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 07/10/2025

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 07/10/2025, Surveyor completed a verification visit at Hampton II. As result, 2 of the previous 13 deficiencies were corrected. Eight of the previous deficiencies were re-cited with 3 new deficiencies; therefore, 11 total deficiencies identified. 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. 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 with date of preparation.	{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}		

This is a repeat deficiency. See Statement of Deficiency (SOD) BZPE13, dated 04/25/2024.

Findings include:

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

On 06/10/2025, Surveyors reviewed the facility's electronic file with the department and identified the following:

On 04/25/2024, Surveyors completed a standard survey, verification visit and complaint investigation. As a result of this survey, the complaint was substantiated, and 9 deficiencies were identified; 2 of 9 deficiencies were repeat citations. The deficiencies are as follows:

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 07/02/2024, the Department issued SOD BZPE13, which included the following Special Orders from the Notice and Order Letter:

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{N 214}	Continued From page 2 " ...SPECIAL ORDERS 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall protect and promote each resident's right to physical and emotional privacy in treatment, living arrangements, and in caring for personal needs. The licensee will develop and implement corrective measures to ensure electronic monitoring that transmits or records images or sounds of residents receiving care and treatment, engaged in activities of daily living, addressing personal needs, or visiting with guests, staff, or other residents will not be used in living areas (space used for daily activities such as dining, recreation, sleeping) or hallways that lead to resident rooms ...." On 06/10/2025, Surveyors conducted a verification visit, at Hampton II. As a result of the survey, the following 8 deficiencies were identified, 7 deficient practices were repeat deficiencies: 83.15(3)(a) Administrator Shall Supervise Daily Operations (repeat) 83.25 Continuing Education (repeat) 83.27(2)(c) Admissions Compatible with Program Statement (repeat) 83.35(3)(f) Staff access to assessment and ISP 83.37(1)(g) Disposition of Medications (repeat) 83.41(3)(b) Food Safety (repeat) 83.55(6)(b) Bath and Toilet Areas: Water Temperature (repeat) 50.09(1)(f) Resident's Rights in Certain Facilities (repeat) On 07/10/2025, at 1:00 PM, Surveyors interviewed Licensee A. Surveyors relayed details regarding repeat deficiencies. Licensee A did not	{N 214}		

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{N 214}	Continued From page 3 offer any information.	{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 record review and interview, the provider did not ensure 2 of 2 caregivers received continuing education in all required topics in 2024. Caregiver F and Caregiver X did not receive continuing education in client group of developmentally disabled. This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) BZPE13, dated 04/25/2024 , SOD BZPE12, dated 09/13/2022 and SOD BZPE11, dated 08/20/2021. Findings include: The provider is a class AA Community Based Residential Facility (CBRF) licensed to serve 6 ambulatory residents in the client group of developmentally disabled.	{N 277}		

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{N 277}	Continued From page 4 On 06/11/2025, at 3:15 PM, Surveyors reviewed staff records and identified the following: Caregiver F was hired on 01/01/2014. Caregiver F's record did not contain evidence of continuing education for 2024. Caregiver X was hired on 01/01/2014. Caregiver X's record did not contain evidence of continuing education for 2024. Surveyors reviewed a group training record, dated 04/25/2024, which indicated the training was 2 hours in length and covered "individual service plans, behavior support plans, spring cleaning, Annual training - dietary, client specific, substance abuse with people with developmentally disabled, and memory issues". Caregiver F's and Caregiver X's signature was on the signature sheet. Surveyors reviewed staff meeting agendas and identified the following: 02/02/2024 - All staff meeting: Annual Training - 2 hours Resident rights, Photos, online postings 06/24/2024 - All staff meeting: Annual Training - 3 hours Abuse, neglect, misappropriation, and standard precautions 08/15/2024 - All staff meeting: Annual Training - 3 hours confidentiality fire safety emergency procedures with 1st aid	{N 277}		

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{N 277}	Continued From page 5 10/10/2024 - All staff meeting: Annual Training - 2 hours client specific aging and memory issues safe driving The document was saved as "Staff Meeting Agenda 12-24" but was dated for 10/10/2024 - All staff meeting: Annual Training - 3 hours medication management safe driving Surveyor was not provided with documentation of attendance for the staff meeting agendas to indicate what staff attended the trainings. On 07/10/2025, at 1:00 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he had staff sign a sign in sheet during trainings or the back of the agendas if the sign in sheet was not available during the training. Surveyors relayed concerns of not reviewing staff signatures for all but one of the trainings, therefore Surveyors were unable to determine who had completed the trainings. Licensee A acknowledged Surveyors concerns.	{N 277}		
{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 observation, record review, and	{N 289}		

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{N 289}	Continued From page 6	{N 289}		

interview, the provider did not ensure 1 of 1 resident met the criteria of the client groups as described by the facility's program statement and license.

