kitchen counter). Resident 2 was observed still wandering around the area, including near the kitchen counter. Resident 1 was observed sitting in a recliner in the living area. The plate with Resident 4's medications was still out. No one was observed to redirect Resident 2 when s/he wandered near kitchen counter with Resident 4's medications or move the medications to a location inaccessible to Resident 2.

Surveyor continued to observe Resident 4's plate of medications on the counter up to when s/he reviewed them with Caregiver B at approximately 9:49 a.m. During this time, Caregiver C was observed in Resident 4's room, assisting him/her getting ready, and out of view of the counter. Coordinator A was observed at the dining table working on his/her laptop. Caregiver B was observed conducting tasks at times within view of the counter and at times out of view. Resident 1 was still seated in a recliner and Resident 2 was still wandering around the area.

At approximately 9:49 a.m., Surveyor interviewed Caregiver B about the contents of Resident 4's medications that had been prepared on the plate. Caregiver B showed Surveyor from the plate and Resident 4's medication administration record (MAR) the medication solutions s/he prepared. These included the following:

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- Levothyroxine 50 mcg tablet (a medication used to treat hypothyroidism), which was dissolved in water

- Clobazam 10 mg tablets (a medication used to treat seizures), which were dissolved in water

- Flaxseed 1000 mg capsulea

- Docusate 50 mg / 5 mL liquid

At approximately 9:55 a.m., Surveyor observed Caregiver B administer Resident 4's medications to him/her.

On 07/31/2025, Surveyor reviewed the current individual service plan (ISP) for Resident 2, last dated as reviewed 07/10/2025. Resident 2's diagnoses included profound intellectual and developmental disability, autism, and a history of pica. Resident 2's ISP indicated that s/he was at "risk to ingest non-food items." Under a section detailing risks for Resident 2, the following was documented: " ...[S/he] also has a history of putting inedible items in [his/her] mouth (leaves, socks, crumbs on the floor, anything that resembles food, etc."

On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A. Coordinator A confirmed s/he was not aware that Resident 4's medications had been sitting out. Coordinator A confirmed that his/her role with the provider didn't entail direct medication administration or oversight of medication administration. S/he reported s/he didn't know the protocols or processes for how medications were administered but reported s/he didn't think medications should be left out. Coordinator A reported understanding of Surveyor's concern

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that Resident 4's medications were left out, at times unsupervised, and accessible to residents.

Example 2 - Resident 1's physical behaviors

On 07/30/2025, at approximately 9:07 a.m., Surveyor entered the home to conduct a survey. The home's common areas were observed to be "open concept" style with no separation between the living area, dining area, and kitchen. Shortly after entering the home, Surveyor observed Caregiver C feeding Resident 2.

At approximately 9:10 a.m., Surveyor interviewed Caregiver C about staffing. Caregiver C reported that typically 2 staff worked the morning/day shift, 1-2 staff worked the afternoon/evening shift, and 1 staff worked the overnight (NOC) shift. Surveyor observed 2 staff - Caregivers B and C - working.

At approximately 11:27 a.m., while reviewing medications, Surveyor observed Resident 1, who was independently ambulatory, approach Resident 4, who was in a wheelchair that s/he was not observed to independently operate. Resident 1 began pulling Resident 4's hair. Resident 1 required verbal and physical redirection from Caregiver C to let go of Resident 4's hair and walk away.

At approximately 2:15 p.m., Surveyor was conducting survey work at the dining table. Caregiver C was in the same common area providing handoff communication to Caregiver D, who had just arrived to work the second shift alone. Caregiver D confirmed s/he worked for an agency and not directly for the provider. Surveyor observed Resident 4, in his/her wheelchair, at a side room off the dining area receiving a g-tube

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feeding. Resident 1 approached Surveyor and reached out towards his/her hair. Surveyor attempted to verbally redirect Resident 1. Caregiver C reported that Resident 1 would try to pull Surveyor's hair and was observed telling Resident 1 that s/he should not pull hair. Shortly after this, Caregiver C left due to his/her shift ending.

At approximately 2:20 p.m., Surveyor observed Resident 1 grab and hold Resident 2 in a chokehold-type position, with his/her arm around Resident 2's neck and bending his/her neck down towards him/her. Coordinator A physically intervened to pull Resident 1 away from Resident 2. Caregiver D was not observed in the area.

At approximately 2:25 p.m., Resident 1 approached Surveyor and began pulling on Surveyor's hair. Surveyor pulled his/her hair out of Resident 1's grasp and attempted to verbally redirect Resident 1. Caregiver D was not observed in the area.

At approximately 2:28 p.m., Resident 1 approached Resident 2 and began to put his/her arms around Resident 2 before being redirected by Coordinator A. Caregiver D was not observed in the area.

At approximately 2:40 p.m., Resident 1 approached Resident 2 and began pulling Resident 2's hair. Resident 2 attempted to walk away. Resident 1 then let go and approached Surveyor. Resident 1 reached out twice towards Surveyor's hair and required Surveyor to verbally redirect him/her away. During this encounter, Caregiver D was observed in the kitchen washing dishes and was within sight and hearing range of Surveyor redirecting Resident 1.

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N 205	Continued From page 8 At approximately 2:45 p.m., Resident 1 approached Resident 2 and began grabbing Resident 2's hair. Resident 1 did not stop until Coordinator A intervened. During this encounter, Caregiver D was assisting Resident 3 in the bathroom. At approximately 2:52 p.m., Surveyor observed Resident 1 enter the side room where Resident 4 sat after his/her g-tube feeding. Resident 1 began pulling Resident 4's hair. Surveyor drew the attention of Caregiver D, who was in the area, who then physically redirected Resident 1. At approximately 2:57 p.m., Surveyor observed Resident 1 grab and hold Resident 2 in a chokehold-type position, with his/her arm around Resident 2's neck and bending his/her neck down towards him/her. Surveyor also observed Resident 2 pulling on Resident 1's left ear. Coordinator A physically intervened to pull Resident 1 away from Resident 2. Caregiver D was not observed in the area. Immediately after being pulled away from Resident 2, Resident 1 attempted to grab Resident 2 again but was stopped by Coordinator A. At this time, Surveyor interviewed Coordinator A, who reported s/he worked in an offsite office for the provider and was not scheduled to perform shifts at the provider's homes. Coordinator A confirmed s/he was only onsite to conduct the survey with Surveyor. Coordinator A confirmed that s/he was not a caregiver and did not perform caregiving duties. Surveyor discussed with Coordinator A his/her concerns regarding the lack of Caregiver D's supervision over the residents, particularly with Resident 1. Coordinator A reported s/he understood Surveyor's concerns. In	N 205		

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response to Surveyor sharing the concern that it was unknown how long each physical altercation would have continued without Coordinator A's intervention, Coordinator A reported s/he understood Surveyor's concerns. Caregiver D was not observed in the area during this interview, though Residents 1 and 2 were present.

At approximately 3:13 p.m., Coordinator A was observed redirecting Resident 2 who attempted to leave out the front door. During this, Resident 1 was observed to walk near them, reach out, and grab Resident 2's hair. Caregiver D was not observed in the area.

At approximately 3:17 p.m., Surveyor observed Coordinator A physically blocking Resident 1 from getting to Resident 2. Caregiver D was not observed to assist.

At approximately 3:20 p.m., Surveyor heard Caregiver D call out. Surveyor saw Resident 1 holding onto Caregiver D's hair and Caregiver D was trying to pull his/her hair out of Resident 1's grasp while verbally redirecting him/her. Coordinator A then assisted and was observed physically pulling Resident 1's fingers/hands out of Caregiver D's hair.

At approximately 3:30 p.m., Resident 1 began swatting at Surveyor, and required Surveyor to redirect him/her. During this, Caregiver D was in the kitchen preparing dinner.

At approximately 3:31 p.m., Resident 1 was observed wrapping his/her arms around Resident 2. Coordinator A physically pulled Resident 1 away from Resident 2. Caregiver D continued preparing food in the kitchen throughout the

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interaction.

At approximately 3:36 p.m., Resident 1 approached Surveyor and grabbed Surveyor's hair. Surveyor required Coordinator A to assist in pulling his/her hair out of Resident 1's grasp. Immediately after this, Resident 1 approached Resident 2. Coordinator A physically blocked Resident 2 from Resident 1.

On 07/30/2025, Surveyor reviewed partial resident records, including ISPs, of the 3 other residents who resided with Resident 1 in the home, which detailed the following:

- Resident 2's diagnoses included profound intellectual and developmental disability and autism. Resident 2 was documented as being non-verbal. Resident 2's ISP, dated 07/10/2025, documented that s/he required 24-hour supervision, required total assistance for cares, and was not able to make his/her needs known.

- Resident 3 was documented as being developmentally disabled and non-verbal. Resident 3's ISP, dated 03/13/2025, documented that s/he required 24-hour supervision, required total assistance for cares, and was not able to make his/her needs known. Resident 3 was documented to be at risk for falls.

- Resident 4's diagnoses included profound intellectual and developmental disability and spastic tetraplegia. Resident 4 was documented as being non-verbal. Resident 4's ISP, dated 05/14/2025, documented that s/he required total assistance for cares, which included for setting up and administration of g-tube feedings and flushes. According to his/her g-tube schedule, a flush was to occur at 5:00 p.m., and a feeding

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was to occur at 6:00 p.m. Resident 4's ISP also documented that s/he utilized a wheelchair, that s/he was unable to self-propel, for mobility. Resident 4's ISP documented that s/he required 24-hour supervision and was not able to make his/her needs known.

At approximately 4:07 p.m., prior to leaving, Surveyor discussed concerns of Resident 1's behavior management with Coordinator A. Surveyor shared his/her observation that Coordinator A, who was not scheduled to work that day and was not involved in caregiving, was required to intervene in almost all the above observed interactions due to Caregiver D not being present to see them or not intervening him/herself. Coordinator A confirmed with Surveyor that other tasks had yet to be conducted by Caregiver D that evening, which would limit his/her ability to supervise Resident 1 adequate to the frequency of his/her behaviors and intervene - including plating and serving dinner, directly supervising dinner, retrieving Resident 3 for dinner, preparing and administering Resident 4's evening g-tube flushes and feedings, evening cares (including toileting), and evening medication administration. Surveyor asked how Caregiver D was going to complete those tasks while still being able to supervise Resident 1 to ensure s/he didn't get to other residents or intervene if Resident 1 did get ahold of other residents once Surveyor and Coordinator A left. Coordinator A replied, "I don't know."

On 07/30/2025, Surveyor reviewed Resident 1's partial record. Resident 1's diagnoses included severe intellectual disability. Resident 1's ISP documented that s/he was non-verbal but could communicate needs through sign language, yes/no questions, and some words. Under the

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"Positive Behavior Supports" section, the following was documented: "Sometimes I invade people's personal space and need to be reminded to not get to [sic] close ...I may also need reminders to not touch/rub other's [sic] arms ...Redirect as necessary ...Most of my negative behaviors are when I am seeking attention. If you keep me occupied, I am less likely to have these behaviors." Resident 1's ISP documented that s/he enjoyed "Manipulating small items like paper, hair, and rocks." Resident 1's ISP also documented that Resident 1 "needs to be monitored to be sure of [his/her] whereabouts at all times. If left unattended, [s/he] will get curious and explore things on his/her own."

On 08/01/2025, Surveyor reviewed psychotropic medication reviews conducted by the provider's staff. One review, dated 09/25/2024, documented the following for Resident 1: "Many behaviors including attempting to elope, pulling hair of peers + staff. Behaviors fluctuate ..."

On 08/08/2025, at approximately 10:55 a.m., Surveyor interviewed Nurse Case Manager G, who was the registered nurse (RN) case manager for Resident 4. During the interview, Nurse Case Manager G reported s/he was also messaging Case Manager H for additional corroborating information. During the interview, Nurse Case Manager G reported that s/he was aware the home had residents with some "heavier behaviors." When asked to clarify, Nurse Case Manager G reported s/he knew that one resident pulls others' hair. S/he reported that when s/he was at the home in attendance of a care conference for Resident 4 in May 2025, s/he saw this resident pull Caregiver F's hair. Nurse Case Manager G reported that in that instance another staff member who was present had to

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help get that resident to let go of Caregiver F's hair. When asked if Nurse Case Manager G reported if there were any instances of that resident having any physical altercations with Resident 4 and/or pulling his/her hair, s/he replied, "Not to our knowledge."

On 08/14/2025, at approximately 9:25 a.m., Surveyor interviewed Case Manager N, who was the managed care organization's case manager for Resident 1. Case Manager N confirmed that Resident 1 pulling on others' hair was a typical behavior for him/her but noted that the frequency of this behavior was increasing, which s/he personally observed during his/her last few visits. Case Manager N reported s/he noticed the behavior increasing since around March 2025.

On 08/14/2025, Surveyor reviewed Resident 1's behavior support plan (BSP). The BSP identified that Resident 1 demonstrated aggression by pinching, kicking, hair pulling, and putting others in headlocks. The BSP outlined several strategies that staff were to utilize when Resident 1 demonstrated, or attempt to demonstrate, aggressive behavior. Surveyor noted that s/he did not observe Caregiver D utilize any of the strategies documented on the above occasions when Resident 1 exhibited aggression towards others.

On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A. Coordinator A reported understanding of Surveyor's concern that Caregiver D's lack of supervision of Resident 1 and lack of escalating interventions allowed him/her to continue his/her physical behaviors towards others that afternoon. Coordinator A confirmed that Caregiver D was agency staff and reported s/he assumed Caregiver D worked in

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the home before but wasn't sure. Coordinator A confirmed that regardless, Caregiver D would have been expected to be familiar with residents' ISPs and BSPs. Coordinator A reported that after Surveyor left on 07/30/2025 s/he asked if Caregiver D would be okay working on his/her own, to which Caregiver D reportedly replied that s/he was. Surveyor shared the observation that for several of the physical altercations, as noted above, Caregiver D was not present to observe them and their frequency and so s/he might not have been aware how much supervision s/he needed to provide that evening after Coordinator A left, to which Coordinator A agreed. Surveyor asked Coordinator A if s/he made Caregiver D aware of how much s/he him/herself had to physically intervene to break up and/or prevent physical altercations. Coordinator A replied s/he had not.

Example 3 - Food and stove

On 07/30/2025, at approximately 9:07 a.m., Surveyor entered the home to conduct a survey. The home's common areas were observed to be "open concept" style with no separation between the living area, dining area, and kitchen.

At approximately 9:15 a.m., Surveyor observed Resident 1 approach food that had been left out on the counter from breakfast. Caregiver C verbally and physically redirected Resident 1 away from the area.

At approximately 3:20 p.m., Surveyor observed Caregiver D in the kitchen area preparing food.

At approximately 3:24 p.m., Surveyor observed Resident 1 approach food that was sitting in a pot on the kitchen stove. Coordinator A was observed

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running towards Resident 1 to prevent him/her from touching the food and redirected him/her away from the kitchen area. Caregiver D, who was the sole caregiver working that shift, was not in the area.

At approximately 3:36 p.m., Surveyor observed Caregiver D, who had been in the kitchen area preparing food, walk out of sight. Shortly afterwards, Surveyor observed both Residents 1 and 2 walk into the kitchen towards the stove. Coordinator A redirected both residents away from the kitchen. Surveyor observed food in a pot on the stove and a lit indicator on the appliance panel that indicated the stove's burners were hot.

At approximately 3:42 p.m., Surveyor observed Resident 1 approaching the food on the stove again. Surveyor did not observe Caregiver D in the area. When Surveyor observed Resident 1 reaching towards the pot, Surveyor quickly directed Coordinator A, who had been attending to Resident 2 in the living area, to the situation to prevent potential outcome. Coordinator A quickly approached Resident 1 and redirected him/her away from the area. Caregiver D was not observed in the area. Coordinator A confirmed that the stove's burners were still hot.

