STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014895	A. BUILDING: _____ B. WING _____	R-C 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON II	7019 W HAMPTON AVENUE MILWAUKEE, WI 53218

(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
{N 000}	Initial Comments On 04/25/2024, Surveyor completed a standard survey, a complaint investigation, and a verification visit at Hampton II. As a result, 9 deficiencies were identified, 2 deficient practices were a repeat deficiency. See Statement of Deficiency (SOD) BZPE11, dated 08/20/2021, and SOD BZPE12, dated 09/13/2022. One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 5	{N 000}		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the administrator did not ensure s/he supervised the daily operation of the Community Based Residential Facility (CBRF), including but not limited to resident care and supervision, personnel, and physical plant. Resident 1 had eloped and sustained a gunshot wound. Resident	N 214		

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

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N 214	Continued From page 1	N 214		

1 did not have an Individual Service Plan (ISP) developed. Staff did not have completed continuing education training. Water temperature in resident bathrooms was too hot. Food found in the kitchen was expired and not labeled or stored correctly.

Findings include:

This facility is licensed to serve up to 6 residents in the client group of developmentally disabled.

On 04/10/2024, Surveyor conducted a standard survey, verification visit, and complaint investigation at Hampton II. As a result of the survey, the following 10 deficiencies were identified, 2 deficient practices were repeat deficiencies:

83.15(3)(a) Administrator Shall Supervise Daily Operations
83.25 Continuing Education (repeat)
83.27(2)(c) Admissions Compatible with Program Statement
83.32(3)(i) Rights of Residents: Adequate Treatment
83.35(3)(a) Comprehensive Individualized Service Plan
83.37(1)(g) Disposition of Medications
83.38(1)(b) Supervision
83.41(3)(b) Food Safety (repeat)
83.55(6)(b) Bath and Toilet Areas: Water Temperature
50.09(1)(f) Resident's Rights in Certain Facilities

On 04/25/2024, 10:00 AM, Surveyor interviewed Licensee A. Licensee A confirmed s/he was also the administrator. Licensee A reported s/he would come to the facility weekly or sometimes every other day. Licensee A reported s/he utilized lead

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N 214	Continued From page 2 staff to assist with the home. Licensee A reported s/he was currently transitioning 2 new lead staff.	N 214		
{N 277}	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 2 of 2 staff received at least 15 hours per calendar year of continuing education in 2022 and 2023. Caregiver T did not have any evidence of continuing education in 2022 and 2023. Caregiver F did not have at least 15 hours per calendar year of continuing education in 2022 and 2023. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) BZPE11, dated 08/20/2021, and SOD BZPE12, dated 09/13/2022. Findings include: On 04/10/2024, at approximately 2:30 PM,	{N 277}		

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{N 277}	Continued From page 3 Surveyor interviewed Licensee A. Licensee A reported s/he had the credentials and completed all continuing education for her/his staff in-house. Licensee A reported s/he had a sign-in sheet at each training s/he held. Surveyor requested continuing education documentation for Caregiver F and Caregiver T. Licensee A reported Caregiver T was a rehire on 03/05/2024. When surveyor inquired if Caregiver T had the orientation training completed upon rehire, Licensee A reported Caregiver T was not a rehire, but had limited hours s/he worked. Licensee A reported Caregiver T did not separate from the facility but was working on an on-call basis for a few months and went back to full-time status on 03/05/2024. On 04/22/2024, Licensee A provided the following documentation of completed in-house trainings s/he held in 2022 and 2023: 1. Sign-in sheet labeled 'Group Training Record' for 05/19/2022; training held from 12:00 PM - 2:30 PM, for a total of 2.5 hours. The topics included were client issues, individual service plans (ISPs), staffing issues, annual training on first aid and emergency procedures, and Occupational Safety and Health Administration (OSHA). 2. Sign-in sheet labeled 'Group Training Record' for 07/06/2022; training held from 12:00 PM - 2:45 PM, for a total of 2.75 hours. The topics included were client issues, ISPs, staff concerns, and annual training on confidentiality, safe driving, and fire safety. 3. Sign-in sheet labeled 'Group Training Record' for 09/15/2022; training held from 12:00 PM - 3:00 PM, for a total of 3 hours. The topics included were client issues, ISPs, documentation,	{N 277}		