This is a repeat deficiency. See Statement of Deficiency (SOD) BZPE13, dated 04/25/2024.

Findings include:

The provider is a class AA Community Based Residential Facility (CBRF) licensed to serve 6 ambulatory residents in the client group of developmentally disabled.

On 06/10/2025, at 2:25 PM, Surveyors observed a resident returning to the facility with Licensee A. The resident identified herself/himself as Resident 2.

Record Review

On 06/10/2025, at 7:00 AM, Surveyors reviewed the Departments files. Surveyors did not review any evidence of an updated program statement.

On 06/10/2025, at 3:00 PM, Surveyors reviewed Resident 2's record. 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,

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{N 289}	Continued From page 7 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. At the time of admission, Resident 2 did not have a diagnosis of developmentally disabled. On 06/10/2025, at 4:05 PM, Surveyors interviewed Licensee A. Surveyors inquired if Licensee A had submitted an updated the program statement to the Department. Licensee A reported s/he updated the program statement last year but confirmed s/he had not submitted the updated program statement to the Department. Licensee A reported s/he was unaware s/he needed to submit the program statement to the Department. On 07/10/2025, at 1:00 PM, Surveyors interviewed Licensee A. Licensee A reported s/he still thought Resident 2 had a developmental disability even though it was not a primary diagnosis. Licensee A acknowledged s/he needed to submit an updated program statement.	{N 289}		
N 391	83.35(3)(f) Staff access to assessment and ISP Availability. All employees who provide resident care and services shall have continual access to the resident ' s assessment and individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all staff who provided resident care and services had continual access to assessments and individual service plans	N 391		

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N 391	Continued From page 8 (ISPs) for the residents who resided in the community based residential facility (CBRF) at the time of the survey for 5 of 5 residents (Residents 2, 3, 4, 5, and 6) reviewed. Findings include: On 06/10/2025, at approximately 2:50 PM, Surveyors reviewed resident records and identified the following: Resident 2 was admitted on 06/01/2023, with the following diagnoses: hypokalemia, essential hemorrhagic thrombocythemia, chronic mild anemia, myocardial infarction, 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, onychomycosis, alcohol use disorder/abuse, cocaine use disorder, opioid abuse, cannabis abuse, drug dependence, dizziness, and nicotine dependence. Resident 2's record did not contain an annual assessment or ISP. Resident 3 was admitted on 07/31/202, with diagnoses including developmental disability, schizophrenia, depressive disorder, and anxiety. Resident 3's record did not contain an annual assessment or ISP. Resident 4 was admitted on 02/10/1993, with diagnoses including mild mental retardation, psychotic disorder, organic personality disorder and intermittent explosive disorder. Resident 4's record did not contain an annual assessment or ISP.	N 391		

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N 391	Continued From page 9 Resident 5 was admitted on 06/05/2003 with diagnoses including moderate mental retardation, organic personality disorder, osteoarthritis and esotropia. Resident 5's record did not contain an annual assessment or ISP. Resident 6 was admitted on 03/30/2009 with diagnoses including severe mental retardation and Tourette syndrome. Resident 6's record did not contain an annual assessment or ISP. On 06/10/2025, at 3:33 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement all employees who provide resident care and services should have continual access to the residents' assessment and ISP. Licensee A reported all residents' ISPs were in the staff log. Licensee A reported staff must have taken the ISPs out of the book. Licensee A reported s/he had all ISPs on her/his computer, but s/he could not access her/his email. Licensee A reported s/he was unable to locate the resident's ISPs in the home. On 07/10/2025, at 1:00 PM, Surveyors interviewed Licensee A. Licensee A reported after the survey, s/he printed off all ISPs and put them in the home for staff.	N 391		
N 401	83.37(1)(b) Medication label permanently attached. Medications. Prescription medications shall come from a licensed pharmacy or a physician and shall have a label permanently attached to the outside of the container. Over-the-counter medications maintained in the manufacturer ' s container shall be labeled with the resident ' s	N 401		

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N 401	Continued From page 10 name. Over-the-counter medications not maintained in the manufacturer ' s container shall be labeled by a pharmacist. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure medications were labeled to ensure proper and safe usage for 2 of 2 medications. Findings include: On 06/10/2025, at 2:45 PM, Surveyors observed resident medications. Resident medications were stored in the hallway medication closet. Inside the closet Surveyors located Walgreens 12-hour mucus relief DM and Nicorette lozenges. Surveyors did not observe a label on the box which indicated who was prescribed the medication. On 06/18/2025, at 3:59 PM, Surveyors reviewed Resident 3's record. Resident 3 was admitted on 07/31/2021, with diagnoses including developmental disability, schizophrenia, depressive disorder, and anxiety. Resident 3's medication administration record (MAR) indicated Resident 3 was prescribed nicotine lozenges 4 milligrams every 2 hours. On 07/10/2025, at 1:00 PM, Surveyor interviewed Licensee A. Licensee A reported the medications belonged to Resident 2. Licensee A reported as needed (PRN) medications belonged in each resident's PRN drawer. Licensee A reported s/he was unaware the over-the-counter medications needed labels.	N 401		