On 07/30/2025, Surveyor reviewed Resident 1's partial record. Resident 1's ISP documented that s/he was at high risk for choking and aspirating and that, " ...staff must make sure that I eat my food slowly and take drinks in between bites." The ISP noted 2 past choking episodes from food in 2009 as well as a choking occurrence "in January 2025, which required staff to perform the Heimlich maneuver on [him/her] ([s/he] took a peer's hot dog) ..." The ISP also documented, "I do not assist with food prep because of my

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tendency to try and take food." The ISP noted that Resident 1 required full assistance with kitchen safety and documented, "[Resident 1] does not understand kitchen safety ...[S/he] does enjoy helping staff prep meals but must be monitored at all times." Resident 1's ISP also documented that Resident 1 "needs to be monitored to be sure of [his/her] whereabouts at all times. If left unattended, [s/he] will get curious and explore things on his/her own."

On 08/14/2025, at approximately 9:25 a.m., Surveyor interviewed Case Manager N, who was the managed care organization's case manager for Resident 1. Case Manager N confirmed that Resident 1 was at risk for choking and aspiration, and experienced past choking and aspirating incidents. Case Manager N reported that it would be typical for Resident 1 to approach and try to ingest food if it were left out within view.

On 08/14/2025, Surveyor reviewed Resident 1's behavior support plan (BSP). The BSP identified that Resident 1 "has a tendency to food steal during meal prep times. When [Resident 1] steals food, [s/he] will often swallow it without chewing, which puts [him/her] at risk for choking. Please follow the guidelines below to help prevent [Resident 1] from stealing." The BSP documented that staff were to redirect Resident 1 away out of the kitchen during meal prep. Surveyor noted that Caregiver D was not present to be aware of any of the above occurrences where Resident 1 had access to the food being prepared.

On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A. Coordinator A reported understanding of Surveyor's concern that food and the stove, which had hot burners, were accessible to residents - 2 of whom were

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N 205	Continued From page 17 known to have food-related risk behaviors. Cross Reference: N0396 DHS 83.36(1)(a) Adequate Staff to Meet Resident Needs	N 205		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 1 staff reviewed who had been with the provider for at least 4 years, Caregiver C, had a background check completed every 4 years after hire. Caregiver C's most recent background check was approximately 3 months late during the survey. Findings include: On 07/30/2025, Surveyor conducted a review of	N 219		

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N 219	Continued From page 18 employee background checks to verify compliance with background check requirements. Within a staff binder provided by Coordinator of Administrative Services (Coordinator) A, Surveyor observed that Caregiver C, who was hired on 04/01/2021, completed a BID on 03/23/2021. Within the binder a Department of Justice (DOJ) check and Governmental Findings Report for Caregiver C was dated 04/21/2021. Surveyor requested the most recent complete background check for Caregiver C from Coordinator A. On 07/31/2025, Surveyor reviewed the background check for Caregiver C, which was provided via e-mail from Coordinator A to Surveyor on 07/30/2025. The background information disclosure (BID) for Caregiver C was dated 07/15/2025. The DOJ check and Governmental Findings Report were dated 07/30/2025 - the day of the survey. On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reported that s/he had been provided Caregiver C's background check from human resources staff and did not realize the DOJ check and Governmental Findings Report were done the day of the survey.	N 219		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.	N 352		

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N 352	Continued From page 19 This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that 2 of 2 residents reviewed received all their prescribed medications in the dosages and at intervals prescribed by their practitioners. When administered as prescribed, 1 bottle of Resident 3's fluticasone nasal spray would last 30 days. On 07/30/2025, Surveyor observed that staff were still administering Resident 3's fluticasone from a bottle that was dispensed on 01/10/2025 - approximately 6.5 months prior to the survey - and was still approximately 10% full. Of 152 potential daily administrations from 03/01/2025 through 07/30/2025, staff initialed off on 149 of them (the remainder being blank), which would have correlated with approximately 5 total bottles administered. However, all 6 bottles dispensed since 03/01/2025 (Surveyor's review period start) appeared full. Additionally, the 4 bottles dispensed prior to that date were full as well. Resident 3 did not receive at least 152 doses of his/her fluticasone during the period Surveyor reviewed. Resident 3 was reported to have difficulties breathing in the morning, which was alleviated by his/her fluticasone use. When administered as prescribed, 1 container of Resident 3's polyethylene glycol powder would last 15 days (or approximately 1/2 month). On 07/30/2025, Surveyor observed that staff were still administering Resident 3's polyethylene glycol powder from a container that was dispensed on 04/28/2025 - approximately 3 months prior to the survey - and was still approximately 1/3 full. Of 184 potential administrations from 04/29/2025 through 07/29/2025, staff initialed off on 179 of them (the remainder being blank), which would	N 352		

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have correlated with approximately 6 total containers administered. However, all containers dispensed since 04/28/2025 were observed still sealed. Resident 3 did not receive at least 154 doses of his/her polyethylene glycol. Resident 3 was documented to have constipation-related concerns.

When administered as prescribed, 1 container of Resident 4's polyethylene glycol powder would last 30 days. On 07/30/2025, Caregiver B confirmed with Surveyor that Resident 4 was administered his/her polyethylene glycol that morning. Afterwards, Caregiver C reported to Surveyor that Resident 4's polyethylene glycol was out and staff requested a refill on 07/25/2025, which was reportedly on backorder. Upon further investigation, Resident 4's polyethylene glycol was last dispensed on 03/28/2025, which would have lasted until approximately 04/27/2025 (corroborated by staff having initialed off on daily administration). There was no evidence of staff having requested a refill after 03/28/2025 and before the survey. Of 93 potential administrations from 04/28/2025 through 07/29/2025, staff initialed off on 91 of them (the remainder being blank), which would have correlated with approximately 3 total containers administered. Resident 4 did not receive approximately 92 doses of his/her polyethylene glycol (the 91 doses from 04/28/2025 through 07/29/2025, and then 07/30/2025). One of Resident 4's diagnoses was constipation, and s/he was noted to not be consistently receiving his/her only other 2 scheduled medications for constipation (as documented in this citation).

When administered as prescribed, 1 bottle of Resident 4's liquid multivitamin would last approximately 47 days. On 07/30/2025, Surveyor

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N 352	Continued From page 21 observed that staff were still administering Resident 4's liquid multivitamin from a bottle that was dispensed on 10/28/2024 - approximately 9 months prior to the survey - and still had a small layer of liquid along its bottom. Of 151 potential daily administrations from 03/01/2025 through 07/29/2025, staff initialed off on 148 of them (the remainder being blank). A pharmacy audit of the provider's medication area on 12/23/2024 noted that at that time there were 3 full bottles of Resident 4's liquid multivitamin and that as a result, the pharmacist was holding refills until staff specifically requested them in order to use up the liquid multivitamin on hand. Even if administered as prescribed from that point, Resident 4's liquid multivitamin should have been out on approximately 05/13/2025. As a result, Resident 4 did not receive at least 77 doses of his/her liquid multivitamin. On 07/30/2025, Surveyor observed 1 bottle of Resident 4's liquid senna onsite that, when administered as prescribed, would last approximately 24 days. Staff were still administering from a bottle observed by Surveyor which was dispensed on 06/25/2025 - approximately 35 days prior to the survey - and still approximately 10% full. Of 151 potential daily administrations from 03/01/2025 through 07/29/2025, staff initialed off on 145 of them (the remainder being blank). A pharmacy audit of the provider's medication area on 12/23/2024 noted that at that time there were 4 full bottles of Resident 4's liquid senna and that as a result, the pharmacist was holding refills until staff specifically requested them in order to use up the liquid senna on hand. Even if administered as prescribed from that point, in conjunction with only 2 refills from that date, Resident 4 did not receive at least 55 doses of his/her liquid senna.	N 352		

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N 352	Continued From page 22 One of Resident 4's diagnoses was constipation, and s/he was noted to not be consistently receiving his/her only other 2 scheduled medications for constipation (as documented in this citation). On 07/30/2025, Surveyor observed 11 total bottles of Resident 4's liquid docusate - one of which, dated 01/31/2025, staff were currently administering from and was approximately 1/3 full, and 10 of which were full. When administered as prescribed, 3 bottles of Resident 4's liquid docusate, which is how the pharmacy dispensed it, would last 30 days. Of 302 potential administrations from 03/01/2025 through 07/29/2025, staff initialed off on 294 of them (the remainder being blank). A pharmacy audit of the provider's medication area on 12/23/2024 noted that at that time there were 15 full bottles of Resident 5's liquid docusate. Even if administered as prescribed from that point, including consideration of all refills that occurred, Resident 4 did not receive approximately 60 doses of his/her liquid docusate. One of Resident 4's diagnoses was constipation, and s/he was noted to not be consistently receiving his/her only other 2 scheduled medications for constipation (as documented in this citation). On 07/30/2025, Surveyor observed 5 total bottles of Resident 4's liquid levetiracetam - one of which, dated 06/02/2025, staff were currently administering from and was approximately 25% full, and 4 of which were full with seals intact. When administered as prescribed, 2 bottles of Resident 4's levetiracetam, which is how the pharmacy dispensed it, would last 27 days. In total, Surveyor noted an approximate administration gap of at least approximately 108 administrations, or 54 days - 27 days between	N 352		

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N 352	Continued From page 23 03/10/2025 - 04/07/2025 and 27 days from 06/02/2025 - 07/29/2025 (as evidenced by the 2.25 bottles unused) in which Resident 4 did not receive his/her levetiracetam. Resident 4 had a seizure disorder and experienced 4 seizures since December 2024. Findings include: Example 1 - Resident 3's fluticasone nasal spray On 07/30/2025, at approximately 11:27 a.m., Surveyor observed the medication storage area. Within the area where Resident 3's daily medications were stored, Surveyor observed a bottle located within a baggie. The pharmacy label on the baggie indicated that the bottle contained fluticasone 50 mcg nasal spray. The label showed that it was prescribed to Resident 3 and that the bottle was dispensed on 01/10/2025. The prescription on the label directed, "Spray 2 sprays in each nostril every evening for allergic rhinitis *wait 1 min between sprays and 5 mins between different sprays*" The manufacturer's label on the bottle indicated that the bottle contained 120 metered sprays. The bottle appeared approximately 10% full. In a separate section of Resident 3's medication storage area, Surveyor observed a container with 10 other baggies, each containing bottles of Resident 3's fluticasone. The 10 bottles each appeared to be full. Dispense dates on the baggies' pharmacy labels indicated that 1 bottle was dispensed on each of the following dates: 10/18/2024, 11/15/2024, 12/13/2024, 02/07/2025, 03/07/2025, 04/04/2025, 05/02/2025, 05/30/2025, 06/27/2025, and 07/25/2025. The pharmacy labels on each baggie contained the same prescription instructions - 2 sprays in each nostril	N 352		

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every evening. Each bottle's manufacturer's label indicated that one bottle contained 120 metered sprays. Surveyor noted that when administered as prescribed to Resident 3, 1 bottle of his/her fluticasone contained 30 daily doses (120 sprays total divided into 2 daily sprays in each nostril).

While observing Resident 3's medications, Surveyor interviewed Caregiver C. Caregiver C reported that staff typically administered Resident 3's fluticasone in the morning as opposed to the evenings because Resident 3 was known to at times have difficulties breathing then and the fluticasone helped. Caregiver C reported that s/he had contacted Resident 3's medical provider and obtained approval of staff administering it in the morning as opposed to the evening. Caregiver C reported that Resident 3 was not known to refuse fluticasone.

On 07/31/2025, Surveyor reviewed medication administration records (MARs) for Resident 3 from 03/01/2025 - 07/30/2025. Resident 3's prescription instructions on the MARs were the same as what was on each bottle's pharmacy label. Within the MARs, staff initialed off on administering Resident 3's fluticasone on 149 of 152 potential administration days. On the 3 days in which staff didn't initial administering Resident 3's fluticasone, the entries were blank with no other annotations. Surveyor noted that 149 days of administration would have equaled 596 metered sprays of fluticasone administered to Resident 3, or approximately 5 bottles of fluticasone. Surveyor noted that this was not consistent with the supply of his/her fluticasone observed on site.

On 08/05/2025, at approximately 1:43 p.m., Surveyor interviewed Prescription Manager E

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from the pharmacy that dispensed Resident 3's medications. Prescription Manager E confirmed all the same dispense dates as noted by Surveyor printed on each fluticasone baggie's pharmacy label. Prescription Manager E reported that Resident 3's fluticasone was on a continuous fill program, with a new bottle sent approximately every 30 days since 1 bottle contained 30 days' worth of fluticasone for Resident 3.

On 08/05/2024, Surveyor reviewed Resident 3's partial record. Resident 3 was admitted to the provider on 06/01/2021. Resident 3 was documented as being non-verbal, having a legal guardian, and requiring staff assistance to manage all medications. Of note, Resident 3's current individual service plan (ISP), dated 03/13/2025, documented the following: "[Caregiver F] would like to have [Resident 3]'s Flonaise [sic] administered in the A.M. versus the P.M. [S/he] will talk with [Resident 3's medical provider] to get the administration time changed."

On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reported that his/her role with the provider didn't entail direct medication administration or oversight of medication administration and s/he was unaware of medication administration concerns.

On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A again. Coordinator A reported understanding of Surveyor's concern that Resident 3 was not receiving his/her fluticasone as prescribed (and as reported and documented by staff) and that the provider had begun to work on addressing the medication administration concerns.

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N 352	Continued From page 26 Example 2 - Resident 3's polyethylene glycol On 07/30/2025, at approximately 11:27 a.m., Surveyor observed the medication storage area. Within the area where Resident 3's daily medications were stored, Surveyor observed 1 container of polyethylene glycol 3350 powder. The pharmacy label on the container showed that it was prescribed to Resident 3 and dispensed on 04/28/2025. The prescription on the label directed, "Mix 17 grams (fill cap to line) in 4-8 oz liquid, stir well and drink twice daily (hold for loose stool)." The container appeared approximately 1/3 full. The manufacturer's label on the container indicated that it contained 30 once-daily doses. Surveyor noted that with Resident 3's prescription directive to take 17 grams twice daily (instead of once daily) that 1 container would contain 15 days' worth of polyethylene glycol for Resident 3 when administered as prescribed. Along the back of Resident 3's medication storage area, Surveyor observed 7 other containers of Resident 3's polyethylene glycol powder. Dispense dates on the containers' pharmacy labels indicated that 1 container was dispensed on each of the following dates: 05/09/2025, 05/23/2025, 06/06/2025, 06/19/2025, 07/02/2025, 07/15/2025, 07/28/2025. Each of the 7 containers were observed with intact seals. The pharmacy labels on each container contained the same prescription instructions - 17 grams twice daily. Each container's manufacturer's label indicated that 1 container contained 30 once-daily doses (which Surveyor noted again would be 15 days' worth of powder for Resident 3, who was directed to take polyethylene glycol twice daily). While observing Resident 3's medications, Surveyor interviewed Caregiver C. Caregiver C	N 352		

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reported that Resident 3 was given polyethylene glycol each morning with juice and that s/he was known to drink it daily without issues.

On 07/31/2025, Surveyor reviewed MARs for Resident 3. While reviewing the MARs, Surveyor observed that the start date of Resident 3's polyethylene glycol, with the directive of 2 administrations daily, was 03/20/2025. In MARs reviewed from 04/29/2025 (the day after Resident 3's only open bottle of polyethylene glycol powder was dispensed) through 07/29/2025, Surveyor observed that staff initialed off on administering Resident 3's polyethylene glycol on 179 of 184 administrations. On the 5 occasions in which staff didn't initial administering Resident 3's polyethylene glycol, the entries were blank with no other annotations. Surveyor noted that 179 administrations would have equaled approximately 6 containers' worth of polyethylene glycol administered to Resident 3. Surveyor noted that this was not consistent with the unused supply of his/her polyethylene glycol observed on site.

