STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014544	A. BUILDING: _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A BETTER LIVING FAMILY SERVICES SITE 4	3915 N 62ND STREET MILWAUKEE, WI 53216

(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 10/15/2024, Surveyors completed a standard licensure survey and complaint investigation at A better Living Family Services Site 4. As a result, 9 deficiencies were identified. One of the 9 deficiencies was a repeat violation (see SOD 4MV411, dated 10/31/2016, and SOD HIRS13, dated 07/17/2023). One complaint was unsubstantiated. Census: 2	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	M 114		

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

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M 114	Continued From page 1 activities of the adult family home, the licensing agency may deny, revoke, 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 1 of 2 service providers had background checks. Caregiver E did not have a background check. 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 10/15/2024, Surveyors reviewed Caregiver E's record. Caregiver E was hired on 08/15/2022. Caregiver E's record contained no evidence of a background check being completed within 60 days of employment. On 10/15/2024 at 1:45 PM, Surveyors interviewed Licensee A regarding background checks of	M 114		

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M 114	Continued From page 2 caregivers. Licensee A reported Caregiver E's background check had been conducted human resources and that the human resources contact was not available to assist with providing documentation due to being out on medical leave. Licensee A reported s/he would look for the BID, DOJ, and IBIS and provide it to the Surveyors by 10/16/2024 at 9:30 AM. Licensee A provided Surveyors with a BID that did not contain a signature page. Surveyors could not determine when the BID from was signed by Caregiver E. As of 10/16/2024 at 9:30 AM no additional information was received regarding Caregiver E's DOJ and IBIS upon hire.	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 obtain documentation indicating staff had been screened for illnesses detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse or a physician's	M 232		

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M 232	Continued From page 3 assistant, within 90 days before the start of providing service for 2 of 2 staff reviewed. Caregiver B and Caregiver D were not screened for communicable disease, including TB, within 90 days prior to the start of providing service. Findings include: On 10/15/2024, at approximately 11:00 A.M., Surveyors reviewed staff records and identified the following: -Surveyors reviewed Caregiver B's records. Caregiver B was hired on 11/18/2018. Caregiver B's record did not contain evidence of a TB skin test within 90 days prior to start of service. - Surveyors reviewed Caregiver D's records. Caregiver D was hired on 06/21/2024. Caregiver D's record did not contain evidence of a communicable disease screening 90 days prior to start of service. On 10/15/2024, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported Caregiver B's TB skin test and Caregiver D's communicable disease documentation should have been in his/her employee file. Licensee A reported they would go back to the office and check their files to ensure they did not miss it. Surveyors gave Licensee A until 9:30 AM on 10/16/2024 to send any additional information. As of 10/16/2024, at 9:30 AM, no additional information regarding Caregiver B's TB skin test and Caregiver D's communicable disease screening was received.	M 232		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE	M 336		

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M 336	Continued From page 4 The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is 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 the facility's smoke detectors were tested monthly for 5 of 5 smoke detectors. There was no evidence the smoke detectors were tested in April, May, June, July, August, and September of 2024. This is a repeat deficiency. See Statement of Deficiency (SOD) 4MV411, dated 10/31/2016,and SOD HIRS13, dated 07/17/2023. Findings include: On 10/15/2024, at approximately 11:00 AM, Surveyors reviewed the facility safety files. There was no evidence of smoke detector testing for April, May, June, July, August, and September of 2024. On 10/15/2024, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed s/he was aware of the code requirement to test smoke detectors monthly. Licensee A reported the house leads were responsible for ensuring monthly smoke detector test were completed. Licensee A reported s/he thought the current house lead had completed this task and was not	M 336		

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M 336	Continued From page 5 sure why it was not completed. Licensee A reported s/he had an employee who audited the homes quarterly to ensure compliance with all codes, but s/he had been behind with his/her audits due to training new staff.	M 336		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents (Resident 2) was evaluated for fire evacuation to determine whether the resident was able to evacuate the home without any assistance within 2 minutes. Resident 2 was not evaluated for fire evacuation. Findings include: On 10/15/2024, at approximately 11:00 AM, Surveyors reviewed Resident 2's record and observed the following: Resident 2 was admitted to the facility on 07/10/2024. Resident 2's record showed no evidence Resident 2 was evaluated for fire evacuation.	M 344		

