STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018568	A. BUILDING: _____ B. WING _____	C 09/12/2025

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EICKSTAEDT	101 EICKSTAEDT LANE WATERTOWN, WI 53094

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N 000	Initial Comments On 09/04/2025, with information obtained through 09/12/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Eickstaedt, a community-based residential facility (CBRF) located in Watertown, WI. As a result of the survey, 7 deficiencies were identified. The complaint was substantiated. Census: 5	N 000		
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. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that Resident 3 received his/her benzoyl peroxide 5% facial gel as prescribed. Findings include: On 09/04/2025, Surveyor conducted a complaint investigation into concerns that staff were signing out medications but not administering them. At approximately 12:35 p.m., Surveyor reviewed the medication storage area with Lead Caregiver	N 352		

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

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N 352	Continued From page 1 A. Surveyor observed an unlabeled baggie. Within the baggie was a tube with both the manufacturer's label and pharmacy label indicating that the tube contained benzoyl peroxide 5% gel. The pharmacy label also indicated that the gel was prescribed to Resident 3, dispensed on 02/28/2024, and contained instructions to, "Apply to affected area topically once daily." The tube, which contained 3.2 oz (or 90 grams) of gel according to the manufacturer's label, appeared to be approximately 50% full (Photos 2-4). While observing the gel, Surveyor interviewed Lead Caregiver A. When asked if staff were administering Resident 3's gel, Lead Caregiver A replied that they should have been because it was a scheduled medication. Lead Caregiver A reported that s/he noticed the gel had not been getting low in supply as would be expected if it was administered daily. Lead Caregiver A reported that s/he spoke with a night shift staff member, Caregiver D, about his/her concern since the gel was to be administered at night and Caregiver D worked nights with the provider. Lead Caregiver A reported that Caregiver D claimed to have been administering the gel. Lead Caregiver A reported that Caregiver D had only been working with the provider for the past couple of months and prior to him/her, different agency staff had worked nights. On 09/04/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 06/21/2021 with diagnoses including profound developmental disability, blindness, hearing loss, and acne. Resident 3's prescriptions included benzoyl peroxide 5% gel, active as of 02/28/2024, with the same directions as on the tube's label but with the added clarification, "for acne." Surveyor	N 352		

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reviewed Resident 3's most recent 12 months of medication administration records (MARs), from 09/01/2024 - 09/04/2025. Out of 367 potential administrations, staff initialed off on 284. The 77 entries that were not initialed off on were blank.

At approximately 3:00 p.m., Surveyor Lead Caregiver A and Coordinator of Administrative Services (Coordinator) G. Both reported understanding of Surveyor's concern that Resident 3 was not receiving his/her benzoyl peroxide gel as prescribed.

On 09/09/2025, at approximately 1:45 p.m., Surveyor interviewed Pharmacy Representative J, from the pharmacy that dispensed Resident 3's medications. Pharmacy Representative J reported that Resident 3's benzoyl peroxide gel was most recently filled on 08/27/2025 but prior to that, was last filled around approximately 02/25/2024.

Surveyor noted that with the tube onsite having been approximately 50% full (or, approximately 1.6 oz remaining), and in accounting for any administrations occurring on or after 08/27/2025, when Resident 3's new tube was dispensed, that approximately 276 of the initialed administrations would have come from the tube dispensed on 02/28/2024. Surveyor noted that this would have been approximately 0.005 oz per administration and that this would not have included any additional 7 months-worth of administrations that would have occurred between 02/28/2024 (when the tube was dispensed) and 09/01/2024 (Surveyor's MAR review start) or the 77 blank entries.

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N 388	Continued From page 3	N 388		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that Resident 1's individual service plan (ISP) was implemented as written in relation to his/her gastrostomy tube (g-tube) water flushes. Findings include: On 09/04/2025, Surveyor conducted a complaint investigation into allegations that g-tube flushes were not being done correctly. On 09/04/2025, at approximately 11:10 a.m., Surveyor observed Caregiver B prepare and administer Resident 1's lunchtime medication via his/her g-tube. Caregiver B was observed to take a measuring cup which s/he filled a little past the top (approximately 600 mL) with water and then administer that water via separate syringe administrations into Resident 1's g-tube until it was gone. Surveyor noted that the maximum label on the measuring cup was 500 mL and that past that the maximum capacity of the cup appeared to be approximately 650 mL (though anything above 500 wasn't labeled). When asked how much water s/he knew to use, Caregiver B replied that s/he filled the measuring cup to the top each time s/he did a flush with Resident 1. After Resident 1's medication administration, Surveyor observed Caregiver B administer Resident 2's g-tube feeding and Caregiver C begin feeding Resident 1 lunch. Surveyor did not observe any additional flushes occur around that	N 388		

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N 388	Continued From page 4 time for Resident 1. On 09/04/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/21/2021 with diagnoses including hypernatremia and intellectual disability. Resident 1 was documented as being "at times" verbal with yes/no responses and being able to verbalize "a few key phrases." Resident 1 was documented as having a legal guardian and needing total assistance for self-cares. Within Resident 1's current ISP, dated 03/10/2025, the following was documented: "To meet Hydration [sic] needs: [Resident 1] is to receive 4000 mL water via g tube daily to be given as indicated below:" The "Water Flush Schedule" documented underneath that detailed that 800 mL of water was to be used to flush Resident 1's g-tube with medication administrations that occurred at 7:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Surveyor noted that the approximate 600 mL of water flushed at approximately 11:10 a.m. with Resident 1's noon medication was inconsistent with the ISP directive for 800 mL needing to be flushed. At approximately 3:00 p.m., Surveyor interviewed Lead Caregiver A and Coordinator of Administrative Services G. In discussing the concerns regarding the amount of water used to flush Resident 1's g-tube, Lead Caregiver A reported that Caregiver B should have known that 800 mL was the required amount of water used.	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities	N 389		

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or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that Resident 1's individual service plan (ISP) was updated to reflect no longer requiring weekly weight monitoring.

Findings include:

On 09/04/2025, Surveyor conducted a complaint investigation into concerns of resident weight loss.

At approximately 10:05 a.m., Surveyor requested from Lead Caregiver A all resident weights since 01/01/2025. In reviewing the records that were provided, Surveyor observed that each resident had their weights recorded on a monthly basis.