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{N 277}	Continued From page 4 staff issues, and annual training on medication training. 4. Sign-in sheet labeled 'All Staff Meeting Omega Community Services Agenda' for 12/08/2022; annual training during the meeting was a total of 2.5 hours. The topics included were resident rights and abuse/neglect. 5. Sign-in sheet labeled 'Group Training Record' for 03/24/2023; training held from 12:00 PM - 2:45 PM, for a total of 2.75 hours. The topics included were tracking documentation, client cares, healthy foods, and annual training on confidentiality, safe driving, client issues, and ISPs. 6. Sign-in sheet labeled 'Group Training Record' for 05/26/2023; training held from 12:00 PM - 2:30 PM, for a total of 2.5 hours. The topics included were client oral care, healthy foods, spring cleaning, OSHA, and annual training on first aid, emergency procedures, client issues, and ISPs. 7. Sign-in sheet labeled 'Group Training Record' for 07/28/2023; training held from 12:00 PM - 2:30 PM, for a total of 2.5 hours. The topics included were communication, company resources, and annual training on abuse, neglect and misappropriation, resident rights, client issues, and ISPs. 8. Sign-in sheet labeled 'Group Training Record' for 11/17/2023; training held from 12:00 PM - 3:00 PM, for a total of 3 hours. The topics included were communication, tracking, healthy foods, cleaning, and annual training on fire safety, medication management, client issues, and ISPs.	{N 277}		

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{N 277}	Continued From page 5 On 04/23/2024, Surveyor reviewed caregiver training records and identified the following: Caregiver T was hired on 01/01/2014. Caregiver T's record did not include evidence of continuing education for 2022 or 2023. Caregiver F was hired on 01/01/2014. Caregiver F's record did not have evidence of continuing education in client group related training for residents with developemental disabilities and behaviors related to the client group for 2022 and 2023. Caregiver F's record reported a total of 10.75 hours of continuing education for 2022 and a total of 10.75 hours of continuing education for 2023, which did not meet the requirement of at least 15 hours per calendar year. On 04/25/2024, at 10:00 AM, Surveyor interviewed Licensee A. Licensee A reported Caregiver T worked most of 2023 on a part-time/on-call basis, but did not recall the exact date s/he went from full-time status to part-time status. Licensee A reported Caregiver T was supposed to bring in documentation of trainings s/he attended at her/his other job, but Licensee A never received documentation. Surveyor inquired if Licensee A was aware of how many continuing education hours are required each year. Licensee A reported 15 hours of continuing education were required annually. Licensee A was unaware her/his in-house trainings totaled 10.75 hours annually, and not the required 15 hours. Licensee A stated, "I'm trying to ramp it up. I usually complete in-house training 6 times a year." Surveyor inquired about the in-house trainings and what each topic entailed. Licensee A did not complete in-house trainings which covered client group.	{N 277}		

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N 289	Continued From page 6	N 289		
N 289	83.27(2)(c) Admissions compatible with program statement A CBRF may not admit or retain any of the following persons: A person who has physical, mental, psychiatric or social needs that are not compatible with the client group as described in the CBRF ' s program statement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed (Resident 2) met the criteria of the client groups as described by the facility's program statement and license. Findings include: The provider is a class AA Community Based Residential Facility (CBRF) licensed to serve 6 ambulatory residents in the client groups of developmentally disabled and public funding. On 04/23/2024, Surveyor reviewed Resident 2's records and identified the following: Resident 2 was admitted on 06/01/2023 with the following diagnoses: hypokalemia, constipation, gastroesophageal reflux disease (GERD), Hyperlipidemia, vitamin D deficiency, high cholesterol, essential hemorrhagic thrombocythemia, chronic mild anemia, myocardial infarction, benign essential hypertension, hypotension, moderate to severe aortic stenosis, syncope, arthritis, arthralgia, chronic pain, weakness, hydrocephalus, amnesia, Chronic obstructive pulmonary disease (COPD), shortness of breath (SOB), reactive airway disease, anxiety disorder, memory impairment,	N 289		

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N 289	Continued From page 7	N 289		

major depressive disorder, suicidal ideations, vertigo, bilateral hearing loss, onychomycosis, alcohol use disorder/abuse, cocaine use disorder, opioid abuse, cannabis abuse, drug dependence, dizziness, and nicotine dependence.

