STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310044	A. BUILDING: _____ B. WING _____	C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
META HOUSE RIVERWEST CAMPUS NO	**2626 N BREMEN ST MILWAUKEE, WI 53212**

(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 08/13/2024 with information gathered through 08/14/2024, Surveyors conducted a standard survey and complaint investigation at Meta House Riverwest Campus North, a Community-Based Residential Facility (CBRF) in Milwaukee, WI. Three deficiencies identified. One of three deficiencies was a repeat deficiency. Complaint unsubstantiated. Census: 16	N 000		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide 2 of 3 (Caregiver B and Caregiver C) caregivers reviewed with orientation training including job responsibilities, prevention and reporting of resident abuse, neglect and misappropriation of resident property, emergency	N 230		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310044	A. BUILDING: _____ B. WING _____	C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
META HOUSE RIVERWEST CAMPUS NO	**2626 N BREMEN ST MILWAUKEE, WI 53212**

(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 230	Continued From page 1 and disaster plan and evacuation procedures, Community Based Residential Facility policies and procedures and recognizing and responding to resident changes of condition. Findings include: On 08/13/2024, Surveyor reviewed Caregiver B's record. Caregiver B was hired on 03/09/2020. Surveyor could not locate orientation training including resident rights, preventing and reporting abuse and change for condition for Caregiver B. On 08/13/2024, Surveyor reviewed Caregiver C's record. Caregiver C was hired on 09/06/2022. Surveyor could not locate orientation training including job responsibilities, prevention and reporting of resident abuse, neglect and misappropriation of resident property, emergency and disaster plan and evacuation procedures, Community Based Residential Facility policies and procedures and recognizing and responding to resident changes of condition for Caregiver C. On 08/14/2024, at approximately 10:25 AM, Surveyor interviewed Quality Assurance Specialist (QAS) A. QAS A confirmed s/he did not have evidence of orientation training including resident rights, preventing and reporting abuse and change for condition for Caregiver B and orientation training including job responsibilities, prevention and reporting of resident abuse, neglect and misappropriation of resident property, emergency and disaster plan and evacuation procedures, Community Based Residential Facility policies and procedures and recognizing and responding to resident changes of condition for Caregiver C.	N 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310044	A. BUILDING: _____ B. WING _____	C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
META HOUSE RIVERWEST CAMPUS NO	**2626 N BREMEN ST MILWAUKEE, WI 53212**

(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 277	Continued From page 2	N 277		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers completed continuing education training in required topics for calendar year 2023. Caregiver B did not have training in resident rights, and Caregiver C did not have training in medications. This is a repeat deficiency. See Statement of Deficiency (SOD) #CM6P11, dated 01/12/2022. Findings include: On 08/13/2024, Surveyor reviewed Caregiver B's record. Caregiver B was hired on 02/27/2020. Caregiver B did not have evidence of resident right training for calendar year 2023. On 08/13/2024, Surveyor reviewed Caregiver C's record. Caregiver C was hired on 06/17/2022. Caregiver B did not have evidence of medication training for calendar year 2023.	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310044	A. BUILDING: _____ B. WING _____	C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
META HOUSE RIVERWEST CAMPUS NO	**2626 N BREMEN ST MILWAUKEE, WI 53212**

(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 277	Continued From page 3 On 08/14/2024 at 10:25 AM, Surveyor interviewed Quality Assurance Specialist (QAS) A. QAS A stated s/he sent all of Caregiver B's and Caregiver C's training. Surveyor did not find evidence of resident right training for Caregiver B in calendar year 2023 and medication training for Caregiver C in calendar year 2023.	N 277		
Z 022	50.065(3)(b) COMPLETE BACKGROUND CHECK PROCESS Every 4 years or at any other time within that period that an entity considers appropriate, the entity shall request the information specified in sub. (2) (b) 1. to 5. for all caregivers of the entity. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 caregiver reviewed had a background check completed every 4 years. Caregiver B did not have a 4 year background check completed from his/her hire date. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis.	Z 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310044	A. BUILDING: _____ B. WING _____	C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
META HOUSE RIVERWEST CAMPUS NO	**2626 N BREMEN ST MILWAUKEE, WI 53212**

(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
Z 022	Continued From page 4 Admin. Code ch. 12, a complete CBC, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check" letter from the Department of Health Service, also referred to as the Integrated Background Information System (IBIS). On 08/13/2024 at approximately 2:45 PM, Surveyor reviewed Caregiver B's record provided by Quality Assurance Specialist A. Caregiver B's record indicated s/he was hired on 03/09/2020. The record contained the following: - BID, dated 02/27/2020. - DOJ, dated 03/04/2020. - IBIS, dated 03/04/2020. On 08/14/2024 at 9:19 AM, Surveyor interviewed Quality Assurance Specialist (QAS) A. Surveyor asked QAS A if Caregiver B had a 4 year background check. QAS A stated Caregiver B's background check was in progress and they could send the updated one as soon as it was completed.	Z 022		