STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013759	A. BUILDING: _____ B. WING _____	C 08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLAGG STREET MANOR LLC	**5845 N 92ND ST MILWAUKEE, WI 53223**

(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 08/09/2024, Surveyor conducted a standard survey and complaint investigation at Flagg Street Manor LLC. As a result, 8 deficient practices were identified. One complaint was unsubstantiated. Census: 2	M 000		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 interior doors used by residents who were not able to walk, had a clear	M 262		

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

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M 262	Continued From page 1	M 262		

opening of at least 32 inches. Two of 2 residents utilized wheelchairs for mobility. One of 3-bedroom doorways did not have a clear opening of at least 32 inches. The interior exit doorway, in the kitchen, leading to the exterior hall and to the secondary emergency exit door, did not have a 32-inch clear opening.

Findings include:

On 08/09/2024, at 9:30 a.m., Surveyor conducted an onsite tour of Flagg Street Manor LLC. Surveyor observed Resident 1 and Resident 2 in wheelchairs. Caregiver A confirmed both residents utilized wheelchairs for mobility.

At approximately 10:00 a.m., Surveyor observed a hallway off the family room. The hallway led to 3 bedrooms and 1 bathroom. During a tour of the facility, Surveyor observed scrapes, gouges and markings on the doorways and walls, caused by wheelchairs.

On 08/09/2024, at 10:50 a.m., Administrator A provided Surveyor with Resident Evacuation Plan. Administrator A confirmed the posted exit plan was current. The posted exit plan identified two emergency exits at the front of the facility.

The emergency exits were side by side doors located at the front of the facility, entering next to one another, with an interior wall separating the two doors. One door entered the facility living room. The second door entered a hallway that provided access to four areas within the duplex: the second floor, the basement, another exit on the side of the home and a door leading into the facility kitchen.

The kitchen door into the facility, which was

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M 262	Continued From page 2 identified as an a door out to the emergency exit, did not have a 32-inch clear opening. On 08/09/2024, at 1:30 p.m., Surveyor observed the first bedroom, located to the left, belonged to Resident 2. Resident 2's bedroom doorway had a clear opening of 29.5 inches. Resident 2's doorframe was observed to have multiple scrapes. Resident 2 utilized a motorized wheelchair for mobility. On 08/09/2024, at 1:40 p.m., Surveyor interviewed Administrator A, who recalled the interior doors had to have a clear opening of 32 inches for individuals who were non-ambulatory. Administrator A confirmed the kitchen exit did not have a 32-inch clear opening and the interior bedroom door did not have a clear opening of 32 inches.	M 262		
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 maintain a safe, clean, and well-maintained homelike environment for 2 of 2 residents in the home. The kitchen surfaces were sticky and dirty. The inside of the oven was soiled with brown and orange areas, consistent with	M 276		

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M 276	Continued From page 3	M 276		

dried food splatters. The outside glass oven door was being held together by a large office binder clip. There were black scuff marks along the walls in the hallway, and missing trim around the resident bathroom door.

Findings include:

On 08/09/2024, at 10:00 a.m., Surveyor toured the facility and observed the following:

Resident Bathroom

-The vanity light fixture was missing a light bulb.
-The bathroom ceiling fan/vent was not covered.
-The shower walls and tiled floor grout was stained dark brown/black, consistent with mold.
-The ceramic tile and grout, where the wall met the floor, was stained, and contained areas of mildew.
- The bathroom door trim was missing trim around one side of the bathroom door.
-The bathroom door trim was worn, gouged, and scratched on other sides.

Kitchen

-The stove top was sticky and dirty.
-The inside of the oven was soiled with brown and orange areas, consistent with dried food splatters. The interior door contained a sticky substance.
-The surrounding area, cabinet, and knobs were sticky and grimy to the touch. The back splash and vent were grimy and sticky.
-The outside glass oven door was being held together by a large office binder clip.

Hallway

-The hallway wall between Bedroom 1 and the

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M 276	Continued From page 4 resident bathroom contained large scrapes prominently focused on the bottom and the middle of the wall. -The hallway wall between resident bathroom and Bedroom 2 had a large wooden board, which was nailed to the wall. The board was painted beige and covered approximately half of the wall from floor to ceiling. There were scrapes out of the paint along the length of the hallway. The scape marks were prominently focused on the bottom and the middle of the board. The scrape marks were consistent with the approximate size of a wheelchair rubbing against the wall. -Around the corner from the kitchen, the medication door contained black scuff marks and scrapes across the full length of the door, approximately 16 inches high. On 08/09/2024, at 1:40 p.m., Surveyor interviewed Administrator A, who stated, "We just repainted a lot of this. Resident 2 has an electric wheelchair that scrapes the hallway walls. S/He is new and still learning to negotiate our home." On 08/09/2024, at 4:05 p.m., Surveyor interviewed Administrator A and House Manager (HM) B. Administrator A confirmed s/he was aware of the condition of the home. S/He noted the bathroom fan and lightbulbs should be fixed. Administrator A stated, "That looks like mold in the shower." House Manager (HM) B explained, "The clip on the oven door looks like it's there to hold things together."	M 276		
M 290	88.05(3)(e)2.b INSPECTIONS-GAS FURNACE A gas furnace shall be inspected and serviced every 3 years by a heating contractor or local utility company.	M 290		

