STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019389	A. BUILDING: _____ B. WING _____	C 09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSING MATTERS 2 LLC	21470 LEES CT BROOKFIELD, WI 53045

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N 000	Initial Comments On 09/15/2026 with information gathered through 09/22/2026, Surveyor conducted 1 complaint investigation at Housing Matters 2 LLC. Two deficiencies were identified. Census: 6	N 000		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure copies of the resident record was made available within 30 days after requested in writing to the resident's legal representative. Licensee A did not provide Family Member C, Resident 1's Power of Attorney for Health Care (POAHC) agent/legal representative, with a copy	N 346		

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

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N 346	Continued From page 1	N 346		

of Resident 1's medication administration record (MAR) dated 05/01/2026-07/13/2026, as requested in writing.

Findings include:

On 07/22/2026, the Department received a complaint regarding resident records.

Screen shots of text messages received (via email 08/27/2026 10:41 PM) from Family Member C:
-07/10/2026 8:40 AM text from Family Member C to Licensee A " ...Please also provide [Resident 1's] Medical Administration chart from May 1st to present. With all the changes that happened during this time just need a visual to go along with the resident of [his/her] chart ..."
-07/13/2026 10:33 AM text from Family Member C to Licensee A " ...Also, please advise when I will receive the documentation previously requested regarding [Resident 1's] med administration chart from May 1st to the present date so I can pay the [name of pharmacy] bill."
-07/15/2026 11:49 AM text from Family Member C to Licensee A " ...Also following up and final request for the med chart documentation that has been requested. We are not moved out yet, so I'm still expecting responses to my reasonable requests and that they won't go ignored."
Licensee A responded via text " ...Unfortunately, my staff and I continue to feel harassed by you. I would like for this to stop as this is awkward for our home and [Resident 1's initials] ..."

On 09/15/2026 at 11:16 AM, Surveyor interviewed Licensee A who stated Family Member C asked for Resident 1's records but it felt like harassment because s/he (Licensee A) was having trouble with the electronic medical record and Family

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Member C was asking for "a bunch of bizarre stuff we couldn't provide." Licensee A stated s/he requested a meeting with the managed care organizations (MCO) case manager to discuss concerns but never received a meeting date and then Resident 1 moved. Licensee A stated s/he told Family Member C and the MCO case manager about the issues with the electronic medical record and pharmacy. Licensee A stated Resident 1 should have requested the record, and s/he (Licensee A) did not remember receiving the request for the record in writing. Licensee A stated s/he was not sure if Resident 1's POAHC was activated or not (Note: When a POAHC is activated, the designated agent becomes legal representative for health care decisions). Licensee A stated s/he handled it the best way s/he could. Surveyor reviewed DHS 83.32(3)(b) with Licensee A who stated s/he would like his/her lawyer available to interpret the regulation.

On 09/15/2026, Surveyor reviewed Resident 1's record (note: Licensee A did not provide a facility face sheet with admission date).
Admission agreement was signed 11/08/2025 by both Resident 1 and Family Member C.

POAHC document created 07/21/2025 by Resident 1 designated Family Member C as primary health care agent. The record did not contain a POAHC activation form.

The record contained a MCO face sheet stating " ...[Family Member C] ...Durable Power of Attorney - Health- Activated ..." and MCO Care Plan dated 04/01/2026 stating " ... [Durable Power Of Attorney - Health Care] activated [Family Member C's name] ..."

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N 346	Continued From page 3 On 09/18/2026 at 3:57 PM, Surveyor interviewed Licensee A who stated without a POAHC activation form they had not established Family Member C was the POAHC agent (legal representative) and s/he told Resident 1 if s/he needed anything to let him/her (Licensee A) know. Licensee A stated the MCO face sheet was incorrect because s/he (Licensee A) was never shown proof the POAHC document was activated. Licensee A stated at time of admission s/he had both Resident 1 and Family Member C sign the admission agreement to cover all bases. Licensee A stated s/he did not know if s/he (Licensee A) communicated to Family Member C that s/he (Licensee A) did not have the POA-HC activation form. On 09/18/2026 at 4:16 PM, Surveyor interviewed MCO Case Manager D who stated Resident 1's POAHC document was activated when Resident 1 was enrolled with the MCO. On 09/21/2026 at 3:16 PM, Surveyor received Resident 1's POA-HC activation form via fax from the MCO. The activation form was signed into effect on 11/13/2025. On 09/22/2026 at 3:25 PM, Surveyor discussed concern regarding not providing Resident 1's record to Family Member C with Licensee A. Licensee A stated Resident 1's POA-HC document's activation form was never provided to him/her despite his/her requesting it multiple times, and the MCO told him/her they were in the process of setting up a meeting to discuss concerns. As of 09/22/2026, Licensee A had not provided Family Member C Resident 1's record.	N 346		

