STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018555	A. BUILDING: _____ B. WING _____	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWSON RESIDENTIAL INC 4	4031 N 61ST 4 MILWAUKEE, WI 53216

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M 000	INITIAL COMMENTS On 05/22/2024, Surveyor completed a standard survey at Newson Residential Inc 4. Six deficiencies were identified. Census: 3	M 000		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a homelike environment for 3 of 3 residents. Food was stored in a locked area in the basement, as well as a kitchen cabinet. There were not at least 3 complete sets of eating utensils for 3 of 3 residents' use. The living room window was open for ventilation and did not contain a screen. The stove was unplugged and not readily available for use. Findings include: On 05/20/2024, at 9:38 AM, Surveyor toured the home and observed the following: - The freezer contained 2 boxes of Velveeta cheese, 1 open bag of popsicles, and 1 unopened bag of popsicles. The refrigerator contained 1 container of butter, 1 box of eggs, 1 open gallon of milk, 2 bottles of coffee creamer, 1 bottle of lemon juice, 1 bottle of lime juice, 3	M 276		

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

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M 276	Continued From page 1 personal water bottles, and 1 jug of water. - The cabinets contained minimal canned food items. - The basement had an area, which consisted of chicken wire and wood to form a storage type area. The area contained a door with a locking mechanism, which was engaged. Inside the storage area, were shelves containing dry storage for food and snacks. Also inside the locked storage area was a chest freezer which contained frozen foods. - The kitchen drawers contained 1 spoon and 1 spatula. - A window in the living room was open and did not contain a screen. A bracket for a window air conditioning unit was in place. Resident 1 stated, "an air conditioner is supposed to be there, but they told us it was too early and not warm enough yet to put it in." Surveyor observed the thermostat in the home to be 80° Fahrenheit (F). On 05/20/2024, at 9:38 AM, Surveyor interviewed Resident 1. Resident 1 reported dry food was locked up in the cabinet, due to her/his behavior of constantly eating if it was available. Resident 1 reported s/he kept her/his coffee creamer and water in the refrigerator, but the rest of the foods were stored in the basement for staff to distribute. Resident 1 reported s/he loved to cook and try new recipes, but s/he was unable to due to the stove having been unplugged and unavailable for use. On 05/20/2024, at 9:52 AM, Surveyor interviewed Resident 3. Resident 3 reported dry food was locked in a cabinet in the kitchen, due to Resident	M 276		

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M 276	Continued From page 2 1's behaviors. On 05/20/2024, at 10:30 AM, Surveyors interviewed Owner A. Owner A reported the following. Food was securely stored to ensure staff did not steal from the facility. The facility prepared 3 meals and 2 snacks a day for the residents and were typically cooked in apartment 1 for all four apartments/homes; therefore, food was not stored in each apartment. Management would dispense the food to the individual apartments/homes. The facility purchased another refrigerator for the basement to allow management to place food from the secured storage area into the refrigerator in the basement for the apartments/homes. If food was stored in the individual apartments/homes, staff would steal the food, resulting in little to none left for residents. Some residents had behaviors which resulted in consuming all the food available.	M 276		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire	M 332		

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M 332	Continued From page 3 extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 fire extinguishers were inspected annually by an authorized dealer. The fire extinguishers, located in the kitchen and at the head of the stairway were last inspected February 2023. Findings include: On 05/20/2024, at 9:38 AM, Surveyor toured the facility and observed the following: -The fire extinguisher, located in the kitchen had an inspection tag which identified the fire extinguisher was last inspected in February 2023. -The fire extinguisher, located at the head of the stairway had an inspection tag which identified the fire extinguisher was last inspected in February 2023. On 05/22/2024, at 8:30 AM, Surveyors interviewed Caregiver G. Caregiver G reported s/he told Owner A to check the fire extinguishers due to the inspection tag. Caregiver G reported s/he reported this to Owner A several times. Prior to Surveyors exiting the survey, Caregiver G and some residents took the fire extinguishers to be inspected and tagged.	M 332		