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M 290	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the gas furnace was inspected and serviced every 3 years by a heating contractor or local utility company. The provider's furnace had not been serviced since 09/25/2020. Findings include: On 08/09/2024, at 10:25 a.m., Surveyor requested most recent gas furnace inspection. Administrator A stated Co-Licensee D would email it to Surveyor. On 08/09/2024 at 2:29 p.m., Surveyor received a copy of a gas furnace inspection dated 05/02/2017. On 08/09/2024, at 3:05 p.m., Surveyor interviewed House Manager (HM) B. HM B stated Co-Licensee D handled gas furnace inspections. On 08/09/2024, at 3:05 p.m., Surveyor interviewed Administrator A, who confirmed the gas furnace inspection was overdue, and they would schedule it soon. On 09/12/2024 at 2:00 p.m., Surveyor reviewed Department records for provider, including documentation of physical plant. Surveyor located evidence of gas furnace inspection dated 09/25/2020.	M 290		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS	M 332		

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M 332	Continued From page 6 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 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 extinguishers were located on each floor of the facility for 1 of 2 floors. There was no fire extinguisher in the basement. Findings include: On 08/09/2024, at 3:05 p.m., Surveyor toured the facility's physical environment with House Manager (HM) B. Surveyor observed that there was not a fire extinguisher in the basement. On 08/09/2024, at 3:05 p.m., Surveyor interviewed HM B. Surveyor asked HM B to identify the location of the fire extinguisher in the	M 332		

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M 332	Continued From page 7 basement. HM B stated, "There is not a fire extinguisher in the basement. I never saw one. I'll text [Co-Licensee D]." On 08/09/2024, at 3:09 p.m., HM B received a text from Co-Licensee D, who confirmed there was not a fire extinguisher in the basement. On 08/09/2024, at 4:05 p.m., Surveyor interviewed Administrator A, who confirmed s/he would let [Co-Licensee D] know the code required a fire extinguisher on each floor of the facility.	M 332		
M 338	88.05(4)(c)1 EXITING FROM THE FIRST FLOOR Exiting from the first floor. The first floor of the home shall have at least 2 means of exiting which provides unobstructed access to the outside. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the first floor of the home had at least 2 means of exiting which provided unobstructed access to the outside for 2 of 2 residents. The path to the rear exit, identified at an emergency exit, was blocked by two 18-inch x (by)18-inch x 24-inch U-Haul cardboard boxes. Surveyor observed a 2-foot by 3-foot rug, with curled up corners. Findings include: On 08/09/2024, at 10:00 a.m., Surveyor toured facility and observed 2 exits. Surveyor verified that exits were both indicated on the emergency	M 338		

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M 338	Continued From page 8 exit plan. The second exit was a rear door, in the kitchen, that opened to a hallway. Surveyor observed two 18-inch x (by)18-inch x 24-inch U-Haul cardboard boxes and a 2-foot by 3-foot rug, with curled up corners underneath the boxes. On 08/09/2024, at 1:50 p.m., Surveyor interviewed Administrator A, who confirmed the cardboard boxes and the rug with curled up corners were blocking the emergency exit. Administrator A confirmed that the boxes were obstructing access to the outside for the residents in case of an emergency.	M 338		
M 342	88.05(4)(d)1 FIRE SAFETY EVACUATION PLAN The licensee shall have a written plan for the immediate and safe evacuation of all occupants of the home in the event of a fire. The plan shall identify an external meeting place. This Rule is not met as evidenced by: Based on record review, observation and interview, the provider did not have a written plan for the immediate and safe evacuation of all occupants of the home in the event of a fire or natural disaster. Resident 1 and Resident 2 were Hoyer Lift transfer assists and listed as Point of Rescue (POR) on their evacuation assessments. The provider did not consult with their local fire department to prepare a fire safety evacuation plan. Findings include: On 08/09/2024, at 9:30 a.m., Surveyor conducted	M 342		

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M 342	Continued From page 9	M 342		

an onsite tour of Flagg Street Manor LLC. Surveyor observed Resident 1 and Resident 2 in wheelchairs. Caregiver A confirmed both residents utilized wheelchairs for mobility and required a mechanical lift for transfers.

