STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 08/06/2024, Surveyor completed a standard survey, verification visit and complaint investigation. As a result, 4 of the previous deficiencies were corrected and 6 deficiencies were identified. Two of the 6 deficiencies were repeat deficiencies and were cited for a fourth time, 1 citation is being cited for a third time and 1 citation is a repeat deficiency. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 8	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the provider and its operation did not comply with all laws governing the Community-Based Residential Facility (CBRF). As a result of the verification survey, 8 deficiencies were identified. Two of the 8 deficiencies were repeat violations and were cited for a fourth time, 1 citation is being cited for a third time and 1 citation is a repeat citation. Deficiencies were identified in the areas of health screening of caregivers, assessments of residents and updating the Individual Service Plans (ISP) for residents. This had the potential to negatively affect 8 of 8 residents.	N 196		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 196	Continued From page 1 This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) 1YX213, dated 08/09/2023, SOD 1YX212, dated 06/28/2022, and SOD 1YX211, dated 12/14/2021. Findings include: The facility was licensed on 08/15/2017, to serve up to 8 residents in the client groups of advanced aged, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, traumatic brain injury and developmentally disabled. On 06/28/2024, Surveyor conducted a standard survey, verification visit and complaint investigation. Six deficiencies were identified. Two of the 6 deficiencies were repeat deficiencies and were cited for a fourth time, 1 citation is being cited for a third time and 1 citation is a repeat deficiency. 83.14(2)(a) Licensee Ensures facility Complies with Laws - repeat 83.17(2)(a) Employees Screened for Communicable Disease - repeat 83.35(1)(a) Pre-Admission and Ongoing Assessments - repeat 83.35(3)(d) Service Plans Updated Annually or on Changes 83.45(3) Toxic Substances 83.47(3) Fire Inspection - repeat On 06/28/2024, at 7:15 AM, Surveyor reviewed department documents and identified the provider was issued SOD IYX213, dated 08/09/2023, on 11/15/2023. Along with the SOD was the Notice and Order Letter, which identified Special Orders. The letter stated, "NOTICE OF ACCURING FORFEITURE 1. In addition to other sanctions enumerated in Wis. Stat. § 50.03(5g)(b)1. to 8.,	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 196	Continued From page 2 according to Wis. Stat. § 50.03(5g)(c)1.a., the Department of Health Services may set daily forfeiture amounts that increase periodically. Therefore, pursuant to Wis. Stat. §§ 50.03(5g)(c)1., 50.03(5g)(c)1.a., and 1.b., IT IS HEREBY ORDERED that a FORFEITURE OF $10 per day will ACCRUE beginning the first day following receipt of this Notice and Order letter until the date the licensee submits evidence, acceptable to the Department, to verify compliance with Employee and Resident health screenings and documentation in a3ordance with Wis. Admin. Code §§ DHS 83.17(2)(a) and 83.28(4)(a), as identified in Statement of Deficiency 1YX213." On 08/06/2024, at 2:30 PM, Surveyor interviewed Administrator A. Administrator A reported s/he did not see the order indicating s/he was required to send employee and resident health screenings. Administrator A reported s/he did not send the Department health screenings for employees and residents. Administrator A reported s/he did not believe s/he should be cited for communicable disease screenings due to a misunderstanding between Administrator A and a former surveyor. When Surveyor relayed the concerns of the survey, Administrator A expressed s/he was unhappy with the repeat citations.	N 196		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 220	Continued From page 3 control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis (TB), within 90 days before the start of employment for 2 of 2 caregivers reviewed (Caregiver H and Caregiver I). Caregiver I's TB test was completed 17 days after start of employment. Caregiver I did not have a signed communicable disease screening in her/his record. Caregiver H did not have a signed communicable disease screening in her/his record. This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) 1YX213, dated 08/09/2023, SOD 1YX212, dated 06/28/2022, and SOD 1YX211, dated 12/14/2021. Findings include: On 06/28/2024 at 1:30 PM, Surveyor reviewed staff files and identified the following: Caregiver I was hired on 04/12/2024. Caregiver I's record contained a document titled "Communicable disease/Tuberculosis Screening Questionnaire." The questionnaire contained	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 220	Continued From page 4 circled answers to the questions and was signed by Caregiver I on 04/12/2024. The form