Wisconsin Department of Health Services

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 02/27/2026

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 02/27/2026, Surveyors completed a verification visit at Hampton II. As a result, 10 of the previous 11 deficiencies were corrected. One deficiency is being cited for a 3rd time. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 5	{N 000}		
{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 The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws.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:	{N 406}		

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

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{N 406}	Continued From page 1 Based on observation, interview, and record review, the provider did not establish an effective procedure for proper destruction and disposal of discontinued medications. Resident 3's discontinued ibuprofen was intermingled with Resident 2's as needed (PRN) medication. This requirement is being cited for a third time. See Statements of Deficiency (SOD) BZPE13, dated 04/25/2024 and SOD BZPE14, dated 07/10/2025. Findings include: On 02/27/2026 at approximately 10:57 AM, Surveyor observed the medication closet. Within the medication closet, Surveyor observed a shelf that contained two plastic 2-drawer desktop units. Each drawer contained PRN medications for each resident. Resident 2's drawer contained two blister packs. One of the blister packs had a pharmacy label with Resident 3's name on it. Resident 3's name was scratched out with what appeared to be a black marker. Resident 2's name and initials were written on the label with the black marker (Photo 1). On 02/27/2026 at approximately 11:30 AM, Surveyor reviewed the resident's medication administration record (MAR) binder, and the following was identified: Resident 2 was admitted on 06/01/2023. The MAR binder contained a physician order for ibuprofen 600 milligrams (mg) tablets to be used as needed for pain for Resident 2. Resident 3 was admitted on 07/31/2021. The	{N 406}		

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{N 406}	Continued From page 2 MAR binder did not contain a physician order for ibuprofen 600 mg tablets for Resident 3. On 02/27/2026 at approximately 11:33 AM, Surveyor interviewed Licensee A. Licensee A acknowledged the blister pack originally had Resident 3's name on it. Licensee A acknowledged Resident 3's name was crossed out, and Resident 2's name was written on the blister pack. Licensee A confirmed Resident 3 was no longer prescribed ibuprofen. Licensee A stated because Resident 2 was prescribed the same medication and dosage as Resident 3's discontinued ibuprofen medication, and "to not waste the medication," Resident 3's name was crossed out, and Resident 2's name was written on the blister pack. Surveyor read the code to Licensee A regarding discontinued medication. Licensee A did not agree with Surveyor stating Resident 3's discontinued medication should have been disposed of, if an order was not obtained by a physician to keep the discontinued medication.	{N 406}		