STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015293	A. BUILDING: _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEXT STEP IN RESIDENTIAL SERVICES WATER	W164 N9470 WATER STREET MENOMONEE FALLS, WI 53051

(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 08/07/2024, with information collected through 08/23/2024, Surveyor conducted a standard survey and complaint investigation at Next Step in Residential Services Water. Three (3) deficiencies were identified. The complaint was substantiated. Census: 3	M 000		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not keep a record of all prescription medications dispensed or administered by the provider for 3 of 3 residents. Findings include: On 07/30/2024, the department received a complaint in regard to resident care and staff competency in medication administration. On 08/07/2024, Surveyor conducted a standard licensing survey and complaint investigation.	M 466		

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

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M 466	Continued From page 1 Example 1 - Resident 1 Surveyor asked to review the closed record of Resident 1. Resident 1 was admitted to the provider on 10/02/2014 with diagnoses including developmental disability, autism spectrum disorder, non-verbal, seizures and bipolar disorder. Surveyor reviewed Resident 1's physician orders which included: Ammonium Lac 12% Cream to apply topically twice daily. Bacitr Zinc 500/gm ointment to apply topically twice daily. Bisacodyl 5 mg ec tab to take one tablet twice daily. Divalproex 250 mg tablet to take 1 tablet twice daily. Enulose 10 gm/15ml Sol to take 30ml twice daily. Fluvoxamine 100mg tablet to take 1 tablet twice daily. Hydroxyz Hcl 50 mg tab to take one tablet twice daily. Linzess 290mcg cap to take 1 capsule daily. Magnesium citrate lemon solt to take one bottle weekly. Melatonin 10mg tab to take 1 tablet every night at bedtime. Motegrity 1mg tab to take 1 tablet every other day. Pantoprazole 40mg tab to take 1 tablet daily. Polyethylene Glycol 2250 pow to dissolve 17 grams in 8oz of liquid and drink daily. Reguloid Orng SF 57.6% pow to mix 2 teaspoonfuls mixed in liquid and drink daily. Risperidone 2mg tab to take 1 tablet twice daily. Trazodone 100mg tab to take 2 tablets at	M 466		

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M 466	Continued From page 2	M 466		

bedtime.

Surveyor reviewed Resident 1's June 2024 medication administration record (MAR). Medication administration times were documented as 7:00 a.m. and 8:00 p.m. Resident 1's medications were not documented as administered on the following dates:

Ammonium Lac - 06/01/2024 (p.m.), 06/13/2024 (a.m.), 06/14/2024 (p.m.), 06/29/2024 (p.m.).
Bacitr Zic - 06/01/2024 (p.m.), 06/13/2024 (a.m.), 06/14/2024 (p.m.), 06/29/2024 (p.m.).
Bisacodyl 5 mg - 06/01/2024 (a.m. & p.m.), 06/02/2024 (a.m.), 06/13/2024 (a.m.), 06/14/2024 (p.m.), 06/29/2024 (p.m.).
Divalproex 250 mg - 06/01/2024 (a.m. & p.m.), 06/13/2024 (a.m.), 06/14/2024 (p.m.), 06/29/2024 (p.m.).
Enulose 10 gm/15ml Sol - 06/01/2024 (a.m. & p.m.), 06/05/2024 (a.m.), 06/13/2024 (a.m.), 06/14/2024 (p.m.).
Fluvoxamine 100mg - 06/01/2024 (a.m. & p.m.), 06/02/2024 (a.m.), 06/05/2024 (a.m.), 06/13/2024 (a.m.), 06/14/2024 (p.m.).
Hydroxyz Hcl 50 mg - 06/01/2024 (a.m. & p.m.), 06/05/2024 (a.m.), 06/07/2024 (p.m.), 06/13/2024 (a.m.), 06/14/2024 (p.m.).
Linzess 290mcg - 06/01/2024, 06/02/2024, 06/05/2024, 06/08/2024, 06/09/2024, 06/11/2024, 06/12/2024, 6/17/2024, 06/20/2024, 06/29/2024.
Magnesium citrate - 06/05/2024, 06/12/2024, 06/19/2024, 06/26/2024; all scheduled doses.
Melatonin 10mg - 06/01/2024, 06/14/2024.
Pantoprazole 40mg - 06/01/2024, 06/05/2024, 06/13/2024, 06/20/2024, 06/29/2024.
Polyethylene Glycol - 06/01/2024, 06/05/2024, 06/13/2024, 06/20/2024, 06/29/2024.
Reguloid Orng SF - 06/01/2024, 06/05/2024, 06/06/2024, 06/13/2024, 06/20/2024, 06/29/2024.

