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 04/23/2025

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 04/23/2025, Surveyor completed a verification visit and 2 complaint investigations at Tosa RN Adult Family home. As a result, 3 of the previous deficiencies were corrected, 1 deficiency was recited, and 1 new deficiency was identified. One complaint was substantiated, and 1 complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 4	{M 000}		
{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. 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 1 resident (Resident 3). Resident 3 did not have a written order which indicated who could	{M 464}		

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

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{M 464}	Continued From page 1 administer her/his medications This is a repeat deficiency. See Statement of Deficiency (SOD) 62TC12, dated 10/15/2024. Findings include: On 04/22/2025, at 11:00 AM, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 03/24/2025. Resident 3's record did not contain evidence of a written order from a physician indicating who could administer medications. On 04/22/2025, at 11:30 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 3 had been administered medications by staff since her/his admission. Licensee A reported s/he was unsure why the order was missing.	{M 464}		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it.	M 556		

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M 556	Continued From page 2	M 556		

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure the resident right to self-direction was respected or promoted for 1 of 1 resident in the home. Resident 2 was dropped off at the hospital when her/his funding ran out.

Findings include:

On 04/16/2025, the department received a complaint alleging a resident was dropped off at the hospital to be considered homeless.

Interviews

On 04/22/2025, at 10:40 AM, Surveyor interviewed Resident 2. Resident 2 reported on Licensee A took her/him to the Veteran's Affairs (VA) hospital first, and they would not admit her/him. Resident 2 then reported s/he went to the other hospital. Surveyor inquired if Resident 2 was sick or injured, Resident 2 stated, "I felt fine, I wasn't sick or nothing, I guess I ran out of money. You would need to ask [Licensee A]."

On 04/22/2025, at 11:40 AM, Surveyor interviewed Licensee A. Licensee A reported s/he gave Resident 2 a 30 day notice due to inability to pay. Licensee A reported s/he charged Resident 2 $250 a day. Surveyor requested to review invoices billed to Resident 2. Licensee A reported s/he did not have invoices, s/he would tell Resident 2 what s/he owed and Resident 2 would write a check. Licensee A reported s/he contacted the Aging Disability Resource Center (ADRC) for assistance with getting Resident 2 into a managed care organization (MCO). Licensee A reported the worker came out to assess Resident 2 and s/he had not heard anything back. Licensee A reported s/he took Resident 2 to the

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M 556	Continued From page 3	M 556		

hospital to talk with a social worker. Licensee A reported s/he took Resident 2 to the VA first and "the VA fought me." Licensee A reported s/he took Resident 2 to St. Joesph Hospital after. Licensee A reported s/he only took Resident 2 to the hospital to speak with a social worker because her/his funds ran out, but s/he did not leave Resident 2 there to be homeless. When Surveyor inquired if Licensee A stayed with Resident 2, s/he replied no, s/he had a baby at home. Licensee A reported the police brought Resident 2 back to the home.

Record Review

On 04/22/2025, at 10:50 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 07/18/2024 with diagnoses including atrial fibrillation, blood clots and syncope.

A doctor's order, dated 08/08/2024, indicated Resident 2 required the following services: 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.

An after-visit summary (AVS) from the emergency department of St. Joseph Hospital, dated 04/14/2025, which indicated the following:

"Reason for visit: Housing Issues."
"Diagnosis: Lack of housing."

On 04/24/2025, at 2:00 PM, Surveyor reviewed a police report, dated 04/14/2025, which indicated the following:

"04/14/2025 9:29 PM 70 [year old] [fe/male] from a group home. [Fe/Male] is out of funding, and

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M 556	Continued From page 4	M 556		

the owner dropped the [fe/male] off at the hospital. All property is at the group home. Owner drooped [sic] [her/him] off and left, stating 'I guess [s/he's] homeless now.' [Subject] is currently in the [emergency department] room 14."

"04/14/2025 11:01 PM [Resident 2] was dropped off by [her/his] group home owner [sic] [Licensee A] at the hospital. When questioned by hospital social work, [Licensee A] stated [Resident 2] was out of funding and [s/he] was leaving [her/him] at the hospital and that [s/he] was now homeless. I attempted to contact [Licensee A] multiple times with negative results. I spoke with [Resident 2] regarding [her/his] trip to the hospital. [Resident 2] stated [Licensee A] initially took [her/him] to the VA were [sic] [her/his] vitals were taken [sic] and [s/he] was immediately released. [Resident 2] said [s/he] was then brought to St Joseph where [Licensee A] then left [her/him]. [Resident 2] continued saying [s/he] lived at [Tosa RN Adult Family Home] for approximately 9 months [sic] and all [her/his] belongs [sic] were still at the residence. [Resident 2], along with hospital staff, confirmed [s/he had no medical need to be at the hospital. [Resident 2] stated [s/he] felt safe at the group home and was being treated well by staff. [Resident 2] requested to be given a ride home. [Resident 2] was provided a ride to [her/his] residence where [s/he] was welcomed by third shift staff."