On 08/05/2025, at approximately 1:43 p.m., Surveyor interviewed Prescription Manager E from the pharmacy that dispensed Resident 3's medications. Prescription Manager E confirmed that Resident 3's polyethylene glycol prescription for twice daily began on 03/20/2025. Prescription Manager E reported that after this order began, polyethylene glycol containers were dispensed to Resident 3 on the same dispense dates as noted by Surveyor printed on each container's pharmacy label, as well as 1 container each on 04/02/2025 and 04/15/2025. Prescription Manager E reported that Resident 3's polyethylene glycol was on a continuous fill program, with a new container sent approximately

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every 15 days since 1 container contained 15 days' worth of polyethylene glycol for Resident 3.

In reconciling the information from Prescription Manager E regarding Resident 4's polyethylene glycol dispense dates, prescription, and MARs, Surveyor observed that the last container of Resident 3's polyethylene glycol, dispensed on 04/28/2025, and administered near daily as initialed off by staff, would have been out on approximately 05/13/2025 (one administration entry was blank during this time period - the 8:00 p.m. entry on 04/29/2025). Approximately 5 additional containers would have been needed to administer the amount of polyethylene glycol that staff initialed off as having administered from 05/13/2025 to Surveyor having been on site on 07/30/2025 - approximately 154 doses. Surveyor noted that the container from 04/28/2025 having appeared to be approximately 1/3 full made 154 missed doses a conservative approximation.

On 08/05/2024, Surveyor reviewed Resident 3's partial record. Resident 3 was admitted to the provider on 06/01/2021. Resident 3 was documented as being non-verbal, having a legal guardian, and requiring staff assistance to manage all medications. Resident 3's current individual service plan (ISP), dated 03/13/2025 noted that Resident 3 had "constipation/rectal medication" protocols and delegated tasks. The ISP also noted that Resident 3 had been experiencing hemorrhoids which were "doing okay." In reviewing Resident 3's prescriptions, Surveyor observed that Resident 3 was prescribed senna 8.6 mg tablets, bisacodyl 10 mg suppositories, and fleet enemas - all to be used as needed (PRN) for constipation.

According to the National Institutes of Health

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(NIH), hemorrhoids "can yield symptoms ranging from minimal discomfort or inconvenience to excruciating pain ...Conservative measures are considered first-line ..." Conservative measures include stool softeners, including the use of polyethylene glycol to soften the stool by increasing its water content. This "can decrease straining and the sheering pressure associated with passing stool," (Source: National Institutes of Health: National Library of Medicine, External Hemorrhoid, August 8, 2023, https://www.ncbi.nlm.nih.gov/books/NBK500009/ (retrieval date - August 7, 2025).).

On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reported that his/her role with the provider didn't entail direct medication administration or oversight of medication administration and s/he was unaware of medication administration concerns.

On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A again. Coordinator A reported understanding of Surveyor's concern that Resident 3 was not receiving his/her polyethylene glycol as prescribed (and as reported and documented by staff) and that the provider had begun to work on addressing the medication administration concerns.

Example 3 - Resident 4's polyethylene glycol

On 07/30/2025, at approximately 9:49 a.m., Surveyor observed Caregiver B preparing to administer Resident 4's medications, which had to be administered via his/her gastrostomy tube (g-tube). Caregiver B confirmed that all of Resident 4's medications were administered via

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g-tube. In response to being asked how staff knew how Resident 4's medications were to be prepared, Caregiver B gestured towards an administration schedule posted on the wall that staff followed for Resident 4. In observing the posting, Surveyor observed that the following was directed for 8 AM: 120 mL water flush - administer polyethylene glycol - 120 mL water flush - administer medications individually, separating each medication with a 15 mL water flush - 120 mL water flush. Surveyor observed the tray with Caregiver B and had him/her explain each medication solution s/he had prepared. Caregiver B did not report that any of the prepared solutions contained polyethylene glycol. When Surveyor asked about Resident 4's polyethylene glycol, Caregiver B replied that it had already been administered but denied that s/he had administered it. Caregiver C, who was in the area and overheard the interview, reported that Resident 4's polyethylene glycol was out. Caregiver C reported that s/he called the pharmacy to reorder it last Friday (07/25/2025) but was told that it was on backorder.

On 07/31/2025, Surveyor reviewed MARs for Resident 4 from 03/01/2025 - 07/29/2025. The entry for Resident 4's polyethylene glycol contained a start date of 09/20/2023 and the following instructions: "Mix 17 grams (fill cap to line) in 4-8 oz liquid, stir well and drink once daily for constipation." Within the MARs, staff initialed off on administering Resident 4's polyethylene glycol on 149 of 151 potential administration days.

On 08/05/2025, at approximately 1:43 p.m., Surveyor interviewed Prescription Manager E from the pharmacy that dispensed Resident 4's medications. Prescription Manager E reported

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N 352	Continued From page 31 that since 2025, 1 container of Resident 4's polyethylene glycol, containing 30 once-daily doses, was dispensed on each of the following dates: 01/31/2025, 02/28/2025, 03/28/2025, and 08/04/2025. Surveyor noted that the last dispense date was after Surveyor had been on site reviewing resident medications. Prescription Manager E reported that Resident 4's polyethylene glycol was not on a continuous fill, so staff would have to call each time to request a refill. Prescription Manager E reported that the pharmacy had not received any refill request for Resident 4's polyethylene glycol between 03/28/2025 and 08/04/2025 and denied that it had been on backorder. Prescription Manager E reported that after 03/28/2025, the only refill request that the pharmacy received was on 08/03/2025. Surveyor again noted that this was after s/he had been on site reviewing resident medications and inconsistent with Caregiver C's report. Surveyor observed that prior to 03/28/2025, the dates and amounts of Resident 4's polyethylene glycol dispensed correlated with what would be administered to Resident 4 when it was administered as prescribed. In reconciling the information from Prescription Manager E regarding Resident 4's polyethylene glycol dispense dates, prescription, and MARs, Surveyor observed that the last container of Resident 4's polyethylene glycol, dispensed on 03/28/2025, and administered daily as initialed off by staff, would have been out on approximately 04/27/2025. Approximately 3 additional containers would have been needed to administer the amount of polyethylene glycol that staff initialed off as having administered from 04/28/2025 to Surveyor having been on site on 07/30/2025 - approximately 92 doses.	N 352		

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N 352	Continued From page 32 On 08/05/2024, Surveyor reviewed Resident 4's partial record. Resident 4 was admitted to the provider on 08/30/2022 with diagnoses including constipation and profound intellectual and developmental disability. Resident 4 was documented as being non-verbal, having a legal guardian, and requiring staff assistance to manage all medications. Resident 4 was prescribed 3 different scheduled medications for constipation - docusate sodium, senna, and polyethylene glycol - all of which s/he was not consistently receiving (as documented in this citation). On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reported that his/her role with the provider didn't entail direct medication administration or oversight of medication administration and s/he was unaware of medication administration concerns. On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A again. Coordinator A reported understanding of Surveyor's concern that Resident 4 was not receiving his/her polyethylene glycol as prescribed (and as reported and documented by staff) and that the provider had begun to work on addressing the medication administration concerns. Example 4 - Resident 4's Multi-Vite liquid On 07/30/2025, at approximately 9:49 a.m., Surveyor observed Caregiver B preparing to administer Resident 4's medications, which had to be administered via his/her g-tube. Caregiver B confirmed that all of Resident 4's medications were administered via g-tube.	N 352		

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N 352	Continued From page 33 At approximately 11:27 a.m., Surveyor observed the medication storage area. Within the storage area for Resident 4's medications, Surveyor observed the following: - 1 bottle of Multi-Vite Liquid. The manufacturer's label on the bottle indicated that it contained 8 fluid ounces (fl oz) / 236 mL) of liquid. The pharmacy label on the bottle contained instructions to, "Take 5 mL per g-tube once daily" and showed a dispense date of 10/28/2024. The bottle contained a small layer of liquid along its bottom. Surveyor did not observe any other bottles of Resident 4's liquid multivitamin. On 07/30/2025, Surveyor reviewed a "Med Area Audit" document that was conducted by a pharmacist from the pharmacy that dispensed the provider's residents' medications. Surveyor observed the following comment in the report: "[Resident 4] has 3 full bottles of [liquid multivitamin] ...Pharmacy will place hold on [cycle filled prescription] to use up supply. Please contact pharmacy when supply is low to restart auto fill." Surveyor noted that this audit was dated 12/23/2024, and that excess on-hand supply was noted for 3 other medications between Residents 3 and 4. On 07/31/2025, Surveyor reviewed MARs for Resident 4 from 03/01/2025 - 07/29/2025. The entry for Resident 4's liquid multivitamin contained a start date of 09/13/2023 and the same instructions as Surveyor had previously observed on the bottle. Within the MARs, staff initialed off on administering Resident 4's liquid multivitamin on 148 of 151 potential	N 352		

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administration days. On the 3 occasions in which staff didn't initial administering Resident 4's liquid multivitamin, the entries were blank with no other annotations. Surveyor noted that 148 administrations would have equaled approximately 3 bottles' worth of liquid multivitamin administered to Resident 3 (5 mL daily with 236 mL per refill).

On 08/05/2025, at approximately 1:43 p.m., Surveyor interviewed Prescription Manager E from the pharmacy that dispensed Resident 4's medications. Prescription Manager E reported that the last 3 dates Resident 4's liquid multivitamin was refilled were 09/16/2024, 10/28/2024 and 12/09/2024. Prescription Manager E denied having received any refill requests since then. Prescription Manager E confirmed that each refill of Resident 4's liquid multivitamin was dispensed in 236 mL bottles.

In reconciling the information from Prescription Manager E regarding Resident 4's liquid multivitamin dispense dates with the pharmacy audit from 12/23/2024, Surveyor noted that the 3 full bottles of liquid multivitamin documented as being observed by the pharmacist correlated with the most recent 3 refills, the last of which occurred on 12/09/2024. Surveyor noted that 1 bottle would contain approximately 47 days' worth of multivitamin liquid for Resident 4 when administered as prescribed. As such, 3 bottles being used even from a start date of 12/23/2024 (when the pharmacist noted 3 full bottles present), would have been out around approximately 141 days later, or approximately 05/13/2025. Surveyor noted that this was not consistent with the supply of his/her multivitamin observed on site, the near daily initialed administrations on his/her MARs, and refills.

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N 352	Continued From page 35 Surveyor noted that at least approximately 77 doses of Resident 4's liquid multivitamin were not administered to him/her. On 08/05/2025, Surveyor reviewed Resident 4's partial record. Resident 4 was admitted to the provider on 08/30/2022 with diagnoses including constipation and profound intellectual and developmental disability. Resident 4 was documented as being non-verbal, having a legal guardian, and requiring staff assistance to manage all medications. On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reported that his/her role with the provider didn't entail direct medication administration or oversight of medication administration and s/he was unaware of medication administration concerns. When asked who reviewed the pharmacy audit that occurred back on 12/23/2024 that had identified unused supply of Resident 4's liquid multivitamin, Coordinator A reported that s/he received the document and forwarded it to Caregiver F, who was the lead caregiver and responsible for direct oversight of the home. Coordinator A reported that around the time s/he received the report s/he asked Caregiver F to confirm that issues identified on the audit had been addressed but that s/he wasn't sure if Caregiver F realized that the excess medications on hand potentially indicated a medication administration issue. On 08/14/2025, Surveyor reviewed an e-mail exchange between Coordinator A and Caregiver F regarding the pharmacy audit. In the initial e-mail sent on 01/08/2025 at 9:09 a.m., Coordinator A informed Caregiver F of the 3 full bottles of Resident 4's liquid multivitamin, among	N 352		

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the other excess on-hand medications the reviewing pharmacy representative observed, and that the medications were going to be on hold until staff called in for refills. Coordinator A asked Caregiver F to address concerns that the pharmacy audit identified and let him/her know when the items were addressed. The next e-mail, sent by Coordinator A on 02/04/2025 at 12:16 p.m. (approximately 1 month since the last e-mail), asked Caregiver F if the pharmacy audit issues had been addressed. Caregiver F replied to Coordinator A on 02/05/2025 at 3:04 p.m., "All have been completed. Thank you [Caregiver F]."

On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A again. Coordinator A reported understanding of Surveyor's concern that Resident 4 was not receiving his/her liquid multivitamin as prescribed (and as reported and documented by staff) and that the provider had begun to work on addressing the medication administration concerns. When discussing the role of Caregiver F, who was tasked with following through with the concerns identified from the pharmacy's audit, Coordinator A confirmed that Caregiver F typically worked full-time shifts at the home, and so s/he was there as much as any other caregiver that worked in the home. Surveyor asked if Caregiver F, who would've been familiar then with how residents' medications were dispensed from the pharmacy, would've realized that excess medication supply on hand indicated a medication administration problem since the pharmacy didn't dispense extra bottles. Coordinator A replied that s/he would've thought so since Caregiver F would be familiar with the residents' medications. Coordinator A reported understanding of Surveyor's concern that Resident 4's lack of liquid multivitamin

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administration likely was occurring even before the pharmacy audit, as indicated by its excess on hand that the pharmacy representative observed during his/her audit on 12/23/2204. Coordinator A reported understanding of Surveyor's concern that despite the findings on that audit, medication administration issues were not discovered by the provider's staff until Surveyor's own investigation.

Example 5 - Resident 4's senna liquid

On 07/30/2025, at approximately 9:49 a.m., Surveyor observed Caregiver B preparing to administer Resident 4's medications, which had to be administered via his/her g-tube. Caregiver B confirmed that all of Resident 4's medications were administered via g-tube.

At approximately 11:27 a.m., Surveyor observed the medication storage area. Within the storage area for Resident 4's medications, Surveyor observed the following:

- 1 bottle of senna 8.8 mg/5 mL liquid. The manufacturer's label on the bottle indicated that it contained 8 fl oz / 237 mL of liquid. The pharmacy label on the bottle contained instructions to, "Take 10 mL (17.6 mg) per g-tube at bedtime for constipation" and showed a dispense date of 06/25/2025. The bottle appeared approximately 10% full.

Surveyor did not observe any other bottles of Resident 4's liquid senna.

On 07/30/2025, Surveyor reviewed a "Med Area Audit" document that was conducted by a pharmacist from the pharmacy that dispensed the provider's residents' medications. Surveyor observed the following comment in the report:

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N 352	Continued From page 38 "[Resident 4] has ...4 full bottles of Senna liquid ... Pharmacy will place hold on [cycle filled prescription] to use up supply. Please contact pharmacy when supply is low to restart auto fill." Surveyor noted that this audit was dated 12/23/2024 and that excess on-hand supply was noted for 3 other medications between Residents 3 and 4. On 07/31/2025, Surveyor reviewed MARs for Resident 4 from 03/01/2025 - 07/29/2025. The entry for Resident 4's senna liquid contained a start date of 09/13/2023 and the same instructions as Surveyor had previously observed on the bottle. Within the MARs, staff initialed off on administering Resident 4's liquid senna on 145 of 151 potential administration days. On the 6 occasions in which staff didn't initial administering Resident 4's liquid senna, the entries were blank with no other annotations. Surveyor noted that 145 administrations would have equaled approximately 6 bottles' worth of liquid senna administered to Resident 4 (10 mL daily with 237 mL per refill). On 08/05/2025, at approximately 1:43 p.m., Surveyor interviewed Prescription Manager E from the pharmacy that dispensed Resident 4's medications. Prescription Manager E reported that Resident 4's liquid senna used to be dispensed in 280 mL bottles to equate to a 28-day supply, and that 1 bottle each in that size was dispensed on 09/10/2024, 10/08/2024, 11/05/2024, 12/03/2024, and 05/12/2024. Surveyor noted an approximate 5-month gap between the 12/03/2024 and 05/12/2024 bottles. (Of note, 12/23/2024 is when the pharmacy audit revealed 4 full bottles of senna liquid and had held auto refilling any additional bottles.) Prescription Manager E reported that after May	N 352		

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2025, the bottle had changed due to a different manufacturer being used, and that the only times senna was refilled after this was on 06/25/2025 and 08/04/2025 (after Surveyor had been on site reviewing resident medications). Prescription Manager E confirmed that the bottle change was to a 237 mL bottle for a 24-day supply.