On 09/04/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/21/2021 with diagnoses including hypernatremia and intellectual disability. Resident 1 was documented as being "at times" verbal with yes/no responses and being able to verbalize "a few key phrases." Resident 1 was documented

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N 389	Continued From page 6 as having a legal guardian and needing total assistance for self-cares. Within Resident 1's current ISP, dated 03/10/2025, the following was documented: "**[Resident 1] should be weighed weekly." At approximately 3:00 p.m., Surveyor interviewed Lead Caregiver A and Coordinator of Administrative Services G. Lead Caregiver A denied that weights were done weekly for Resident 1 and reported that s/he hadn't required weekly weight monitoring for at least the last 1.5 years.	N 389		
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 record review, observation, and interview, the provider did not ensure that staff were provided in sufficient numbers on a 24-hour basis to meet the needs of the residents. The provider's home was typically staffed with a 1:5 ratio on afternoon/evening shifts, and on several days, morning shifts. Both morning and afternoon/evening shifts required the caregiver on shift to prepare meals, conduct caregiving tasks, and conduct leisure time activities. Four of the provider's 5 residents, Resident 1, Resident 2, Resident 3, and Resident 4, were documented as requiring full or total assistance to complete personal care tasks and requiring 24/7 supervision. Four of the 5 residents, Resident 1, Resident 2, Resident 3, and Resident 4, had	N 396		

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N 396	Continued From page 7 impaired verbal/communication abilities, with 2 of the 4 not being able to make their needs known and the remainder 2 of the 4 requiring assistance to make their needs known. Three of the 5 residents, Resident 1, Resident 2, and Resident 4, required a mechanical lift for transfers and utilized wheelchairs for mobility. Resident 1, Resident 2, Resident 3, and Resident 4 required staff assistance for mobility. Resident 1 and Resident 2 had gastrostomy tubes (g-tubes) for which they required staff to manage schedules of flushing, feeds, and medication administration throughout the day. Resident 1, Resident 2, Resident 3, and Resident 4 were incontinent and required a regular schedule, generally every 2 hours, of checks and changes to be completed by staff. All 5 residents required staff to administer medications. Resident 1, Resident 3, and Resident 4 required staff to prepare and serve food which required specific preparation of their food in accordance with their specialty diets (not counting Resident 2's g-tube feedings). Resident 1 required staff assistance to eat meals and Resident 3 required to be directly fed by staff. On 09/04/2025, 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 incontinence checks/cares were delayed. Surveyor also observed part of the afternoon/evening shift, in which 1 caregiver worked. During this shift, Surveyor also observed that incontinence checks/cares were delayed, an afternoon activity was not offered in accordance with the schedule, and Lead Caregiver A, who was not scheduled to work, stepped in to assist with resident g-tube feedings after Surveyor	N 396		

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asked about Resident 1's 3:00 p.m. g-tube feeding that had not yet occurred by approximately 4:00 p.m.

Findings include:

On 09/04/2025, Surveyor conducted a complaint investigation into allegations of resident cares not being conducted.

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

On 09/04/2025, Surveyor conducted a survey at the provider's home and was onsite from approximately 9:00 a.m. - 12:56 p.m. and 1:40 p.m. - 4:05 p.m. The home's common areas were observed to be "open concept" style with no separation between the living area, dining area and kitchen. From the common area, Surveyor could observe the hallway that the bedrooms for Resident 1 and Resident 3 were off.

Upon arriving onsite, Surveyor observed Caregiver C feeding Resident 1, and Caregiver B cleaning in the kitchen. Surveyor observed that they were the only staff working. Resident 4 was seated in his/her wheelchair in the living area facing the television, eating breakfast. Resident 3 was in his/her room with the door shut. Resident 2 was laying in his/her bed. None of the residents appeared to be conversationally verbal.

At approximately 9:10 a.m., Surveyor observed an activity schedule posted on a bulletin board in the hallway. The activity schedule documented that the activities scheduled that day included

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light exercise and movement games in the morning, "cooking time" in the afternoon, and card games in the evening.

At approximately 9:18 a.m., Caregiver C pushed Resident 1 in his/her wheelchair to the living area in front of the television and then sat at the computer to document. Caregiver B pushed Resident 4 in his/her wheelchair from the living area to his/her room, where s/he turned the television on for him/her.

At approximately 9:24 a.m., Surveyor observed a staff schedule posted on a whiteboard in the kitchen area. The schedule, identified as being for September, showed 2 staff members working morning shift hours (between 6:00 a.m. - 2:00 p.m.), 1 staff member working afternoon/evening hours (between 2:00 p.m. - 10:00 p.m.), and 1 staff member working overnight (NOC) shifts each day.

At approximately 9:44 a.m., Surveyor observed Caregiver B and Caregiver C approach Resident 2, who was in bed. Caregiver B confirmed they were going to get him/her changed and ready for the day.

At approximately 9:45 a.m., Surveyor interviewed Lead Caregiver A regarding residents' needs and abilities. Lead Caregiver A reported it was his/her day off but since Caregiver B called him/her about Surveyor being onsite, s/he came in to assist with the survey. Through this interview, Lead Caregiver A reported that 4 of the provider's 5 residents (including Resident 1, Resident 2, Resident 3, and Resident 4) required total assistance for all care tasks and were incontinent. Additionally, Lead Caregiver A reported the following:

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N 396	Continued From page 10 - Resident 1 utilized a manual wheelchair for mobility (pushed by staff) and a lift for all transfers. S/he required two g-tube feedings which were scheduled for 3:00 p.m. and 5:00 p.m. Resident 1 was mostly nonverbal and noncommunicative. - Resident 2 utilized a manual wheelchair for mobility that typically staff pushed and a lift for all transfers. S/he required scheduled g-tube feedings. In terms of communication, Resident 2 could say some words but was not generally communicative. - Resident 3 was blind and deaf. Staff pushed him/her in a manual wheelchair when outside of his/her room but s/he otherwise ambulated by crawling on the floor and could transfer independently. Resident 3 also required a pureed food diet. Resident 3 was mostly nonverbal and noncommunicative. - Resident 4 utilized a manual wheelchair for mobility (pushed by staff) and a lift for all transfers. S/he could feed him/herself but required a chopped food diet. Resident 4 was nonverbal and noncommunicative but made some sounds. - Resident 5 was independent with self-care tasks but required staff to administer his/her daily medications. During the interview, at approximately 10:15 a.m., Caregiver B and Caregiver C walked back into the common area from Resident 2's room, where they had been since earlier observed by Surveyor. Resident 2 was pushed by Caregiver B in his/her manual wheelchair and was placed in	N 396		

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front of the television.

At approximately 10:20 a.m., Surveyor observed Caregiver C engaged in an activity with Resident 1 in the living area, utilizing differently colored blocks.

At approximately 10:32 a.m., Surveyor walked around the home. Resident 1 and Resident 2 were in the living area in front of the television, Resident 3 was still in his/her room with the door closed, and Resident 4 was still in his/her room in front of the television.

At approximately 10:45 a.m., Surveyor observed Caregiver C prepare lunch.

At approximately 11:10 a.m., Surveyor observed Caregiver B and Caregiver C conducting the lunchtime medication pass. As part of this, Caregiver B was observed to crush and dissolve a medication for Resident 1, which s/he then administered to him/her via his/her g-tube. Caregiver B also flushed Resident 1's g-tube with water.

