Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012348	A. BUILDING: ______ B. WING ______	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVE-A-HEART ADULT DAY CARE	**W10356 HWY 29 RIVER FALLS, WI 54022**

(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
E 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted on 09/30/2025 at Have A Heart Adult Day Care Center in River Falls, WI. Have A Heart Adult Day Care Center is out of compliance with the Wisconsin Administrative Code DHS (Department of Health Services) 105.14 for Adult Day Care Centers. Census on the day of survey was 8. Citations are issued. Square Footage of the facility is 1841 square feet. The facility is able to serve 36 participants and is currently licensed for 30.	E 000		
E 175	105.14(4)(e)1-2. DOCUMENTATION OF EMPLOYEE TRAINING 1. The ADCC shall maintain documentation of orientation and all the applicable training under sub. (4), pars. (a), (b) and (d) of this section. Documentation shall include the name of the employee, the name of the instructor, the dates of training, a description of the course content, and the length of the training. 2. Orientation, training, and hours of continuing education shall be documented in the employee's file. This Rule is not met as evidenced by: Based on record review and interview the facility failed to document orientation for 1 (Program Director A) of 1 Program Director files reviewed, and failed to document ongoing training and task specific training for 2 (Caregiver B and C) of 2 caregiver files reviewed. Findings:	E 175		

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

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Review of Program Director A's employee file hire date of 02/24/2025 revealed no evidence of orientation completed upon hire and no evidence of ongoing training completed as of 09/30/2025. Review of Caregiver B's personnel file hire date of 08/18/2025 revealed no evidence of completed training for handwashing, standard precautions or safe food handling and no evidence of education on task specific training for Participant #1. Review of Caregiver C's personnel file hire date of 08/04/2025 revealed no evidence of completed training for handwashing, standard precautions or safe food handling and no evidence of education on task specific training for Participant #1.

Review of Participant #1's medical record revealed Participant #1 had a Belly Button Mitrofanoff (a surgically created channel that connects the bladder to a small opening in the belly button) and no evidence of the catheterization procedure, care of the site or frequency of the procedure was documented in participant #1's medical record. Ongoing review of Participant #1's enrollment information revealed Participant #1 had to be fed pureed foods due to their inability to chew and swallow solid foods.

On 09/30/2025 at 10:00 AM during a tour and observation with Program Director A, observed Staff B wash their hands, apply gloves, open a cabinet and remove a catheter and supplies, lay the catheter supplies on the plastic cot, clean Participant #1's belly button, open the sterile catheter and apply lubricant to the tip then insert the catheter into Participant #1's belly button. Staff B used the same pair of gloves for the entire procedure. When Staff B was asked how they knew to do the procedure and when to wash their

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hands, Staff B said, "I was trained by one of the other staff that used to work here."

On 09/30/2025 at 10:05 AM an interview was conducted with Program Director A, A stated, "I was trained by the guardian. We do this procedure at 10 AM and 1 PM." When Director A was asked for evidence of training, Director A stated, "We didn't document it."

On 09/30/2025 at 11:20 AM observed Caregiver C feeding Participant A a pureed lunch. Participant A was observed to cough periodically after being given a spoonful of food.

An interview was conducted with Program Director A on 09/30/2025 at 3:00 PM, when Director A was asked if the training was documented, A stated, "No, it is part of the Relias (computer program) training and it's not completed yet."

E 200 105.14(7)(b)1. SERVICE PLAN: DEVELOPED WITHIN 30 DAYS E 200

Within 30 days of enrollment and based on the assessment completed under par. (a) of this subsection, the ADCC shall develop and implement a service plan to identify the services and activities the program will provide in order to meet the individual needs and personal interests of the participant. The service plan shall be developed by staff members with experience, or training pertinent to the participant population served by the program.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to develop and implement an individual

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service plan (ISP) identifying the services and activities provided by the facility to meet the individual needs and interests of each participant within 30 days of enrollment for 13 (Participant #1- #13) of 13 participants enrolled at the facility.

