STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012873	A. BUILDING: _____ B. WING _____	R-C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASY LIVING SENIOR HOME	**7219 W MEDFORD AVE MILWAUKEE, WI 53218**

(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 000}	INITIAL COMMENTS On 02/29/2024, Surveyors conducted a standard survey, verification visit, and a complaint investigation at Easy Living Senior Home AFH. Six deficiencies were identified. One of the 6 deficiencies was a repeat violation (see Statement of Deficiency (SOD) 2BO611, dated 02/11/2022). One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 4	{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 the home was well-maintained, clean, and a homelike environment for 4 of 4 residents. The bathroom, hallway, resident rooms, living room, and kitchen/dining room required cleaning and/or repairs. Findings include: On 02/06/2024, at 12:15 PM, Surveyors conducted an onsite tour of the facility and observed the following. Bathroom:	M 276		

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

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M 276	Continued From page 1	M 276		

- The flooring was cracked and curling up near the flooring transition strip. The crack/curling measured approximately 24 inches in length.
- The flooring tile was separating down the middle of the room and had a gap of approximately ¼ inch along the entire length of the bathroom.
- The door had black scuff marks which stretched the entire width of the door.
- The doorframe was chipped and dented.
- The baseboard shoe was chipped and had rough exposed wood areas.
- The sink and the storage closet had long dark pieces of hair on them.
- The ceiling vent fan was covered in approximately ¼ inch of a grayish substance, consistent with dust and debris.
- The ceiling corner near the window had cobwebs hanging from it.

Hallway:
- The heating vent was dented and covered in a blackish/gray substance, consistent with dust and debris.

Resident Rooms:
- The doors had black scuff marks which stretched the entire width of the doors.
- The door frames were chipped and scuffed, and chips of paint were on the floor.
- The floors in 2 of 3 resident rooms were covered in small pieces of debris.
- Room 2 did not have baseboards and the wall in the area was covered in a black hue, consistent with dirt and dust.
- Room 2 had two 5 drawer dressers. Both dressers were missing 3 of 5 knobbed handles.

Living Room:
- The couch was sunk-in and worn looking.
- The middle seat cushion on the couch had a

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M 276	Continued From page 2	M 276		

stain measuring approximately 5 inches wide.
- The middle backrest cushion on the couch had a stain measuring approximately 8 inches wide.
- The end seat of the couch was not usable due to a chair pushed against it.

Kitchen/Dining Room:
- Two of the dining room chairs were unstable and shifted side-to-side when moved.
- The dining room ceiling had a brownish dried liquid splatter.
- The refrigerator door handle was missing.
- Inside the refrigerator, the face of the left drawer was shattered which caused the frame to have sharp plastic edges exposed.
- The right drawer in the refrigerator was missing.
- The seal in the refrigerator was cracked and lifted away from the door.
- The bracket for the shelving inside of the freezer door was missing, causing food to fall out onto the floor when the door was opened.
- The window above the kitchen sink was open and stuffed with paper towels.

Rear Living Room:
- The back entrance/exit door was covered with a brown dried splashed liquid.
- The blinds on the window, next to the door, was also covered in a brown dried splashed liquid.

Staircase:
- The carpet on the open staircase, which led into the basement, was worn down and fading and peeling up at the edges.
- Dust and debris covered the carpeting on the stairs.

On 02/06/2024, at 1:10 PM, Surveyors interviewed Lead Caregiver B. Lead Caregiver B reported s/he did not know why the paper towels

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M 276	Continued From page 3 were in the kitchen window. Surveyors observed Lead Caregiver B remove the paper towels and attempt to close the window. The window could not be closed. On 02/29/2024, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported the caregivers are responsible for cleaning the residence and s/he is responsible for maintenance and repairs. Licensee A reported s/he usually contracted with individuals when something in the residence needs repair. Licensee A reported s/he was unaware of the window in the kitchen stuffed with paper towel and unaware of the missing and broken parts on the refrigerator. Licensee A stated, "The building is just old; I've done floors and painting ...After a while you just get blind to it." Licensee A reported s/he would work on having the residence cleaned.	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 4 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 or the local fire department. The fire extinguishers were due to be inspected by January 2024 and were not. Findings include: On 02/06/2024, at 12:15 PM, Surveyors conducted an onsite tour of the facility. Surveyors observed fire extinguishers at the head of the stairway and in the basement dated January 2023. On 02/29/2024, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code fire extinguishers require annual inspection by an authorized dealer or the local fire department. Licensee A stated s/he thought s/he had the fire extinguishers inspected in the last 3 months. S/He stated Lead Caregiver B usually checked and documented fire extinguisher inspections. S/He was unaware the fire extinguishers were last tagged on January 2023 and were overdue for inspection.	M 332		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION	M 346		

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M 346	Continued From page 5 Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete an annual evacuation assessment review for 2 of 4 residents reviewed who lived in the facility beyond one year. Resident 1 and Resident 3 did not have an evacuation assessment completed in 2023. This is a repeat deficiency. See Statement of Deficiency (SOD) 2BO611, dated 02/11/2022. Findings include: On 02/06/2024, at 1:00 PM, Surveyor reviewed resident records and identified the following: Resident 1 was admitted to the facility on 11/01/2015, with diagnoses including, schizophrenia and delusions. Resident 1's record contained a Resident Evacuation Assessment, dated 10/11/2022. Resident 1's record did not contain an annual evacuation assessment review for 2023. Resident 3 was admitted to the facility on 08/25/2022, with diagnoses including dementia and anxiety. Resident 3's record contained a Resident Evacuation Assessment, dated 07/20/2022. Resident 3's record did not contain an annual evacuation assessment review for	M 346		

