

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/13/2024
NAME OF PROVIDER OR SUPPLIER K & D ADULT FAMILY HOMES LLC II		STREET ADDRESS, CITY, STATE, ZIP CODE 3707 10TH AVE RACINE, WI 53402		
(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 06/13/2024, Surveyor completed a verification visit and 2 complaint investigations at K&D Adult Family Homes LLC II. As a result, 3 of the previous 4 deficiencies were corrected. One of the previous deficiencies were re-cited, and 1 new deficiency was identified; therefore, 2 total deficiencies were identified. See Statement of Deficiency (SOD) GKI12, dated 02/21/2024. One complaint was substantiated. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee will be assessed. Census: 4	{M 000}		
{M 330}	88.05(3)(o) HOME NOT BE USED FOR OTHER BUSINESS The home shall not be used for any business purpose that regularly brings customers to the home so that the residents' use of the home as their residence or the resident's privacy is adversely affected. This Rule is not met as evidenced by: Based on record review, observation, and interviews, the provider exceeded the licensed capacity of an adult family home (AFH) by providing services to residents from 1 other separate AFH, with a total of 6 residents within the home, thus running a business which regularly brings customers to the home so the residents' use of the home as their residence, and/or the residents' privacy was adversely affected. The 2 persons from a separate facility	{M 330}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/13/2024
NAME OF PROVIDER OR SUPPLIER K & D ADULT FAMILY HOMES LLC II		STREET ADDRESS, CITY, STATE, ZIP CODE 3707 10TH AVE RACINE, WI 53402		
(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 330}	Continued From page 1 were provided services which included at least 1 meal. This is a repeat deficiency. See Statement of Deficiency (SOD) GKI12, dated 02/21/2024. Findings include: The facility is licensed to serve up to 4 residents in the following client groups: emotionally disturbed/mental illness, public funding, traumatic brain injury, and developmentally disabled. On 05/29/2024, at 9:30 AM, Surveyor reviewed the resident roster and identified the following: Resident 1 was admitted on 03/27/2012. Resident 3 was admitted on 10/04/2021. Resident 4 was admitted on 12/21/2010. Resident 10 was admitted on 10/02/2023. On 05/29/2024, between 8:50 AM and 12:45 PM, Surveyor observed the following: - The home is located in the lower half of a duplex style building. The building has 2 licensed AFHs, owned and operated by Licensee C. - The residents were able to move freely from the upper unit to the lower unit, with the use of an interior open staircase. - Four residents (Resident 1, Resident 3, Resident 4, and Resident 10) and 2 persons (Person H and Person I), residents from the upper unit, were observed in the home. - Throughout the survey Resident 1, Resident 3, Resident 4, and Resident 10, stayed inside their bedrooms, and only came out to smoke	{M 330}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/13/2024
NAME OF PROVIDER OR SUPPLIER K & D ADULT FAMILY HOMES LLC II		STREET ADDRESS, CITY, STATE, ZIP CODE 3707 10TH AVE RACINE, WI 53402		
(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 330}	Continued From page 2 cigarettes or use the bathroom. Resident 1, Resident 3, Resident 4, and Resident 10, did not use the common space in the home during the survey. - Person H was wandering around the home from 9:15 AM until 10:33 AM, and had requested candy from House Manager A and Caregiver E multiple times. At 10:33 AM, Person H was escorted to the upper unit by Caregiver E for a shower. At 11:26 AM, Person H returned to the lower unit and remained there until Surveyor exited at 12:45 PM. - Person I entered the home at 9:15 AM. Person I was sitting on the couch in the living room watching television and speaking with House Manager A and Caregiver E. Person I moved from the couch to smoke cigarettes and to retrieve some items throughout the survey, but had otherwise remained in the home until Surveyor exited at 12:45 PM. - At 9:26 AM, Case Manager G arrived at the home, and was requesting to speak with Person J. Case Manager G reported s/he needed Person J to sign insurance paperwork. House Manager A reported Person J was not at the home and was at her/his AFH on Loraine Avenue. - At 11:35 AM, Caregiver E was moving food, for lunch service, from the refrigerator and cabinets between the home and the upper unit. - At approximately 11:45 AM, House Manager A was in the lower unit preparing lunch for the residents in the home and for the residents who resided in the upper unit. - At 12:01 PM, Person H brought dinner plates to	{M 330}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/13/2024