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N 432	Continued From page 4	N 432		
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 interview and record review, the provider did not ensure that the CBRF provided medication administration appropriate to Resident 1's needs. Resident 1, who required staff assistance with medication administration was provided his/her medication by Resident 2. Findings include: The facility is licensed as a Class AA (ambulatory) CBRF able to serve up to 8 residents within the client groups of traumatic brain injury, advanced aged, developmentally disabled, emotionally disturbed/mental illness and irreversible dementia/Alzheimer's. According to the guidebook developed by the University of Wisconsin - Green Bay for its trainers' medication administration courses,	N 432		

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approved by the Department, CBRF staff who administer medications are directed to, "Observe the resident to ensure that the medication was ingested if taken orally," (Source: University of Wisconsin - Green Bay, Medication Administration Training Participant Guide, March 2020).

On 07/22/2026, the Department received a complaint alleging inappropriate medication administration.

On 09/15/2026 at 11:09 AM, Surveyor interviewed Resident 2 who stated one time staff had him/her take medications to Resident 1.

On 09/15/2026 at 11:16 AM, Surveyor interviewed Licensee A who stated on 07/12/2026 Resident 1 was being vicious toward Caregiver B. Licensee A stated Resident 2, who generally followed staff around, took the cup, containing Resident 1's medications and labeled with Resident 1's initials, off the table and delivered it to Resident 1. Licensee A stated s/he then had a 20-minute conversation with Caregiver B reiterating only staff were allowed to administer medications.

On 09/15/2026 at approximately 10:45 AM, Surveyor requested Resident 1's record including facility face sheet and individual service plan with signature sheet from Licensee A.

On 09/15/2026, Surveyor reviewed Resident 1's record. Admission agreement was signed 11/08/2025 (Note: Licensee A did not provide a facility face sheet with admission date). Diagnoses included: multiple sclerosis, unspecified; overactive bladder; constipation; and insomnia.

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Schedule physician orders included: dimethyl fumarate 240 MG 1 capsule twice daily (start date 05/12/2026); melatonin 10 MG 1 capsule at bedtime for insomnia (start date 06/10/2026) and evening primrose 500 MG 2 capsules once daily at bedtime (start date 05/05/2026).

July 2026 Medication Administration Record (MAR):
On 07/12/2026, Caregiver B documented s//he administered 8:00 PM dimethyl fumarate, melatonin and evening primrose to Resident 1.

Managed care organization (MCO) Care Plan dated 04/01/2026 identified medications were managed by CBRF staff.

30 Day Assessment (received from Licensee A on 09/23/2026 at 7:57 AM via email) (Note: Licensee A did not provide an individual service plan):
In the area of Medication Management- "
...Needs assistance administering medications
...To receive assistance from staff administering medications ..."

On 09/22/2026 at 3:25 PM, Surveyor discussed concern of Resident 2 delivering Resident 1's medications with Licensee A. Licensee A stated Caregiver B was frustrated because s/he cooked dinner, Resident 1 refused dinner and went to his/her room, then returned asking for dinner and returned to his/her room again. Licensee A stated Resident 2 saw Caregiver B was frustrated and when Caregiver B took his/her eyes off of the cup containing Resident 1's medication, Resident 2 took the cup to Resident 1's room in the basement. Licensee A stated Resident 2 was trying to be helpful since his/her room was also in the basement and was on his/her way to his/her own room anyway. Licensee A stated s/he

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N 432	Continued From page 7 discussed concern with Caregiver B that night.	N 432		