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M 346	Continued From page 6 2023. On 02/29/2024, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed the annual evacuation assessment reviews were to be completed annually. Licensee A reported s/he thought the assessment reviews were completed for 2023. Licensee A reported s/he would update them.	M 346		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a statement of agreement with the Individual Service Plan (ISP) was dated and signed by all persons involved in developing the plan for 4 of 4 residents (Resident 1, Resident 2, Resident 3, and Resident 4). Findings include: On 02/06/2024, at 12:40 PM, Surveyors reviewed resident records and identified the following: Resident 1 was admitted to the facility on 11/01/2015. Resident 1's Individual Service Plans (ISPs) were dated 08/26/2022 and 01/24/2023. Resident 1's ISP identified Resident 1 had a Managed Care Organization (MCO) case management team. Resident 1's ISP contained Resident 1's signature. A note on the Agent or	M 420		

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Designated Representative signature line stated, "conversation with My Choice care manager." Resident 1's ISPs did not contain a guardian signature or MCO case management team signatures.

Resident 2 was admitted to the facility on 05/27/2021. Resident 2's Individual Service Plans (ISPs) were dated 01/24/2022, 06/01/2022, and 01/18/2023. The resident roster identified Resident 2 had an MCO case management team. A note on the Resident or Guardian signature line stated, "[Guardian F] via telephone." Resident 2's ISPs did not contain a guardian signature or MCO case management team signatures.

Resident 3 was admitted to the facility on 08/25/2022. Resident 3's Individual Service Plans (ISP) were dated 08/25/2022 and 01/24/2023. The resident roster identified Resident 3 had an MCO case management team. Guardianship paperwork, dated 01/19/2021, identified Resident 3 had a guardian. Resident 3's ISP, dated 08/25/2022, had a note on the Resident or Guardian signature line which stated, "[Guardian G family member] via telephone". The Agent or Designated Representative signature line stated, "[Case Manager H] via phone". Resident 3's ISP dated 01/24/2023, had a note on the Resident or Guardian signature line which stated, "[Guardian G] via telephone". The Agent or Designated Representative signature line stated, "[Case Manager H] via phone". Resident 3's ISPs did not contain a guardian signature or MCO case management team signatures.

Resident 4 was admitted to the facility on 12/19/2023. Resident 4's Individual Service Plan (ISP) was dated 01/12/2024. Surveyors reviewed a Power of Attorney for Health Care Statement of

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M 420	Continued From page 8 Incapacity document, dated 09/26/2022 which identified Resident 4 had a guardian. Resident 4's face sheet, undated, identified Resident 4 had an MCO case management team. A note on the Other signature line stated, "discussed - [Case Manager] via phone". Resident 4's ISP contained Resident 4's signature. Resident 4's ISP did not contain a guardian signature or MCO case management team signatures. On 02/29/2024, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported s/he is responsible for creating residents' ISPs. Licensee A stated s/he met with everyone involved with the ISPs, "over the phone, if not in person." Licensee A reported Resident 1 and Resident 2 had guardians. Surveyors inquired if guardians and MCOs had signed the ISPs for Resident 1, Resident 2, Resident 3, and Resident 4. Licensee A stated, "it's really hard to get them in a particular spot to sign." Licensee A reported s/he was unaware ISPs needed to be signed by all persons involved in developing the plan. Licensee A stated, "a surveyor told me I could just talk to them on the phone and obtain their signature that way." S/He reported s/he would communicate by email, or another means in the future to obtain signatures.	M 420		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the	M 424		

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M 424	Continued From page 9 resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 residents' Individual Service Plans (ISPs) were reviewed at least once every six months and/or with changes. Resident 3's, Resident 1's, and Resident 2's ISPs were due to be reviewed in 07/2023 and 01/2024. Findings include: On 02/06/2024, at 12:40 PM, Surveyors reviewed resident records and identified the following: Resident 1 was admitted to the facility on 11/01/2015. Resident 1's Individual Service Plans (ISP) were dated 08/26/2022, and 01/24/2023. Resident 1's ISP was due to be reviewed in February 2022, July 2023, and January 2024. Resident 1's ISPs were not reviewed every 6 months. Resident 2 was admitted to the facility on 05/27/2021. Resident 2's Individual Service Plan (ISP) was dated 01/18/2023. Resident 2's ISP was due to be reviewed in July 2023 and January 2024. Resident 2's ISP was not reviewed every 6 months.	M 424		

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M 424	Continued From page 10 Resident 3 was admitted to the facility on 08/25/2022. Resident 3's Individual Service Plans (ISP) were dated 08/25/2022 and 01/24/2023. Resident 3's ISP was due to be reviewed in July 2023 and January 2024. Resident 3's ISPs were not reviewed every 6 months. On 02/29/2024, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code resident ISPs need review every 6 months and/or with changes. Licensee A stated, "I usually do it in January and June". Surveyors reported ISPs for Resident 1, Resident 2, and Resident 3 were due for review in July 2023 and January 2024. Licensee A stated, "I must have the wrong year in there."	M 424		
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 4 of 4 residents were provided a safe environment to live. The dryer vent was not connected to an outside duct, causing lint and	M 570		

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M 570	Continued From page 11 debris to cover the basement. Findings include: On 02/06/2024, at 12:15 PM, Surveyors toured the laundry area. Surveyors observed the dryer vent was connected to the dryer but was not connected to the outside duct. Surveyors observed a thick, dust-like substance, consistent with lint, all over the wall and outside opening behind the dryer. Numerous cobwebs were present around the dryer and were covered in a thick, dust-like substance, consistent with lint. On 02/29/2024, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code residents need to be provided a safe environment to live. Licensee A was unaware the dryer vent was disconnected from the outside duct. Licensee A stated s/he would have the dryer vent reconnected.	M 570		