was not signed by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating Caregiver I was screened for communicable diseases. Caregiver I's record contained a TB test, dated 04/29/2024, 17 days after Caregiver I started employment. Caregiver H was hired on 06/03/2024. Caregiver H's record contained a document titled "Communicable disease/Tuberculosis Screening Questionnaire." The questionnaire contained circled answers to the questions and was signed by Caregiver H on 06/03/2024. The form was not signed by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating Caregiver H was screened for communicable diseases. On 08/06/2024, at 2:30 PM, Surveyor interviewed Administrator A. Administrator A reported Registered Nurse (RN) J completes the communicable disease screening. Administrator A confirmed the communicable disease screenings were not signed by RN J. Administrator A reported s/he would ensure the screenings are all signed by RN J.	N 220		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 381	Continued From page 5 receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on review of resident records and staff interview, the provider did not ensure each resident's needs, abilities, and physical and mental condition were assessed at least annually or upon changes for 3 of 3 residents reviewed. Resident 3 did not have annual assessments in 2022 and 2023. Resident 4 did not have an annual assessment in 2023. Resident 5 was not assessed for her/his ability to consent to an intimate relationship. This requirement is being cited for a third time. See Statement of Deficiency (SOD) 1YX212, dated 06/28/2022, and SOD 1YX211, dated 12/14/2021. Findings include: On 06/28/2024, at 12:30 PM, Surveyor reviewed resident records and identified the following: Example 1 - Annual Assessments Resident 3 was admitted on 11/04/2021. Resident 3's record did not contain any annual assessments identifying Resident 3's needs, abilities, and physical and mental conditions in 2022 and 2023. Resident 4 was admitted on 02/25/2022. Resident 4's record did not contain any annual	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 381	Continued From page 6 assessments identifying Resident 4's needs, abilities, and physical and mental conditions in 2023. Example 2 - Assessment for Changes in Behavior Resident 5 was admitted on 10/10/2023. Resident 5's record contained an admission assessment, dated 10/11/2023. Resident 5's admission assessment reported s/he was admitted to the provider due to needing assistance "due to multiple clinical conditions and inability to make safe decisions." For "Social history", Resident 5 has children and grandchildren, and does not have contact with family. Resident 5's ISP, dated 11/10/2023, identified Resident 5 was his/her own person. S/He requires supervision due to his/her physical condition, chronic pain, inability to manage medications, and provide proper self-care. Resident 5 was at high risk of falls. Resident 5's record contained the following incident reports: 12/29/2023 - "I was doing checks and notice [Resident 5] was in another member [sic] room w/ [sic] [her/him], door was closed and it was dark [sic] both with no clothing [sic] ..." 03/01/2024 - "[Resident 5] was in [Resident 4] [sic] room tying to have sex an [sic] staff redirect [her/him] and [s/he] said that [s/he] didnt [sic] wanna live her [sic] so [s/he] left and [s/he] is not filling out no [sic] papers" 04/06/2024 - "[Resident 5] was caught by staff Saturday night around 9:20pm having intercourse with another resident inside the facility where	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 381	Continued From page 7 [s/he] lives. Administration was notified as well as case manager [sic] staff separated the two." Resident 5's record did not contain an assessment for Resident 5's ability to consent to an intimate relationship. On 08/06/2024, at 2:30 PM, Surveyor interviewed Administrator A. Administrator A reported Registered Nurse (RN) J was responsible for completing the annual assessments. Administrator A reported s/he was unsure why the annual assessments were not completed. Administrator A reported RN J was busy and running behind. Administrator A was unaware of Resident 5's desire to be in an intimate relationship. Administrator A was unaware Resident 5 should have been assessed for the ability to consent to an intimate relationship. Cross reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 381		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 389	Continued From page 8	N 389		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 3 of 3 residents' (Resident 4, Resident 5, and Resident 3) Individual Service Plans (ISP) updated annually or on changes. Resident 4 ISP was due to be reviewed in April 2023 and April 2024. Resident 3's ISP was due to be reviewed in April 2024. Resident 5's ISP needed to be updated due to the development an intimate relationship with another resident.