On 04/23/2024, Surveyor reviewed caregiver training records and identified the following:

Caregiver T was hired on 01/01/2014. Caregiver T's record did not have evidence of continuing education in the area of client group.

Caregiver F was hired on 01/01/2014. Caregiver F's record did not have evidence of continuing education in the area of client group.

On 04/24/2024, Surveyor reviewed the provider's program statement which stated target groups served are: "developmental disabilities;" target groups not served are: "alcoholic, correctional persons, drug dependent, mental illness, social disabilities accompanying pregnancy, disabilities associated with infirmities of aging, and physical disabilities."

On 04/24/2024, Surveyor reviewed Resident 2's long term care plan completed on 02/14/2023, by RN Case Manager W and observed the following:

Resident 2 was screened and the report stated her/his target groups were "frail elder and severe and persistent mental illness."

At the time of admission, Resident 2 did not have a diagnosis of developmentally disabled.

On 04/25/2024, at 10:00 AM, Surveyor interviewed Licensee A. Surveyor inquired what diagnoses Resident 2 had. Licensee A reported

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N 289	Continued From page 8 s/he had been working with a neurologist to figure out Resident 2's memory issues. Licensee A reported Resident 2 had anemia, anxiety, gastroesophageal reflux disease (GERD), alcohol and other drug abuse (AODA) issues, including alcohol dependence and drug use. Surveyor inquired what client groups Hampton II served. Licensee A reported having served the following client groups: developmental disability, mental health, cognitive delays, traumatic brain injury, and memory. Surveyor inquired, "Are you aware you are licensed, and your program statement states you only serve developmental disability clients?" Licensee A stated, "only?" Licensee A reported s/he will look into applying for an amendment with the Department.	N 289		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the	N 386		

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N 386	Continued From page 9	N 386		

provider did not develop a comprehensive individualized service plan (ISP) for 1 of 2 residents reviewed (Resident 2), to identify her/his needs, desired outcomes, program services, frequency, approaches; to establish measurable goals; and specify methods and who is responsible for delivering care.

Findings include:

On 04/10/2024, at 1:47 PM, Surveyor reviewed resident files for Resident 2 and identified the following:

Resident 2 was admitted on 06/01/2023 and received funding from Community Care. Resident 2 had diagnoses of hypokalemia, constipation, gastroesophageal reflux disease (GERD), Hyperlipidemia, vitamin D deficiency, high cholesterol, essential hemorrhagic thrombocythemia, chronic mild anemia, myocardial infarction, benign essential hypertension, hypotension, moderate to severe aortic stenosis, syncope, arthritis, arthralgia, chronic pain, weakness, hydrocephalus, amnesia, Chronic obstructive pulmonary disease (COPD), shortness of breath (SOB), reactive airway disease, anxiety disorder, memory impairment, major depressive disorder, suicidal ideations, vertigo, bilateral hearing loss, onychomycosis, alcohol use disorder/abuse, cocaine use disorder, opioid abuse, cannabis abuse, drug dependence, dizziness, and nicotine dependence. Resident 2 did not have an ISP in her/his file which detailed her/his needs, desired outcomes, program services, frequency, approaches, measurable goals, methods and who is responsible for delivering care.

