STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015156	A. BUILDING: _____ B. WING _____	08/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON HOUSE	2956 S 60TH ST MILWAUKEE, WI 53219

(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 08/04/2026 with information gathered through 08/10/2026, Surveyor conducted a standard survey and a self-report review at Jackson House. One deficiency was identified. Census: 11	N 000		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the prescribing practitioner, supervising nurse or pharmacist, as soon as possible, after 1 of 2 residents (Resident 1) reviewed missed medications for more than 2 consecutive days. Findings include: On 08/04/2026 at approximately 11:00 AM,	N 410		

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

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N 410	Continued From page 1 Surveyor reviewed Resident 1's record. Resident 1 was admitted on 12/13/2017 with diagnoses including schizoaffective disorder bipolar type. Resident 1's individual service plan (ISP), dated 03/03/2026, indicated staff assisted Resident 1 with medication management and administration. Resident 1's record did not identify correspondence from the provider with Resident 1's prescribing physician about missed medications. Resident 1's medication administration record (MAR) indicated Resident 1 was prescribed to take olanzapine 20 milligrams (medication to treat bipolar disorder) at bedtime. Resident 1's July 2026 MAR indicated Resident 1 refused olanzapine on the following dates: July 1st, 2026 July 2nd, 2026 July 3rd, 2026 July 4th, 2026 July 5th, 2026 July 6th, 2026 July 7th, 2026 July 8th, 2026 July 13th, 2026 July 17th, 2026 July 18th, 2026 July 19th, 2026 Progress note, dated 07/16/2026 at 8:27 AM, authored by Clinical Coordinator B (CC B), confirmed Psychiatrist C was notified of Resident 1's medication noncompliance during a staffing meeting on that day. On 08/04/2026, Surveyor reviewed the department records and identified the provider	N 410		

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N 410	Continued From page 2 submitted a self report related to Resident 1. The self report, dated 07/20/2026, identified, on 07/19/2026 at 7:20 AM staff could not locate Resident 1. Staff reported Resident 1 was up all night going in and out of the home. Staff reported this behavior had been going on for the past couple of nights. When trying to locate Resident 1, staff called Resident 1's family. Resident 1's family reported Resident 1 was found behind a grocery store with a gun next to him/her, and a bullet wound to the head. Resident 1 was deceased. On 08/10/2026 at 10:05 AM, Surveyor interviewed Resident Coordinator A who confirmed CC B is responsible for contacting the prescribing physician regarding medication concerns. Surveyor reviewed DHS 83.37(1)(k)2 (this requirement) requirement that indicated prescribing physicians should be notified as soon as possible, after a resident missed medications for more than 2 consecutive days. Resident Coordinator A confirmed they would review this with CC B and all staff involved with medication administration.	N 410		