Findings Include:

A review of 13 Participant Medical records revealed the following:
Participant #1 was enrolled on 04/01/2022 an ISP was completed on 10/25/2023, 18 months and 24 days after enrollment.
Participant #2 was enrolled on 11/20/2024, no ISP was completed
Participant #3 was enrolled on 08/05/2024, an ISP was completed on 05/30/2025, 9 months and 25 days after enrollment. Participant #3 was involuntarily discharged on 06/16/2025 due to unmanageable behaviors and negative interactions between staff and other participants.
Participant #4 was enrolled on 08/05/2024, an ISP was completed on 06/16/2025, 10 months and 11 days after enrollment.
Participant #5 was enrolled on 04/19/2023, an ISP was completed on 05/26/2023, 1 month and 7 days after enrollment.
Participant #6 was enrolled on 11/17/2023, no ISP was completed.
Participant #7 was enrolled on 03/09/2023, an ISP was completed on 06/25/2025, 15 months and 16 days after enrollment.
Participant # 8 was enrolled on 01/09/2025, no ISP was completed.
Participant #9 was enrolled on 04/12/2024, no ISP was completed.
Participant #10 was enrolled on 04/12/2024, no ISP was completed.
Participant #11 was enrolled on 04/12/2024, no ISP was completed.

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Participant #12 was enrolled on 06/24/2025, no ISP was completed.
Participant #13 was enrolled on 05/21/2024, and ISP was completed on 06/25/2025, 13 months and 4 days after enrollment.

On 09/30/2025 at 3:30 PM in an interview with Program Director A, Director A said, "All have been over a year without any ISP." When asked how can you meet the needs of the participants if you don't have a completed ISP, Director A said, "We weren't aware they weren't completed until we tried to discharge [Participant #3] and didn't have documentation of what was happening. We realized none had been completed. The previous director had left and I started in February. I've only completed 4 ISP's, it is hard to complete them when I'm also helping with programming."

E 201

105.14(7)(b)2. SERVICE PLAN: REVIEW AT LEAST EVERY 6 MONTHS

The service plan will be reviewed and revised every 6 months or when necessary due to changes in the participant's functioning, health condition, or preferences. Changes shall be documented in the participant's record.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to review and revise the Individual Service Plan (ISP) every 6 months or more frequently due to changes in the participants functioning, health condition or preferences for 2 (Participant #1 and Participant #5) of 13 participant records reviewed.

Findings:

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Participant #1 was enrolled on 04/01/2022 an ISP was completed on 10/25/2023, 18 months and 24 days after enrollment.
Participant #5 was enrolled on 04/19/2023, an ISP was completed on 05/26/2023, 1 month and 7 days after enrollment.

Ongoing review of Participant #1 and Participant #5's medical records revealed no evidence of every 6 month review of the ISP's.

On 09/30/2025 at 3:30 PM in an interview with Program Director A, when asked if the above findings were correct, Program Director A stated, "That is correct."

E 206 — 105.14(7)(c)6. STAFFING: WRITTEN SCHEDULE — E 206

The ADCC shall maintain a current written schedule for every caregiver at the ADCC. The schedule shall include each caregiver's full name, job assignment, and time worked.

This Rule is not met as evidenced by:
Based on interview the facility failed to maintain a written schedule that included the caregiver's full name, job assignment and time worked for 3 (Program Director A, Caregiver B and C) of 3 caregivers working at the facility.

Findings:

In an interview with Program Director A on 09/30/2025 at 9:45 AM when asked for the written staff schedule and assignments for staff working on 09/30/2025. Program Director A stated, "I don't have a written schedule. All the staff we

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E 206	Continued From page 6 have work everyday and work with everyone here."	E 206		
E 210	105.14(7)(d)3.a-f. MEDICATIONS: CAREGIVER ADMINISTRATION REQS Caregiver administered medications shall be stored, obtained, and assembled for the participant. The caregiver is responsible for ensuring the correct medication, in the correct dose, at the correct time is administered to the correct participant. Medications administered by a caregiver shall meet all of the following conditions: a. A written order from the prescribing practitioner shall be in the participant's record. b. A listing of current medications with the dosage, frequency, and route of administration shall be in the participant's record. c. Over-the-counter and prescription medications shall remain in the original labeled containers and be stored in a locked, safe place. d. Non-licensed caregivers shall consult with the prescribing practitioner or pharmacist about each medication to be administered. e. Written information describing side effects and adverse reactions of each medication shall be kept in the participant's record. f. The administration of medications shall be documented in the participant's permanent record to include the name of the medication, dosage, method of administration, date and time administered, and name of the caregiver who administered the medication. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to have a written order	E 210		

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from the prescribing practioner indicating the dose, frequency, route, side effects and adverse reactions for 2 Participants (Participant #2 and #3) of 2 participants receiving scheduled medications at the facility and failed to keep all prescription medications in the original labeled container in 1 of 1 medication administration programs reviewed.