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M 332	Continued From page 4 On 05/22/2024, at 10:15 AM, Surveyors interviewed Owner A. Owner A confirmed the fire extinguishers were to be inspected annually. Owner A offered no reason as to why the fire extinguishers were not inspected annually.	M 332		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 3 of 3 smoke detectors were located on the ceiling in all required locations. The smoke detectors in Resident 1's bedroom, Resident 2 and Resident 3's shared bedroom were located on the wall. The smoke detector located in the living room was located on the wall. Findings include: On 05/20/2024, at 9:38 AM, Surveyor toured the	M 334		

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M 334	Continued From page 5 facility and observed the following: - The smoke detector in Resident 1's bedroom was located on the wall. - The smoke detector in Resident 2 and Resident 3's shared bedroom was located on the wall. - The smoke detector in the living room was located on the wall. On 05/22/2024, at 10:15 AM, Surveyors interviewed Owner A. Owner A confirmed the smoke detectors were required to be on the ceiling. Owner A reported s/he had moved the smoke detectors to the walls because s/he wanted to turn the adult family home into a community based residential facility. Owner A reported s/he was unable to move the smoke detectors to the ceiling due to them having been hard-wired in. Owner A reported s/he would need to purchase new smoke detectors for the ceiling.	M 334		
M 434	88.07(1)(e) OVERNIGHT SUPERVISION The licensee shall arrange for a service provider to be present in the home when the licensee is gone overnight or when the licensee's absence prevents the resident from receiving the services, training or supervision specified in the resident's individual service plan under s. HSS 88.06(3). This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not arrange for a service	M 434		

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provider to be present in the home when a resident requires services or supervision. The provider shared staff between 4 provider homes and did not ensure the provider's home was staffed when 2 of 2 residents reviewed (Resident 1 and Resident 2) required continuous care.

Findings include:

DHS 88.02(9) defines "continuous care" as the need for supervision, intervention or services on a 24-hour basis to prevent, control and ameliorate a constant or intermittent mental or physical condition which may break out or become critical during any time of the day or night.

Observations:

On 05/20/2024, at 9:00 AM, upon entrance to the adult family home (AFH), Surveyor observed the building had 4 apartments, 2 on the upper level and 2 on the lower level. The front doors to all 4 apartments were closed. Surveyors were greeted by Manager D and Manager C, who let surveyors into the building. At approximately 9:35 AM, Surveyor entered and toured apartment 4. Surveyor did not observe a caregiver present in apartment 4. The door to apartment 4 was open to the hallway. In the hallway was a set of stairs to the lower apartments, apartment 1 and apartment 2. Both apartment 1's and apartment 2's rear exits were open. At 9:38 AM, Caregiver G came over from apartment 3 and entered apartment 4.

Interviews:

On 05/20/2024, at approximately 9:10 AM, Surveyors interviewed Caregiver E. Caregiver E confirmed all apartments were licensed as AFHs. Caregiver E reported s/he was working in all 4

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homes while the other caregiver was transporting residents to their day programming facilities.

On 05/20/2024, at 10:30 AM, Surveyors interviewed Owner A. Surveyors inquired about staffing, and Owner A reported s/he had enough staff for all 4 apartments. Surveyors reported on arrival at the home, there was only 1 staff working for all 4 apartments/homes. Owner A reported staff were responsible for transporting residents to and from appointments and day programming throughout the day.

On 05/22/2024, at 7:50 AM, Surveyors interviewed Caregiver F. Caregiver F stated, "It's only the 2 of us right now, myself and [Caregiver H]. We are getting everyone ready for appointments and day programming."