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Risperidone 2mg tab - 06/01/2024 (a.m. & p.m.), 06/05/2024 (a.m.), 06/07/2024 (p.m.), 06/13/2024 (a.m.), 06/14/2024 (p.m.), 06/20/2024 (a.m.), 06/29/2024 (p.m.).
Trazodone 100mg - 06/01/2024, 06/05/2024, 06/14/2024.

Example 2 - Resident 2

Surveyor reviewed Resident 2's physician orders which included:
Melatonin 5mg tab to take 1 tablet every night at bedtime.
Multivitamin tab to take 1 every morning.
Naproxen 500mg tab to take 1 tablet twice daily.
Phenobarb 64.8mg tab to take 1 tablet every morning.
Vitamin D3 25mcg (10000) tab to take 1 tablet daily.

Surveyor reviewed Resident 2's July and August 2024 MAR. Medication administration times were documented as 7:00 a.m. and 8:00 p.m. Resident 2's medications were not documented as administered on the following dates:

Melatonin 5mg - 07/13/2024, 07/14/2024, 08/03/2024, 08/04/2024, 08/06/2024.
Multivitamin - 07/14/2024, 07/21/2024, 07/22/2024, 08/01/2024-08/30/2024 were all signed off as administered.
Naproxen 500mg - 07/13/2024 (p.m.), 07/14/2024 (a.m.), 07/22/2024 (a.m.), 07/23/2024-07/25/2024 (a.m. & p.m.), 07/26/2024 (p.m.), 07/27/2024 (a.m.), 08/03/2024-08/05/2024 (a.m. & p.m.), 08/06/2024 (p.m.) 08/07/2024 (p.m.).
Phenobarb 64.8mg - 07/14/2024, 07/22/2024, 08/01/2024-08/21/2024 were all signed off as administered.
Vitamin D3 25mcg (10000) - 07/05/2024,

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M 466	Continued From page 4 07/14/2024, 07/25/2024-07/27/2024, 08/01/2024-08/17/2024 were all signed off as administered. At approximately 10:00 a.m., Director A told Surveyor that s/he was aware there are concerns with medication documentation and that steps are being taken to correct that. S/he also stated that the provider will be replacing Resident 2's August MAR and s/he is unsure why someone would have signed off on medications for dates that have not passed yet. Example 3 - Resident 3 Surveyor reviewed Resident 3's physician orders which included: Buspirone 15mg tab to take 1 tablet 3 times daily. Depakote Spr 125mg cap to take 2 capsules twice daily. Guanfacine 2mg tab to take 1 tablet 4 times daily. Metformin 500mg tab to take 1 tablet twice daily. Olanzapine 10mg to take 1 tablet daily at 4:00 p.m. Olanzapine 5mg to take 1 tablet twice daily. Senexon-S 8.6-50mg tab to take 1 tablet every other day. Vyvanse 70mg cap to take 1 capsule every morning. Ziprasidone 60mg cap to take 1 capsule twice daily after meals. Zonisamide 100 cap to take 2 capsules every morning. Zonisamide 100 cap to take 3 capsules at bedtime. Surveyor reviewed Resident 3's July 2024 MAR. Resident 3's medications were not documented as administered on the following dates: Buspirone 15mg - 07/13/2024 (p.m.), 07/14/2024	M 466		

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M 466	Continued From page 5 (a.m.), 07/25/2024 (a.m.), 07/26/2024 (p.m.) Depakote Spr 125mg - 07/13/2024 (p.m.), 07/14/2024 (a.m.) Metformin 500mg - 07/14/2024 (a.m.), 07/23/2024 (p.m.) Olanzapine 10mg - 07/23/2024 Olanzapine 5mg - 07/14/2024 (a.m.) Senexon-S 8.6-50mg - 07/14/2024, 07/20/2024, 07/26/2024, 07/28/2024 Vyvanse 70mg - 07/14/2024, 07/25/2024 Ziprasidone 60mg - 07/04/2024, 07/14/2024 (a.m.), 07/25/2024 (a.m.), 07/26/2024 (p.m.) Zonisamide 200mg - 07/14/2024, 07/25/2024 Zonisamide 300mg - 07/13/2024, 07/14/2024	M 466		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, Resident 1 did not receive prompt and adequate treatment and services appropriate to meet his/her needs. On 07/01/2024, Resident 1 was admitted to the hospital after a change in condition where s/he was not eating or able to walk for 2 days. Findings include: On 07/30/2024, the department received a complaint in regard to resident care and staff competency in medication administration. On 08/07/2024, Surveyor conducted a standard licensing survey and complaint investigation. The provider is licensed as an adult family home	M 580		

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M 580	Continued From page 6	M 580		

(AFH), able to serve up to 4 residents within the client groups of: traumatic bring injury, emotionally disturbed/mental illness, physically disabled, developmentally disabled and advanced age.