On 08/09/2024, at 10:50 a.m., Administrator A provided Surveyor with Resident Evacuation Plan. Administrator A confirmed posted exit plan was current. The posted exit plan identified three emergency exits.

On 08/09/2024, at 11:00 a.m., Surveyor interviewed Administrator A and House Manager (HM) B. HM B stated when the facility conducted a fire drill, Resident 2 usually stayed in his/her bedroom. Surveyor asked what the provider would do if the residents were in bed and there was a fire, since both residents utilized wheelchairs for mobility and required a mechanical lift for transfers. HM B stated, "We would leave the residents in bed with the door closed. We would put a blanket or towel under the door and call 911 to let fire department know what room the residents are in."

On 08/09/2024, at 11:15 a.m., Surveyor asked Administrator A and House Manager (HM) B to see the providers written fire safety evacuation plan from when they consulted with their local fire department. Administrator A stated s/he had no knowledge of that. HM B stated s/he was not aware of that being done.

On 08/09/2024, at 11:40 a.m., Surveyor reviewed Resident 1's Resident Evacuation Assessment, updated on 08/18/2023. It read, "[Resident 1] stays at designated location in a safe area." It was hand marked, "yes."

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M 342	Continued From page 10 On 08/09/2024, at 11:50 a.m., Surveyor reviewed Resident 2's Resident Evacuation Assessment, dated on 08/01/2024. It read, "[Resident 2] stays at designated location in a safe area." It was hand marked, "yes". The document included a hand-written, evaluator remark, "[Resident 2] will remain in bedroom if s/he cannot get out in time [sic] Meaning in bed [sic] door would be closed [sic] blanket or towel will be under door [sic] call 911 and let fire department know what room [Resident 2] in [sic]". On 09/12/2024 at 3:30 p.m., Surveyor reviewed note section for Wis. Admin. Code § DHS 88.05(4)(d), which stated, "Licensees are encouraged to consult with their local fire department in preparing a fire safety evacuation plan."	M 342		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the	M 380		

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M 380	Continued From page 11 provider did not ensure each resident admitted to the facility was screened for communicable disease, including tuberculosis (TB), for 1 of 1 resident. Resident 2 was not screened for communicable disease, including TB. Findings include: On 08/09/2024, at 12:15 p.m., Surveyor reviewed the resident roster provided by Co-Licensee D and identified the following: Resident 2 was admitted to the home on 08/01/2024. On 08/09/2024, at 11:45 a.m., Surveyor requested to review Resident 2's record. Resident 2's record contained a document with his/her name at the top, dated 08/01/204, that read, "Resident mentioned above is in good health and free of any illness that would be detrimental to the other resident's, including TB." No additional records were available. On 08/09/2024, at 12:05 p.m., Surveyor interviewed House Manager (HM) B regarding Resident 2's TB test. HM B stated, "I thought it was done. I thought we had it signed." On 08/09/2024, at 3:20 p.m., Surveyor interviewed Resident 2 who stated s/he did not have a TB test prior to moving into the facility.	M 380		
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	M 466		

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M 466	Continued From page 12	M 466		

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 observation, record review, and interview, the provider did not ensure a record was kept of all prescription medications controlled, dispensed, and administered by the provider for 1 of 1 resident. Resident 1 requested the provider to control, dispense, and administer their medications to them. Resident 1's clonazepam record did not match the physical count of pills available.

Findings include:

On 08/09/2024, at 9:30 a.m., Surveyor conducted an onsite tour of Flagg Street Manor LLC. Caregiver A confirmed s/he dispensed medication for Resident 1.

Surveyor requested to see Resident 1's clonazepam. Caregiver A showed Surveyor two clonazepam cards for Resident 1's clonazepam: one for morning and one for bedtime. Surveyor observed Resident 1 had a total of 6 pills: three in each pill card on hand.

Caregiver A explained that at the end of each shift, the caregivers counted the medications in the cards and documented in the electronic medication administration record (MAR) what was left in the cards.

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M 466	Continued From page 13 Surveyor requested to confirm the count with the MAR. Caregiver A showed Surveyor Resident 1's clonazepam medication count in his/her MAR. The last clonazepam administered was at 7:04 a.m. and the total number of pills documented was 16. Surveyor asked Caregiver A why s/he put the count of '16' in the computer, when the actual count was six. Caregiver A stated if s/he tried to add the correct number, the electronic MAR would not allow it. Only House Manager (HM) B could fix any medication errors. Caregiver A had reported the error to HM B previously. On 08/09/2024, at 10:10 a.m., Surveyor interviewed HM B regarding the medication count being off. HM B stated, "The numbers are off because the caregivers do not document the way they are supposed to." Surveyor followed up HM B's statement by asking who and when is monitoring of the medication happening. HM B stated s/he was responsible for caregiver and medication count oversight.	M 466		