At approximately 11:30 a.m., Surveyor observed Caregiver C push Resident 3 in a wheelchair from his/her room to the dining table. Caregiver C fed Resident 3 while Caregiver B finished Resident 1's g-tube flush and conducted Resident 2's scheduled g-tube feeding. While Caregiver B was still finishing Resident 2's g-tube feeding, Caregiver C began feeding Resident 2. Caregiver C was observed alternating between Residents 1 and 3 for feeding until approximately 11:45 a.m., when Caregiver C finished Resident 2's g-tube feeding and took over feeding Resident 1.

At approximately 11:45 a.m., Caregiver C

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reported s/he was going to conduct incontinent cares with Resident 3. (Surveyor noted that this was the first time since having arrived on site at 9:00 a.m. that cares were being done for Resident 3.)

At approximately 12:00 p.m., when Caregiver B finished feeding Resident 1, s/he brought him/her to his/her room to conduct incontinent cares. (Surveyor noted that this was the first time since having arrived on site at 9:00 a.m. that cares were being done for Resident 1.) At this time, Caregiver C came from Resident 3's room and began using a lift to transfer Resident 2 from his/her wheelchair to a recliner in the living area. Resident 2 was heard making an utterance that Surveyor could not clearly hear. Surveyor then heard Caregiver C reply that s/he understood Resident 2 to say s/he wanted to do a puzzle. Caregiver C reported that s/he would do a puzzle with him/her later.

At approximately 12:10 p.m., after transferring Resident 2, Caregiver C then entered Resident 4's room where s/he reported s/he would do his/her incontinence cares. (Surveyor noted that this was the first time since having arrived on site at 9:00 a.m. that cares were being done for Resident 4.)

Between the time Resident 2 was initially brought to the living area (at approximately 10:15 a.m.), to the time s/he was transferred to the recliner (approximately 12:00 p.m.) and then until Surveyor left offsite at 12:56 p.m., no incontinence cares were conducted for Resident 2.

At approximately 1:40 p.m., when Surveyor arrived back onsite, Resident 2 was observed still

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seated in his/her recliner. Coordinator of Administrative Services (Coordinator) G confirmed that Resident 2 had been there since Surveyor had left.

Between 2:00 - 2:30 p.m., Surveyor observed different conversations between Caregiver B, Caregiver C, and Lead Caregiver A regarding who was coming in to work second shift. Caregiver B and Caregiver C were heard asking who the second shift staff would be and when they were coming in. Lead Caregiver A replied that s/he didn't know. Surveyor reviewed the posted schedule for that day, which showed second shift from 2:00 p.m. - 10:00 p.m. as "open." Caregiver C reported s/he would stay until s/he got relieved. At approximately 2:23 p.m., Caregiver B left the home due to it being the end of his/her scheduled shift. At approximately 2:30 p.m., Surveyor heard Caregiver C ask Lead Caregiver A if s/he should give Resident 2 a shower since s/he wasn't supposed to be working then but it was Resident 2's scheduled shower day and shift. Lead Caregiver A replied that Caregiver C should. After this conversation, Caregiver C was observed transferring Resident 2 to his/her wheelchair and taking him/her into the bathroom. (Surveyor noted that this was approximately 2.5 hours since s/he was transferred to the recliner and overall approximately 4 hours since incontinence cares were last done for him/her.)

Throughout Surveyor's observations up to that point, the only leisure activity observed was when Caregiver C engaged in a block activity with Resident 1 earlier that morning.

On 09/04/2025, Surveyor reviewed individual service plans (ISPs) for Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5, which

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N 396	Continued From page 14 identified the following needs/services: - Resident 1 (ISP dated 03/10/2025): Diagnosed with intellectual disability, spastic quadriplegia, and urinary incontinence. Resident 1 was identified as receiving a bath/shower every other day but was known to be physically resistive to cares. Resident 1 was documented under the "Toileting" heading as needing to be "freshened" every 2 hours secondary to his/her incontinence. Resident 1 utilized a mechanical lift for transfer. Resident 1 required medications to be administered by staff at 7:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.; and for the medications to be crushed and administered via his/her g-tube along with 800 mL water flushes during each administration. Resident 1 required food to be served in bite-sized pieces and for staff to assist him/her with eating. Resident 1 required g-tube feedings to be administered at 3:00 p.m. and "at dinner." To meet Resident 1's hydration needs, staff were to ensure s/he consumed 500 mL of water with each meal as well as 300 mL each between breakfast and lunch, lunch and supper, and after supper. Any water not drank was to be administered by staff via Resident 1's g-tube in the evenings. Resident 1 was identified as having a history of falls out of his/her bed as well as behaviors of pulling/crawling him/herself out of bed. Resident 1 was identified as requiring 24-hour supervision, total assistance for cares, and needing assistance with making his/her needs known. Resident 1 could "sometimes" reply to yes/no questions and be verbal with "a few key phrases." Resident 1 utilized a wheelchair for all ambulation and had range of motion (ROM) exercises that "should be practiced every shift." Resident 2 (ISP dated 06/12/2025): Diagnosed	N 396		

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with intellectual and developmental disability, cerebral palsy, and hemiplegia/hemiparesis. Resident 2 was identified to require "full assistance to complete all personal cares," which included a mechanical lift for transfers and a manual wheelchair for mobility. Resident 2 was documented under the "Toileting" heading as needing to be "freshened" every 2 hours "or as needed" secondary to his/her incontinence. Resident 2 required medications to be administered at 8:00 a.m., 2:00 p.m., 5:00 p.m., and 8:00 p.m. and for the medications to be crushed and administered via his/her g-tube. Resident 2 required all nutrition to be received via his/her g-tube, with feedings administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. in addition to water flushes before and after each feeding. Resident 2 was identified as requiring 24-hour supervision and not being able to make his/her needs known. Resident 2 was identified as being able to say a few words and body language / facial expression to communicate.

Resident 3 (ISP dated 08/07/2025): Diagnosed with profound developmental disability, blindness, hearing loss, and bilateral hip dysplasia. Resident 3 was identified to require "full assistance from my staff with bathing and personal cares." Resident 3 was documented under the "Toileting" heading as having staff "freshen" him/her "every two hours or more often if needed." Resident 3 required staff guidance for transferring and a wheelchair for transport. Resident 3 required medications to be administered at 8:00 a.m., 12:00 p.m., and 8:00 p.m., and these medications were required to be crushed and administered with food. Resident 3 required foods to be pureed and for staff to feed him/her at all meals. Resident 3 was identified as requiring 24-hour supervision and needing assistance for making

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his/her needs known. Resident 3 was known to make noises or facial expressions, say some words, bite his/her wrist, or grab onto staff to express him/herself.