On 04/10/2024, at approximately 1:50 PM,

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N 386	Continued From page 10 Surveyor interviewed Licensee A. Licensee A reported staff removed the current ISPs from the residents' files to view. Licensee A stated, "an old lead staff left on March 1st and some of my paperwork might be in her mailbox." As of 04/23/2024, at 4:45 PM, Surveyor had not received an ISP for Resident 2. On 04/25/2024, at 10:00 AM, Surveyor interviewed Licensee A. Licensee A reported s/he and her/his lead staff are responsible for creating ISPs. Licensee A reported the resident, and their entire team was a part of the creating resident ISPs and completing 6-month reviews of the ISPs. Licensee A did not report having an ISP for Resident 2.	N 386		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness,	N 406		

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N 406	Continued From page 11 sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not establish an effective procedure for proper destruction and disposal of expired medications. Expired medications were observed stored with residents' non-expired medications for 4 of 6 residents (Resident 4, Resident 1, Resident 3, and Resident 5). Resident prescription medications from previous months were located inside the medication closet, totaling 7 expired medications. Findings include: On 04/10/2024, at 11:40 AM, Surveyor observed the medication closet and observed the following medications: Resident 4: - Loperamide 2 milligrams (mg) capsule as needed (PRN); quantity 30, do not use beyond 12/13/2023 - Unlabeled clear plastic bag which contained 2 burnt rolled cigarettes and 9 trazodone hydrochloride 100 mg tablets Resident 1: - Alprazolam 2 mg tablets; quantity 15, do not use beyond 12/19/2023 Resident 3: - Hydroxyzine hydrochloride (HCL) 25 mg; quantity 25, do not use beyond 12/20/2023 - Baclofen 10 mg; quantity 21, do not use beyond	N 406		

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N 406	Continued From page 12 09/12/2022 - Nicotine Polacrilex Gum United States Pharmacopeia (USP) 4 mg nicotine, quantity 10, expired 12/2023 Resident 5: -Triamcinolone acetonide ointment 0.1%, discard after 10/03/2018 On 04/25/2024, at 10:00 AM, Surveyor interviewed Licensee A. Licensee A reported the lead staff were responsible for maintaining residents' medications and were supposed to clean the medication closet and inform Licensee A on any medications which needed disposing. Licensee A reported s/he returned what s/he could to the pharmacy and destroyed what cannot be returned to them. Licensee A was unaware of expired medications which were being stored with residents' non-expired medications. On 04/29/2024, at 10:00 AM, Surveyor reviewed annual medication regimen reviews for 2022 and 2023 and observed the following: A medication regimen review was completed on 07/27/2022 and signed by a pharmacist. Notations on the review stated, "pulled several expired meds; closet is hard to navigate; pens/bulks are hard to find/see, probably contributing to expired meds." A medication regimen review was completed on 09/13/2023 and signed by a pharmacist. Notations on the review stated, "lots of expired PRNs pulled; . . . dark hard to see all medications; consider some re-organizing of closet to make it easier."	N 406		

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N 426	Continued From page 13	N 426		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure appropriate supervision for 1 of 1 resident (Resident 1). Resident 1 eloped from the facility, and sustained a gunshot wound. The provider did not know Resident 1 eloped from the facility until 26 hours after the injury. Findings include: On 04/10/2024, Surveyor interviewed Licensee A. Licensee A reported s/he received a call from the Adult Day Care Center (ADCC) on 04/04/2024, at 11:18 AM. Licensee A reported the ADCC reported Resident 1 had bled through her/his underwear and pants and had 2 wounds on her/his thigh and buttock area. Licensee A reported s/he texted the staff who had worked during the night and into the morning with Resident 1 to inquire if anything happened to Resident 1. Both staff reported nothing had happened. Caregiver T did report Resident 1 was walking funny, and Caregiver F asked if Resident	N 426		

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N 426	Continued From page 14	N 426		

1 was ok, and Resident 1 reported s/he was and was not in any pain.
Licensee A reported s/he took Resident 1 to urgent care about 4:30 PM. Licensee A reported urgent care recommended Resident 1 to be seen at the emergency room. Licensee A reported they arrived at Froedtert emergency department around 7:00 PM. Licensee A reported a hospital security guard arrived in Resident 1's room at 2:30 AM.

