STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018429	A. BUILDING: _____ B. WING _____	R-C 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF HOPE RESIDENTIAL LIVING HOME	4944 N 38TH STREET MILWAUKEE, WI 53209

(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 06/05/2024, Surveyors concluded a complaint investigation and verification visit at House of Hope Residential Living Home LLC for Statement of Deficiency (SOD) QE3711 and J8QK11. Four deficiencies were identified. Three of 4 deficiencies were repeat deficiencies identified in the following SODs: QE3711, dated 08/02/2023, M 0424 and M 0582 were repeat deficiencies. J8QK11, dated 06/06/2023, M 0384 and M 0424 were repeat deficiencies. The complaint was unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 2	{M 000}		
{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	{M 384}		

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{M 384}	Continued From page 1 provider did not ensure a service agreement was completed, dated, and signed for 1 of 2 residents (Resident 2). This is a repeat deficiency. See Statement of Deficiency (SOD) J8QK11, dated 06/02/2023. Findings include: On 05/29/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 09/23/2021. Resident 2 had a guardian. Resident 2's record did not include a completed, signed, and dated admission agreement. The service agreement was signed by Licensee A and Resident 2. Resident 2's guardian did not sign the admission agreement. On 06/06/2024, at approximately 1:30 PM, Surveyor interviewed Licensee A. Licensee A reported s/he did not know Resident 2's guardian was required to sign the admission agreement since the managed care organization was the entity who placed Resident 2. Licensee A confirmed Resident 2's guardian did not sign his/her admission agreement. Licensee A reported s/he would have each residents' responsible party sign the admission agreement prior to admission moving forward.	{M 384}		
{M 424}	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating	{M 424}		

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{M 424}	Continued From page 2 in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's Individual Service Plan (ISP) was reviewed and updated at least every 6 months for 2 of 2 residents. Resident 1's and Resident 2's ISP should have been reviewed and updated by 02/2024. This is being cited for a third time. See Statement of Deficiency (SOD) QE3711, dated 08/02/2023, and SOD J8QK11, dated 06/02/2023. Findings include: On 05/29/2024, Surveyors reviewed resident records and identified the following: -Resident 1 was admitted on 07/02/2021, with diagnoses including paranoid schizophrenia, bipolar disorder, hypothyroidism, and unspecified intellectual disabilities. Resident 1's ISP was dated 08/03/2023. Resident 1's record did not include evidence Resident 1's ISP was reviewed and updated in 02/2024. -Resident 2 was admitted on 09/23/2021, with diagnoses including pre-diabetes, hypothyroidism, dependent personality disorder,	{M 424}		

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{M 424}	Continued From page 3 and mild intellectual disability. Resident 2's ISP was dated 08/03/2023. Resident 2's record did not include evidence Resident 2's ISP was reviewed and updated in 02/2024. On 06/05/2024, at approximately 1:30 PM, Surveyor interviewed Licensee A. Licensee A reported it was his/her responsibility to ensure development of ISPs. Licensee A reported s/he reviewed the ISPs with the house manager and there were no changes, so s/he did not obtain new signatures or include case managers or guardians to verify the accuracy of the ISP. Licensee A reported s/he would ensure moving forward they would complete the 6-month reviews.	{M 424}		
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 observation, record review, and interview, the provider did not ensure a resident received all medications at the intervals prescribed by the resident's physician for 1 of 1 resident. Resident 1 was not given medication as ordered when s/he was given an as needed (PRN) medication on a schedule (75 doses) and	M 582		

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M 582	Continued From page 4	M 582		

missed 2 doses of a scheduled psychotropic medication. Resident 1's PRN haloperidol was packaged with a scheduled medication, lorazepam. Resident 1 received both medications when lorazepam was due for administration without exhibiting behaviors needed for justification for administering the PRN haloperidol.

This is a repeat deficiency. See Statement of Deficiency (SOD) QE3711, dated 08/02/2023.

Findings include:

On 05/29/2024, at 11:32 AM, Surveyor observed Resident 1's medications in the storage area. Resident 1's medication was in unit dose packaging. Surveyor observed Resident 1's haloperidol 5 milligrams (mg) and lorazepam 0.5 mg were packaged together in the same bubble pack for the month.

On 05/29/2024, Surveyors reviewed Resident 1's record. Resident 1 was admitted on 07/02/2021, with diagnoses including paranoid schizophrenia, bipolar disorder, and unspecified intellectual disabilities. Resident 1's Individual Service Plan (ISP), dated 08/03/2023, identified Resident 1 required staff assistance with medication administration. Resident 1's most recent physician appointment documentation, dated 04/17/2024, identified Resident 1 was prescribed haloperidol 5 mg twice a day as needed, and lorazepam 0.5 mg twice a day (scheduled). Surveyor did not identify any behavior reports located in Resident 1's record.
-Resident 1's medication administration record (MAR) from 04/19/2024 through 05/29/2024, identified Resident 1 did not receive his/her scheduled lorazepam on 05/28/2024 at 4:00 PM

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M 582	Continued From page 5	M 582		

or 05/29/2024 at 8:00 AM. Resident 1's MAR also identified Resident 1 received his/her PRN medication along with his/her scheduled medication on the following days and times, without additional documentation regarding the rationale for use and effects of the medication:
--8:00 AM dose Haloperidol 5 mg-Take 1 tablet by mouth 2 times a day as needed-Administered 04/19/2024 through 05/25/2024 and 05/27/2024 through 05/28/2024 (38 doses given)
--4:00 PM dose haloperidol 5 mg-Take 1 tablet by mouth 2 times a day as needed-Administered 04/19/2024 through 05/25/2024 and on 05/27/2024 (37 doses given)

