STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016513	A. BUILDING: _____ B. WING _____	C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
K & D AFH LLC 4	2627 JEAN AVE RACINE, WI 53404

(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 02/20/2024 with information gathered through 02/21/2024, Surveyors conducted a standard survey and complaint investigation at K&D AFH LLC 4. Eleven deficiencies identified. One complaint substantiated. Census: 1	M 000		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke,	M 114		

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

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M 114	Continued From page 1 refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 staff members (Caregiver E and Caregiver F) reviewed had background checks. A complete background check consists of the following: - A completed Background Information Disclosure (BID) form. - A report of findings from the Department of Justice (DOJ). - Integrated Background Information System (IBIS) letter from the Department of Health Services (DHS). Findings include: On 02/20/2024 at approximately 12:00 PM, Surveyor requested staff records for Caregiver E and Caregiver F. House Manager (HM) A reported s/he did not have access to the staff records because Administrator C was the one who normally managed those, but s/he had doctor appointments scheduled so s/he was not sure when s/he would have access to send Surveyors the information. Surveyors asked how long Caregiver E and Caregiver F had been working there. HM A stated they had both worked there for at least 2 years. Surveyors gave HM A	M 114		

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M 114	Continued From page 2 until 02/21/2024 at 8:00 AM to send evidence of background checks for Caregiver E and Caregiver F. As of 02/21/2024 at 8:00 AM, no additional information was received. On 02/21/2024 at approximately 1:22 PM, Surveyors interviewed Licensee B about not receiving any additional information from HM A. Licensee B reported, "unfortunately [s/he] wasn't able to meet the timeframe so I am aware of the fines and penalties."	M 114		
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 2 of 2 employees reviewed received tuberculosis (TB) skin tests. Caregiver E and Caregiver F did not have evidence of a TB skin test within 90 days of hire. Findings include: On 02/20/2024 at approximately 12:00 PM,	M 232		

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M 232	Continued From page 3 Surveyor requested staff records for Caregiver E and Caregiver F. House Manager (HM) A reported s/he did not have access to the staff records because Administrator C was the one who normally managed those, but s/he had doctor appointments scheduled so s/he was not sure when s/he would have access to send Surveyors the information. Surveyors asked how long Caregiver E and Caregiver F had been working there. HM A stated they have both worked there for at least 2 years. Surveyors gave HM A until 02/21/2024, at 8:00 AM, to send evidence of TB skin tests for Caregiver E and Caregiver F within 90 days of hire. As of 02/21/2024 at 8:00 AM, no additional information was received. On 02/21/2024 at approximately 1:22 PM, Surveyors interviewed Licensee B about not receiving any additional information from HM A. Licensee B reported, "unfortunately [s/he] wasn't able to meet the timeframe so I am aware of the fines and penalties."	M 232		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid.	M 244		

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M 244	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees reviewed received 15 hours of orientation training within 6 months of hire. Caregiver E and Caregiver F did not have evidence of 15 hours of orientation training within 6 months of hire. Findings include: On 02/20/2024 at approximately 12:00 PM, Surveyor requested staff records for Caregiver E and Caregiver F. House Manager (HM) A reported s/he did not have access to the staff records because Administrator C was the one who normally managed those but s/he had doctor appointments scheduled, so s/he was not sure when s/he would have access to send Surveyors the information. Surveyors asked how long Caregiver E and Caregiver F had been working there. HM A stated they had both worked there for at least 2 years. Surveyors gave HM A until 02/21/2024 at 8:00 AM to send evidence of 15 hours of initial orientation training for Caregiver E and Caregiver F within 6 months of hire. As of 02/21/2024 at 8:00 AM, no additional information was received. On 02/21/2024 at approximately 1:22 PM, Surveyors interviewed Licensee B about not receiving any additional information from HM A. Licensee B reported, "unfortunately [s/he] wasn't able to meet the timeframe so I am aware of the fines and penalties."	M 244		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and	M 246		

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M 246	Continued From page 5 (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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each caregiver completed 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights, and treatment of residents for 2 of 2 employees who required annual training. Caregiver E and Caregiver F did not receive annual training in 2023. Findings include: On 02/20/2024 at approximately 12:00 PM, Surveyor requested staff records for Caregiver E and Caregiver F. House Manager (HM) A reported s/he did not have access to the staff records because Administrator C was the one who normally managed those, but s/he had doctor appointments scheduled so s/he was not sure when s/he would have access to send Surveyors the information. Surveyors asked how long Caregiver E and Caregiver F had been working there. HM A stated they had both worked there for at least 2 years. Surveyors gave HM A until 02/21/2024 at 8:00 AM to send evidence of continuing education for calendar year 2023 for Caregiver E and Caregiver F.	M 246		