In reconciling the information from Prescription Manager E regarding Resident 4's liquid senna dispense dates with the pharmacy audit from 12/23/2024, Surveyor noted that the 4 full bottles of liquid senna documented as being observed by the pharmacist correlated with the most recent 4 refills, the last of which prior to the audit was dispensed on 12/03/2024. Surveyor noted that for these bottles, packaged in the old manufacturer's amount of 280 mL, 1 bottle would contain 28 days' worth of liquid senna when administered as prescribed. As such, 4 bottles being used even from a start date of 12/23/2024 (when the pharmacist noted 4 full bottles present), would have been out approximately 112 days later, or approximately 04/14/2025 - leaving an administration gap of approximately 28 days between then and its next dispensing on 05/12/2025. Surveyor noted that the bottle dispensed on 05/12/2025 (still in the 280 mL size), when administered as prescribed, would have been out approximately 28 days later, or approximately 06/09/2025 - leaving an administration gap of approximately 16 days between then and its next dispensing on 06/25/2025. Surveyor noted that the bottle dispensed on 06/25/2025 (in the 237 mL size), when administered as prescribed, would have been out approximately 07/19/2025 - leaving an administration gap of approximately 11 days between then and when Surveyor was on site. Surveyor noted that this was not consistent with

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N 352	Continued From page 40 the supply of his/her senna observed on site, the near daily initialed administrations on his/her MARs, and refills. Surveyor noted that in total, at least approximately 55 doses of Resident 4's liquid senna were not administered to him/her. On 08/05/2024, Surveyor reviewed Resident 4's partial record. Resident 4 was admitted to the provider on 08/30/2022 with diagnoses including constipation and profound intellectual and developmental disability. Resident 4 was documented as being non-verbal, having a legal guardian, and requiring staff assistance to manage all medications. Resident 4 was prescribed 3 different scheduled medications for constipation - docusate sodium, senna, and polyethylene glycol - all of which s/he was not consistently receiving (as documented in this citation). On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reported that his/her role with the provider didn't entail direct medication administration or oversight of medication administration and s/he was unaware of medication administration concerns. When asked who reviewed the pharmacy audit that occurred back on 12/23/2024 that had identified unused supply of Resident 4's liquid senna, Coordinator A reported that s/he received the document and forwarded it to Caregiver F, who was the lead caregiver and responsible for direct oversight of the home. Coordinator A reported that around the time s/he received the report s/he asked Caregiver F to confirm that issues identified on the audit had been addressed but that s/he wasn't sure if Caregiver F realized that the excess medications on hand potentially indicated a medication administration issue.	N 352		

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N 352	Continued From page 41 On 08/14/2025, Surveyor reviewed an e-mail exchange between Coordinator A and Caregiver F regarding the pharmacy audit. In the initial e-mail sent on 01/08/2025 at 9:09 a.m., Coordinator A informed Caregiver F of the 4 full bottles of Resident 4's liquid senna, among the other excess on-hand medications the reviewing pharmacy representative observed, and that the medications were going to be on hold until staff called in for refills. Coordinator A asked Caregiver F to address concerns that the pharmacy audit identified and let him/her know when the items were addressed. The next e-mail, sent by Coordinator A on 02/04/2025 at 12:16 p.m. (approximately 1 month since the last e-mail), asked Caregiver F if the pharmacy audit issues had been addressed. Caregiver F replied to Coordinator A on 02/05/2025 at 3:04 p.m., "All have been completed. Thank you [Caregiver F]." On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A again. Coordinator A reported understanding of Surveyor's concern that Resident 4 was not receiving his/her liquid senna as prescribed (and as reported and documented by staff) and that the provider had begun to work on addressing the medication administration concerns. When discussing the role of Caregiver F, who was tasked with following through with the concerns identified from the pharmacy's audit, Coordinator A confirmed that Caregiver F typically worked full-time shifts at the home, and so s/he was there as much as any other caregiver that worked in the home. Surveyor asked if Caregiver F, who would've been familiar then with how residents' medications were dispensed from the pharmacy, would've realized that excess medication supply on hand indicated a medication administration	N 352		

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problem since the pharmacy didn't dispense extra bottles. Coordinator A replied that s/he would've thought so since Caregiver F would be familiar with the residents' medications. Coordinator A reported understanding of Surveyor's concern that Resident 4's lack of liquid senna administration likely was occurring even before the pharmacy audit, as indicated by its excess on hand that the pharmacy representative observed during his/her audit on 12/23/2204. Coordinator A reported understanding of Surveyor's concern that despite the findings on that audit, medication administration issues were not discovered by the provider's staff until Surveyor's own investigation.

Example 6 - Resident 4's docusate sodium liquid

On 07/30/2025, at approximately 9:49 a.m., Surveyor observed Caregiver B preparing to administer Resident 4's medications, which had to be administered via his/her g-tube. Caregiver B confirmed that all of Resident 4's medications were administered via g-tube.

At approximately 11:27 a.m., Surveyor observed the medication storage area. Within the storage area for Resident 4's medications, Surveyor observed the following:

- 1 bottle of docusate sodium 50 mg/5 mL liquid. The pharmacy label on the bottle indicated that it contained 400 mL of liquid, contained instructions to, "Take 20 mL (200 mg) per g-tube twice daily at 8AM and 8PM for constipation," and showed a dispense date of 01/31/2025. The bottle also indicated that this 400 mL bottle was 1 of 3 total bottles dispensed on that date, for a total of 1,200 mL of docusate sodium liquid dispensed. The bottle on hand was specifically labeled as being bottle "2 of 3," and appeared approximately 1/3

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N 352	Continued From page 43 full. On the floor of the medication storage area, Surveyor observed a plastic container that contained several other bottles consistent in appearance Resident 4's medication bottles. Upon further inspection, Surveyor observed 10 additional bottles of Resident 4's docusate sodium liquid. All contained the same originally dispensed amounts and prescription instructions per their labels as indicated in the previously observed bottles. The 10 docusate sodium bottles contained the following specific information unique to each bottle (ordered from the oldest dispensed to most recent): 1. Docusate sodium liquid dispensed on 11/08/2024, labeled as "1 of 3", with a handwritten open date of 11/08/2024. This appeared near full. 2. Docusate sodium liquid dispensed on 01/03/2025, labeled as "2 of 3." This appeared full. 3. Docusate sodium liquid dispensed on 01/03/2025, labeled as "3 of 3." This appeared full. 4. Docusate sodium liquid dispensed on 01/31/2025, labeled as "1 of 3." This appeared full. 5. Docusate sodium liquid dispensed on 02/28/2025, labeled as "1 of 3." This appeared full. 6. Docusate sodium liquid dispensed on 02/28/2025, labeled as "2 of 3." This appeared full.	N 352		

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N 352	Continued From page 44 7. Docusate sodium liquid dispensed on 02/28/2025, labeled as "3 of 3." This appeared full. 8. Docusate sodium liquid dispensed on 03/28/2025, labeled as "1 of 3." This appeared full. 9. Docusate sodium liquid dispensed on 03/28/2025, labeled as "2 of 3." This appeared full. 10. Docusate sodium liquid dispensed on 03/28/2025, labeled as "3 of 3." This appeared full. On 07/30/2025, Surveyor reviewed a "Med Area Audit" document that was conducted by a pharmacist from the pharmacy that dispensed the provider's residents' medications. Surveyor observed the following comment in the report: "[Resident 4] has ...15 full bottles of docusate. Pharmacy will place hold on [cycle filled prescription] to use up supply. Please contact pharmacy when supply is low to restart auto fill." Surveyor noted that this audit was dated 12/23/2024 and that excess on-hand supply was noted for 3 other medications between Residents 3 and 4. On 07/31/2025, Surveyor reviewed MARs for Resident 4 from 03/01/2025 - 07/29/2025. The entry for Resident 4's liquid docusate contained a start date of 09/13/2023 and the same instructions as Surveyor had previously observed on the bottles. Within the MARs, staff initialed off on administering Resident 4's liquid docusate on 294 of 302 potential administrations. On the 8 occasions in which staff didn't initial administering Resident 4's liquid docusate, the entries were	N 352		

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blank with no other annotations. Surveyor noted that 294 administrations would have equaled approximately 15 bottles' worth of liquid docusate administered to Resident 4 (20 mL per administration with 400 mL per bottle).

On 08/05/2025, at approximately 1:43 p.m., Surveyor interviewed Prescription Manager E from the pharmacy that dispensed Resident 4's medications. Prescription Manager E confirmed that three 400-mL bottles (for a total of 1,200 mL), for a 30-day supply, were dispensed each time that Resident 4's liquid docusate was dispensed. Prescription Manager E reported that 1,200 mL were most recently dispensed on the following dates: 09/13/2024, 10/11/2024, 11/08/2024, 12/06/2024, 01/03/2025, 01/31/2025, 02/28/2025, and 03/28/2025. Prescription Manager E confirmed that the last refill was on 03/28/2025.

In reconciling the information from Prescription Manager E regarding Resident 4's liquid docusate with the pharmacy audit from 12/23/2024, Surveyor noted that the 15 bottles that were noted as observed by the pharmacist would have correlated with 5 months' worth of docusate solution. From Surveyor's own observation, Surveyor noted that 1 bottle s/he observed was dispensed before the pharmacy audit on 12/23/2024, which was the bottle dated 11/08/2024 - indicating that 14 bottles had been used in medication administration to Resident 4. In considering Surveyor's observations of the bottles on hand, approximately 3 and 2/3 bottles that were dispensed after the pharmacy audit had been absent (presumed to have been administered) - 2 bottles from 01/03/2025, 1 bottle from 01/31/2025, and 2/3 of a second bottle from 01/31/2025 that staff were currently administering from. This indicated that in total,

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approximately 17 and 2/3 bottles had been administered to Resident 4 since the pharmacy's audit (14 dispensed prior to 12/23/2025 and 3 and 2/3 after). Surveyor noted that with the quantity the pharmacy dispensed, 3 bottles would be used every 30 days (or, approximately 1 month). As such, 17 and 2/3 bottles, when administered as prescribed, would have accounted for approximately 6 months' worth of docusate administration to Resident 4 after the pharmacy audit on 12/23/2024. Surveyor noted that 6 months from 12/23/2024 was approximated to be around 06/23/2025 - leaving an approximate administration gap of approximately 1 month (60 doses) where Resident 4's docusate was not administered to him/her.

On 08/05/2024, Surveyor reviewed Resident 4's partial record. Resident 4 was admitted to the provider on 08/30/2022 with diagnoses including constipation and profound intellectual and developmental disability. Resident 4 was documented as being non-verbal, having a legal guardian, and requiring staff assistance to manage all medications. Resident 4 was prescribed 3 different scheduled medications for constipation - docusate sodium, senna, and polyethylene glycol - all of which s/he was not consistently receiving (as documented in this citation).

On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reported that his/her role with the provider didn't entail direct medication administration or oversight of medication administration and s/he was unaware of medication administration concerns. When asked who reviewed the pharmacy audit that occurred back on 12/23/2024 that had identified unused supply of Resident 4's

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liquid docusate, Coordinator A reported that s/he received the document and forwarded it to Caregiver F, who was the lead caregiver and responsible for direct oversight of the home. Coordinator A reported that around the time s/he received the report s/he asked Caregiver F to confirm that issues identified on the audit had been addressed but that s/he wasn't sure if Caregiver F realized that the excess medications on hand potentially indicated a medication administration issue.

On 08/14/2025, Surveyor reviewed an e-mail exchange between Coordinator A and Caregiver F regarding the pharmacy audit. In the initial e-mail sent on 01/08/2025 at 9:09 a.m., Coordinator A informed Caregiver F of the 15 full bottles of Resident 4's liquid docusate, among the other excess on-hand medications the reviewing pharmacy representative observed, and that the medications were going to be on hold until staff called in for refills. Coordinator A asked Caregiver F to address concerns that the pharmacy audit identified and let him/her know when the items were addressed. The next e-mail, sent by Coordinator A on 02/04/2025 at 12:16 p.m. (approximately 1 month since the last e-mail), asked Caregiver F if the pharmacy audit issues had been addressed. Caregiver F replied to Coordinator A on 02/05/2025 at 3:04 p.m., "All have been completed. Thank you [Caregiver F]."

On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A again. Coordinator A reported understanding of Surveyor's concern that Resident 4 was not receiving his/her liquid docusate as prescribed (and as reported and documented by staff) and that the provider had begun to work on addressing the medication administration

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concerns. When discussing the role of Caregiver F, who was tasked with following through with the concerns identified from the pharmacy's audit, Coordinator A confirmed that Caregiver F typically worked full-time shifts at the home, and so s/he was there as much as any other caregiver that worked in the home. Surveyor asked if Caregiver F, who would've been familiar then with how residents' medications were dispensed from the pharmacy, would've realized that excess medication supply on hand indicated a medication administration problem since the pharmacy didn't dispense extra bottles. Coordinator A replied that s/he would've thought so since Caregiver F would be familiar with the residents' medications. Coordinator A reported understanding of Surveyor's concern that Resident 4's lack of liquid docusate administration likely was occurring even before the pharmacy audit, as indicated by its excess on hand that the pharmacy representative observed during his/her audit on 12/23/2204. Coordinator A reported understanding of Surveyor's concern that despite the findings on that audit, medication administration issues were not discovered by the provider's staff until Surveyor's own investigation.

Example 7 - Resident 4's levetiracetam

On 07/30/2025, at approximately 9:49 a.m., Surveyor observed Caregiver B preparing to administer Resident 4's medications, which had to be administered via his/her g-tube. Caregiver B confirmed that all of Resident 4's medications were administered via g-tube.

At approximately 11:27 a.m., Surveyor observed the medication storage area. Within the storage area for Resident 4's medications, Surveyor observed the following:

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N 352	Continued From page 49 - 1 bottle of levetiracetam 100 mg/mL oral solution. The manufacturer's label on the bottle indicated that it contained 473 mL of solution. The pharmacy label on the bottle contained instructions to, "Take 17.5 mL (175 mg) per g-tube twice daily for seizures" and showed a dispense date of 06/02/2025. The bottle also had a pharmacy sticker labeling it as bottle "2 of 2." The bottle appeared to be approximately 25% full. On the floor of the medication storage area, Surveyor observed a plastic container that contained several other bottles consistent in appearance Resident 4's medication bottles. Upon further inspection, Surveyor observed 4 additional bottles of Resident 4's levetiracetam oral solution. All contained the same originally dispensed amounts and prescription instructions per their labels as indicated in the previously observed bottles. The 4 levetiracetam bottles still had their seals intact, indicating that they had not been opened, and contained the following specific information unique to each bottle (ordered from the oldest dispensed to most recent): 1. Levetiracetam liquid dispensed on 06/02/2025, labeled as "1 of 2" with seal intact. Surveyor noted that this was the complementary bottle that had been dispensed with the bottle staff were actively using. 2. Levetiracetam liquid dispensed on 06/30/2025, labeled as "2 of 2" with seal intact. 3. Levetiracetam liquid dispensed on 07/28/2025, labeled as "1 of 2" with seal intact. 4. Levetiracetam liquid dispensed on 07/28/2025,	N 352		

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N 352	Continued From page 50 labeled as "2 of 2" with seal intact. On 08/05/2025, at approximately 1:43 p.m., Surveyor interviewed Prescription Manager E from the pharmacy that dispensed Resident 4's medications. Prescription Manager E confirmed that two 473-mL bottles (for a total of 946 mL), for a 27-day supply, were dispensed on an automatic cycle refill each time that Resident 4's levetiracetam was dispensed. Prescription Manager E reported that 946 mL were most recently dispensed on the following dates: 09/23/2024, 10/21/2024, 11/18/2024, 12/16/2024, 01/13/2025, 02/10/2025, 04/07/2025, 05/05/2025, 06/02/2025, 06/30/2025, and 07/28/2025. Prescription Manager E reported s/he was not sure why bottles were not dispensed between 02/10/2025 - 04/07/2025. In reconciling the information from Prescription Manager E regarding Resident 4's levetiracetam with the bottles observed by Surveyor, Surveyor noted that when administered as prescribed, Resident 4's levetiracetam that was dispensed on 02/10/2025 would have been out on approximately 03/10/2025 (27 days later). On 08/05/2025, Surveyor reviewed MARs for Resident 4 from 03/01/2025 - 07/29/2025. The entry for Resident 4's levetiracetam contained an original start date of 04/04/2024 and the same instructions as Surveyor had previously observed on the bottles. Within the MARs, staff initialed off on administering Resident 4's levetiracetam for every administration (twice daily) between 03/10/2025 and 04/07/2025 (when it was next dispensed) except for the evening administration on 03/31/2025. That administration entry was blank with no other annotations. Surveyor noted that this was inconsistent with Resident 4's	N 352		

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levetiracetam dispensing as reported by Prescription Manager E and left an administration gap of approximately 27 days (54 administrations).