On 05/29/2024 at approximately 11:00 AM, Surveyor interviewed Caregiver B. Caregiver B reported s/he usually worked overnight shifts at the adult family home, but needed to help fill shifts because other caregivers were unable to work. Caregiver B reported s/he had been working some daytime shifts beginning 05/28/2024. Caregiver B reported s/he was responsible for medication administration. Surveyor asked Caregiver B if there was a reason s/he had not given Resident 1 his/her lorazepam 05/28/2024 and 05/29/2024. Caregiver B stated, "Since Resident 1 was not having any negative behaviors, I didn't think [s/he] needed to receive the medications." Caregiver B reported it was confusing having both an as needed medication packaged with a scheduled medication. Caregiver B reported s/he thought they were both PRN medications.

On 06/05/2024, Surveyors reviewed the provider's Medication Procedure, not dated. The procedure stated, "4. Staff will compare the medication sheet with the label of each medication for the following: a. Right person; b.

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M 582	Continued From page 6 Right medication; c. Right date; d. Right time; e. Right route; f. Right dose; g. Expiration date. If there is a discrepancy, the medication will not be administered. Instructions will be verified by contacting the House Manger [sic]/Owner who in turn [sic] may contact the pharmacist or prescriber." On 06/05/2024 at approximately 1:30 PM, Surveyors interviewed Licensee A. Licensee A reported s/he was not aware a PRN haloperidol 5 mg medication and a scheduled lorazepam 0.5 mg medication were packaged together in the same medication card. Licensee A reported Resident 1 was supposed to receive his/her PRN haloperidol when s/he had negative behaviors and increases in aggression. Licensee A reported caregivers had not noticed any negative behaviors in the prior months. Licensee A confirmed Resident 1 received more doses of haloperidol than s/he needed during the past month. Licensee A reported s/he would speak to the pharmacy to address the packaging issue. Licensee A reported the provider had a medication procedure, which described what steps should have been taken when checking in medications from the pharmacy and when administering medications. Licensee A confirmed caregivers should have confirmed the labels on the medication cards as it was part of the 6 rights of medication on the facility medication policy. Licensee A was unsure why their internal system of checking in medications did not catch the pharmacy error.	M 582		
M 610	88.11(1) REPORTING OF ABUSE AND NEGLECT A licensee or service provider who	M 610		

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M 610	Continued From page 7	M 610		

knows or has reasonable cause to suspect that a resident has been abused or neglected as defined in s. 46.90 or 940.285, Stats., shall immediately contact the licensing agency. Providing notice under this subsection does not relieve the licensee or other person of the obligation to report an incident to law enforcement authorities. If the licensee has reason to believe a crime has been committed, the incident shall immediately be reported to law enforcement authorities.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not report abuse to the Department for 1 of 1 resident. Resident 3 alleged Caregiver C hit him/her and the provider did not report the incident to the Department.

Findings include:

On 05/29/2024, Surveyor reviewed police call documentation involving Resident 3 for the month of February 2024. On 02/05/2024, Resident 3 reported Caregiver C banged his/her head against the wall and threatened him/her. The police officers went to the adult family home and interviewed staff regarding the allegation of abuse.

On 05/29/2024, Surveyors reviewed Department documentation and did not identify the provider submitted a report to the department regarding

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M 610	Continued From page 8	M 610		

the allegation of Caregiver C abusing Resident 3.

On 05/28/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 11/03/2023, with diagnoses including anxiety disorder, post traumatic stress disorder, impulse disorder, disruptive mood dysregulation disorder, schizoaffective disorder-bipolar type, and psychotic disorder with delusions.

On 06/05/2024, at 1:15 PM, Surveyors interviewed Licensee A. Licensee A confirmed Resident 3 reported to law enforcement Caregiver C abused him/her. The same day, Licensee A conducted an internal investigation. Surveyor requested for Licensee A to send the internal investigation. Licensee A confirmed Caregiver C stayed at the facility to care for residents the entire day and was there when Resident 3 arrived home from day programming. That evening Resident 3 attempted to elope. Licensee A confirmed s/he did not report the allegation to the Department. Licensee A was unaware allegations of caregiver misconduct were required to be reported to the Department immediately.

On 06/05/2024, Surveyors received and reviewed the provider's internal investigation regarding the incident on 02/05/2024. The investigation summary identified Licensee A was notified by Caregiver C the police were at the facility asking questions about Resident 3's allegation of abuse. Licensee A investigated the allegation. On the morning of 02/05/2024, Caregiver F worked the overnight shift and Caregiver C came in to work the day shift. As Resident 3 was getting ready to leave for day programming, s/he got mad at Caregiver C and started yelling and swearing. Resident 1, Resident 2, Caregiver C and

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M 610	Continued From page 9 Caregiver E were present when Resident 3 was yelling. Licensee A picked Resident 3 up from the facility to take him/her to day programming. After Resident 3 went to his/her day program, the day programming staff called the police due to an allegation of Resident 3 stating Caregiver C abused him/her and s/he was afraid to go home. The report included witness statements from Resident 1, Resident 2, and Caregiver C. There was no statement from Resident 3 or Caregiver E regarding the allegation.	M 610		