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M 344	Continued From page 6 On 10/15/2024, at 1:45 PM, Surveyors interviewed Licensee A. When Surveyors inquired if Licensee A evaluated Resident 2 for fire evacuation, Licensee A reported s/he did not assess Resident 2 for fire safety evacuation. Licensee A reported the house lead was responsible for completing resident evacuation assessments upon admittance to the facility. Licensee A reported the previous house lead was working on creating new files prior to resigning. Licensee A reported s/he retrieved records from the previous house lead and would be working on organizing files. Licensee A reported s/he was unable to locate any assessment for Resident 2.	M 344		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents (Resident 1) admitted to the facility for at least one year, was evaluated annually for evacuation times using the department form in 2024. Findings include: On 10/15/2024, at approximately 11:00 AM, Surveyors reviewed Resident 1's record and observed the following:	M 346		

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M 346	Continued From page 7 Resident 1 transferred to the facility on 06/04/2024. Resident 1's last annual evacuation was completed on 05/13/2023. Resident 1's annual evacuation assessment was not completed in 2024. On 10/15/2024 at approximately 1:45 PM, Surveyor interviewed Licensee A regarding 2024's annual evacuation assessment for Resident 1. Licensee A reported the house lead was responsible for completing annual resident evacuation assessments. Licensee A reported the previous house lead was working on creating new files prior to resigning. Licensee A reported s/he was currently working with Compliance/Trainer C to resolve record concerns.	M 346		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 2) reviewed had a service	M 384		

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M 384	Continued From page 8 agreement completed prior to admission that was signed. Findings include: On 10/15/2024, at approximately 11:00AM, Surveyors reviewed Resident 1's and Resident 2's record and identified the following: -Resident 1 was admitted to the facility on 06/04/2024. Resident 1's record did not contain evidence of a service agreement. -Resident 2 was admitted to the provider on 07/10/2024. Resident 2's record did not contain evidence of a new service agreement upon moving into the facility. On 10/15/2024 at 01:45 PM, Surveyors interviewed Licensee A. Licensee A reported the previous house lead was responsible for completing all paperwork, which included service agreements with Resident 1 and Resident 2. Licensee A explained the house lead resigned. Licensee A reported the Compliance/Trainer C would be training a new house lead to assist with correcting resident files. Licensee A reported that s/he would look for Resident 1's and Resident 2's service agreements and provide them to the department by 9:30 AM, on 10/16/2024. As of 10/16/2024, 9:30AM, Surveyors did not receive additional information regarding service agreements for Resident 1 and Resident 2.	M 384		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons	M 420		

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M 420	Continued From page 9 involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a statement of agreement with the Individual Service Plan (ISP) was dated and signed by all persons involved in developing the plan for 2 of 2 residents (Resident 1 and Resident 2). Findings include: On 10/15/2024, at approximately 11:00 AM, Surveyors reviewed resident records and identified the following: Resident 1 was admitted to the facility on 06/04/2024. Resident 1's ISP was dated 06/19/2024. Resident 1's face sheet, undated, identified Resident 1 had a managed care organization (MCO) case management team and a legal guardian. Resident 1's ISP contained a signature from his/her MCO case manager. Resident 1's ISP did not contain signatures from the legal guardian, Licensee A, and house lead. Resident 2 was admitted to the facility on 07/10/2024. Resident 2's ISP was date 07/10/2024. Resident 2's face sheet, undated, identified Resident 2 had a managed care organization (MCO) case management team. Resident 2's face sheet also identified Resident 2 as his/her own person. Resident 2's ISP did not contain signatures from the MCO case management team, Licensee A, and house lead. On 10/15/2024, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed	M 420		