Surveyor also noted that when administered as prescribed, the levetiracetam that was dispensed on 05/05/2025 would have been out on approximately 06/02/2025 (correlating with the dispense dates of the next bottles). From that point up to 07/30/2025 when Surveyor was on site, when administered as prescribed, all 4 of the bottles dispensed on 06/02/2025 and 06/28/2025 should have been out. In reviewing the MARs again, Surveyor observed that staff initialed off on administering Resident 4's levetiracetam for every administration (twice daily) between 06/03/2025 and 07/29/2025 except for the following 5 administrations: 06/11/2025 (8:00 p.m.), 06/27/2025 (8:00 a.m.), and 07/22/2025 through 07/24/2025 (all 8:00 p.m.). Those entries were blank with no other annotations. Surveyor noted this was inconsistent with his/her observation of 2.25 bottles from those dates still present (2 which were unused and 1 which was approximately 75% used). Surveyor noted an administration gap of at least 27 days (54 administrations).

In total, Surveyor noted an approximate administration gap of at least approximately 54 days, or 108 administrations - 27 days between 03/10/2025 - 04/07/2025 and 27 days from 06/02/2025 - 07/29/2025 (as evidenced by the 2.25 bottles unused) from his/her review period of 03/01/2025 - 07/29/2025.

On 08/05/2024, Surveyor reviewed Resident 4's partial record. Resident 4 was admitted to the provider on 08/30/2022 with diagnoses including

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N 352	Continued From page 52 seizure disorder and profound intellectual and developmental disability. Resident 4 was documented as being non-verbal, having a legal guardian, and requiring staff assistance to manage all medications. Incident reports for Resident 4 showed that Resident 4 experienced seizures on 12/05/2024, 01/12/2025, and 02/26/2025. Review of Resident 4's medical records also indicated that Resident 4 was admitted to the emergency department on 04/11/2025 due to "respiratory distress. By report the patient had a breakthrough seizure earlier in the day ..." On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reported that his/her role with the provider didn't entail direct medication administration or oversight of medication administration and s/he was unaware of medication administration concerns. On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A again. Coordinator A reported understanding of Surveyor's concern that Resident 4 was not receiving his/her levetiracetam as prescribed (and as reported and documented by staff) and that the provider had begun to work on addressing the medication administration concerns. Cross Reference: N0432 DHS 83.38(1)(h) Medication Administration	N 352		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and	N 388		

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N 388	Continued From page 53 follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure that Resident 4's individual service plan (ISP) was followed as written with respect to his/her gastrostomy tube (g-tube) schedule or that Resident 3's ISP was followed as written with respect to his/her toileting supervision. Findings include: Example 1 - Resident 3 On 07/30/2025, at approximately 1:54 p.m., Surveyor entered the home from offsite. The resident bathroom closest to the laundry area had its door shut. Caregiver C confirmed that Resident 3 was on the toilet. From that point, Surveyor sat at the dining area table conducting survey work, within view of the resident bathroom. At approximately 2:15 p.m., Surveyor observed Caregiver C providing handoff communication to Caregiver D, who had just arrived to work the second shift alone. Resident 3 was still in the resident bathroom with the door closed. From approximately 1:54 p.m. (when Surveyor entered the home) up to 2:43 p.m. (49 minutes), Surveyor observed no one checking in or attending to Resident 3 in the bathroom. At approximately 2:43 p.m., Surveyor discussed this concern with Coordinator of Administrator Services (Coordinator) A. Surveyor observed Coordinator A then approach and talk with Caregiver D, and shortly afterwards, Caregiver D entered the bathroom where Resident 3 was.	N 388		

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N 388	Continued From page 54 On 07/30/2025, Surveyor reviewed Resident 3's ISP, dated as last reviewed on 03/13/2025. - Resident 3 was documented as being developmentally disabled and non-verbal. Resident 3's ISP, dated 03/13/2025, documented that s/he required 24-hour supervision, required total assistance for cares, and was not able to make his/her needs known. Resident 3 was documented as being at risk for falls, and the following was documented within the "Toileting" section: "Do not leave me alone in the bathroom as I am a risk for falls." Resident 3 was documented as requiring assistance to toilet and that s/he could at times become "unsteady and may require the transfer assistance of a 1-person pivot with the use of a gaitbelt." On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reported that it was not his/her role to conduct resident cares or oversee the care needs of residents, so s/he was generally unaware of the specific resident care needs. Coordinator A reported s/he was unaware of Resident 3's toileting supervision needs without referencing his/her ISP. Example 2 - Resident 4 On 07/30/2025, at approximately 9:15 a.m., Surveyor observed Caregiver B preparing Resident 4's medications, which included dissolving tablets into water, pouring capsule contents into water, preparing liquid medications and readying a water cup - all of which s/he placed on a plate on a counter between the kitchen and living areas. Surveyor observed Resident 1 approach the counter where Resident 4's medications were sitting out before s/he was redirected by Caregiver C.	N 388		

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N 388	Continued From page 55 At approximately 9:49 a.m., Surveyor observed Caregiver B preparing to administer Resident 4's medications, which had to be administered via his/her gastrostomy tube (g-tube). Caregiver B confirmed that all of Resident 4's medications were administered via g-tube. In response to being asked how staff knew how Resident 4's medications were to be prepared, Caregiver B gestured towards an administration schedule posted on the wall that staff followed for Resident 4. The posted schedule was titled, "Feeding and Flushing Schedule for [Resident 4]." The schedule was documented as created by Resident 4's managed care organization (MCO) team. The schedule outlined the times at which and the specific step-by-step process of which staff were to utilize to conduct various g-tube tasks - including medication administration, flushing, and feeding. A brief summary of the schedule included the following tasks: - "8 AM" -Medication administration with flushes - "9 AM" - Flushing and feeding - "11 AM" - Flushing and prune juice - "1 PM" - Flushing and administration of "Prosource Plus" (liquid protein) - "3 PM" - Flushing The bottom of the schedule contained a section for "Special Considerations" which included additional guidance, including, "Keep 1 hour between provision of Levothyroxine and tube feeding formula." As part of the same interview, Surveyor asked	N 388		

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N 388	Continued From page 56 Caregiver B about the contents of Resident 4's medications that had been prepared on the plate. Caregiver B showed Surveyor from the plate and on Resident 4's medication administration record (MAR) the medication solutions s/he prepared. One of the medication solutions that Caregiver B prepared included Resident 4's levothyroxine 50 mcg. At approximately 9:55 a.m., Surveyor observed Caregiver B administer Resident 4's medications to him/her. Surveyor noted that this was approximately 2 hours after the morning medication administration time per Resident 4's posted schedule. At approximately 10:06 a.m., Surveyor observed Caregiver B begin Resident 4's g-tube feeding. Surveyor noted that this was approximately 10 minutes after Resident 4 was administered his/her levothyroxine (as opposed to the 1-hour gap directed in his/her schedule). On 07/30/2025, Surveyor reviewed Resident 4's ISP, dated as last reviewed on 05/14/2025. Resident 4 was admitted to the provider on 08/30/2022 with diagnoses including profound intellectual and developmental disability and spastic tetraplegia. Resident 4 was documented as being non-verbal, having a legal guardian, and requiring staff assistance to manage all medications. The ISP documented that s/he required total assistance for cares. The ISP also documented that s/he utilized a wheelchair, that s/he was unable to self-propel, for mobility. The ISP documented that s/he required 24-hour supervision and was not able to make his/her needs known. Within the "Diet" section of Resident 4's ISP, his/her g-tube schedule was referenced.	N 388		

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N 388	Continued From page 57 On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reported that it was not his/her role to conduct resident cares or oversee the care needs of residents, so s/he was generally unaware of the specific resident care needs. Coordinator A reported being unaware that during the onsite survey staff were late on following Resident 4's medication administration and feeding schedule.	N 388		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not provide employees in sufficient numbers on a 24-hour basis to meet the needs of residents. The provider's home was typically staffed with a 1:4 ratio (1 staff to 4 residents), with the caregiver on shift expected to prepare meals, conduct caregiving tasks, and conduct leisure activities three times daily. All 4 residents were documented to be intellectually and/or developmentally disabled, be non-verbal, require total assistance for cares, require 24/7 supervision, and not make their needs known. Resident 4 required a Hoyer to transfer and used a wheelchair for mobility that had to be propelled by staff. Resident 3 at times required staff assistance to transfer. Resident 4 had a gastrostomy tube (g-tube), for which s/he required staff to manage a schedule of flushing,	N 396		

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feeds, and medication administration throughout the day. All 4 residents had a 2-hour toileting schedule, 3 of whom staff needed to physically assist. All 4 residents required staff to administer medications and prepare and serve food. Three of the 4 residents required specific preparation of their food in accordance with their specialty diets (not counting Resident 4's g-tube feedings). Two of the 4 residents required direct staff supervision throughout meals to cue for safe eating as they were at risk for choking (1 of whom was also at risk for aspirating and had experienced a recent choking incident). One resident required 30-minute checks and was documented as being at risk for falls. Two residents were at risk for exit-seeking or elopement. One resident was known to have typical behaviors of physical aggression towards others, which including putting others in headlocks or pulling their hair.

On 07/30/2025, Surveyor observed the morning shift, which included 2 caregivers conducting tasks. Even with both caregivers engaged in tasks throughout their shift Surveyor noted that a morning activity (in accordance with the provider's activity schedule) did not take place and that staff were late in administering Resident 4's morning medications and g-tube feeding. Surveyor also observed the afternoon shift, in which 1 caregiver worked. During this shift, Surveyor observed 2 occurrences of Resident 1 placing Resident 2 in a chokehold, 1 occurrence of Resident 1 grabbing Resident 2, 9 occurrences of exit seeking by either Residents 1 or 2, 10 occurrences of hair pulling by Resident 1, 5 occurrences of Resident 2 either chewing or attempting to grab cloth laying around to chew, and 3 occurrence of Residents 1 and/or 2 approaching the kitchen area while food was being cooked unsupervised. For most the above occasions, Caregiver D was engaged in

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tasks out of sight and Coordinator A, who was not responsible for caregiving duties and was only onsite to conduct the survey, had to physically intervene. Additional interviews identified a known frequency increase of Resident 1's aggressive behaviors, to the point where s/he even required 1:1 staff supervision to participate in day programming. Additional interview and review of Resident 1's behavior support plan identified that engaging Resident 1 in structured activities and/or going for walks helped to mitigate his/her behaviors - participation in which by a single caregiving staff would be limited due to the abilities, supervision requirements, and care needs of the other residents.

From the above observations of resident behaviors and care needs corroborated by record review, Surveyor noted that the ability of 1 caregiver to conduct a personal care task (e.g. toileting, bathing, dressing) to the level each resident required inherently limited his/her ability to supervise and intervene for the exit-seeking and physical behaviors of Residents 1 and 2. Consequently, the need to supervise Residents 1 and 2 to the level their behaviors were observed, reported, and/or documented, inherently limited the ability of 1 caregiver to conduct personal cares for the remaining residents.

Findings include:

The provider is licensed to serve up to 6 nonambulatory residents within the client groups of traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, physically disabled, and alcohol/drug dependent.

On 07/30/2025, from approximately 9:07 a.m. - 12:25 p.m., and 1:54 p.m. - 4:10 p.m., Surveyor

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was onsite. Between approximately 9:07 a.m. - 2:15 p.m., the following took place while 2 caregivers - Caregivers B and C - worked, demonstrating the tasks that both were engaged in throughout their shift as well as the observed residents' needs and abilities:

- After Surveyor entered the home at approximately 9:07 a.m., Resident 1 was observed walking near the front door. At approximately 9:10 a.m., Resident 1 was observed attempting to walk out the front door. Caregiver B was observed redirecting Resident 1 back into the home and then placed a chair against the front door to block its access from Resident 1. Caregiver B then was observed cleaning up and washing breakfast dishes.

- After this, Surveyor observed the home's enclosed patio, where Caregiver C was observed feeding Resident 2. Surveyor interviewed Caregiver C about staffing. Caregiver C reported that typically 2 staff worked the morning/day shift, 1-2 staff worked the afternoon/evening shift, and 1 staff worked the overnight (NOC) shift. Surveyor observed 2 staff - Caregivers B and C - working. Surveyor observed the home's enclosed patio, where Caregiver C was observed feeding Resident 2. Caregiver C reported that Resident 2 was known to chew clothing. Caregiver C reported that there were 4 residents who resided in the home.