Licensee A reported the police showed up shortly after. Licensee A reported s/he then found out Resident 1 was shot. Licensee A reported s/he looked at Resident 1's GPS monitoring and saw Resident 1 left the home on Thursday, 04/04/2024, at 1:38 AM, walked to 69th and Hampton, which was 0.1 miles away from the facility, then returned home at 1:41 AM. Licensee A reported s/he looked at the security cameras at the home and did not see Resident 1 leave the home. Licensee A reported there was an alarm on the second-floor door to alert staff if Resident 1 leaves the home and Resident 1 had a dedicated staff due to Resident 1's elopements from the home. Licensee A reported s/he spoke with staff. Staff reported the alarm did not activate during the night. Licensee A reported the staff who was Resident 1's 1:1 staff was in the bathroom at the time of Resident 1's elopement. Licensee A reported detectives found bullet casings in the street at 69th and Hampton and found blood and bullet holes on a pair of pajamas found in Resident 1's room.

On 04/10/2024, at 10:10 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 11/20/2015 with diagnoses including autism, intellectual disability, anxiety, and attention deficit hyperactivity disorder. Resident

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N 426	Continued From page 15 1's Individual Service Plan (ISP), dated 03/01/2024, reported Resident 1 had a history of elopements. Resident 1 wears a GPS tracking device as her/his elopements were unpredictable. Resident 1's ISP indicated Resident 1's elopements had decreased due to stability of routines, medications, staff interventions and a reward program if Resident 1 did not elope. As a reward, Resident 1 could earn a ride to the gas station to get a snack. Resident 1's ISP reported there are alarms on the entrance doors and security cameras inside and outside of the house. Resident 1's behavior support plan (BSP), with a review date of 03/04/2024, reported Resident 1 attempts to or does leave the area without supervision, and had a history of entering neighboring homes or businesses. Resident 1's BSP reported interventions for Resident 1's elopement were to redirect Resident 1 not to leave the area and keep Resident 1 in eyesight at all times. On 04/25/2024, at 10:00 AM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 1 had dedicated staff to ensure s/he did not elope. Licensee A reported the staff who was on duty with Resident 1 went downstairs to use the restroom due to another resident being in the bathroom upstairs. Licensee A reported they did not have a plan in place for when a staff member had to use the restroom. Licensee A reported s/he would test the alarm when s/he came to the facility. Licensee A was unsure of when the alarm was previously tested as s/he did not keep track of when the alarm was tested. Licensee A reported staff tested the alarm the next day and had to reset the alarm for the alarm to work. Licensee A reported once the alarm was reset, it worked appropriately.	N 426		

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{N 452}	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving.	{N 452}		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure food was stored in a sanitary manner for the prevention of food borne illnesses. Foods in the refrigerator, freezer, and cabinets were not sealed, dated, and/or labeled.

This deficiency is being cited for a 3rd time. See Statement of Deficiency (SOD) BZPE11, dated 08/20/2021, and SOD BZPE12, dated 09/13/2022.

Findings include:

On 04/10/2024, at approximately 10:00 AM, Surveyor toured the facility's kitchen and

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{N 452}	Continued From page 17 observed the following: The refrigerator contained the following items: Expired or beyond the best by date - 1 open bottle of Italian dressing, best by date 12/13/2023 - 1 open bottle of French dressing, best by date 01/04/2024 - 1 open bottle of French dressing, best by date 04/27/2023 - 1 open bottle of French dressing, best by date 04/25/2022 - 1 open jar of apple sauce, best by 12/01/2023 - 1 open bottle of Italian dressing, best by 02/14/2023 - 1 open jar of coleslaw dressing, best by date 11/02/2023 - 1 open jar of strawberry preserves, best by date 01/26/2024 - 1 open container of sour cream, best by date 04/10/2024 - 1 open container of sour cream, best by date 02/10/2024 (labeled - opened 03-11) - 1 open bottle of creamy French dressing, best by date 02/28/2024 - 1 open container of homestyle coleslaw, best by date 04/01/2024 - 1 unopened gallon of 2% milk, sell by date 04/05/2024 - 1 open jar of kosher dill pickle spears, best by 03/10/2024 - 1 open bottle of prune juice, best by 07/2023 - 1 open package of flour tortillas, expire date 03/24/2024 - 1 open package of flour tortillas, expire date 03/06/2024 - 1 open bag of baby-cut carrots, best by date 02/27/2024 - 1 open bag of iceberg lettuce shreds, best by	{N 452}		