NAME OF PROVIDER OR SUPPLIER K & D ADULT FAMILY HOMES LLC II		STREET ADDRESS, CITY, STATE, ZIP CODE 3707 10TH AVE RACINE, WI 53402		
(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 330}	Continued From page 3 the home from the upper unit. On 05/29/2024, at 9:01 AM, Surveyor interviewed Resident 3. Resident 3 reported Person I would often be in the home during the day. Resident 3 reported s/he did not get along with Person I, after s/he had hit her/him in the back of the head during an argument they had. Resident 3 reported s/he would be very upset if Person I was in her/his home again, due to her/his dislike for her/him. On 05/29/2024, at 10:40 AM, Surveyor interviewed Person I. Person I reported s/he and the other residents in the upper unit were given the option to stay in the lower unit during the day when they would like. Person I reported s/he enjoyed having the choice to be in the home. Person I reported caregivers regularly cooked meals in the lower unit and residents brought their food to the upper unit to eat. On 05/29/2024, at 12:35 PM, Surveyor interviewed House Manager A. House Manager A reported lunch was being cooked in the lower unit and the upper unit residents would take their lunch upstairs to eat in their home. House Manager A reported this was a regular thing the home did. On 06/11/2024, at 2:41 PM, Surveyor interviewed Case Manager G. Case Manger G reported on 05/29/2024, s/he went to the home looking for Person J. S/He reported Person J was usually brought to the home from her/his residence by staff and stayed at the home throughout the day. On 06/12/2024, at 11:00 AM, Surveyor interviewed Licensee C. Licensee C stated, "residents from the upper became laxed."	{M 330}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/13/2024
NAME OF PROVIDER OR SUPPLIER K & D ADULT FAMILY HOMES LLC II		STREET ADDRESS, CITY, STATE, ZIP CODE 3707 10TH AVE RACINE, WI 53402		
(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 330}	Continued From page 4 Licensee C reported the residents in the upper unit would come down to have a cigarette and would stay in the lower unit. Licensee C reported s/he spoke with everyone about it and stated, "I think we are doing better with it."	{M 330}		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner. 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. This had the potential to affect 4 of 4 residents (Resident 1, Resident 3, Resident 4, and Resident 10). Food was stored on the ground of the basement with water damage and feces. Findings include: On 05/29/2024, at 12:18 PM, Surveyor toured the pantry storage in the basement with Caregiver E, and observed the following: - Notebooks and paperwork were on top of a filing cabinet covered in white and black spots, consistent with mold from water damage. - Plastic bags filled with groceries were scattered on the floor. - Cleaning compounds, including laundry detergent, disinfectant spray, and Pine-Sol multi-surface cleaner, were stored nearby food	M 474		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/13/2024
NAME OF PROVIDER OR SUPPLIER K & D ADULT FAMILY HOMES LLC II		STREET ADDRESS, CITY, STATE, ZIP CODE 3707 10TH AVE RACINE, WI 53402		
(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 474	Continued From page 5 items. - Black circles were on the wooden shelving units used to store food items - Black rice like substance, consistent with mouse feces, was scattered about on the shelving units. On 05/29/2024, at 12:18 PM, Surveyor interviewed Caregiver E. Caregiver E reported the bathroom above the basement had been leaking into the pantry area, causing water damage near the filing cabinets. The bathroom was remodeled, and the leak was fixed. Caregiver E reported the residents assisted in bringing in groceries and had dropped some of the bags onto the floor. Caregiver E reported the home had a problem with mice getting in and leaving feces in the pantry. An exterminator came out to the home and sprinkled powder/pellets around the perimeter of the home and poured it into an opening in the basement cinder blocks. The opening in the cinder blocks was filled in and closed up. Caregiver E reported s/he and House Manger A had cleaned the pantry after the exterminator came, and s/he didn't realize the mice had come back since. On 06/12/2024, at 11:00 AM, Surveyor interviewed Licensee C. Licensee C reported s/he was aware of the mice and mold issues in the food pantry. Licensee C reported the exterminator was hired to come every 6 months, and s/he thought the problem had been corrected. Licensee C reported a contractor was hired to remodel the bathroom; the sink, vanity, and the area around the bathtub were replaced. Licensee C reported s/he would get the pantry cleaned up and follow-up with the exterminator.	M 474		