Resident 4 (ISP dated 04/10/2025): Diagnosed with developmental disability and scoliosis. Resident 4 was identified as needing "full assistance during my personal cares." Resident 4 utilized a wheelchair for mobility and a mechanical lift for transfers. Resident 4 was documented under the "Toileting" section as needing to be "freshened every two hours or more often as needed." Resident 4 required food to be served chopped. Resident 4 required medications to be administered at 7:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Under the "Things that are important to me" heading, one of the identified items was, "1:1 time with staff and going for walks." Resident 4 was identified as requiring 24-hour supervision and not being able to make his/her needs known.

Surveyor also reviewed the individual service plan (ISP) that had been developed for Resident 5, who was admitted on 08/04/2025. The ISP did not have a date but identified medication administration by staff as one of Resident 5's needs.

At approximately 3:00 p.m., Surveyor interviewed Lead Caregiver A and Coordinator G. Throughout Surveyor's observations up to that point, the only leisure activity observed was when Caregiver C engaged in a block activity with Resident 1 earlier that morning. Lead Caregiver A confirmed that while some outside professionals occasionally came in to provide an activity (such as music therapy), the caregivers on shift were expected to conduct all resident cares, prepare meals

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(including g-tube feedings and preparing the meals in accordance with the specialty diets of Resident 1, Resident 3, and Resident 4), administer resident medications, and carry out leisure activities. Surveyor discussed the concern that even with 2 staff members present, the provider's activity programming schedule was not followed and resident incontinence cares or checks were not observed to be completed in accordance with residents' ISPs. Lead Caregiver A agreed with Surveyor's observations and reported that when s/he worked shifts alone s/he sometimes was able to complete everything s/he needed to but sometimes s/he wasn't. Lead Caregiver A reported that s/he had been told by Program Manager I that the home was only supposed to schedule 1 staff per shift for all shifts, but that s/he kept scheduling 2 staff for the morning shifts in order to meet residents' needs.

At approximately 3:35 p.m., Surveyor observed Caregiver C finish with Resident 2's shower and begin conducting incontinence cares for Resident 1. (Surveyor noted that this was approximately 3.5 hours since the last cares were completed for him/her at 12:00 p.m., and only the 2nd time since Surveyor arrived onsite at 9:00 a.m. that cares were done).

On 09/04/2025, while reviewing resident individual service plans (ISPs), Surveyor observed that Resident 1's current ISP, dated 03/10/2025, directed for staff to administer him/her a g-tube feeding daily at 3:00 p.m. Resident 2's current ISP, dated 06/12/2025, directed for staff to administer him/her a g-tube feeding daily at 4:00 p.m. At approximately 4:00 p.m., Surveyor asked Lead Caregiver A and Caregiver C when Resident 1 was going to receive his/her 3:00 p.m. g-tube feeding.

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N 396	Continued From page 18 Afterwards, Caregiver C began preparing and administering Resident 1's g-tube feeding. At approximately 4:05 p.m., Surveyor observed Lead Caregiver A administer Resident 2 his/her 4:00 p.m. g-tube feeding. (Of note, Lead Caregiver A was not scheduled to work that day and the provider would typically have had only one staff member working during that time per the schedule.) From medication administration records (MARs) for Resident 1, Resident 2, and Resident 3 from September 2025 that Surveyor reviewed as a sample on 09/04/2025, the following medications were identified as having to be administered yet that evening: 12 medications for Resident 1, 7 medications for Resident 2, and 6 medications for Resident 3. Tablets for all 3 were required to be crushed, as identified in each of their ISPs. The MARs for Resident 1 and Resident 2 also contained entries for their g-tube feeding administrations, which identified an additional tube feeding was to occur for Resident 1 at 5:00 p.m. and one for Resident 2 at 8:00 p.m. On 09/04/2025, Surveyor reviewed the resident shower schedule, which identified Resident 2 as receiving showers on the "PM"/evening shifts on Tuesdays, Thursdays, and Saturdays. Resident 1 received showers on the "AM"/morning shifts on Tuesdays, Thursdays, and Saturdays, and Resident 4 received showers on the "AM"/morning shifts on Mondays, Wednesdays, and Fridays. From the above information, Surveyor noted the following had yet to occur that evening, all by 1 staff member as identified from the staff schedule:	N 396		

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N 396	Continued From page 19 - Preparing, plating, and serving dinner, which would also require whoever was going to be working that day's second shift (not identified up to that point), to prepare Resident 1's food into bite-sized pieces, to puree Resident 3's food, and to "chop" Resident 4's food in accordance with each of their ISPs - Directly feed Resident 3 and assist in feeding Resident 2 throughout dinner - Administer Resident 1's 5:00 p.m. and Resident 2's 8:00 p.m. g-tube feedings - Conduct 800 mL water flushes via Resident 1's g-tube at 4:00 p.m. and 8:00 p.m. - Ensure Resident 1 was provided and consumed 300 mL water between lunch and supper as well as after supper, or administer whatever water Resident 1 did not consume during the day through his/her g-tube that evening - Prepare and administer each resident's evening medications, with administration times of 4:00 p.m., 5:00 p.m., and 8:00 p.m., including crushing tablet medications for Resident 1, Resident 2, and Resident 3. Surveyor noted that this included 25 total medications for Resident 1, Resident 2, and Resident 3 alone. - Provide incontinence cares for Resident 1, Resident 2, Resident 3, and Resident 4 based on their 2-hour scheduling. Surveyor noted that based on each resident's last observed check, Residents 1 and 2 would require to be changed again at approximately 5:35 p.m., Resident 3, who had last been changed at 11:45 a.m. was already overdue, and Resident 4, who had last been changed as 12:10 p.m., was already	N 396		

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N 396	Continued From page 20 overdue. - Conduct nighttime cares, including dressing for bedtime readiness and bed transfers using lifts for Resident 1, Resident 2, and Resident 4; and dressing for bedtime readiness for Resident 3. For comparison, Surveyor had previously observed that morning cares for Resident 2 alone by both Caregivers B and C took approximately 30 minutes. - Conduct an afternoon and evening activity in accordance with the posted activity schedule (cooking time and card games, respectively). Of note, from Surveyor's earlier observation Caregiver C had identified at approximately 12:00 p.m. that Resident 2 had wanted to complete a puzzle, which had not yet taken place. On 09/04/2025, Surveyor reviewed the staff schedule from 07/01/2025 - 09/03/2025 and identified the following dates had 1 employee staffed to work first or second shift (during typical wake hours for residents when the above cares would be conducted), including the following: - All second shifts (2:00 p.m. - 10:00 p.m.) from 07/01/2025 through 07/23/2025, 07/25/2025, 07/28/2025 through 09/03/2025 - First shifts on 07/05/2025, 07/06/2025, 07/17/2025, 07/19/2025, 07/20/2025, 07/25/2025, 07/26/2025, 07/27/2025, 08/01/2025 through 08/03/2025, 08/09/2025 through 08/11/2025, 08/14/2025 through 08/18/2025, 08/23/2025, 08/24/2025, 08/30/2025, and 08/31/2025	N 396		
N 415	83.37(2)(d) Documentation of medication administration.	N 415		