On 05/22/2024, at approximately 8:30 AM, Surveyor interviewed Caregiver G. Caregiver G reported s/he was supposed to be utilized in staffing as needed (PRN), but had been working 12-hour shifts multiple days per week. S/He reported staff were not scheduled at a specific apartment and coordinated with each other at the start of the shift to determine who was responsible for each specific apartment. Caregiver G reported staffing was usually short and s/he had been working more hours/days than s/he wanted to be.

On 05/22/2024, at 10:15 AM, Surveyors interviewed Manager C and Owner A. Surveyors inquired about staffing within the home. Owner A reported s/he had attempted to switch the licenses from AFH to a community based residential facility (CBRF). Owner A reported s/he was unable to switch to a different license due to the physical plant of the AFH did not meet the

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code requirement for a CBRF. Owner A reported if the apartments/homes were licensed as a CBRF s/he would not need to staff with 4 staff. Surveyors reported the home was licensed as an AFH and s/he would need to ensure each apartment/home had staff to accommodate the needs of the residents at all times.

Record Review:

On 05/20/2024, at 1:30 PM, Surveyor reviewed resident records and identified the following:

Resident 1 was admitted to the home on 12/29/2022, with diagnoses including schizoaffective disorder, bipolar, and major depressive disorder. Resident 1's individual service plan (ISP), dated 12/29/2022, 06/29/2023, and 12/04/2023, reported the following:
- S/He needed 24-hour supervision
- Monitored food intake
- Assistance with medication 5 times per day
- Nightly use and monitoring of continuous positive airway pressure (CPAP) machine
- Unable to use room key - staff will provide assistance in and out of apartment

Resident 2 was admitted to the home on 09/08/2023, with diagnoses including diabetes, sleep apnea, hypertension, and asthma. Resident 2's individual service plan (ISP), dated 09/02/2023, 03/02/2023, 09/02/2023, and 03/02/2024, reported the following:
- S/He needed 24-hour supervision
- Assistance with medication 3 times per day
- Nightly use and monitoring of continuous positive airway pressure (CPAP) machine
- Staff to monitor whereabouts and curfew 8:00 AM - 5:00 PM

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M 434	Continued From page 9 On 05/22/2024, Surveyor reviewed a resident incident report, dated 02/06/2024, 7:10 AM - 7:48 AM, reported by Caregiver M. The incident report stated, "I heard loud noise in apartment # 4 I ran upstairs to [Resident 1] yelling and roommate in living room saying that [explicit] got me [explicit]. [s/he] better leave me alone [s/he] keep messing with me while im [sic] sleep [Resident 1] kept yelling picking up stuff try to throw it. So I told room-mate to leave and go down stairs I tried to calm [Resident 1] down [s/he] was still upset to where [s/he] was saying [explicit] me and called me all kind of [explicit] [sic]." On 05/23/2024, at 9:30 AM, Surveyors reviewed the staffing schedule for 05/05/2024 - 05/20/2024, for all 4 apartments/homes and identified the following: 05/05/2024 Caregiver J 7:00 AM - 3:00 PM; Caregiver K 3:00 PM - 12:00 AM; Caregiver L 11:00 PM - 7:00 AM 05/06/2024 Caregiver F 7:00 AM - 3:00 PM; Caregiver K 7:00 AM - 3:00 PM; Caregiver E 7:00 AM - 3:00 PM; Manager C 8:00 AM - 5:00 PM; Manager D 8:00 AM - 4:00 PM; Caregiver H 3:00 PM - 7:00 AM 05/07/2024 Caregiver E 7:00 AM - 3:00 PM; Caregiver J 7:00 AM - 3:00 PM; Manager D 8:00 AM - 4:00 PM; Manager C 8:00 AM - 5:00 PM; Caregiver K 3:00 PM - 11:20 PM; Caregiver L 11:00 PM - 7:00 AM 05/08/2024 Caregiver F 7:00 AM - 3:00 PM; Caregiver E 7:00 AM - 3:00 PM; Manager C 8:00 AM - 5:00 PM; Manager D 8:00 AM - 4:00 PM; Caregiver K 3:00 PM - 11:00 PM; Caregiver H 3:00 PM - 7:00 AM	M 434		