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M 246	Continued From page 6 On 02/21/2024 at approximately 1:22 PM, Surveyors interviewed Licensee B about not receiving any additional information from HM A. Licensee B reported, "unfortunately [s/he] wasn't able to meet the timeframe so I am aware of the fines and penalties."	M 246		
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, record review, and interview, the provider did not ensure the home was safe, clean, and well-maintained for 1 of 1 (Resident 1) resident residing in the home. The living room and hallway heating vents were covered with a heavy layer of a black dust-like substance. -The living room heating vent, underneath the picture window, was covered with an orange-colored substance consistence with rust. -The kitchen floor contained an area, approximately 3 feet x 2 feet of brown and dark orange discoloration. -An area around the floor drain of the basement, approximately 2 feet to 4 feet, contained what appeared to be dry sewage backup. Findings include: On 02/20/2024, between 12:00 PM and 12:15	M 276		

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M 276	Continued From page 7 PM, Surveyor toured the facility and observed the following: -The living room and hall heating vent was covered in a heavy layer of a black substance consistent with mold. -The living room heating vent, underneath the picture window, was covered with an orange-colored substance consistence with rust. -The kitchen floor, near the back door, contained an area, approximately 3 feet x 2 feet of brown and dark orange discoloration. -An area around the floor drain in the basement, approximately 2 feet to 4 feet, contained what appeared to be dry sewage backup. There was dried brown unknown substance and dried white substance consistent with toilet paper. The area was directly in front of the washer and dryer. On 02/20/2024, at 12:30 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 10/02/2023 with a diagnosis of chronic pulmonary obstructive disease. On 02/20/2024, at 12:40 PM, Surveyor interviewed House Manager (HM) A. HM A reported a staff member dropped hot grease on the kitchen floor which caused the stain. HM A reported the sewer drain backed up about 3 weeks ago. HM A reported staff were working on cleaning it up. HM A reported there were no residents or staff until October 2023. HM A confirmed the home needed deep cleaning.	M 276		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one	M 332		

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M 332	Continued From page 8 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, record review and interview, the provider did not ensure 2 of 2 fire extinguishers were inspected annually by an authorized dealer. The fire extinguisher in the kitchen and the fire extinguisher in the basement had an inspection tag of July 2022. Findings include: On 02/20/2024, at 12:15 PM, Surveyor observed fire extinguishers in the kitchen and in the basement. Both fire extinguishers had an inspection tag of July 2022. Both fire extinguishers were due to be serviced in July 2023. On 02/20/2024, at 12:35 PM, Surveyor reviewed	M 332		

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M 332	Continued From page 9 Resident 1's record. Resident 1 was admitted 10/02/2023. On 02/20/2024, at 12:20 PM, Surveyor interviewed House Manager (HM) A. HM A confirmed s/he was aware of the requirement to have the fire extinguishers serviced annually. HM A reported the home had no residents for 2 years and did not have the fire extinguishers serviced. Cross Reference 0334 DHS 88.05(4)(b)(1) Fire Safety-Smoke Detectors Cross Reference 0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing and Maintenance	M 332		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there was a smoke detector in 4 of	M 334		

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M 334	Continued From page 10 6 required locations. There were no smoke detectors in the living room, Resident 1's bedroom, and at the head of each open stairway. Findings include: On 02/20/2024, at 12:05 PM, Surveyor toured the home and observed the following: -The living room did not contain a smoke detector, only the base was attached to the ceiling. -Resident 1's bedroom did not contain a smoke detector, only the base was attached to the ceiling. -The open stairway near the back door did not contain a smoke detector, only the base was attached to the ceiling. On 02/20/2024, at 12:10 PM, Surveyor interviewed House Manager (HM) A regarding the smoke detectors. HM A reported staff removed them from the base last week to change the batteries. HM A reported s/he was waiting for new batteries. HM A reported staff removed them a week ago. Cross Reference 0332 DHS 88.05(4)(b) Fire Safety-Fire Extinguishers Cross Reference 0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing and Maintenance	M 334		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is	M 336		

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M 336	Continued From page 11 operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure monthly smoke detector testing for 2 of 2 years reviewed. There was no evidence smoke detectors were checked in 2022 and 2023. Findings include: On 02/20/2024, Surveyor reviewed safety records for the facility. There was no evidence of smoke detector testing to date. On 02/20/2024 at 12:05 PM, Surveyors interviewed House Manager (HM) A regarding the smoke detector testing. HM A stated the smoke detector checks would be in the records if they were completed. HM A reported they did not complete the monthly smoke detector checks because there were no residents living in the house until Resident 1 moved in which was in October of 2023. Cross Reference 0332 DHS 88.05(4)(b) Fire Safety-Fire Extinguishers Cross Reference 0334 DHS 88.05(4)(b)(1) Fire Safety-Smoke Detectors	M 336		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a	M 404		

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M 404	Continued From page 12	M 404		

written assessment and individual service plan is completed and developed for each resident within 30 days after placement.

This Rule is not met as evidenced by:
Based on record review and interview, the licensee did not ensure a written assessment and individual service plan (ISP) was completed for 1 of 1 resident (Resident 1) within 30 days of placement.