- Between approximately 9:15 - 9:30 a.m., Resident 1 was observed to be provided nearly constant physical and/or verbal redirection by Caregivers B or C due to him/her approaching a counter where medications were out, approaching food in the kitchen, and approaching Surveyor. Shortly before 9:30 a.m., Caregiver C

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N 396	Continued From page 61 entered Resident 4's room and began conducting his/her morning cares. - At approximately 9:33 a.m., Resident 1 was observed opening the front door of the house and attempt to walk out. An alarm sounded, and Caregiver B redirected him/her. Caregiver C was still in Resident 4's room, assisting him/her. - At approximately 9:49 a.m., Surveyor observed Caregiver B preparing to administer Resident 4's medications, which had to be administered via his/her g-tube. Caregiver C was still in Resident 4's room, assisting him/her. Caregiver B confirmed that all Resident 4's medications were administered via g-tube. In response to being asked how staff knew how Resident 4's medications were to be prepared, Caregiver B gestured towards an administration schedule posted on the wall that staff followed for Resident 4. The posted schedule was titled, "Feeding and Flushing Schedule for [Resident 4]." The schedule was documented as created by Resident 4's managed care organization (MCO) team. The schedule outlined the times at which and the specific step-by-step process of which staff were to utilize to conduct various g-tube tasks - including medication administration, flushing, and feeding. A summary of the schedule included the following tasks: - "8 AM" - Medication administration with flushes - "9 AM" - Flushing and feeding - "11 AM" - Flushing and prune juice - "1 PM" - Flushing and administration of "Prosource Plus" (liquid protein)	N 396		

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N 396	Continued From page 62 - "3 PM" - Flushing - "6 PM" - Flushing and feeding - "8 PM" - Medication administration with flushes - At approximately 9:50 a.m., Surveyor observed Caregiver C bring Resident 4 out to the dining area from his/her room. Surveyor noted that this was approximately 20 minutes after s/he began assisting him/her in his/her room. - At approximately 9:55 a.m., Surveyor observed Caregiver B administer Resident 4's medications to him/her. Surveyor noted that this was approximately 2 hours after the morning medication administration time per Resident 4's posted schedule. - At approximately 10:06 a.m., and immediately after Caregiver B was done administering Resident 1's morning medications with g-tube flushes, Surveyor observed Caregiver B begin Resident 4's g-tube feeding. Surveyor noted that this was approximately 1 hour after his/her morning feeding time from his/her posted schedule and that the medication administration process for Resident 4's morning medications and flushes took approximately 10 minutes. - At approximately 11:24 a.m., Surveyor observed Resident 1 walk out the front door. Caregiver B was then observed to go to him/her and bring him/her back inside. - At approximately 11:27 a.m., while reviewing medications, Surveyor observed Resident 1 pull Resident 4's hair. Resident 1 required verbal and physical redirection from Caregiver C to let go of Resident 4's hair and walk away.	N 396		

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N 396	Continued From page 63 - From approximately 9:07 a.m. - 12:25 p.m., while Surveyor was on site, no activity programming took place. At approximately 1:54 p.m., Surveyor entered the home from offsite. The resident bathroom closest to the laundry area had its door shut. Caregiver C confirmed that Resident 3 was on the toilet. From that point, Surveyor sat at the dining area table conducting survey work, within view of the resident bathroom. At approximately 2:15 p.m., Surveyor observed Caregiver C providing handoff communication to Caregiver D, who had just arrived to work the second shift alone. Resident 3 was still in the resident bathroom with the door closed. Caregiver D confirmed s/he worked for an agency and not directly for the provider. Surveyor observed Resident 4, in his/her wheelchair, at a side room off the dining area receiving a g-tube feeding. Caregiver C confirmed that this was Resident 4's 1:00 p.m. feeding (per his/her posted schedule). Resident 1 approached Surveyor and reached out towards his/her hair. Surveyor attempted to verbally redirect Resident 1. Caregiver C reported that Resident 1 would try to pull Surveyor's hair and was observed telling Resident 1 that s/he should not pull hair. After this, Resident 2 was observed on 2 occasions to approach the front door and open it. Caregiver C redirected him/her both times. After this, Caregiver C left due to his/her shift ending. On 07/30/2025, Surveyor reviewed partial resident records, including ISPs, of the provider's 4 residents, which detailed the following: - Resident 1's diagnoses included severe	N 396		

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intellectual disability. Resident 1 was documented as being non-verbal but able to communicate some needs with yes/no questions, some words, and sign language. Resident 1's ISP, dated 03/13/2025, documented that s/he required 24-hour supervision and required total assistance for cares. In another section of the ISP, Resident 1 was documented as not able to make his/her needs known. Resident 1's ISP identified s/he was at high risk for choking and aspirating and that, " ...staff must make sure that I eat my food slowly and take drinks in between bites." The ISP documented that Resident 1 required moist and soft-textured food with pieces no larger than ¼ inch in size and nectar-thickened liquids. The ISP also noted, "Staff need to sit with me and make sure that I eat slowly, chew my food, and swallow." The ISP noted 2 past choking episodes from food in 2009 as well as a choking occurrence "in January 2025, which required staff to perform the Heimlich maneuver on [him/her] (he took a peer's hot dog) ..." The ISP also documented, "I do not assist with food prep because of my tendency to try and take food." Resident 1's ISP also documented that Resident 1 "needs to be monitored to be sure of [his/her] whereabouts at all times. If left unattended, [s/he] will get curious and explore things on his/her own." The ISP noted that "most" of Resident 1's negative behaviors were when s/he was seeking attention and that, "If you keep me occupied, I am less likely to have these behaviors." The ISP also noted that Resident 1 liked to keep busy, "spend time with staff and peers," help with chores, and go for walks. Resident 1's ISP noted that s/he required a reminder from staff every 2 hours (during the day) to use the restroom.

- Resident 2's diagnoses included profound intellectual and developmental disability and

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autism. Resident 2 was documented as being non-verbal. Resident 4's ISP, dated 07/10/2025, documented that s/he required 24-hour supervision, required total assistance for cares, and was not able to make his/her needs known. Resident 2 was documented to be at risk for elopements, falls, aspiration, and ingesting non-food items. Resident 2 was documented as requiring foods to be cut up in bite-sized pieces and supervision while eating "because [s/he] eats too fast and puts too much food in [his/her] mouth especially when [s/he] starts eating." Along with this, Resident 2 was documented as having a history of choking and requiring staff cuing to slow down and chew his/her food thoroughly throughout his/her meals. Resident 2's ISP identified that s/he had a history of wandering/elopement and documented, "I enjoy being outside and going for walks and will often go to the door. All of the doors in my home have a chime on them to alert staff that the door has been open." Resident 2's ISP noted that s/he was on a 2-hour toileting schedule.

- Resident 3 was documented as being developmentally disabled and non-verbal. Resident 3's ISP, dated 03/13/2025, documented that s/he required 24-hour supervision, required total assistance for cares, and was not able to make his/her needs known. Resident 3 was documented to be at risk for falls and aspiration. Resident 3 was documented as requiring "chopped" solids with his/her meals. Resident 3 was documented as having unsteady gait and balance and at times required staff assistance to pivot transfer and walk. Resident 3 was otherwise noted to utilize a wheelchair for ambulation. Resident 3's ISP identified that s/he enjoyed his/her personal space in his/her bedroom and privacy in the bathroom, though it was noted that

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staff were to not leave Resident 3 unattended in the bathroom due to his/her fall risk. The ISP directed for staff to check on Resident 3 every 30 minutes during waking and sleeping hours. Resident 3's ISP noted that staff were to assist him/her to toilet every 2 hours.

- Resident 4's diagnoses included profound intellectual and developmental disability and spastic tetraplegia. Resident 4 was documented as being non-verbal. Resident 4's ISP, dated 05/14/2025, documented that s/he required total assistance for cares, which included for setting up and administration of g-tube feedings and flushes. The ISP directed for a specific schedule of medication administration, flushes, and feedings that staff were to follow that involved 7 different times g-tube tasks were supposed to be conducted. Resident 4's ISP also documented that s/he utilized a wheelchair, that s/he was unable to self-propel, for mobility. Resident 4's ISP documented that s/he required 24-hour supervision and was not able to make his/her needs known. Resident 4's ISP noted that s/he was on a 2-hour toileting schedule. Resident 4's shower schedule indicated s/he was to receive showers in the afternoons/evenings on Mondays, Wednesdays, and Fridays. Surveyor noted that the day s/he was onsite was a Wednesday.

From approximately 2:20 p.m. through 4:10 p.m., when Caregiver D as the sole caregiver worked, the following took place:

- No activity programming was observed to take place. At approximately 2:50 p.m., Surveyor interviewed Coordinator of Administrative Services (Coordinator) A who confirmed that caregiving staff typically conducted activities and confirmed that none had happened that day.

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N 396	Continued From page 67 - From approximately 2:20 - 2:43 p.m. (23 minutes), Surveyor observed that Caregiver D did not check in on Resident 3 in the bathroom. Caregiver D was observed conducting various other tasks - at times within view and at other times out of view within the common areas. At approximately 2:43 p.m., Surveyor discussed the concern with Coordinator A that Resident 3 was still in the bathroom without having been checked on since Surveyor had been onsite at 1:54 p.m. (a total period of approximately 49 minutes). Surveyor observed Coordinator A then approach and talk with Caregiver D, and shortly afterwards, Caregiver D checked on Resident 3. - On 2 occasions - 2:20 p.m. and 2:57 p.m. - Resident 1 was observed to grab Resident 2 and hold him/her in a chokehold-type position, with his/her arm around Resident 2's neck and bending his/her neck down towards him/her. On both occasions, Coordinator A physically intervened to pull Resident 1 away from Resident 2. Caregiver D was not observed in the area on either occasion. Immediately after being pulled away from Resident 2 on the second occasion, Resident 1 attempted to grab Resident 2 again but was stopped by Coordinator A. - At approximately 3:31 p.m., Resident 1 was observed wrapping his/her arms around Resident 2. Coordinator A physically pulled Resident 1 away from Resident 2. Caregiver D was preparing food in the kitchen throughout the interaction. - On 9 occasions, Surveyor observed exit-seeking behavior, including the following: 1) At approximately 2:27 p.m., Surveyor observed	N 396		

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N 396	Continued From page 68 Resident 2 attempt to leave out the front door. While Coordinator A redirected Resident 2, Resident 1 approached Resident 2 and began to put his/her arms around Resident 2 before being redirected by Coordinator A. Caregiver D was not observed in the area. 2) At approximately 2:31 p.m., Resident 2 opened the front door. Caregiver D physically redirected Resident 2 away from the door. 3) At approximately 2:50 p.m., Resident 2 walked out the front door. Surveyor observed that it was raining outside. Resident 2 made it to the driveway where s/he was then redirected back inside by Coordinator A. Caregiver D was not observed in the area. 4) Almost immediately after the 2:50 p.m. occurrence, Resident 1 attempted to leave out the front door. Caregiver D approached and both him/her and Coordinator A were observed redirecting Resident 1 away from the door. 5) At approximately 3:02 p.m., Resident 2 approached the front door and was redirected by Coordinator A. Caregiver D was attending to Resident 4 during this encounter. 6) At approximately 3:05 p.m., while Coordinator A was attending to Resident 1, Resident 2 opened the front door. Coordinator A redirected Resident 2. 7) At approximately 3:13 p.m., Resident 2 attempted to walk out the front door and was redirected by Coordinator A. 8) At approximately 3:24 p.m., while Coordinator A was in the kitchen assisting Caregiver D, whose	N 396		

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hair was in Resident 1's grasp, Resident 2 walked out the front door. Coordinator A redirected Resident 2 back inside.

9) At approximately 3:51 p.m., Resident 2 walked out the front door. Coordinator A redirected Resident 2 back inside. Caregiver D was not in sight.

- On 10 occasions, Surveyor observed Resident 1 either pull or attempt to pull others' hair, including the following:

1) At approximately 2:25 p.m., Resident 1 approached Surveyor and began pulling on Surveyor's hair. Surveyor pulled his/her hair out of Resident 1's grasp and attempted to verbally redirect Resident 1. Caregiver D was not observed in the area.

2) At approximately 2:28 p.m., Resident 1 approached Resident 2 and began to put his/her arms around Resident 2 before being redirected by Coordinator A. Caregiver D was not observed in the area.

3) At approximately 2:40 p.m., Resident 1 approached Resident 2 and began pulling Resident 2's hair. Resident 2 attempted to walk away. Resident 1 then let go and approached Surveyor. Resident 1 reached out twice towards Surveyor's hair and required Surveyor to verbally redirect him/her away. During this encounter, Caregiver D was observed in the kitchen washing dishes and was within sight and hearing range of Surveyor redirecting Resident 1.

4) At approximately 2:45 p.m., Resident 1 approached Resident 2 and began grabbing Resident 2's hair. Resident 1 did not stop until

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N 396	Continued From page 70 Coordinator A intervened. During this encounter, Caregiver D was assisting Resident 3 in the bathroom. 5) At approximately 2:52 p.m., Surveyor observed Resident 1 enter the side room where Resident 4 sat after his/her g-tube feeding. Resident 1 began pulling Resident 4's hair. Surveyor drew the attention of Caregiver D, who was in the area, who then physically redirected Resident 1. 6) At approximately 3:13 p.m., Coordinator A was observed redirecting Resident 2 who attempted to leave out the front door. During this, Resident 1 was observed to walk near them, reach out, and grab Resident 2's hair. Caregiver D was not observed in the area. 7) At approximately 3:17 p.m., Surveyor observed Coordinator A physically blocking Resident 1 from getting to Resident 2. Caregiver D was not observed to assist. 8) At approximately 3:20 p.m., Surveyor heard Caregiver D call out. Surveyor saw Resident 1 holding onto Caregiver D's hair and Caregiver D was trying to pull his/her hair out of Resident 1's grasp while verbally redirecting him/her. Coordinator A then assisted and was observed physically pulling Resident 1's fingers/hands out of Caregiver D's hair. 9) At approximately 3:30 p.m., Resident 1 began swatting at Surveyor, and required Surveyor to redirect him/her. During this, Caregiver D was in the kitchen preparing dinner. 10) At approximately 3:36 p.m., Resident 1 approached Surveyor and grabbed Surveyor's hair. Surveyor required Coordinator A to assist in	N 396		

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pulling his/her hair out of Resident 1's grasp. Immediately after this, Resident 1 approached Resident 2. Coordinator A physically blocked Resident 2 from Resident 1.

On 5 occasions, Surveyor observed Resident 2 either attempt to grab items s/he intended to chew or chew on items, including the following:

1) At approximately 2:45 p.m., Resident 2 was observed chewing on a cloth before Resident 1 approached him/her and grabbed his/her hair (as noted above). Coordinator A was observed retrieving the cloth from Resident 2. As previously documented, Caregiver D was assisting Resident 3 in the bathroom during this encounter.

2) At approximately 3:42 p.m., Coordinator A pulled a cloth away from Resident 2 that s/he was chewing on.

3) At approximately 3:49 p.m., Surveyor pulled his/her coat away from Resident 2. Coordinator A confirmed Resident 2 would attempt to chew on the coat if s/he got ahold of it.

4) At approximately 3:58 p.m., Coordinator A pulled Caregiver D's sweatshirt, which had been previously laying near the dining area, away from Resident 2.

5) At approximately 4:07 p.m., Resident 2 was observed in the living room chewing on a cloth. Upon his/her attention being directed to it, Coordinator A pulled the cloth away. During this encounter, Caregiver D was observed in the kitchen reviewing paperwork.

- From 1:54 p.m., when Surveyor first observed Resident 4 receiving his/her g-tube feeding in the

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side room off the dining area, until 2:52 p.m., when Surveyor directed Caregiver D to the situation of Resident 1 pulling Resident 4's hair while s/he was in the side room, no one checked in on Resident 4, which included the approximate 32 minutes that Caregiver D worked alone (from 2:20 - 2:52 p.m.). The entire time Resident 4 was facing outwards towards a window.

- After assisting Resident 3 in the bathroom at 2:45 p.m., Caregiver D assisted Resident 3 back to his/her room, which was located at the end of the hall and within limited view of the common areas. Resident 3 remained in his/her room when Surveyor left the home at approximately 4:10 p.m. Surveyor noted that any additional occurrences that Caregiver D either checked in or would check in on Resident 3 would thus limit Caregiver D's view of the other areas of the home.

- On 3 occasions - 3:24 p.m., 3:36 p.m., and 3:42 p.m. - after Caregiver D began preparing that evening's dinner, Resident 1 and/or Resident 2 required redirection from Coordinator A to move away from the food and hot stove. Caregiver D had been out of sight of the kitchen during each of these observations, though food was on a stove and an indicator on the stove indicated that it had hot burners.