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M 434	Continued From page 10 05/09/2024 Caregiver J 7:00 AM - 3:00 PM; Manager C 8:00 PM - 5:00 PM; Caregiver E 7:00 AM - 3:00 PM; Manager D 8:00 AM - 4:00 PM; Caregiver K 3:00 PM - 11:00 PM 05/10/2024 Caregiver F 7:00 AM - 3:00 PM; Caregiver J 7:00 AM - 3:00 PM; Manager C 8:00 AM - 5:00 PM; Manager D 8:00 AM - 5:00 PM; Caregiver H 3:00 PM - 11:00 PM; Caregiver K 3:00 PM - 7:00 AM 05/11/2024 Caregiver F 7:00 AM - 3:00 PM; Caregiver E 7:00 AM - 3:00 PM; Caregiver J 3:00 PM - 11:00 PM; Caregiver H 3:00 PM - 11:00 PM; Caregiver K 11:00 PM - 7:00 AM 05/12/2024 Caregiver K 8:00 AM - 3:00 PM; Caregiver H 3:00 PM - 7:00 AM 05/13/2024 Caregiver F 7:00 AM - 3:00 PM; Caregiver K 7:00 AM - 3:00 PM; Caregiver E 7:00 AM - 3:00 PM; Manager C 8:00 AM - 5:00 PM; Manager D 8:00 AM - 4:00 PM; Caregiver H 3:00 PM - 7:00 AM 05/14/2024 Caregiver E 7:00 AM - 3:00 PM; Caregiver J 7:00 AM - 3:00 PM; Manager D 8:00 AM - 4:00 PM; Manager C 8:00 AM - 5:00 PM; Caregiver K 3:00 PM - 11:00 PM; Caregiver H 11:00 PM - 7:00 AM 05/15/2024 Caregiver F 7:00 AM - 3:00 PM; Caregiver E 7:00 AM - 3:00 PM; Manager C 8:00 AM - 5:00 PM; Manager D 8:00 AM - 4:00 PM; Caregiver K 3:00 PM - 11:00 PM; Caregiver H 3:00 PM - 7:00 AM 05/16/2024 Caregiver E 7:00 AM - 3:00 PM; Caregiver J 7:00 AM - 3:00 PM; Manager D 8:00	M 434		

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M 434	Continued From page 11 AM - 4:00 PM; Manager C 8:00 AM - 5:00 PM; Caregiver K 3:00 PM - 11:00 PM; Caregiver L 11:00 PM - 7:00 AM 05/17/2024 Caregiver F 7:00 AM - 3:00 PM; Caregiver J 7:00 AM - 3:00 PM; Manager D 8:00 AM - 4:00 PM; Manager C 8:00 AM - 5:00 PM; Caregiver H 3:00 PM - 11:00 PM; Caregiver K 11:00 PM - 7:00 AM 05/18/2024 Caregiver J 7:00 AM - 3:00 PM; Caregiver K 3:00 PM - 7:00 AM 05/19/2024 Caregiver K 3:00 PM - 11:00 PM; Caregiver J 7:00 AM - 3:00 PM 05/20/2024 Caregiver F 7:00 AM - 5:00 PM "stayed late because of state;" Caregiver E 7:00 AM - 3:26 PM; Manager D 8:00 AM - 4:00 PM; Manager C 8:00 AM - 5:00 PM; Caregiver K 3:15 PM - 5:23 PM "came in for state;" Caregiver J 3:00 PM - 5:00 PM; Caregiver H 3:00 PM - 7:00 AM In summary, caregivers were being shared between 4 apartments/homes. On many occasions, residents requiring 24-hour supervision were left unsupervised. As a result of a service provider not being present in the home providing services and supervision specified in the residents' ISPs, an incident reviewed resulted in a verbal altercation between 2 residents and a caregiver. Staffing schedules did not indicate which apartment/home staff were assigned. Many of the daily staff schedules did not include a minimum of 4 staff per shift, which indicated each apartment did not have at least 1 dedicated caregiver to provide continuous care.	M 434		