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N 415	Continued From page 21 Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that at the time of medication administration the person administering the medication and/or treatment initialed the medication administration record (MAR). Resident 1's MARs from 07/01/2025 - 09/03/2025 contained121 blank entries across 32 days. Resident 2's MARs from 07/01/2025 - 09/03/2025 contained 67 blank entries across 21 days. Resident 3's MARs from 07/01/2025 - 09/03/2025 contained 15 blank entries across 11 days. Findings include: On 09/04/2025, Surveyor conducted a complaint investigation into concerns that medication administration was not being accurately documented.	N 415		

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N 415	Continued From page 22 Example 1 - Resident 1 On 09/04/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/21/2021 with diagnoses including metabolic disorder and neurotransmitter deficiency. Resident 1's individual service plan (ISP), dated 03/10/2025, identified that s/he required staff to administer g-tube feedings and medications. Resident 1's MARs from 07/01/2025 - 09/03/2025 contained the following 121 blank entries across 32 days of his/her prescribed medications and treatments: - 07/01/2025: Omeprazole 40 mg tablet (8:00 a.m.), lorazepam 1 mg tablet (8:00 a.m. and 8:00 p.m.), taurine 500 mg capsule (8:00 a.m.), vitamin B-50 tablet (8:00 a.m.), vitamin D3 25 mcg tablets (8:00 a.m.), vitamin B-12 1,000 mcg tablet (4:00 p.m.), 5-HTP 50 mg capsule (8:00 a.m. and 8:00 p.m.), betaine HCl capsule (8:00 a.m. and 8:00 p.m.), gamma-aminobutyric acid 100 mg capsule (8:00 a.m.), multivitamin tablet (8:00 a.m.), DHA 100 mg capsule (8:00 p.m.), hydroxyzine 25 mg tablet (8:00 p.m.), melatonin 5 mg tablets (8:00 p.m.), N-acetylcysteine 600 mg capsule (8:00 a.m. and 8:00 p.m.), Jevity g-tube feeding (3:00 p.m. and 5:00 p.m.) - 07/02/2025: Omeprazole 40 mg tablet (8:00 a.m.), zinc 50 mg tablet (8:00 a.m.), lorazepam 1 mg tablet (8:00 a.m. and 8:00 p.m.), taurine 500 mg capsule (8:00 a.m.), 5-HTP 50 mg capsule (8:00 a.m. and 8:00 p.m.), vitamin D3 25 mcg tablets (8:00 a.m.), vitamin B-50 tablet (8:00 a.m.), vitamin B-12 1,000 mcg tablet (4:00 p.m.), multivitamin tablet (8:00 a.m.), gamma-aminobutyric acid 100 mg capsule (8:00 a.m.), betaine HCl capsule (8:00 a.m. and 8:00 p.m.), DHS 100 mg capsule (8:00 p.m.),	N 415		

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hydroxyzine 25 mg tablet (8:00 p.m.), melatonin 5 mg tablets (8:00 p.m.), N-acetylcysteine 600 mg capsule (8:00 a.m., 4:00 p.m., and 8:00 p.m.), polyethylene glycol (4:00 p.m.), Jevity g-tube feeding (3:00 p.m. and 5:00 p.m.)

- 07/03/2025: Omeprazole 40 mg tablet (8:00 a.m.), lorazepam 1 mg tablet (8:00 a.m.), vitamin D3 25 mcg tablets (8:00 a.m.), taurine 500 mg capsule (8:00 a.m.), 5-HTP 50 mg capsule (8:00 a.m.), vitamin B-50 tablet (8:00 a.m.), betaine HCl capsule (8:00 a.m.), gamma-aminobutyric acid 100 mg capsule (8:00 a.m.), multivitamin tablet (8:00 a.m.), N-acetylcysteine 600 mg capsule (8:00 a.m. and 8:00 p.m.)

- 07/05/2025: Cranberry 250 mg capsule (8:00 a.m.), Jevity g-tube feeding (3:00 p.m. and 5:00 p.m.)

- 07/06/2025: Jevity g-tube feeding (5:00 p.m.)

- 07/09/2025: Lorazepam 1 mg tablet (8:00 a.m.)

- 07/11/2025: Hydroxyzine 25 mg tablet (8:00 p.m.)

- 07/18/2025: Triamcinolone 0.1% cream (8:00 a.m.)

- 07/19/2025: N-acetylcysteine 600 mg capsule (8:00 a.m.), 5-HTP 50 mg capsule (8:00 a.m.), DHA 100 mg capsule (8:00 a.m.), cetirizine 10 mg tablet (8:00 a.m.), CO Q-10 100 mg capsule (8:00 a.m.), cranberry 250 mg capsule (8:00 a.m.), carbamazepine 100 mg tablets (8:00 a.m.), betaine HCl capsule (8:00 a.m.), gamma-aminobutyric acid 100 mg capsule (8:00 a.m.), multivitamin tablet (8:00 a.m.), carbidopa-levodopa 25-100 mg tablets (7:00 a.m.

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and 12:00 p.m.), triamcinolone 0.1% cream (8:00 a.m. and 8:00 p.m.)

- 07/20/2025: 5-HTP 50 mg capsule (8:00 p.m.), betaine HCl capsule (8:00 p.m.), carbidopa-levodopa 25-100 mg tablets (8:00 p.m.), carbamazepine 100 mg tablets (8:00 p.m.), DHA 100 mg capsule (8:00 p.m.), hydroxyzine 25 mg tablet (8:00 p.m.), melatonin 5 mg tablets (8:00 p.m.), N-acetylcysteine 600 mg capsule (8:00 p.m.), Jevity g-tube feeding (5:00 p.m.), triamcinolone 0.1% cream (8:00 p.m.)

- 07/22/2025: Triamcinolone 0.1% cream (8:00 a.m.)

- 07/23/2025: Triamcinolone 0.1% cream (8:00 a.m.)

- 07/24/2025: Triamcinolone 0.1% cream (8:00 a.m.)

- 07/26/2025: Jevity g-tube feeding (5:00 p.m.), triamcinolone 0.1% cream (8:00 p.m.)

- 07/27/2025: Jevity g-tube feeding (5:00 p.m.), triamcinolone 0.1% cream (8:00 p.m.)

- 07/28/2025: Triamcinolone 0.1% cream (8:00 a.m.)