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{N 452}	Continued From page 18 04/01/2024 - 1 unopened bag of baby-cut carrots, best by date 02/28/2024 Not labeled with date opened - 1 open bottle of creamy French dressing, best by date 04/16/2024 - 1 open bottle of caesar dressing, best by date 08/12/2024 - 1 open bottle of ranch dressing, expire date 07/25/2024 - 1 open bottle of strawberry fruit spread, best by date 04/27/2024 - 1 open container of sour cream, best by 05/04/2024 - 1 open bottle of tomato ketchup, best by 05/28/2025 - 1 open bottle of yellow mustard, best by 10/31/2024 - 1 open bottle of tomato ketchup, best by 03/28/2025 - 1 open bottle of tomato ketchup, best by 07/17/2025 - 1 open jar of miracle whip, best by date 09/24/2024 - 1 open bottle of yellow mustard, best by date 04/06/2025 - 1 open bottle of barbecue sauce, best by 05/10/2025 - 1 open bottle of barbecue sauce, best by 01/14/2025 - 1 open jar of taco sauce, best by 05/28/2026 - 1 open jar of sliced jalapenos, best by date unreadable - 1 open jar of taco sauce, best by 08/28/2026 - 1 open bottle of taco sauce, best by 12/12/2026 - 1 open bottle of cayenne pepper hot sauce, no date - 1 open bottle of Taco Bell fire sauce, best by date 09/06/2024	{N 452}		

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{N 452}	Continued From page 19 - 1 open bottle of mild taco sauce, best by date 10/02/2026 - 1 open container of Country Crock 38% vegetable oil spread, best by date 08/21/2024 - 1 open bag of Mexican style taco shredded cheese, best by date 07/08/2024 - 1 open package of flour tortillas, expire date 05/13/2024 - 1 open package of jalapeno cheddar cheese smoked sausage, best by date 09/10/2024 - 1 open package of hickory smoked bacon, best by date 06/16/2024 - 1 open package of honey ham, best by date 06/21/2024 "Salad dressing creamy: for freshness and quality, this item should be consumed within 3-4 weeks if refrigerated after opening. Salad dressings commericial, bottled: for freshness and quality, this item should be comsumed within 1-3 months if refrigerated after opening. Luncheon meat or poultry: for freshness and quality, this item should be consumed within 3-5 days after opening.Tortillas flour: for freshness and quality, this item should be consumed within 3 months if refrigerated after opening. Jams, jellies, and preserves: for freshness and quality, this item should be consumed within 6-12 months if refrigerated after opening. Barbecue sauce: for freshness and quality, this item should be consumed within 4 months if refrigerated after opening. Cheese, shredded; cheddar, mozzarella ect: for freshness and quality, this item should be consumed within 6 months if refrigerated from date of purchase. Margarine: for freshness and quality, this item should be consumed within 3 months if refrigerated after opening." (Source: Food Safety, April 26, 2019, https://www.foodsafety.gov/keep-food-safe/foodkeeper-app (retrieval date April 25, 2024).)	{N 452}		

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{N 452}	Continued From page 20 The freezer contained the following items: Expired or beyond the best by date - 1 unopened single serve meal - marsala penne and chicken, best by date 03/13/2024 Not labeled with date opened - 1 open package of French toast sticks, best by date 03/05/2025 Other - 1 unlabeled and undated bag of 2 round patties, consistent with a hamburger patty - 1 unsealed, unlabeled, and undated Solo cup filled halfway with a pinkish blended drink, consistent with a smoothie - 1 unsealed bag of chicken tenders, labeled opened on 02/27, best by date 01/24/2025 The cabinet over the sink area contained the following items: Expired or beyond the best by date - 1 open container of baking powder, best by date 04/16/2021 - 1 open jar of chili garlic sauce, best by date 07/2023 - 1 open unsealed bag of elbow macaroni, best by date 03/05/2023 - 1 open jar of creamy peanut butter, best by date 03/15/2022 - 1 open jar of creamy peanut butter, best by date 05/31/2022 - 1 unopened package of chocolate instant pudding, best by date 06/03/2013 - 1 open container of seasoned breadcrumbs, expire date 01/30/2014 - 1 unopened can of light red kidney beans, best by date 06/29/2023	{N 452}		