Findings include:

On 02/20/2024, Surveyors reviewed Resident 1's record and identified the following:

-Resident 1 was admitted to the facility on 10/02/2023.
-Resident 1's record did not contain a written assessment
-Resident 1's ISP was signed by Resident 1's previous facility's administrator and did not have a date on it.
-Resident 1 is his/her own decision maker.
-Resident 1 did not sign his/her current ISP.

On 02/20/2024 at 12:15 PM, Surveyor interviewed Resident 1. Resident 1 reported s/he had never seen his/her ISP that Surveyor showed him/her. Resident 1 stated the signature on the ISP was from the previous administrator at a different facility, so s/he was not sure where the provider even received the information from.

On 02/20/2024 at approximately 12:20 PM, Surveyors interviewed HM A. HM A stated s/he was not sure who the person was that signed

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M 404	Continued From page 13 Resident 1's ISP, but it was nobody that worked at the facility. HM A stated Administrator C was the one who was responsible for the ISP and s/he did not do it when Resident 1 was admitted because s/he had been out sick. HM A reported a new assessment was never completed because Resident 1 used to live at the facility about 2 years ago, so they just re-admitted Resident 1 and just updated the dates on the old assessment. HM A stated Resident 1's assessment/ISP needed to be redone since there was no date on it, it was not completed by someone that worked at the facility, and Resident 1 did not sign it.	M 404		
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. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the provider did not ensure the residents had the opportunity to make decisions related to care, activities, and other aspects of life for 1 of 1 resident. Resident 1 was unable to remain in her/his home during the day.	M 556		

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M 556	Continued From page 14 Findings include: On 02/20/2024, the Department received a complaint alleging residents had to spend the day at another facility owned by the licensee. On 02/20/2024, Surveyor reviewed the Department's facility file. Surveyor did not observe any waivers or client rights limitation. On 02/20/2024, at 10:55 AM, during a survey at K & D AFH II, another facility owned by the licensee, Surveyor observed Resident 1 in the facility. Resident 1 was observed using the restroom and walking in and out of the home. On 02/20/2024, at 10:55 AM, Surveyor interviewed Resident 1. Resident 1 reported s/he did not live at the facility s/he was observed in, but at another one owned by Licensee B. Resident 1 reported s/he was unable to stay at her/his home Monday through Friday, from approximately 7:00 AM until 3:00 PM. Resident 1 reported s/he had to remain at the other facility owned by Licensee B. Surveyor asked Resident 1 where s/he wanted to be. Resident 1 reported s/he would prefer to be in her/his own home. On 02/20/2024, at 11: 10 AM, Surveyor interviewed Person D, a resident from a different facility owned by Licensee B. Person D reported s/he was a resident at another facility owned by Licensee B. Person D confirmed her/himself, Resident 1 and 2 other residents were unable to spend their days at their homes. Person D reported the residents from other homes had to spend Monday through Friday at a different facility owned by Licensee B.	M 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016513	A. BUILDING: _____ B. WING _____	C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
K & D AFH LLC 4	2627 JEAN AVE RACINE, WI 53404

(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 556	Continued From page 15 On 02/20/2024, at 11:40 AM, Surveyor interviewed House Manager (HM) A. HM A confirmed Resident 1 stayed at another facility, not her/his home, during the day. HM A stated, "[Administrator C] said they have to be here." On 02/20/2024, at 12:30 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 10/02/2023. Resident 1 was identified as her/his own decision maker.	M 556		
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 interview, observation, and record review, the provider did not ensure 1 of 1 resident received all prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1 did not receive the prescribed Ingrezza (medication that treats movements in the face, tongue, or other body parts that cannot be controlled) between 01/20/2024 and 01/29/2024. Findings include: On 02/20/2024, at 12:10 PM, Surveyor interviewed Resident 1. Resident 1 reported s/he	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016513	A. BUILDING: _____ B. WING _____	C 02/21/2024

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M 582	Continued From page 16	M 582		

had not received her/his night medications for several days. Resident 1 reported s/he was out and needed more.

On 02/20/2024, at 12:30 PM, Surveyor observed Resident 1's medications in the medication closet. Stored on the shelf were 2 full cards, 31-day supply of Ingrezza. The medication cards were dated 01/12/2024 and 02/12/2024.

On 02/20/2024, at 12:35 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted 10/02/2023, with diagnoses including bipolar II and schizoaffective disorder. Resident 1's individual service plan, undated, indicated Resident 1's medications were administered by staff. Resident 1's January 2024 medication administration record (MAR) indicated Resident 1 was prescribed Ingrezza 80 milligrams daily at bedtime. Resident 1's January 2024 MAR, between 01/20/2024 and 01/29/2024 contained blank boxes.

On 02/20/2024, at 12:40 PM, Surveyor interviewed House Manager (HM) A. HM A confirmed staff administered Resident 1's medications. HM A reviewed Resident 1's medication cards and confirmed cards were full. HM A reported the medication card, dated 01/12/2024, should not have been full. HM A reported s/he was unaware Resident 1 did not receive her/his medications. HM A stated, "[Staff] should be giving the medications."