- 07/29/2025: Jevity g-tube feeding (5:00 p.m.), triamcinolone 0.1% cream (8:00 p.m.)

- 07/30/2025: Polyethylene glycol (4:00 p.m.), Jevity g-tube feeding (5:00 p.m.), triamcinolone 0.1% cream (8:00 p.m.)

- 07/31/2025: Jevity g-tube feeding (3:00 p.m.), Jevity g-tube feeding (5:00 p.m.), triamcinolone

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N 415	Continued From page 25 0.1% cream (8:00 p.m.) - 08/02/2025: Cetirizine 10 mg tablet (8:00 a.m.) - 08/05/2025: Jevity g-tube feeding (5:00 p.m.) - 08/06/2025: Jevity g-tube feeding (5:00 p.m.) - 08/07/2025: Jevity g-tube feeding (3:00 p.m. and 5:00 p.m.), melatonin 5 mg tablets (8:00 p.m.), polyethylene glycol (8:00 p.m.) - 08/10/2025: DHA 100 mg capsule (8:00 p.m.), lorazepam 1 mg tablet (8:00 p.m.) - 08/11/2025: Polyethylene glycol (8:00 p.m.) - 08/15/2025: Polyethylene glycol (8:00 p.m.) - 08/18/2025: Vitamin E 180 mg capsules (8:00 a.m.), probiotic tablet (8:00 a.m.) - 08/19/2025: Polyethylene glycol (8:00 p.m.) - 08/21/2025: Polyethylene glycol (8:00 p.m.) - 08/29/2025: Polyethylene glycol (8:00 p.m.) - 09/02/2025: Polyethylene glycol (4:00 p.m.), Jevity g-tube feeding (3:00 p.m.) - 09/03/2025: DHA 100 mg capsule (8:00 p.m.), Jevity g-tube feeding (3:00 p.m.) Example 2 - Resident 2 On 09/04/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 02/07/2024 with diagnoses including cerebral palsy and seizure disorder. Resident 2's ISP,	N 415		

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dated 06/12/2025, identified that s/he required staff to administer g-tube feedings and medications. Resident 2's MARs from 07/01/2025 - 09/03/2025 contained the following 67 blank entries across 21 days of his/her prescribed medications:

- 07/02/2025: Clindamycin 1% topical swab (8:00 a.m.)

- 07/05/2025: Jevity g-tube feeding (12:00 p.m.)

- 07/06/2025: Calcium 600 + vitamin D 400 tablet (8:00 a.m.), divalproex 125 mg capsule (8:00 a.m.)

- 07/08/2025: Divalproex 125 mg capsule (5:00 p.m.), lamotrigine 100 mg tablet (8:00 p.m.), risperidone 2 mg tablet (8:00 p.m.), Jevity g-tube feeding (8:00 p.m.), clindamycin 1% topical swab (8:00 p.m.)

- 07/11/2025: Jevity g-tube feeding (12:00 p.m.), clindamycin 1% topical swab (8:00 a.m.)

- 07/18/2025: Clonazepam 1 mg tablet (2:00 p.m.), Jevity g-tube feeding (12:00 p.m.)

- 07/19/2025: Calcium 600 + vitamin D 400 tablet (8:00 a.m.), divalproex 125 mg capsule (8:00 a.m.), famotidine 20 mg tablet (8:00 a.m.), fluoxetine 10 mg capsule (8:00 a.m.), fluoxetine 20 mg capsule (8:00 a.m.), Jevity g-tube feeding (12:00 p.m.)

- 07/20/2025: Calcium 600 + vitamin D 400 tablet (8:00 a.m. and 5:00 p.m.), divalproex 125 mg capsule (8:00 a.m.), divalproex 125 mg capsule (5:00 p.m.), famotidine 20 mg tablet (8:00 a.m. and 5:00 p.m.), fluoxetine 10 mg capsule (8:00

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a.m.), fluoxetine 20 mg capsule (8:00 a.m.), lamotrigine 100 mg tablet (8:00 a.m. and 8:00 p.m.), risperidone 2 mg tablet (8:00 p.m.), clonazepam 1 mg tablets (8:00 a.m., 2:00 p.m., and 8:00 p.m.), polyethylene glycol (8:00 a.m.), Jevity g-tube feeding (8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.), clindamycin 1% topical swab (8:00 a.m. and 8:00 p.m.)

- 07/22/2025: Jevity g-tube feeding (12:00 p.m.)

- 07/27/2025: Clonazepam 1 mg tablet (8:00 p.m.), Jevity g-tube feeding (9:00 p.m.), clindamycin 1% topical swab (8:00 a.m.)

- 07/28/2025: Clindamycin 1% topical swab (8:00 a.m.)

- 07/30/2025: Clindamycin 1% topical swab (8:00 p.m.)

- 07/31/2025: Jevity g-tube feeding (8:00 p.m.), clindamycin 1% topical swab (8:00 p.m.)

- 08/02/2025: Jevity g-tube feeding (4:00 p.m. and 8:00 p.m.)

- 08/07/2025: Calcium 600 + vitamin D 400 tablet (5:00 p.m.), lamotrigine 100 mg tablet (8:00 p.m.), risperidone 2 mg tablet (8:00 p.m.)

- 08/10/2025: Calcium 600 + vitamin D 400 tablet (5:00 p.m.), famotidine 20 mg tablet (5:00 p.m.)

- 08/18/2025: Jevity g-tube feeding (12:00 p.m.)

- 08/21/2025: Calcium 600 + vitamin D 400 tablet (5:00 p.m.)

- 08/31/2025: Calcium 600 + vitamin D 400 tablet

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(5:00 p.m.), Divalproex 125 mg capsules (8:00 p.m.), famotidine 20 mg tablet (5:00 p.m.), lamotrigine 100 mg tablet (8:00 p.m.), risperidone 2 mg tablet (8:00 p.m.), clonazepam 1 mg tablet (8:00 p.m.), Jevity g-tube feeding (8:00 p.m.), clindamycin 1% topical swab (8:00 p.m.)

- 09/01/2025: Azithromycin 200 mg/5 mL suspension (8:00 a.m.)

- 09/02/2025: Azithromycin 200 mg/5 mL suspension (8:00 a.m.)

Of note, from Surveyor's review of Resident 2's record on 09/04/2025, Resident 2's azithromycin had been prescribed during his/her last hospitalization from 08/29/2025 - 08/31/2025 which was due in part to concerns of possible aspiration pneumonia.

Example 3 - Resident 3

On 09/04/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 06/21/2021 with diagnoses including profound developmental disability and major depressive disorder. Resident 3's MARs from 07/01/2025 - 09/03/2025 contained the following 15 blank entries across 11 days of his/her prescribed medications:

- 07/03/2025: Acetaminophen 500 mg tablet (8:00 p.m.)