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{N 452}	Continued From page 21 - 1 open can of plain breadcrumbs, expire date 09/15/2022 - 1 open bag of imitation bacon bits, best by date 10/22/2022 - 1 unopened package of flour tortillas, best by date 01/26/2024 - 1 open unsealed package of sage and onion cubed stuffing, best by date 10/05/2023 - 1 open unsealed package of yellow cornmeal, best by date 07/09/2023 Not labeled with date opened - 1 open bag of cheese and garlic croutons, best by date 10/10/2024 - 1 open unsealed bag of all-purpose flour, best by date 09/15/2024 - 1 open bag of imitation bacon bits, best by date 10/06/2024 - 1 unlabeled container of a reddish/brown liquid, consistent with hot sauce - 1 open unsealed package of Carnation breakfast essentials nutritional powder drink mix rich milk chocolate, best by date 11/15/2024 - 1 open unsealed package of low-calorie drink mix, no date - 1 open unsealed package of taco seasoning, no date - 1 open jar of parmesan cheese, best by date 05/16/2024, labeled "refrigerate after opening" - 1 open jar of parmesan cheese, best by date 04/11/2024, labeled "refrigerate after opening" - 1 open unsealed bag of long grain brown rice, packaged date 09/2022 - 1 open unsealed package of linguine noodles, best by date 09/2024 - 1 open unsealed package of seasoned fish fry seafood breading mix, best by date 11/29/2026 The cabinet over the stove contained the following items:	{N 452}		

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{N 452}	Continued From page 22 Expired or beyond the best by date - 1 unopened package of California seedless raisins, best by 02/2024 - 1 open package of nonfat dry milk, best by date 04/21/2022 - 1 open package of nonfat dry milk, best by date 11/21/2022, labeled opened on 02/17/2023 - 1 open bag of dry lentils, best by date 12/03/2022, labeled opened on 05/15/2023 - 1 open bag of dry green peas, best by date 11/26/2022, labeled opened on 05/15/2023 - 1 open container of vanilla nutritional powder, best by date 11/2022 - 1 open jar of creamy peanut butter, best by date 10/24/2023 - 1 unopened box of Pasta Roni parmesan cheese, best by date 08/21/2022 - 1 open jar of creamy peanut butter, best by date 02/02/2024 - 1 unopened package of ramen noodle soup soy sauce flavor, best by date 09/12/2023 - 1 open package of flour tortillas, best by date 12/17/2023, labeled "refrigerate after opening" - 1 open unsealed bag of tortilla chips, best by date 04/01/2024 Not labeled with date opened - 1 open package of spaghetti noodles, best by date 10/26/2025 - 1 open unsealed bag of whole grain parboiled brown rice, no date - 1 open unsealed box of mashed potatoes, best by date 08/31/2024 - 1 open unsealed bag of tootie fruities cereal, best by date 12/02/2024 - 1 open container of plain breadcrumbs, best by date 09/13/2024 "Pasta dry, without eggs: for freshness and	{N 452}		

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{N 452}	Continued From page 23 quality, this item should be consumed within 1 year if in pantry after opening. Rice, brown: for freshness and quality, this item should be consumed within 1 year if in pantry after opening. Breadcrumbs commercial: for freshness and quality, this item should be consumed within 6 months if in pantry after opening." (Source: Food Safety, April 26, 2019, https://www.foodsafety.gov/keep-food-safe/foodkeeper-app (retrieval date April 25, 2024).) Other - 1 open unsealed box of rice crisps, best by date 11/18/2024, labeled 02/27 On 04/25/2024, at 10:00 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was aware food items should have been dated on the date of opening. Licensee A did not report anything further on the above foods in the refrigerator, freezer, and cabinets which were not sealed, dated, and/or labeled.	{N 452}		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 617		