Surveyor asked to review the closed record of Resident 1. Resident 1 was admitted to the provider on 10/02/2014 with diagnoses including developmental disability, autism spectrum disorder, non-verbal, seizures and bipolar disorder.

At approximately 9:30 a.m., Surveyor asked Director A why Resident 1 was no longer living at the facility. Director A stated that Resident 1 was acting like his/herself and was sent to the hospital. Director A stated s/he has not heard from the hospital or received a discharge summary, but that it is believed that Resident 1 may have received another resident's medication and that is why s/he had a change in condition. Director A stated that after Resident 1's admission to the hospital, s/he was made aware that the power of attorney for health care would be finding alternative placement for Resident 1 when s/he was discharged from the hospital.

Surveyor reviewed progress notes for Resident 1 that stated:
06/28/2024, ate all breakfast, took all scheduled meds
06/29/2024, no documentation
06/30/2024, first shift, "[Resident 1] did not eat breakfast or lunch [s/he] seems to be droopy in the face. On-call was called. Kind of falling while walking. Was showered, layed(sic) on couch. Toileted as needed."
06/30/2024, second shift, "Was standing, kind of falling. Still drooping in the face. Updated

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M 580	Continued From page 7 manager..." 06/30/2024, third shift, "...[S/he] was offered breakfast, but didn't eat..." At approximately 10:00 a.m., Director A stated that the provider interviewed 2 caregivers that were working the weekend before Resident 1 was sent to the hospital. Surveyor reviewed discussion notes from Caregiver B and Caregiver C's interviews regarding Resident 1. Caregiver B's discussion notes stated, "Director A met with Caregiver B to discuss the medication error that took place on 06/29/2024. [Caregiver B] did not have a direct part in the actual error, however [s/he] did work the following day from roughly 8 AM - 8 PM. [Caregiver B] walked [Director A] through the events of the day. [S/he] stated that when [s/he] arrived, [s/he] noticed that [Resident 1] was not [his/her]self. [Resident 1] was not very steady on [his/her] feet and seemed to have a droopy face. [Caregiver B] reports that [s/he] did call the on-call manager as well as [his/her] regional supervisor to report the change in condition. [S/he] states [s/he] was told to continue to monitor [Resident 1] for any further change in condition. [Caregiver B] reports that [s/he] continued to monitor [Resident 1] and questioned [him/herself] about calling 911. [Caregiver B] reported that [s/he] did document the change in condition on the client daily logs as well." Caregiver C's discussion notes stated, "During that meeting, [Caregiver C] explained that [s/he] had passed medications on the morning of 06/29/2024. [S/he] stated that [s/he] followed policy and procedure during that pass...[Director D] suspended [Caregiver C's] medication passing privileges indefinitely."	M 580		

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M 580	Continued From page 8 At approximately 10:30 a.m., Director A stated that the provider cannot be sure, and has not received a discharge summary from the hospital, but that Resident 1 started to experience a change in condition after the morning medication pass on 06/29/2024, so the provider suspects that a medication error may have been made where Resident 1 received Resident 2's medication(s) in error. Surveyor confirmed the timeline with Director A, stating that on 06/29/2024, Resident 1 started to experience a change in condition, although it was not documented. On 06/30/2024, it was documented that Resident 1 did not eat any meals and could not ambulate. The on-call manager and regional supervisor were made aware of the change in condition and instructed staff to continue to monitor. On 07/01/2024, Resident 1 was sent out to the hospital. Director A confirmed understanding that Resident 1 should have been sent to the hospital earlier, but that staff were hesitant to call 911 after being instructed to continue to monitor Resident 1 by the on-call manager and regional supervisor. Surveyor asked if either the on-call manager or regional supervisor had come to the home to assess Resident 1. Director A stated no, they did not. Director A stated that Caregiver B has had repercussions for calling 911 in the past, so Director A had retrained all the staff and assured Caregiver B that if they ever question the need to call 911, they should call immediately. On 08/12/2024, Surveyor reviewed Resident 1's hospitalization from 07/01/2024 to 07/08/2024. Resident 1 was admitted to the hospital for weakness and inability to ambulate, with acute presentation 06/29-06/30. Resident 1 had tested positive for barbiturate reflex and for	M 580		

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M 580	Continued From page 9 Phenobarbital. The hospital physician spoke with Resident 1's pharmacy and primary physician who confirmed that Resident 1 does not have Phenobarbital on his/her current medication list and there were no current medications that could explain Phenobarbital in Resident 1's system.	M 580		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, Resident 1 received a medication that was not prescribed to him/her by his/her physician. On 07/01/2024, Resident 1 was admitted to the hospital and had tested positive for barbiturate reflex and for Phenobarbital in his/her system, which s/he does not have an order for. Findings include: On 07/30/2024, the department received a complaint in regard to resident care and staff competency in medication administration. On 08/07/2024, Surveyor conducted a standard licensing survey and complaint investigation. The provider is licensed as an adult family home	M 582		

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M 582	Continued From page 10	M 582		

(AFH), able to serve up to 4 residents within the client groups of: traumatic bring injury, emotionally disturbed/mental illness, physically disabled, developmentally disabled and advanced age.