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M 420	Continued From page 10 residents' ISPs needed to be signed by all parties in agreement with the plan. Licensee A reported s/he was unsure why Resident 1's and Resident 2's ISPs were not signed by all parties involved. Licensee A reported Compliance Trainer C was responsible for checking ISPs every 6 weeks for completion. Licensee A reported there was a separate signature page for all parties to sign and that it was possible the signature pages may be on file at the office. Licensee A reported s/he would look for the signature pages for Resident 1's and Resident 2's ISPs. Surveyors gave Licensee A until 9:30 AM on 10/16/2024 to send any additional information. As of 10/16/2024, at 9:30 AM, no additional information was received regarding Resident 1's and Resident 2's ISP.	M 420		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 2 resident's (Resident 1) prescription medication was securely stored. Resident 1's insulin pens	M 458		

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M 458	Continued From page 11 were not securely stored in the kitchen refrigerator. Findings include: On 10/15/2024, at 10:15 AM, Surveyors toured the kitchen and observed a lock box in the refrigerator. The lock box contained a locking mechanism, which was not engaged. The lock box contained a box of Ozempic injection insulin pens. Surveyors observed residents moving freely around the facility. On 10/15/2024, at 11:00 AM, Surveyors reviewed Resident 1's record. Resident 1 was admitted on 06/04/2024 with diagnoses including type 2 diabetes, schizoaffective disorder bipolar types, hypothyroidism, Huntington Disease, and hypertension. Resident 1's individual service plan (ISP), dated 06/04/2024, indicated Resident 1 required assistance with medication administration. Resident 1's Medication Administration Record (MAR), dated 09/25/2024 to 10/22/2024, indicated Resident 1 was prescribed Ozempic 2 milligrams/3 milliliters injection once a week. On 10/15/2024, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported Resident 1 had a medication change and the insulin injections were recently added by Resident 1's primary physician. Licensee A confirmed prescription medications should have been securely stored. Licensee A reported all staff completed training on medications to ensure compliance with the code requirements.	M 458		

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M 582	Continued From page 12	M 582		
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 record review, observation, and interview the provider did not ensure 1 of 1 resident received prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1 did not receive her/his prescribed clozapine between 10/13/2024 and 10/14/2024. Findings include: On 10/15/2024, at approximately 11:00 AM, Surveyors reviewed Resident 1's records. Resident 1 was admitted to the facility on 06/04/2024 with diagnoses including type 2 diabetes, Schizoaffective disorder bipolar types, hypothyroidism, Huntington Disease, and Hypertension. Resident 1's individual service plan (ISP), dated 06/04/2024, indicated Resident 1 required assistance with medication administration. Resident 1's Medication Administration Record (MAR), dated 09/25/2024 to 10/22/2024, indicated Resident 1 was prescribed clozapine 37.5 milligrams (mg) by mouth nightly. Resident 1's MAR indicated	M 582		

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M 582	Continued From page 13 clozapine was administered to Resident 1 on 10/14/2024 and there was no administration of the medication on 10/12/2024 and 10/13/2024. Resident 1's MAR did not contain notes indicating Resident 1 declined his/her medication for the dates of 10/12/2024 and 10/13/2024. On 10/15/2024, at approximately 11:45 AM, Surveyors observed Resident 1's medications. Surveyors observed Resident 1's clozapine 37.5 mg tablets were not administered for dates of 10/13/2024 and 10/14/2024. Resident 1's clozapine for the dates of 10/13/2024 and 10/14/2024 were in the bubble packs. On 10/15/2024, at approximately 12:00 PM, Surveyors interviewed Resident 1. Resident 1 reported s/he did not decline medication. Resident 1 reported that s/he was unsure of the medication s/he took on a daily basis. On 10/15/2024, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported medications should be circled and noted in the MAR when not administered or when declined by the resident. Licensee A reviewed Resident 1's MAR and medication. Licensee A took photos of Resident 1's MAR and medication bubble pack. Licensee A removed Resident 1's Clozapine for the dates of 10/13/2024 and 10/14/2024 from the bubble pack. Licensee A confirmed there was a medication error regarding the administration date and documentation of Resident 1's nightly clozapine 37.5 mg medication. Licensee A reported Resident 1 never declined medication. Licensee A reported s/he would follow up with staff to discuss further.	M 582		