- 07/04/2025: Alprazolam 1 mg tablet (8:00 p.m.)

- 07/11/2025: Polyethylene glycol powder (8:00 a.m.)

- 07/12/2025: Alprazolam 1 mg tablet (8:00 a.m.)

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N 415	Continued From page 29 - 07/19/2025: Alprazolam 1 mg tablet (8:00 a.m.) - 07/20/2025: Alprazolam 1 mg tablet (8:00 a.m.) - 07/22/2025: Aripiprazole 5 mg tablet (8:00 a.m.) - 07/27/2025: Alprazolam 1 mg tablet (8:00 p.m.) - 07/28/2025: Multivitamin tablet (8:00 a.m.), senna 8.6 mg tablet (8:00 a.m.), sertraline 100 mg tablet (8:00 a.m.), alprazolam 0.5 mg tablet (8:00 a.m.), polyethylene glycol powder (8:00 a.m.) - 07/30/2025: Alprazolam 1 mg tablet (8:00 a.m.) - 07/31/2025 Melatonin 3 mg tablet (8:00 p.m.) INTERVIEWS: On 09/04/2025, at approximately 3:00 p.m., Surveyor interviewed Lead Caregiver A and Coordinator of Administrative Services (Coordinator) G. Both acknowledged Surveyor's concern of staff not consistently documenting residents' medication administration but said nothing further. On 09/12/2025, at approximately 9:58 a.m., Surveyor interviewed Coordinator G again about blank entries within resident MARs. Coordinator G reported understanding of Surveyor's concern.	N 415		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications,	N 416		

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treatments or preparations delivered vaginally or 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 any of the provider's staff were delegated by a registered nurse (RN) to administer medications via stomal or rectal administration.

Findings include:

On 09/04/2025, at approximately 11:10 a.m., Surveyor observed a medication pass. Surveyor observed Caregiver B prepare Resident 1's medications, which s/he then administered to Resident 1 through his/her gastrostomy tube (g-tube).

At approximately 12:35 p.m., Surveyor observed the medication storage area and observed a baggie containing suppositories. The pharmacy label on the baggie indicated that the suppositories were bisacodyl 10 mg suppositories, dispensed on 08/25/2025, and prescribed to Resident 4. The prescription directed to, "Insert 1 suppository rectally every other day at noon for constipation (hold if has bowel movement."

On 09/04/2025, Surveyor reviewed individual service plans (ISPs) for each of the home's residents. The ISPs for 2 residents - Residents 1 and 2 - identified that their daily medications were administered through their g-tubes.

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N 416	Continued From page 31 On 09/04/2025, Surveyor reviewed the August and September 2025 medication administration records (MARs) for Residents 1 and 2. Surveyor observed 21 different scheduled medications prescribed to Resident 1 with medication administration times of 7:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., 8:00 p.m. Surveyor observed 9 different scheduled medications prescribed to Resident 2 with medication administration times of 8:00 a.m., 2:00 p.m., 5:00 p.m., and 8:00 p.m. On 09/04/2025, Surveyor reviewed Resident 3's prescriptions. One of Resident 3's listed medications included an as-needed (PRN) bisacodyl 10 mg suppository, with an active date of 02/26/2025 and instructions to, "Insert 1 suppository rectally once daily as needed for constipation." On 09/04/2025, Surveyor reviewed the staff schedule for August and September 2025, which identified that the following staff worked shifts alone in the home: Lead Caregiver A, Caregiver C, Caregiver D, and Caregiver E. On 09/04/2025, at approximately 2:15 p.m., Surveyor requested the delegation records for the provider's staff from Coordinator of Administrative Services (Coordinator) G. At approximately 2:30 p.m., Lead Caregiver A then provided Surveyor a binder (Photo 1). The cover page was titled, "RN delegated task training binder." Within the binder, Surveyor observed a "Medication Administration Evaluation Form" which was completed for staff. The form outlined general medication administration procedures as separately numbered tasks and identified "trials" in which an evaluator checked off that the staff	N 416		

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N 416	Continued From page 32 being evaluated successfully demonstrated that procedure. The procedures included tasks like verifying the prescription label, offering water, initialing the MAR, and ensuring secure medication storage. Two of the tasks specifically referenced oral medications (" ...Encouraged the individual to put medication directly in mouth from cup," and, "Staff watched for the person to swallow the medication ...") Evaluators were identified on the forms as either Lead Caregiver A or Licensed Practical Nurse (LPN) F. There was no mention of medications administered rectally or via g-tube. There was no evidence that the staff being evaluated were specifically delegated by a registered nurse to administer medications stomally or rectally. At approximately 3:00 p.m., Surveyor interviewed Lead Caregiver A and Coordinator G. Lead Caregiver A reported that LPN F did training checks with staff and from what s/he recalled, LPN F had last been on site to review medication administration with staff back in July. Coordinator G identified that RN H was the registered nurse associated with the provider. Lead Caregiver A denied having received any training, instruction, or supervision by RN H in administering medications via stomal or rectal administration. On 09/05/2025, at approximately 11:46 a.m., Coordinator G e-mailed Surveyor and confirmed that the only delegation documents were the evaluation forms already reviewed by Surveyor (described above).	N 416		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the	N 431		

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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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review, observation, and interview, the provider did not ensure that the health of Residents 1 and 2 was monitored.

There was no process followed by staff, either through documentation or observation, to monitor Resident 1's oral water intake as directed in his/her individual service plan (ISP). Resident 1 was diagnosed with hypernatremia, reportedly had a history of dehydration-related concerns, and had a minimum amount of water s/he was directed to have from either gastrostomy tube

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flushes or oral intake.

Resident 2 was admitted to the hospital from 08/29/2025 until the afternoon of 08/31/2025. On the morning of 09/01/2025, Lead Caregiver A observed multiple areas of skin breakdown on Resident 2's right abdomen. Lead Caregiver A thought that they occurred while Resident 2 was hospitalized but had no evidence of this. Lead Caregiver A reported having spoke with a nurse from Resident 2's primary care clinic about the skin concern but had no documentation of this communication. Despite Licensed Practical Nurse (LPN) F being made aware of the concern, no follow up assessment or monitoring was conducted or documented by staff and there was no evidence of the skin breakdown areas having been monitored since onset.

Findings include:

Example 1 - Resident 1 total daily hydration monitoring

On 09/04/2025, Surveyor conducted a survey at the provider's home and was onsite from approximately 9:00 a.m. - 12:56 p.m. and 1:40 p.m. - 4:05 p.m. Throughout the survey period, Surveyor made observations of Resident 1, who, for most of first portion of time, sat in his/her wheelchair with a lap tray in the living area and for most of the second portion of time remained in his/her room. Resident 1 was observed at times with a pink-colored opaque water bottle. During lunch, which occurred at approximately 11:10 a.m., Surveyor heard Caregiver B occasionally cue Resident 1 to drink water from his/her bottle while s/he fed him/her.

