STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014987	A. BUILDING: _____ B. WING _____	R 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOSA RN ADULT FAMILY HOME	**4424 N 105TH STREET WAUWATOSA, WI 53225**

(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 10/15/2024, Surveyor completed a complaint investigation, verification visit and standard survey at Tosa RN Adult Family Home. As a result, 3 previous deficiencies were corrected, 3 deficiencies were recited, and 1 new deficiency was identified; therefore, a total of 4 deficiencies were cited. The complaint was unsubstantiated. Census: 4	{M 000}		
{M 232}	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 caregiver (Caregiver B) was screened for tuberculosis (TB) prior to providing cares. Caregiver B was screened for TB 115 days after her/his start date. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) 62TC11, dated 11/16/2021, and SOD U4QP12, dated 10/12/2020.	{M 232}		

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
	0014987	A. BUILDING: _____ B. WING _____	R 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOSA RN ADULT FAMILY HOME	**4424 N 105TH STREET WAUWATOSA, WI 53225**

(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 232}	Continued From page 1 Findings include: On 10/11/2024, at 10:45 AM, Surveyor reviewed employee files and identified the following: Caregiver B was hired on 05/31/2022. Caregiver B was screened for TB on 09/23/2022. On 10/11/2024, at 11:30 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was unaware of the requirements to ensure TB testing was completed prior providing care. Licensee A reported some of the employees were from Africa and needed to have a chest x-ray, due to the TB skin tests would come back as positive. Licensee A reported the x-rays needed to be scheduled and it took some time which is why the TB screening was late. Licensee A confirmed Caregiver B provided care to residents on her/his hire date. Surveyor relayed concerns about the delay in TB screening as the caregivers could be positive and pass TB to the residents.	{M 232}		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file.	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014987	A. BUILDING: _____ B. WING _____	R 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOSA RN ADULT FAMILY HOME	4424 N 105TH STREET WAUWATOSA, WI 53225

(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 464	Continued From page 2	M 464		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not obtain a written order prior to administering medications from the physician who prescribed medications to the resident, stating who can administer the medications for 1 of 2 residents (Resident 2). Resident 2's written order was completed 21 days after admission.

Findings include:

On 10/11/2024, at 11:15 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 07/18/2024, with diagnoses including atrial fibrillation, blood clots and syncope. Resident 2's record contained a doctor order, which indicated the order was taken via phone by Licensee A. The order indicated the following orders: admit to Tosa RN Adult Family Home, staff to administer pt [sic] medications, weekly vital signs and showers, outings as needed, regular diet, 1 assist with walker, soak feet in soap and water weekly, keep skin intact. The order was signed by Licensee A and Resident 2's physician on 08/08/2024, 21 days after admission.

On 05/22/2024, at 10:15 AM, Surveyors interviewed Licensee A. Licensee A confirmed the requirement to have a written order indicating who can pass resident prescription medications. Licensee A confirmed Resident 2 had been administered medications by staff since her/his admission. Licensee A reported s/he was unaware the order was needed prior to staff administering medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014987	A. BUILDING: _____ B. WING _____	R 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOSA RN ADULT FAMILY HOME	**4424 N 105TH STREET WAUWATOSA, WI 53225**

(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 530	Continued From page 3	M 530		
M 530	88.09(2)(a)8 TRAINING DOCUMENTATION Documentation of successful completion of the training requirements under HSS 88.04(5). This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain and keep up to date a personnel record for each service provider which included documentation of successful completion of the training requirements under s. DHS 88.04(5) for 1 of 2 employees reviewed (Caregiver C). Caregiver C's record did not contain evidence of 8 hours of annual training for 2023. DHS 88.04(5)(b) states "(5) TRAINING. (b) Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received." Findings include: On 10/11/2024, at 10:45 AM, Surveyor reviewed Caregiver C's file. Caregiver C was hired on 05/31/2022. Caregiver C's file did not contain any evidence of continuing education training for 2023. On 10/11/2024, at 11:30 AM, Surveyor interviewed Licensee A. Licensee A reported Caregiver C completed all continuing education training. Licensee A reported s/he would send the training to Surveyor by the end of the day.	M 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014987	A. BUILDING: _____ B. WING _____	R 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOSA RN ADULT FAMILY HOME	4424 N 105TH STREET WAUWATOSA, WI 53225

(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 530	Continued From page 4 On 10/15/2024, at 1:14 PM, Licensee A emailed Surveyor and stated, "I must of missed placed [Caregiver C's] education file. Can't find it ..."	M 530		
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 for 4 of 4 residents. The dryer vent consisted of a flexible type of material. This is a repeat deficiency. See Statement of Deficiency (SOD) U4QP11, dated 08/26/2019. Findings include: On 10/11/2024, at 10:34 AM, Surveyor observed the laundry area. The dryer had approximately 15 feet of flexible type vent. On 10/11/2024, at 11:30 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was not aware the dryer vent should be rigid	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014987	A. BUILDING: _____ B. WING _____	R 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOSA RN ADULT FAMILY HOME	**4424 N 105TH STREET WAUWATOSA, WI 53225**

(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 570	Continued From page 5 material. Licensee A reported s/he would get it fixed.	M 570		