Findings:

Review of Facility Policy no date, titled, "Medication Administration, Storage and Disposal Policy," revealed, "Prescription medication...can only be given under the following conditions:...Prescription medication must be in its original container from the pharmacy and labeled with the participants, name of the drug, dosage, directions for administration, date and physician's name."

Review of Participant #2's medical record revealed a medication order for Gabapentin (anti-seizure) medication and Baclofen (antibiotic) medication. Ongoing review of #2's medical record revealed no indications for frequency, route, side effects, adverse reactions or purpose.

Review of Participant #3's medical record revealed a seizure action plan that listed the following daily seizure medications of Anfi/Clobazan (anti-convulsant), Valoporic Acid (anti-convulsant, mood stabilization), Ethosuximide (anti-convulsant for absence seizures), Sabril (anti-seizure), and Memantine (improve memory). Ongoing review of #3's medical record revealed no indications for dose, frequency, route, side effects, adverse reactions or purpose and no physician's order for the above listed medications.

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E 210	Continued From page 8 These findings were confirmed by Program Director A on 09/30/2025 at 3:10 PM. On 09/30/2025 at 10:15 AM during a tour and observation of the medication area with Program Director A, observed a yellow plastic container, no label, containing multiple different sized pills. When Program Director A was asked what this container held, Program Director A stated, "[Participant #2's] Mom gives it to us and then staff adds it to the prescription bottle."	E 210		
E 216	105.14(7)(e)5. PROGRAM SERVICES: HEALTH MONITORING Based on the written description of the program, the ADCC shall provide or arrange for services to meet the needs of each participant in all of the following areas: 5. 'Health monitoring.' The ADCC shall monitor the health of a participant by observing and documenting changes in each participant's health and referring a participant to health care providers when necessary. At a minimum, a quarterly note shall document how a participant is responding to the service plan. The ADCC shall immediately notify the participant's legal representative and the participant's residential provider, if any, when there is a significant change in a participant's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview the facility failed to assess and monitor 13 (Participant #1-#13) of 13 participants and document how each participant was responding to their service plan at	E 216		

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E 216	Continued From page 9 least quarterly in 13 (Participant #1- #13) of 13 medical records reviewed. Findings: A review of Participant #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13's medical records revealed no evidence of assessment or documentation of how each participant was responding to their service plan. These findings were confirmed by Program Director A on 09/30/2025 at 3:30 PM.	E 216		
E 231	105.14(7)(f)6.a-c. FOOD SAFETY: STORE, PREPARE, SERVE TEMPS Whether food is prepared at the ADCC or off-site, the ADCC shall store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The ADCC shall do all of the following: a. Refrigerate and store all foods requiring refrigeration at or below 41 degrees Fahrenheit. Food items not in their original containers shall be covered, labeled and dated. b. Maintain freezing units at 0 degrees Fahrenheit or below. Frozen foods shall be packaged, labeled, and dated. c. Hold hot foods at 135 degrees Fahrenheit or above and cold foods at 41 degrees Fahrenheit or below until served. This Rule is not met as evidenced by:	E 231		

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Based on observation, record review and interview the facility failed to identify professional food safety standards to follow in preparing, distributing and serving food and failed to hold hot foods at 135 degrees Fahrenheit or above in 1 of 1 food programs observed.

Findings:

On 09/30/2025 at 10:15 AM during a tour and observation of the kitchen and food preparation areas with Program Director A, when asked how the food temperatures are checked prior to food being given to participants, Program Director A said, "We don't take temperatures, I don't know what the temperature is supposed to be at." When asked what food safety standards are followed, Program Director A had no answer.

On 09/30/2025 at 11:20 AM observed Staff C feeding Participant #1 a bowl of hot food. When Staff C was asked how the food was heated up to the correct temperature, Staff C said, "I heat it up for 30 seconds in the microwave and if it is too hot I put it in the freezer to cool it down." When asked how did you know if it was too hot, Staff C said, "I can tell by how hot it is in my hands or I put my finger in it to test it." When asked if Staff C ever used a thermometer to make sure the food was hot enough, Staff C said, "No."