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N 617	Continued From page 24 did not ensure 2 of 2 bath and toilet areas had safe water temperatures. The water temperature from the first-floor bathroom faucet tested at 138.7° Fahrenheit (F). The water temperature from the second-floor bathroom faucet tested at 125.8° F. Findings include: The provider is a class AA Community Based Residential Facility (CBRF) licensed to serve 6 ambulatory residents in the client groups of developmentally disabled and public funding. On 04/10/2024, at 9:56 AM, Surveyor tested the water temperature in the first-floor bathroom faucet. The temperature reading was 138.7° F. On 04/10/2024, at 3:07 PM, Surveyor tested the water temperature in the second-floor bathroom faucet. The temperature reading was 125.8° F. On 04/10/2024, at 3:10 PM, Surveyor interviewed Licensee A regarding the hot water temperature in the facility. Licensee A reported the facility had tempering valves, which controlled the water temperature. Licensee A reported s/he was aware of the code requirement for water temperatures. Licensee A reported s/he would have to contact a plumber to investigate the cause of the water temperature readings.	N 617		
Y3100	50.09(1)(f) RESIDENT'S RIGHTS IN CERTAIN FACILITIES (2) The department, in establishing standards for nursing homes and community based residential facilities may establish, by rule, rights in	Y3100		

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Y3100	Continued From page 25 addition to those specified in sub. (1) for residents in such facilities. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure each resident had the right to not be recorded, filmed, or photographed. A surveillance camera was placed in the main hallway on the first floor of the facility, recording common spaces. This had the potential to affect 6 of 6 residents. Findings include: The provider is license to serve up to 6 residents in the client groups of developmentally disabled. The census at the time of the survey was 5. On 04/10/2024, at 9:53 AM, Surveyor toured the facility and observed a camera inside the facility mounted on the wall of the first-floor hallway. On 04/10/2024, at 2:30 PM, Surveyor interviewed Licensee A. Licensee A reported the camera setup in the first-floor hallway records live with sound and video and it was viewable from an application on her/his cell phone. Licensee A reported the camera was put in place to monitor the medication closet due to issues with theft. Licensee A showed Surveyor her/his cell phone	Y3100		

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Y3100	Continued From page 26	Y3100		

and the live feed recording on the camera. The view from the camera showed a portion of the hallway, main living room, and front door entry, which were common spaces used by residents daily. Licensee A reported s/he was unaware the camera was a violation of residents' rights to privacy. Licensee A reported s/he would relocate the camera to inside the medication closet and deactivate the audio recording.

On 04/10/2024, at 10:10 AM, Surveyor reviewed Resident 1's individual service plan (ISP) and observed the following stated in her/his ISP:

"Technology/monitoring - current status - the house where [Resident 1] lives has alarm alerts on entrance doors. There are security cameras inside and outside of the house. Service provided and frequency - staff will monitor [Resident 1's] location in the home daily. Goal/outcome - [Resident 1] will only leave the home on her/his own in an evacuation situation."

On 04/24/2024, at 10:30 AM, Surveyor reviewed Resident 3's individual service plan (ISP) and observed the following stated in her/his ISP:

"Technology/monitoring - current status - possible security cameras at doors and med closets. Service provided and frequency - group home staff to monitor [Resident 3's] movement in and out of the home. Goal/outcome - to continue monitoring as needed."

The provider did not protect the residents' privacy. Residents were being recorded while in the first-floor hallway, and in the first-floor living room.

On 04/25/2024, at 10:00 AM, Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014895	A. BUILDING: _____ B. WING _____	R-C 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON II	7019 W HAMPTON AVENUE MILWAUKEE, WI 53218

(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
Y3100	Continued From page 27 interviewed Licensee A. Licensee A reported s/he included camera monitoring in residents' ISPs due to elopement risks and staff having requested it be in there. Licensee A reported viewing the cameras to aid in locating a resident if they did elope or if an incident occurred.	Y3100		