Findings include:

On 06/28/2024, at 12:30 PM, Surveyor reviewed resident files and observed the following:

Example 1

Resident 4 was admitted on 02/25/2022. Resident 4's ISP was dated 04/05/2022. Resident 4's ISP was due to be reviewed in April 2023 and April 2024.

Resident 3 was admitted on 11/4/2021. Resident 3's ISP was dated 04/05/2023. Resident 3's ISP was due to be reviewed in April 2024.

Example 2

Resident 5 was admitted 10/10/2023. Resident 5's record contained the following incident reports:

12/29/2023 - "I was doing checks and notice [Resident 5] was in another member [sic] room w/ [sic] [her/him], door was closed and it was dark

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 389	Continued From page 9 [sic] both with no clothing [sic] ..." 03/01/2024 - "[Resident 5] was in [Resident 4] [sic] room tying to have sex an [sic] staff redirect [her/him] and [s/he] said that [s/he] didnt [sic] wanna live her [sic] so [s/he] left and [s/he] is not filling out no [sic] papers" 04/06/2024 - "[Resident 5] was caught by staff Saturday night around 9:20pm having intercourse with another resident inside the facility where [s/he] lives. Administration was notified as well as case manager [sic] staff separated the two." Resident 5's ISP, dated 11/10/2023, identified the following: "Capacity for Self-Direction - [Resident 5] is able to make [her/his] needs known and makes own decisions. Staff will positively encourage [Resident 5] to communicate [her/his] needs. [Resident 5] will maintain the current level of independence." "Interpersonal relationships - [Resident 5] has [3 children]. No contact with the family ...[Resident 5] communicates with the staff in a positive manner ... [Resident 5] will continue [sic] maintain positive interpersonal relationship with staff and other residents." Resident 5's ISP did not identify Resident 5's desire to maintain an intimate relationship. On 08/06/2024, at 2:30 PM, Surveyor interviewed Administrator A. Administrator A reported Registered Nurse (RN) B is responsible for updating resident ISPs annually. Administrator A reported RN B had been busy with other jobs and all resident ISPs were completed a couple days	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 389	Continued From page 10 after Surveyor left the facility. Administrator A reported s/he was aware of Resident 4's and Resident 5's desire to pursue a romantic relationship but was unaware both residents had engaged in an intimate relationship. Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission and Ongoing Assessments	N 389		
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 area. Unsecured toxic substances were found on a table in a common area and under the kitchen sink. Findings include: The facility was licensed on 08/15/2017, to serve up to 8 residents in the client groups of advanced aged, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, traumatic brain injury and developmentally disabled. On 06/28/2024, at 12:00 PM, Surveyor toured the facility and observed the following: - On top of a table off the kitchen area was a container of Member's Mark disinfecting wipes, Lysol disinfecting spray, and a can of Febreze air	N 499		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 499	Continued From page 11 mist. - The cupboard under the kitchen sink contained a locking mechanism. The lock was engaged. The key was in the lock. Surveyor was able to open the cupboard. The cupboard contained a bottle of Clorox cleaner with bleach. - The office area door was wide open. On top of a desk was a container of Clorox disinfecting wipes, Lysol disinfecting spray and Febreze air mist. Residents were observed moving freely throughout the facility. On 08/06/2024, at 2:30 PM, Surveyor interviewed Administrator A. Administrator A confirmed toxic chemicals and cleaning compounds were to be securely stored. Administrator A reported staff should not leave the key in the lock.	N 499		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for an annual fire inspection for 2 of 2 years (calendar years 2022 and 2023). This is a repeat deficiency. See Statement of Deficiency (SOD) 1YX211, dated 12/14/2021.	N 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS MANOR II	10620 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 530	Continued From page 12 Findings include: On 06/28/2024, at 2:00 PM, Surveyors reviewed facility safety code documentation. There was no documentation the facility had been inspected by the local fire department or certified fire inspector for the year 2022 and 2023. On 07/01/2024, at 7:24 AM, Surveyor emailed Administrator A and requested the fire inspections. As of 07/09/2024 at 12:00 PM, no documentation was received. On 08/06/2024, at 2:30 PM, Surveyor interviewed Administrator A. Administrator A confirmed fire inspections were to be completed yearly. Administrator A reported s/he just took over scheduling the fire inspections to ensure they were being completed. Administrator A acknowledged they were missing fire inspections.	N 530		