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{N 406}	Continued From page 11	{N 406}		
{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, 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 2 of 5 residents (Resident 4 and Resident 5). This is a repeat deficiency. See Statement of Deficiency (SOD) BZPE13, dated 04/25/2024.	{N 406}		

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{N 406}	Continued From page 12 Findings include: On 06/10/2025, at 2:50 PM, Surveyors observed the medication closet and observed the following medications: Resident 4: - APAP 500 milligrams (mg) tablet as needed (PRN); quantity 14, do not use beyond 04/23/2025 Resident 5: - Meloxicam 15 mg tablets; quantity 21, do not use beyond 04/24/2025 - Triamcinolone 0.1% cream, discard after 10/03/2018 On 07/10/2025, at 1:00 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he and staff were responsible for ensuring expired medications were removed from the medication closet. Licensee A reported s/he kept old medications in her/his office until s/he had enough to destroy. Licensee A reported s/he or staff would go through the medication closet when a new medication was delivered, or if there was a change. Licensee A reported lead staff were to be pulling out medications.	{N 406}		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident prescription medications	N 419		

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N 419	Continued From page 13 were securely stored in 2 of 2 areas. The medication closet, located in a hallway, was unlocked. A bottle of medication was found in the dining room. Findings include: On 06/10/2025, at 2:45 PM, Surveyors toured the facility and observed the following: -The medication closet in the hallway. Surveyors observed the locking mechanism was not engaged. Surveyor pulled on a door, and the door opened. Surveyor observed residents' prescription medications inside the closet. -In the dining room on a shelf was Resident 5's chlorhexidine 0.12% oral solution. Surveyors did not observe any sort of locking mechanism on the shelf. Surveyor observed residents moving freely throughout the facility. On 07/10/2025, at 1:00 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported other items besides medications were stored in the closet, so the closet was utilized for more than just medications, but staff were supposed to lock it up in between. Licensee A reported maybe the closet was unlocked because Surveyors go in the medications closet. Surveyors relayed to Licensee A regarding the medication bottle in the dining room, which was not secured. Licensee A acknowledged Surveyors concerns.	N 419		
{N 452}	83.41(3)(b) Food safety.	{N 452}		

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(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 452}	Continued From page 14 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. 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 and cabinets were not sealed, dated, and/or labeled. This deficiency is being cited for a 4th time. See Statement of Deficiency (SOD) BZPE11, dated 08/20/2021, SOD BZPE12, dated 09/13/2022, and SOD BZPE13, dated 04/25/2024. Findings include: On 06/10/2024, at approximately 2:50 PM, Surveyor toured the facility's kitchen and observed the following:	{N 452}		

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	0014895	A. BUILDING: _____ B. WING _____	R-C 07/10/2025

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{N 452}	Continued From page 15 The refrigerator contained the following items: Expired or beyond the best by date - 1 open bottle of chicken finger dipping sauce, best by date 05/25/2025 - 1 unopened container of Great Value flaky jumbo biscuits, best by date 05/30/2025 - 1 open jar of Kroger strawberry preserves, best by date 01/26/2024 "... Jams, jellies, and preserves: for freshness and quality, this item should be consumed within 6-12 months if refrigerated after opening..." (Source: Food Safety, April 26, 2019, https://www.foodsafety.gov/keep-food-safe/foodkeeper-app (retrieval date June 17, 2025) Other - A clear food storage container which appeared to contain a mixture of eggs, lettuce, and an unknown dressing. Container was not labeled with contents or date prepared. The kitchen cabinets contained the following items: Expired or beyond the best by date - 1 open container of creamy peanut butter, best by date 02/02/2024. The peanut butter had a metallic like smell. - 1 open package of Best Choice classic plain breadcrumbs, best by date 09/13/2024 - 1 open package of Marcum plain breadcrumbs, best by date 09/15/2022 - 1 open container of Nestle Coffee Mate vanilla caramel creamer powdered, best by date 10/17/2022 - 1 opened container of Fit For Life nutritional powder, best by date 11/2022	{N 452}		