E 233 — 105.14(7)(f)6.e. FOOD SAFETY: STORAGE CLEAN, DRY, OFF FLOOR — E 233

Whether food is prepared at the ADCC or off-site, the ADCC shall store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The ADCC shall do all of the following:

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E 233	Continued From page 11 e. Keep food storage areas clean and dry and store food at least six inches off the floor. This Rule is not met as evidenced by: Based on observation and interview the facility failed to store food in accordance with professional standards of food safety and failed to remove expired foods from 1 (Kitchen) of 2 food storage areas observed. Findings: On 09/30/2025 at 9:50 AM during a tour and observation of the kitchen food storage area with Program Director A, observed the following expired foods in the dry storage cupboard in the kitchen: 1 bottle of pedialyte (electrolyte) solution expiration date of 08/01/2025 1 open package of vanilla wafers, no open date, expiration date of 09/27/2025 1 open box of thin wheat crackers, no open date, expiration date of 07/05/2025 1 sealed box of thin wheat crackers, expiration date of 12/29/2024 1 open box of graham crackers, no open date, expiration date of 11/01/2024 1 open box of pretzels, no open date, expiration date of 02/24/2025 In an interview on 09/30/2025 at 9:50 AM, Program Director A stated, "We check for outdates, these shouldn't be here."	E 233		
E 244	105.14(8)(b)3. WATER SUPPLY: TEMPERATURES	E 244		

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The ADCC shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140 degrees Fahrenheit. The temperature of hot water at plumbing fixtures used by residents may not exceed the range of 110 to 115 degrees Fahrenheit.

This Rule is not met as evidenced by:
Based on observation and interview the facility failed to set the temperature of 1 of 1 water heaters observed at a temperature of at least 140 degrees Fahrenheit and failed to ensure the hotwater at plumbing fixtures used by residents to not exceed the range of 110 to 115 degrees Fahrenheit in 1 of 1 plumbing fixtures observed.

Findings:

During a tour and observation on 09/30/2025 at 9:45 AM with Program Director A, observed the bathroom sink used by participants to register a temperature of 116 degrees Fahrenheit. When Program Director A was asked if sink temperatures are checked to make sure they are in the right range, Director A said, "No, what should they be."

During a tour and observation on 09/30/2025 at 11:45 AM with Board Member D, observed the hot water heater to not have a temperature gauge.

In an interview with Board Member B on 09/30/2025 at 11:45 AM, Board Member B said there were two panels and they would have to get a screw driver to remove them and call the plumber to see which one had the thermometer.

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E 244	Continued From page 13 On 09/30/2025 at 1:00 PM a phone interview was conducted with Plumber E, when asked if there was a thermometer attached to the hot water heater, Plumber E said, "There is a dial that is set at low, medium or high or an A, B, C, D. There is no thermometer on the hotwater heater."	E 244		
E 251	105.14(9)(b)4. SAFETY: SMOKE DETECTORS LOCATION, INSPECTIONS Each ADCC shall: 4. Install and maintain smoke detectors in each activity room and hallways, unless the fire department indicates otherwise in writing. Each smoke detector shall be tested monthly. This Rule is not met as evidenced by: Based on record review and interview the facility failed to test 4 of 4 smoke detectors located in the facility monthly. Findings: In an interview on 09/30/2025 at 9:30 AM with Program Director A when asked for the monthly smoke detector tests, Director A stated, "Our maintenance guy comes every week and tests them monthly, but I don't have documentation of the tests."	E 251		
E 252	105.14(9)(b)5. SAFETY: QUARTERLY FIRE DRILLS Each ADCC shall: 5. Conduct and document quarterly fire drills. This Rule is not met as evidenced by: Based on record review and interview the facility	E 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012348	A. BUILDING: ___ B. WING ___	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVE-A-HEART ADULT DAY CARE	**W10356 HWY 29 RIVER FALLS, WI 54022**

(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
E 252	Continued From page 14 failed to document quarterly fire drills for 1 of 1 fire safety programs reviewed. Findings: In an interview on 09/30/2025 at 9:30 AM with Program Director A when asked for the documentation of the fire/tornado drills completed, Director A stated, "We do them and have done 2 in the last year, but I didn't document them."	E 252		
Z 001	Initial Comments An unannounced onsite recertification survey was conducted on 09/30/2025 at Have A Heart Adult Day Care Center in River Falls, WI. Have A Heart Adult Day Care Center is in compliance with the Wisconsin Administrative Codes: DHS 12 and 13 Caregiver Regulations. A total of 3 personel files were reviewed.	Z 001		
L 000	Initial Comments An unannounced onsite recertification survey was conducted on 09/30/2025 at Have A Heart Adult Day Care Center located in River Falls, WI. Have A Heart Adult Day Care Center is in compliance with the Federal Regulations 42 CFR 441.301 Home and Community Based Services benchmarks/requirements. No Citations issued.	L 000		