On 07/30/2025, from sample medication administration records (MARs) that Surveyor reviewed, the following medication passes were identified as having to occur that evening: 5 medications for Resident 2 (one with his/her evening meal and 4 scheduled for 8:00 p.m.), 6 medications for Resident 3 (scheduled for 8:00 p.m.), and 5 medications for Resident 4. Of note, one of Resident 4's nighttime medications was a

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N 396	Continued From page 73 tablet requiring to be dissolved in a solution (per Caregiver B's earlier report of how tablets/capsules were handled) and the others were solutions that needed to be poured out. Per Resident 4's g-tube schedule, water flushes needed to occur before the first medication was administered (120 mL), between the administration of each medication (15 mL each), and after the last medication was administered (120 mL). Resident 1's ISP identified that s/he had medications that were to be administered at 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m. At approximately 2:57 p.m., Surveyor interviewed Coordinator A. Coordinator A reported s/he worked in an offsite office for the provider and was not scheduled to perform shifts at the provider's homes. Coordinator A confirmed s/he was only onsite to conduct the survey with Surveyor. Coordinator A confirmed that s/he was not a caregiver and did not perform caregiving duties. Surveyor discussed his/her concern regarding the lack of Caregiver D's supervision over the residents (at which point several of the physical altercations and elopement attempts occurred, and Resident 3 had been left unsupervised on the toilet for 49 minutes). Coordinator A reported s/he understood Surveyor's concern. In response to Surveyor sharing the concern that the above altercations would have continued without Coordinator A's intervention, Coordinator A reported s/he understood Surveyor's concerns. Caregiver D was not observed in the area during this interview, though Residents 1 and 2 were present. From the above information, Surveyor noted the following had yet to occur that evening:	N 396		

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N 396	Continued From page 74 - Plating and serving dinner, which would require Caregiver D to cut up food pieces no larger than ¼ inch in size and thicken liquids to nectar-thick for Resident 1, cut up food into bite-sized pieces for Resident 2, and "chop" bigger pieces of food up for Resident 3 in accordance with each of their ISPs - Directly supervise and cue both Residents 1 and 2 throughout dinner for safe eating in accordance with their needs as identified in their ISPs - Conduct Resident 4's 6:00 p.m. g-tube flushes of 240 mL total and prepare and administer his/her g-tube feeding - Prepare and administer each resident's evening medications, including the 5 medications for Resident 2, 6 medications for Resident 3, and 5 medications for Resident 4 (via g-tube), and medications to Resident 1 (times of which were identified on his/her ISP). Per Resident 4's g-tube schedule, water flushes needed to occur before the first medication was administered (120 mL), between the administration of each medication (15 mL each), and after the last medication was administered (120 mL). Surveyor noted that his/her observation of Resident 4's medication administration that morning, which included 5 medications each with their respective flushes (the same amount as was to be administered that evening), took approximately 10 minutes. - Physically assist in toileting cares for Residents 2, 3, and 4 based on following their 2-hour toileting schedule at a minimum in accordance with their ISPs. Surveyor noted that Resident 2 would have been due for a check at least at approximately 4:15 p.m. since s/he was not observed to have been checked for toileting	N 396		

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needs since Caregiver D started his/her shift at approximately 2:15 p.m. Surveyor noted that Resident 3 would have been due for a check sometime around 4:45 p.m. based on Surveyor's last observation of having received toileting assistance from Caregiver D at approximately 2:45 p.m. Surveyor noted that in order for Caregiver D to maintain the privacy of Residents 2, 3, and 4 in conducting toileting assistance s/he would inherently be unable to directly supervise the remaining residents.

- Conduct 30-minute checks on Resident 3 in accordance with his/her ISP, who was documented as typically liking to be in his/her room.

- Shower Resident 4, who required total assistance for all cares, in accordance with his/her scheduled shower day that evening. Surveyor noted that Resident 4 required a lift for all transfers, which would add to the time it would take to prepare Resident 4's shower. Surveyor also noted that in order for Caregiver D to maintain the privacy of Resident 4 in conducting his/her shower s/he would inherently be unable to directly supervise the remaining residents.

- Conduct nighttime cares, including dressing for bedtime readiness, grooming, and/or physical assistance to bed for each of the 4 residents. For comparison, Surveyor had previously observed that morning cares for Resident 4 by Caregiver C took approximately 20 minutes.

At approximately 4:07 p.m., prior to leaving, Surveyor discussed concerns of staffing with Coordinator A. Surveyor shared his/her observation that Coordinator A, who was not scheduled to work that day, was required to

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intervene in almost all the above observed interactions due to Caregiver D not being present to see them or not intervening him/herself while being engaged in other tasks. Coordinator A confirmed with Surveyor that dinner still needed to be served, Resident 4 still had an evening g-tube feeding that needed to be prepared, evening cares - including resident toileting - needed to occur (for which Residents 2-4 required total assistance to complete) and evening medications needed to be administered. Surveyor asked how Caregiver D was going to complete those tasks while still being able to supervise Resident 1 in order to prevent him/her from getting physical with other residents, intervene if s/he did, and intervene with Resident 2's exit-seeking behavior (which included multiple occasions that s/he had gotten outside). Coordinator A replied, "I don't know." Coordinator A reported s/he understood Surveyor's concerns.

On 08/01/2025, Surveyor reviewed an activity calendar provided by Coordinator A, which s/he previously reported was the one that was developed by the provider's company for staff to follow. The activity calendar identified 3 different activities to take place each day - mornings, afternoons, and evenings. Documented examples of the evening activities included, "Art and Music," "Game Night," "Card games," "Puzzle & Brain Games," "Guided Meditation," and "Movie Night." Surveyor noted that in previously identifying the tasks with Coordinator A that had yet to be conducted by Caregiver D alone on 07/30/2025, an evening activity was not accounted for.

On 08/01/2025, Surveyor reviewed the staff schedule for June and July 2025 and identified that the majority of the days had 1 employee staffed to work first or second shifts (during

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N 396	Continued From page 77 typical wake hours for residents when the above cares would be conducted), including the following: - 06/01/2025 (first and second shifts) - 06/02/2025 (the entire day, broken into 2 shifts) - 06/03/2025 (first and second shifts) - 06/04/2025 (second shift) - 06/05/2025 (first and second shifts) - 06/06/2025 (first and second shifts) - 06/07/2025 (the entire day, broken into 2 shifts) - 06/08/2025 (the entire day, broken into 2 shifts) - 06/09/2025 (first and second shifts) - 06/10/2025 (second shift) - 06/11/2025 (second shift) - 06/12/2025 (first and second shifts) - 06/13/2025 (first and second shifts) - 06/14/2025 (first and second shifts) - 06/15/2025 (first and second shifts) - 06/16/2025 (the entire day, broken into 2 shifts) - 06/17/2025 (first and second shifts) - 06/18/2025 (first and second shifts) - 06/19/2025 (second shift) - 06/20/2025 (second shift) - 06/21/2025 (the entire day, broken into 2 shifts) - 06/22/2025 (the entire day, broken into 2 shifts) - 06/23/2025 (second shift) - 06/24/2025 (second shift) - 06/25/2025 (first and second shifts) - 06/26/2025 (first and second shifts) - 06/27/2025 (first and second shifts) - 06/28/2025 (first and second shifts) - 06/29/2025 (first and second shifts) - 06/30/2205 (the entire day, broken into 2 shifts) - 07/01/2025 (first and second shifts) - 07/02/2025 (first and second shifts) - 07/03/2025 (first and second shifts) - 07/04/2025 (first and second shifts) - 07/05/2025 (the entire day, broken into 2 shifts) - 07/06/2025 (the entire day, broken into 2 shifts)	N 396		

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N 396	Continued From page 78 - 07/07/2025 (first and second shifts) - 07/08/2025 (part of first shift, 6:00 a.m. - 12:00 p.m.) - 07/09/2025 (second shift) - 07/10/2025 (first and second shifts) - 07/11/2025 (first and second shifts) - 07/12/2025 (first and second shifts) - 07/13/2025 (first and second shifts) - 07/14/2025 (the entire day, broken into 2 shifts) - 07/15/2025 (first and second shifts) - 07/16/2025 (first and second shifts) - 07/17/2025 (first and second shifts) - 07/18/2025 (second shift) - 07/19/2025 (the entire day, broken into 2 shifts) - 07/20/2025 (the entire day, broken into 2 shifts) - 07/21/2025 (second shift) - 07/22/2025 (second shift) - 07/23/2025 (second shift) - 07/24/2025 (first and second shifts) - 07/25/2025 (first and second shifts) - 07/26/2025 (first and second shifts) - 07/27/2025 (first and second shifts) - 07/28/2025 (second shift) - 07/29/2025 (first and second shifts) - 07/30/2025 (second shift - the shift Surveyor observed) On 08/14/2025, at approximately 9:25 a.m., Surveyor interviewed Case Manager N, who was the managed care organization's case manager for Resident 1. Case Manager N confirmed that Resident 1 pulling on others' hair was a typical behavior for him/her but noted that the frequency of this behavior was increasing, which s/he personally observed during his/her last few visits. Case Manager N reported s/he noticed the behavior increasing since around March 2025. Case Manager N confirmed that it was also a typical behavior for Resident 1 to attempt to go outside. Case Manager N reported that Resident	N 396		

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N 396	Continued From page 79 1 loved to be outside, especially in hot weather because s/he liked the warmth and loved to go for walks. Case Manager N reported that his/her understanding was that staff had been trying to go outside with him/her almost hourly for at least a couple of minutes. Case Manager N reported that with this Resident 1 began expecting to go outside and so s/he did have concerns that this could increase his/her elopement risk. Case Manager N reported that Resident 1 required direct 1:1 staff support for day programming due to his/her "high level of behaviors, including elopement" and had not been able to attend day programing due to his/her care team's inability to find a program that would support that level of supervision. When asked why Resident 1 did not require 1:1 staff supervision at the CBRF consistent with the level of supervision s/he required at day programming, Case Manager N reported that Resident 1 was "borderline" with the provider of requiring 1:1 supervision. (Surveyor noted that there were additional levels of supervision between a 1:4 staff-to-resident ratio and a staff member assigned strictly to Resident 1.) When asked what interventions worked to mitigate Resident 1's behaviors, Case Manager N replied that redirecting him/her to a different area of the home, such as the sunroom, and engaging him/her there, going for a walk, or engaging him/her in activities all helped. Case Manager N reported s/he wasn't sure how often staff were actually able to go outside with Resident 1 due to having to supervise the other residents of the home. On 08/14/2025, Surveyor reviewed Resident 1's behavior support plan (BSP). The BSP identified that Resident 1 demonstrated behaviors of wandering outside the home, stealing food and trying to eat food during meal preparation times,	N 396		

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self-injurious behaviors (including attempting "to bang [his/her] head on the heads of others"), and aggression by pinching, kicking, hair pulling, and putting others in headlocks. The severity of his/her aggressive and self-injurious behaviors were categorized as "severe." The BSP documented, "Throughout the day, staff will work with [Resident 1] on various skills including room and self-care, social skills, and self-management (being able to entertain [him/herself] without harming/targeting others ...[Resident 1] benefits from structured activities such as helping with laundry, playing [his/her] keyboard, making [his/her] bed, or looking at books." The BSP also noted that Resident 1 liked to go for walks.

Surveyor noted that staff did not conduct structured activities for Resident 1 when s/he was onsite. From the interview with Case Manager N and review of Resident 1's BSP, Surveyor noted that staff would inherently be unable to go for walks outside with Resident 1 when working shifts alone due to either needing to leave the other residents of the home unsupervised or the documented limitations/needs of the other residents in support of a group walk.

From review of the same records documented above, Surveyor noted that expected tasks on a typical first shift would be fairly close to tasks on second shift - including morning cares (including showering residents in accordance with their schedule), toileting every 2 hours, cooking, serving, and plating breakfast and lunch in accordance with how Residents 1-3 needed; following Resident 4's g-tube administration schedule, supervising Residents 1 and 2 throughout their meals for safety, morning medication administration, and conducting 30-minute checks for Resident 3. In addition to

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N 396	Continued From page 81 these tasks, a morning and afternoon activity was expected to occur by the staff on shift. On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A. Coordinator A agreed that the above were typical tasks for the caregiving staff. Surveyor asked how one staff member would be able to complete all the expected tasks while also supervising Residents 1 and 2 and intervening when Resident 1 demonstrated aggression to other residents or wandered outside or Resident 2 demonstrated exit-seeking behavior or chewed on items s/he found. Coordinator A replied that s/he didn't know. When asked who managed staffing patterns, Coordinator A replied that s/he wasn't sure but confirmed that this wasn't part of his/her role. When asked if s/he knew if management staff were aware of the extent of the residents' high needs, Coordinator A replied that s/he wasn't sure but thought that they were aware of the behaviors. Cross Reference: N0205 DHS 83.14(2)(j) Not Permit a Condition of Substantial Risk	N 396		
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	N 407		

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N 407	Continued From page 82 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 that residents were reassessed by a pharmacist, practitioner, or registered nurse at least quarterly for the desired responses and possible side effects of scheduled psychotropic medications they were prescribed. Only 2 of 4 quarterly psychotropic reviews were conducted in 2024. Reviews done in 2025 were conducted by a licensed practical nurse (LPN) - LPN K. This is a repeat deficiency. See Statement of Deficiency (SOD) 1BXT11, dated 10/28/2022. Findings include: On 07/30/2025, at approximately 2:50 p.m., Surveyor requested from Coordinator of Administrative Services (Coordinator) A records of all quarterly psychotropic reviews conducted in 2024 and 2025. Surveyor gave Coordinator A a due date of 07/31/2025 at 4:00 p.m. On 08/01/2025, Surveyor reviewed the records provided. The records showed that psychotropic reviews were conducted on 02/08/2024, 09/25/2024, "March 2025," "April 2025," "May 2025," and "June 2025." No other reviews conducted in 2024 were provided. All 4 reviews conducted in 2025 did not indicate who conducted the reviews. The reviews, corroborated by Surveyor's review of residents' medication administration records (MARs) that	N 407		

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N 407	Continued From page 83 same day, demonstrated that at least 1 resident, Resident 3, was prescribed scheduled psychotropic medication throughout 2024 and 2025 - which included citalopram 40 mg tablets taken daily and mirtazapine 15 mg tablets. On 08/01/2025, at approximately 2:21 p.m., Surveyor e-mailed Coordinator A to ask who specifically conducted the psychotropic reviews for 2025 and if it was documented on the reviews. On 08/04/2025, at approximately 9:05 a.m., Coordinator A replied to Surveyor's e-mail reporting that Licensed Practical Nurse (LPN) K conducted those psychotropic reviews and confirmed that it was not documented on the reviews. On 08/05/2025, at approximately 11:51 a.m., Surveyor e-mailed Coordinator A asking confirmation if LPN K was an LPN or registered nurse (RN). Coordinator A confirmed at 2:43 p.m. that LPN K was a LPN. On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A. Coordinator A reported s/he was not sure if the provider's staff were aware of the requirement for scheduled psychotropic reviews to be completed by a pharmacist, practitioner, or registered nurse. Coordinator A confirmed s/he had only sent 2 psychotropic reviews for 2024.	N 407		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or	N 416		

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rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3).

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that staff, including Caregivers C, I, and J, were delegated by a registered nurse to administer medications via stomal or rectal administration.

Findings include:

On 07/30/2025, at approximately 9:49 a.m., Surveyor observed Caregiver B preparing to administer Resident 4's medications, which had to be administered via his/her gastrostomy tube (g-tube). Caregiver B confirmed that all of Resident 4's medications were administered via g-tube.

On 07/31/2025, Surveyor reviewed current prescriptions for Residents 3 and 4, which included the following as needed (PRN) medications to be administered rectally:

- Bisacodyl 10 mg suppository prescribed to Resident 3 with instructions to, "Insert 1 suppository rectally once daily as needed for constipation."

- Diazepam 10 mg gel prescribed to Resident 4 with instructions to, "Insert 10 mg rectally as needed for seizures that last longer than 5 minutes."

- Bisacodyl 10 mg suppository prescribed to Resident 4 with instructions to, "Insert 1

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suppository rectally as needed if no bowel movement in 24 hours."

In reviewing Resident 4's prescriptions, Resident 4's scheduled medications included daily levothyroxine and flaxseed oil, Multi-Vite liquid, and senna liquid as well as twice daily clobazam, docusate liquid, and levetiracetam solution. The orders for all these medications specified that they were to be administered via g-tube.

On 08/05/2025, at approximately 11:51 a.m., Surveyor requested via e-mail from Coordinator of Administrative Services (Coordinator) A the current nursing delegations for Caregivers C, I, and J. All 3 had worked shifts alone in July based on Surveyor's review of the staff schedules that day. At approximately 2:43 p.m., Coordinator A replied to Surveyor that s/he sent out an e-mail to licensed practical nurse (LPN) K to request the nursing delegation records. Coordinator A confirmed that LPN K was an LPN.

On 08/06/2025, at approximately 7:18 a.m., Coordinator A e-mailed Surveyor to report the following: "Regarding the nursing delegations, [Registered Nurse (RN) L], RN, delegated the task of reviewing staff med passes to an LPN who did observe the new [direct support staff]'s and did follow up, however [s/he] did not provide the needed documentation. This LPN is no longer an employee. [RN L] said if you want, you can call [him/her] regarding this ..."