On 09/04/2025, Surveyor reviewed Resident 1's

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record. Resident 1 was admitted to the provider on 06/21/2021 with diagnoses including hypernatremia and intellectual disability. Resident 1 was documented as being "at times" verbal with yes/no responses and being able to verbalize "a few key phrases." Resident 1 was documented as having a legal guardian and needing total assistance for self-cares. Within Resident 1's current ISP, dated 03/10/2025, under the "Diet" heading, the following was detailed: "[Resident 1] is to drink 1 extra 16oz. bottle of water added to [his/her] current amount." Underneath that, a g-tube water flush schedule was documented. Underneath the schedule, the following was documented: "To meet Hydration [sic] needs: [Resident 1] is to receive: 2400 mL water by mouth daily to be given as indicated below:

"500 mL water with each meal if [Resident 1] chooses ...
"300 mL water between breakfast and lunch
"300 mL water between lunch and supper
"300 mL water after supper
"If [Resident 1] is unable to consume all 2400 mL water orally staff should administer the remainder of the water via g tube in the evening."

Throughout Surveyor's onsite period, Surveyor did not observe Caregivers B and C, the 2 staff working, to monitor Resident 1's water intake other than when approximately 500 mL was measured and administered to Resident 1 when his/her lunchtime medication was administered at approximately 11:10 a.m. Surveyor observed that that flush loosely aligned with his/her g-tube flush schedule from the ISP, which specifically directed for an 800 mL flush to be conducted with administration of his/her noon medication.

At approximately 3:00 p.m., Surveyor interviewed

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Lead Caregiver A and Coordinator of Administrative Services (Coordinator) G. Both acknowledged Surveyor's concern that neither Caregivers B nor C, the staff who worked during the onsite survey period, were observed to have accounted for Resident 1's oral water intake. Lead Caregiver A reported that staff could generally see what Resident 1 was drinking by seeing through his/her water bottle. When Surveyor reported that Resident 1's water bottle that day was an opaque pink, Lead Caregiver A said nothing further. Lead Caregiver A reported s/he was not sure how handoff between shifts occurred for staff to account for Resident 1's total daily oral water intake. Lead Caregiver A reported that Resident 1's hydration monitoring was related to past concerns of Resident 1 having experienced dehydration. When asked where staff would document Resident 1's oral water intake, Lead Caregiver A replied that if staff were documenting it, it would be in the provider's communication book, where staff documented routine daily charting on the residents. In reviewing the book, which included daily charting notes in September and August, Surveyor observed no evidence of Resident 1's oral water intake having been accounted for.

Example 2 - Resident 2's abdomen skin changes

On 09/04/2025, at approximately 11:30 a.m., Surveyor observed Caregiver B administer a g-tube feeding to Resident 2. After lifting Resident 2's shirt to expose his/her g-tube insertion area, Caregiver B was observed briefly inspecting Resident 2's abdomen. Surveyor observed 3 separate areas of skin breakdown at Resident 2's right abdomen - 2 which were approximately half-dollar sized and appeared like blisters, with redness and peeling skin around the edges, and

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	0018568	A. BUILDING: _____ B. WING _____	C 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EICKSTAEDT	101 EICKSTAEDT LANE 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
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1 which appeared as a dime-sized area of redness with a pinpoint area of skin breakdown in the middle. Caregiver B reported that Resident 2's skin looked better than it had previously. Lead Caregiver A then approached, observed Resident 2's abdomen, and agreed.

At approximately 12:50 p.m., Surveyor interviewed Lead Caregiver A about Resident 2's skin breakdown areas. Lead Caregiver A reported that Resident 2 "came home from the hospital with them." Lead Caregiver A clarified that Resident 2 had been recently admitted to the hospital but arrived back to the provider's home at approximately 3:30 p.m. on 08/31/2025. Lead Caregiver A reported that s/he arrived for work on 09/01/2025 at 6:00 a.m. and saw Resident 2's skin concerns then. Lead Caregiver A reported that prior to him/her seeing the skin breakdown for him/herself s/he never received any report from staff about the areas and could not find any records/notes about them. When asked how Lead Caregiver A was able to confirm that Resident 2 came home from the hospital with the skin breakdown areas, Lead Caregiver A clarified that s/he didn't actually know that and s/he just knew that the marks had appeared at some point prior to his/her shift. Lead Caregiver A confirmed that there would have been 2 other staff who worked shifts between the time Resident 2 came from the hospital and his/her own shift - the afternoon/evening (PM) shift staff member and the overnight (NOC) shift staff member. Lead Caregiver A confirmed that at least one of them would have conducted cares for Resident 2 in that timeframe.

As part of the same interview, Lead Caregiver A reported that s/he reported Resident 2's skin concerns to LPN F and spoke with a nurse from

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Resident 2's primary care provider's (PCP's) office. Lead Caregiver A reported that the nurse from the office said that they would take a look at the areas during Resident 2's next medical appointment, which was scheduled for 09/12/2025 as a post-hospitalization visit. Lead Caregiver A denied having any record of this communication. Regarding the communication with LPN F, Lead Caregiver A provided Surveyor an e-mail exchange. Surveyor reviewed the following from the exchange:

- E-mail from Lead Caregiver A to LPN F and Program Manager I on 09/01/2025 (11:02 a.m.): " ...When getting [Resident 2] ready for the day noticed this on [him/her]. [S/he] must of [sic] come home from the hospital with this on [him/her]." A picture was attached showing Resident 2's right abdomen, with the 3 areas of skin breakdown. The 2 larger areas appeared larger than half-dollar sized. Both of those areas showed a central area of skin breakdown surrounded by larger areas of redness (including darker red outlines).

- E-mail reply from LPN F to Lead Caregiver A on 09/02/2025 (12:11 p.m.): "That looks like a possible allergic reaction. Is [s/he] on anything new?"

- E-mail from Lead Caregiver A to LPN F on 09/02/2025 (2:15 p.m.): "Just the antibiotics [s/he] came home with."

Lead Caregiver A confirmed that there was no other follow up or response from LPN F.

On 09/04/2024, Surveyor reviewed the provider's communication binder, where staff documented routine daily charting on the residents. In

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N 431	Continued From page 39 reviewing the notes from 08/31/2025 - 09/04/2025, Surveyor did not observe any notes regarding Resident 2's skin concerns. On 09/04/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 02/07/2024 with diagnoses including cerebral palsy and intellectual and developmental disorder. Resident 2 was documented as having a legal guardian, not able to make his/her needs known, requiring total assistance for self-cares, and not being verbal other than to say a few words or communicate with body language and facial expressions.	N 431		