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{N 452}	Continued From page 16 "Peanut butter: for freshness and quality, this item should be consumed within 2-3 months if pantry stored after opening. Breadcrumbs: for freshness and quality, this item should be consumed within 6 months if in the pantry from the date of purchase. Coffee creamer powdered: for freshness and quality, this item should be consumed within 2-3 months if pantry stored after opening. Diet powder mixes and drink mixes: for freshness and quality, this item should be consumed within 1-3 months if pantry stored after opening. (Source: Food Safety, April 26, 2019, https://www.foodsafety.gov/keep-food-safe/foodkeeper-app (retrieval date June 17, 2025) On 07/10/2025, at 1:00 PM, Surveyors interviewed Licensee A. Licensee A reported staff were to be looking through the food when they were preparing food and 3rd shift would clean out the refrigerator Friday nights. Surveyors relayed what they found during survey. Licensee A did not offer any explanation.	{N 452}		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored in 2 of 2 resident areas. Unsecured toxic substances were found under the first-floor bathroom sink and in the dining room.	N 499		

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N 499	Continued From page 17 This is a repeat deficiency. See Statement of Deficiency (SOD) BZPE11, dated 08/20/2021. Findings include: The provider is a class AA Community Based Residential Facility (CBRF) licensed to serve 6 ambulatory residents in the client group of developmentally disabled. On 06/10/2024, at approximately 2:50 PM, Surveyor toured the facility and observed the following: - Under the first-floor bathroom sink area was a container of Oxydol multi-surface cleaner and a spray bottle of Clorox multi-surface cleaner. The cupboard under the bathroom sink did not contain a locking mechanism. - A bottle of Arm and Hammer laundry detergent was located on the floor of the dining room. Residents were observed moving freely throughout the facility. On 07/10/2025, at 1:00 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Surveyors relayed the areas of unsecured toxic chemicals. Licensee A did not offer any further information.	N 499		
{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	{N 617}		

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{N 617}	Continued From page 18 140°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 did not ensure the temperature of water at fixtures used by residents did not exceed 115 degrees Fahrenheit (F) in 2 of 2 bathrooms. This is a repeat deficiency. See Statement of Deficiency (SOD) BZPE13, dated 04/25/2024. Findings include: The facility is licensed as a Class A (ambulatory) Community Based Residential Facility which may serve up to 6 developmentally disabled residents. On 06/10/2025, at 2:30 PM Surveyors toured the facility and observed the following: First floor bathroom water temperature was 132.8 degrees F. Second floor bathroom water temperature was 128.3 degrees F. On 07/10/2025, at 1:00 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported there were tempering valves to ensure the water did not exceed the code requirement. Licensee A reported s/he was unsure how it was possible. Licensee A reported staff were responsible for checking water temperatures monthly.	{N 617}		

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{Y3100}	50.09(1)(f) Resident's Rights In Certain Facilities (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to: 1. Privacy for visits by spouse or domestic partner. If both spouses or both domestic partners under ch. 770 are residents of the same facility, the spouses or domestic partners shall be permitted to share a room unless medically contraindicated as documented by the resident ' s physician, physician assistant, or advanced practice nurse prescriber in the resident ' s medical record. 2. Privacy concerning health care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. Persons not directly involved in the resident ' s care shall require the resident ' s permission to authorize their presence. 3. Confidentiality of health and personal records, and the right to approve or refuse their release to any individual outside the facility, except in the case of the resident ' s transfer to another facility or as required by law or 3rd-party payment contracts and except as provided in s. 146.82 (2) and (3).	{Y3100}		

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{Y3100}	Continued From page 20 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 5 of 5 residents. This is a repeat deficiency See Statement of Deficiency (SOD) BZPE13, dated 04/25/2024. 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. Observations On 06/10/2025, at 2:31 PM, Surveyors toured the facility and observed a camera inside the facility mounted on the wall of the first-floor hallway. Surveyors observed a red light on the camera. When Surveyor walked toward the camera, the light turned blue. Surveyors observed the camera view in Licensee A's cell phone. Surveyor was able to view the living room area in front of the television and the entrance to the hallway by the medication closet. Interviews On 06/10/2025, at 4:16 PM, Surveyors interviewed Licensee A. Licensee A reported the camera was put in place to monitor the medication closet due to issues with theft. Licensee A reported s/he did not renew the camera subscription. Licensee A confirmed the	{Y3100}		

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{Y3100}	Continued From page 21	{Y3100}		

camera was not disabled. Licensee A showed Surveyor her/his cell phone 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. When Surveyors inquired about Licensee A's previous report of moving the camera, Licensee A reported s/he was still trying to figure it out. Licensee A reported s/he moved the camera down because residents do not stand in front of the television. Surveyors relayed concerns regarding resident privacy.

On 07/10/2025, at 1:00 PM, Surveyors interviewed Licensee A. Licensee A reported s/he needed to put the camera in the medication closet, but there was no power to the closet, so s/he would need to contact an electrician. Licensee A reported the camera had been disabled since the Surveyors visited.

Record Review

On 06/11/2025, at 10:30 AM, Surveyor reviewed Resident 3's individual service plan (ISP), dated 02/04/2025. Resident 3's ISP stated, "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.