On 08/08/2024, at approximately 11:32 a.m., Surveyor interviewed RN L. RN L reported that LPN M was the previous LPN who was assigned to the area. RN L reported that the provider's delegation process was that the LPN reviewed medication passes performed by staff and if

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N 416	Continued From page 86 performed appropriately, the LPN let RN L know so that staff could be delegated under his/her license. RN L reported s/he did not keep a record of the staff that s/he delegated. On 08/08/2025, at approximately 10:55 a.m., Surveyor interviewed Nurse Case Manager G, who was the registered nurse (RN) case manager for Resident 4. During the interview, Nurse Case Manager G reported s/he was also messaging Case Manager H for additional corroborating information. Nurse Case Manager G reported s/he had a concern of wondering who the skilled person was that trained caregiving staff on Resident 4's g-tube.	N 416		
N 427	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure a daily activity program was provided to residents to	N 427		

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meet their interests and capabilities, or that an activity schedule was posted.

Findings include:

On 07/30/2025, at approximately 11:23 a.m., Surveyor observed an unlabeled calendar tacked to a board in the hallway while touring the home. The calendar identified "Special Days" for each day, and at the top of the page, the following was documented: "**For more information & activity ideas on the 'Special Days' listed please go to holidaycalendar.io." The posted calendar did not identify what month it represented but showed the first day of the month as occurring on a Thursday, with 31 days in the month. The date of the 26th was shown as being on a Monday and was labeled on the calendar as "Memorial Day." Surveyor noted that Memorial Day occurred in May. Surveyor was unable to identify what "Special Day" it was during the survey, because 07/30/2025 was a Wednesday and the calendar identified the 30th day as occurring on a Friday. The "Special Days" for the last week on the calendar were labeled as follows:

- Monday (26th): Memorial Day / National Paper Airplane Day
- Tuesday (27th): National Sunscreen Day
- Wednesday(28th): National Hamburger Day
- Thursday (29th): National Snail Day
- Friday(30th): National Salad Month
- Saturday (31st): National Smile Day

No specific activities were identified on the calendar, and Surveyor did not observe any other activity schedule posted throughout the home. While observing the calendar, Surveyor interviewed Coordinator of Administrative Services (Coordinator) A about the posting of

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activities. Coordinator A reported that typically an e-mail went to staff with weekly activities but that s/he was unable to find an activity schedule in the home. Coordinator A reported that for the "Special Days" calendar, caregiving staff could go to the website documented and get an idea of activities to conduct with residents.

From approximately 9:07 a.m. - 12:25 p.m., and 1:54 p.m. - 4:10 p.m., while Surveyor was on site, Surveyor did not observe any activity programming take place. During the onsite period, Surveyor attempted to interact with each of the provider's 4 residents, none of whom demonstrated the ability to communicate with Surveyor.

On 07/30/2025, Surveyor went to the website identified on the "Special Days" calendar. Surveyor identified that the days for the above week aligned with the "Special Days" for the month of May, except for the 30th day, which on the website identified "National Salad Month" as occurring throughout the entire month and a separate list of 6 "Special Days." For "National Salad Month", the following were identified as "how to celebrate National Salad Month": create a salad potluck, try a new type of salad, make your own salad dressing, host a salad-themed party, and visit a local farmer's market. For "National Snail Day", the 29th day, the following were identified as "how to celebrate National Snail Day": go for a nature walk, visit a snail farm, learn about snail anatomy, make a snail habitat, and cook with snails.

At approximately 2:50 p.m., Surveyor interviewed Coordinator A. Coordinator A confirmed that activities, which were supposed to be conducted by staff, were not observed to take place that day.

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N 427	Continued From page 89 Coordinator A acknowledged Surveyor's concern regarding the lack of activity programming for residents as well as lack of activity schedule. On 07/31/2025, Surveyor reviewed the current individual service plans (ISPs) for all 4 residents of the home. All four, Residents 1-4, were identified as being non-verbal. Resident 1's ISP, dated 03/13/2025, identified the following activities that s/he liked: spending time with staff/peers, helping with chores, walks, swimming, shopping, music, playing the piano, and riding his/her electric bike with staff. Resident 2's ISP, dated 07/10/2025, identified the following activities that s/he liked: going outside and walking around, listening to music, going on van rides, observing group activities, and music therapy. Resident 3's ISP, dated 03/13/2025, identified the following activities that s/he liked: listening to music, eating out, van rides, walks, and sporting events. Resident 4's ISP, dated 05/14/2025, identified the following activities that s/he liked: observing others, sitting in the screened porch, listening to music, holding rattles, going for walks and rides, observing activities taking place, and bird watching. On 08/14/2025 at 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reiterated that the provider had developed its own activity calendar that had been sent out a few months ago which staff were supposed to post and follow. Coordinator A reported understanding of Surveyor's concern that activities did not take place. Cross Reference: N0396 DHS 83.36(1)(a) Adequate Staff to Meet Resident Needs	N 427		

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N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that medication administration was provided appropriate to residents' needs. Resident 3's on hand as needed (PRN) acetaminophen expired on 05/21/2025. Resident 4 was prescribed rectal diazepam which was to be administered when s/he had a seizure lasting longer than 5 minutes. The only rectal diazepam on hand, which was dispensed to a different assisted living provider, had expired in June 2021, approximately 4 years prior to the survey. The provider's contracted pharmacy had not dispensed any diazepam since an order started on 09/29/2023. Resident 4 was prescribed a bisacodyl suppository which was to be administered when s/he did not have a bowel movement in 24 hours. Surveyor did not observe a bisacodyl suppository	N 432		

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on hand. The provider's pharmacy had not dispensed any bisacodyl suppositories since an order started on 09/20/2023.

Findings include:

Example 1 - Resident 3's acetaminophen

On 07/30/2025, at approximately 11:27 a.m., Surveyor observed the medication storage area. Within the storage area for Resident 4's medications, Surveyor observed the following expired medication:

- 1 card of acetaminophen 235 mg tablets. The pharmacy label showed that this was prescribed to Resident 3, was dispensed on 05/22/2024, and expired on 05/21/2025. The prescription instructions directed to, "Take 2 tablets (650 mg) by mouth every 6 hours as needed for pain (max acetaminophen 3000 mg/24 hr)." The card was labeled as initially containing 60 tablets, and Surveyor observed that 20 were punched out.

No current cards for Resident 3's acetaminophen were observed.

On 07/30/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 06/01/2021. Resident 3 was documented as being non-verbal, having a legal guardian, and requiring staff assistance to manage all medications. Surveyor reviewed Resident 3's prescriptions, which included an active prescription for acetaminophen 325 mg tablets, with the same instructions as observed by Surveyor on the medication card.

On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator

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A reported that his/her role with the provider didn't entail direct medication administration or oversight of medication administration and s/he was unaware of medication management concerns.

On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A again. Coordinator A reported understanding of Surveyor's concern that Resident 3's acetaminophen was expired.

Example 2 - Resident 4's diazepam

On 07/30/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 08/30/2022 with diagnoses including seizure disorder and profound intellectual and developmental disability. Resident 4 was documented as being non-verbal, having a legal guardian, and requiring staff assistance to manage all medications. Resident 4's current individual service plan (ISP), dated 05/14/2025 contained a section labeled, "PRN Medications." Within that section, the following was documented: "Diazepam - used for seizures." In reviewing Resident 4's prescriptions, Surveyor observed an active prescription for Resident 4's diazepam which directed the following: "Insert 10 mg rectally as needed for seizures that last longer than 5 minutes." The start date was documented as 09/29/2023.

At approximately 2:25 p.m., Surveyor requested to review the diazepam the provider had on hand for Resident 4. Caregiver C provided a plastic box that appeared to contain medication in it. The pharmacy label on the box showed that the medication was a "Diastat [diazepam] Acudial 5-7.5-10 mg kit" prescribed to Resident 4. The

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prescriptions instructions directed, "Use 10 mg rectally as needed for seizures greater than 5 minutes." The name of a different assisted living provider was printed on the label under Resident 4's name. The dispense date was crossed out, however, the year 2020 was legible. The pharmacy label documented, "Discard after: 6/2021." Surveyor noted that this was approximately 4 years from the survey. Caregiver C confirmed that that was the only PRN medication s/he could find related to Resident 4's seizures.

On 08/05/2025, at approximately 1:43 p.m., Surveyor interviewed Prescription Manager E from the pharmacy that dispensed Resident 4's medications. Prescription Manager E reported that Resident 4's diazepam had never been dispensed since it was prescribed.

On 08/05/2025, Surveyor reviewed the most recent medical record for Resident 4, which was a report from him/her being hospitalized from 07/21/2025 - 07/23/2025. The report contained a current medication list, which included his/her rectal diazepam with the same prescription instruction as previously reviewed.

On 08/14/2025, at approximately 11:27 a.m., Surveyor interviewed Coordinator A. Coordinator A reported that his/her role with the provider didn't entail direct medication administration or oversight of medication administration and s/he was unaware of medication management concerns.

On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A again. Coordinator A reported understanding of Surveyor's concern that Resident 4's rectal

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diazepam on hand had been expired for 4 years (prior to his/her admission to the provider), and that his/her prescription had never been filled since s/he was admitted.

Example 3 - Resident 4's bisacodyl suppository

On 07/30/2025, at approximately 11:27 a.m., Surveyor observed the medication storage area. Surveyor did not observe any suppositories on hand for Resident 4.

On 07/30/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 08/30/2022 with diagnoses including constipation and profound intellectual and developmental disability. Resident 4 was documented as being non-verbal, having a legal guardian, and requiring staff assistance to manage all medications. In reviewing Resident 4's prescriptions, Surveyor observed an active prescription for a bisacodyl 10 mg suppository. The start date was documented as 09/20/2023.

On 08/05/2025, at approximately 1:43 p.m., Surveyor interviewed Prescription Manager E from the pharmacy that dispensed Resident 4's medications. Prescription Manager E reported that Resident 4's bisacodyl suppository had never been dispensed since it was prescribed.

On 08/05/2025, Surveyor reviewed the most recent medical record for Resident 4, which was a report from him/her being hospitalized from 07/21/2025 - 07/23/2025. The report contained a current medication list, which included his/her bisacodyl suppository with the same prescription instruction as previously reviewed.

On 08/14/2025, at approximately 11:27 a.m.,

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N 432	Continued From page 95 Surveyor interviewed Coordinator A. Coordinator A reported that his/her role with the provider didn't entail direct medication administration or oversight of medication administration and s/he was unaware of medication management concerns. On 08/15/2025, at approximately 10:00 a.m., Surveyor interviewed Coordinator A again. Coordinator A reported understanding of Surveyor's concern that Resident 4's rectal bisacodyl prescription had never been filled since s/he was admitted. Cross Reference: N0352 83.32(3)(h) Rights of Residents: Receive Medication	N 432		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that a weekly written menu was prepared that was available to residents. Findings include: On 07/30/2025, at approximately 10:57 a.m.,	N 450		

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N 450	Continued From page 96 Surveyor toured the environment with Coordinator of Administrative Services (Coordinator) A. Surveyor did not observe a weekly menu posted anywhere. While touring the home with Coordinator A, Coordinator A confirmed s/he did not see a posted menu either. At approximately 11:25 a.m., Surveyor interviewed Caregiver C. Caregiver C confirmed that there was no menu and that staff "just make whatever we feel like at the moment." At approximately 2:15 p.m., Surveyor observed Caregiver C giving handoff communication to the next shift caregiver, Caregiver D, who was going to work second shift that evening. Caregiver C told Caregiver D that s/he could make chicken and mashed potatoes for that evening's dinner.	N 450		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that cleaning compounds were stored in a secure area. This is a repeat deficiency. See Statement of Deficiency (SOD) 1BXT11 dated 10/28/2022. Findings include: The provider is licensed to serve up to 6 nonambulatory residents within the client groups	N 499		

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N 499	Continued From page 97 of traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, physically disabled, and alcohol/drug dependent. On 07/30/2025, at approximately 10:57 a.m., Surveyor toured the environment with Coordinator of Administrative Services (Coordinator) A. In the first of 2 resident bathrooms observed at approximately 11:02 a.m., Surveyor opened the door of the upper cabinet and observed several cleaning compounds, which included the following: - 1 container of Ajax (with bleach) - 1 bottle of Clorox Disinfecting All-Purpose Cleaner - 1 bottle of Great Value Glass Cleaner - 1 bottle of Spic and Span Disinfecting All-Purpose Spray and Glass Cleaner - 1 bottle of Hepacide Quat II Virucidal Disinfectant Cleaner While observing the cleaning compounds, Surveyor interviewed Coordinator A. Coordinator A reported that staff were not supposed to store cleaning compounds in an unsecured cabinet. At approximately 11:07 a.m., Surveyor observed the second of 2 resident bathrooms with Coordinator A. Upon opening the door of the upper cabinet located within the bathroom, Surveyor observed the following cleaning compounds: - 1 bottle of Zep All-Purpose Cleaner & Degreaser - 1 container of Ajax Oxygen Bleach Cleanser - 1 bottle of LA's Totally Awesome Window Clean glass and surface cleaner - 2 bottles of Hepacide Quat II Virucidal Disinfectant Cleaner	N 499		

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N 499	Continued From page 98 While observing these cleaning compounds, Surveyor interviewed Coordinator A. Coordinator A confirmed that staff were not supposed to store cleaning compounds in an unsecured cabinet. On 07/31/2025, Surveyor reviewed the current individual service plan (ISP) for Resident 2, dated 07/10/2025. Resident 2's ISP indicated that s/he was at "risk to ingest non-food items." Under a section detailing restrictions for Resident 2, the following was documented: "Cleaning supplies are stored in a locked cabinet. Staff will work with me on skill and safety related to cleaning products in my home." Under a section detailing risks for Resident 2, the following was documented: " ...[S/he] also has a history of putting inedible items in [his/her] mouth (leaves, socks, crumbs on the floor, anything that resembles food, etc." On 07/31/2025, Surveyor reviewed the current ISP for Resident 1, dated 03/13/2025. Under a section detailing risks for Resident 1, the following was documented: " ...Staff ensure that they [cleaning supplies] are stored safely. Cleaning supplies are locked in [his/her] homes [sic]." On 07/31/2025, Surveyor reviewed the current ISP for Resident 3, dated 03/13/2025. Under a section detailing restrictions for Resident 3, the following was documented: "Cleaning supplies are stored in a locked cabinet. Staff will work with me on skill and safety related to cleaning products in my home."	N 499		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways.	N 637		

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N 637	Continued From page 99 All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 2 of 2 exits provided unobstructed travel to the outside. Findings include: The provider is licensed to serve up to 6 nonambulatory residents within the client groups of traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, physically disabled, and alcohol/drug dependent. On 07/30/2025, at approximately 9:07 a.m., Surveyor entered the home to conduct a survey.	N 637		

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N 637	Continued From page 100 After Surveyor entered the home, Resident 1 was observed walking near the front door. At approximately 9:10 a.m., Resident 1 was observed attempting to walk out the front door. Caregiver B was observed redirecting Resident 1 back into the home and then placed a chair against the front door to block its access from Resident 1. After this, Surveyor observed the home's enclosed patio, where Caregiver C was observed feeding Resident 2. Surveyor observed a door that led from the enclosed patio to an outdoor patio, which was blocked by 3 chairs placed side-by-side in front of it. At approximately 9:30 a.m., Surveyor observed the home's exit diagram. The diagram identified both the front door and side door (from the enclosed patio) as the home's exits identified for evacuation. At approximately 9:30 a.m., Coordinator of Administrator Services (Coordinator) A attempted to enter the home through the front door. Coordinator A was observed to push the chair out of the way and told Caregiver B that the chair couldn't be blocking the door. At approximately 2:50 p.m., Surveyor discussed the concern of the 2 blocked exits with Coordinator A. Coordinator A reported s/he understood Surveyor's concern.	N 637		