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M 458	Continued From page 12	M 458		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 residents' (Resident 1 and Resident 2) prescription medications were securely stored. Resident 1's and Resident 2's medications were not securely stored in the medication cart located in the living room. Findings include: On 05/20/2024, at 9:56 AM, Surveyor toured the living room and observed a medication cart. The medication cart contained a locking mechanism, which was not engaged. The medication cart contained medications for Resident 1 and Resident 2, as well as medications for residents in unit 3. Resident 1's unsecured medications: - Allopurinol 100 milligram (mg) tablets - Aripiprazole 30 mg tablets - Atorvastatin 10 mg tablets	M 458		

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(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
M 458	Continued From page 13	M 458		

- Clonazepam 0.5 mg tablets
- Divalproex 500 mg extended release (ER) tablets
- Escitalopram 20 mg tablets
- Furosemide 40 mg tablets
- Levothyroxine 200 microgram (mcg) tablets
- Levothyroxine 75 mcg tablets
- Vitamin D3 50 mcg tablets
- Ziprasidone 80 mg capsules
- Haloperidol 5 mg tablets
- Loperamide 2 mg capsules

Resident 2's unsecured medications:

- Aripiprazole 20 mg tablets
- Chlorthalidone 25 mg tablets
- Famotidine 20 mg tablets
- Furosemide 20 mg tablets
- Lisinopril 20 mg tablets
- Loratadine 10 mg tablets
- Metformin 500 mg tablets
- Metoprolol ER 50 mg tablets
- Omeprazole 20 mg capsules
- Potassium Chloride ER 10 milliequivalent (mEq) tablets
- Vitamin D3 50 mcg tablets
- Ibuprofen 600 mg tablets
- Lactaid 3,000 units caplets
- Diphenhydramine 25 mg capsules
- Ondansetron 4 mg orally disintegrating tablets (ODT)
- Phenylephrine 10 mg tablets

Surveyor observed residents moving freely around the facility.

On 05/20/2024, at approximately 10:00 AM, Surveyor interviewed Caregiver G. Caregiver G stated, "How did you get in there? I was just in there, and I swear I locked it. I can't believe I did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018555	A. BUILDING: _____ B. WING _____	05/22/2024

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NEWSON RESIDENTIAL INC 4	4031 N 61ST 4 MILWAUKEE, WI 53216

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M 458	Continued From page 14 that." Caregiver G confirmed prescription medications were required to be securely stored. On 05/22/2024, at 10:15 AM, Surveyors interviewed Manager C. Manager C confirmed prescription medications should have been securely stored. Manager C reported all staff completed training on medications to ensure compliance with the code requirements.	M 458		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe physical environment by ensuring water temperatures were kept at a safe temperature for 1 of 1 resident bathroom. The hot water temperature in the resident bathroom was 125.6° Fahrenheit (F). Findings include: The home is licensed as a non-ambulatory adult family home caring for up to 4 residents in the	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018555	A. BUILDING: _____ B. WING _____	05/22/2024

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M 570	Continued From page 15 client groups of irreversible dementia/Alzheimer's, advanced age, emotionally disturbed/mental illness, developmentally disabled, terminally ill, physically disabled, and traumatic brain injury. On 05/20/2024, at 10:06 AM, Surveyor tested the water temperature in the residents' bathroom sink faucet. The water temperature was 125.6°F. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g. second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017) On 05/22/2024, at 10:15 AM, Surveyors interviewed Manager C. Manager C reported the water temperature was checked daily. Manager C reported s/he was unsure of what the water temperature should have been at and was unaware the water was too hot.	M 570		