Surveyor asked to review the closed record of Resident 1. Resident 1 was admitted to the provider on 10/02/2014 with diagnoses including developmental disability, autism spectrum disorder, non-verbal, seizures and bipolar disorder.

At approximately 9:30 a.m., Surveyor asked Director A why Resident 1 was no longer living at the facility. Director A stated that Resident 1 was acting like his/herself and was sent to the hospital. Director A stated s/he has not heard from the hospital or received a discharge summary, but that it is believed that Resident 1 may have received another resident's medication and that is why s/he had a change in condition. Director A stated that after Resident 1's admission to the hospital, s/he was made aware that the power of attorney for health care would be finding alternative placement for Resident 1 when s/he was discharged from the hospital. Director A showed Surveyor that the medication administration room has been moved around to make medication administration less distracting and easier for staff to hopefully alleviate further risk for error.

Surveyor reviewed progress notes for Resident 1 that stated:
06/28/2024, ate all breakfast, took all scheduled meds
06/29/2024, no documentation
06/30/2024, first shift, "[Resident 1] did not eat breakfast or lunch [s/he] seems to be droopy in

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M 582	Continued From page 11	M 582		

the face. On-call was called. Kind of falling while walking. Was showered, layed(sic) on couch. Toileted as needed."
06/30/2024, second shift, "Was standing, kind of falling. Still drooping in the face. Updated manager..."
06/30/2024, third shift, "...[S/he] was offered breakfast, but didn't eat..."

At approximately 10:00 a.m., Director A stated that the provider interviewed 2 caregivers that were working the weekend before Resident 1 was sent to the hospital. Surveyor reviewed discussion notes from Caregiver B and Caregiver C's interviews in regard to Resident 1.
-Caregiver B stated discussion notes stated, "Director A met with Caregiver B to discuss the medication error that took place on 06/29/2024. [Caregiver B] did not have a direct part in the actual error, however [s/he] did work the following day from roughly 8 AM - 8 PM. [Caregiver B] walked [Director A] through the events of the day. [S/he] stated that when [s/he] arrived, [s/he] noticed that [Resident 1] was not [his/her]self. [Resident 1] was not very steady on [his/her] feet and seemed to have a droopy face. [Caregiver B] reports that [s/he] did call the on-call manager as well as [his/her] regional supervisor to report the change in condition. [S/he] states [s/he] was told to continue to monitor [Resident 1] for any further change in condition. [Caregiver B] reports that [s/he] continued to monitor [Resident 1] and questioned [him/herself] about calling 911. [Caregiver B] reported that [s/he] did document the change in condition on the client daily logs as well."
-Caregiver C's discussion notes stated, "During that meeting, [Caregiver C] explained that [s/he] had passed medications on the morning of 06/29/2024. [S/he] stated that [s/he] followed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015293	A. BUILDING: _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEXT STEP IN RESIDENTIAL SERVICES WATER	W164 N9470 WATER STREET MENOMONEE FALLS, WI 53051

(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
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policy and procedure during that pass...[Director D] suspended [Caregiver C's] medication passing privileges indefinitely."

At approximately 10:30 a.m., Director A stated that the provider cannot be sure, and has not received a discharge summary from the hospital, but that Resident 1 started to experience a change in condition after the morning medication pass on 06/29/2024, so the provider suspects that a medication error may have been made where Resident 1 received Resident 2's medication(s) in error.

On 08/12/2024, Surveyor reviewed Resident 1's hospitalization from 07/01/2024 to 07/08/2024. Resident 1 was admitted to the hospital for weakness and inability to ambulate, with acute presentation 06/29-06/30. Resident 1 had tested positive for barbiturate reflex and for Phenobarbital. The hospital physician spoke with Resident 1's pharmacy and primary physician who confirmed that Resident 1 does not have Phenobarbital on his/her current medication list and there were no current medications that could explain Phenobarbital in Resident 1's system.

Surveyor reviewed Resident 2's physician orders which included an order for Phenobarbital 64.8mg tab to take 1 tablet every morning.