| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310631 | A. BUILDING: _____ B. WING _____ | 02/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMPTON SUPPORTIVE CARE | 4615 W HAMPTON AVE 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<br><br>On 02/10/2025, Surveyor conducted a desk review for Hampton Supportive Care. As a result, 1 deficiency was identified. | N 000 | | |
| N 141 | 83.09 Biennial report and fees.<br><br>Biennial report and fees. Every 24 months, on a date determined by the department, the licensee shall submit a biennial report on the form provided by department, and shall submit payment of the license continuation fees.<br><br>This Rule is not met as evidenced by:<br>Based on record review and email interview, the licensee did not ensure the biennial report and license fee were submitted to the department within 30 days prior to the license expiration date.<br><br>Findings include:<br><br>On 07/25/2024, the department sent a notice to Licensee A informing them the license for Hampton Supportive Care, would expire on 09/30/2024. The notice indicated the biennial report and license fee were due to the department by 08/31/2024.<br><br>On 08/22/2024, the department sent a second notice to Administrator B and Person C (Licensee Representative) informing them the license for Hampton Supportive Care, would expire on 09/30/2024. The notice indicated the biennial report and license fee were due to the department by 08/31/2024.<br><br>On 08/22/2024, the department received a confirmation of delivery for the above notice. | N 141 | | |

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 |
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| | 310631 | A. BUILDING: _____ B. WING _____ | 02/10/2025 |

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| HAMPTON SUPPORTIVE CARE | 4615 W HAMPTON AVE 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 141 | Continued From page 1<br><br>On 09/13/2024, the department sent a third notice to Licensee A by certified letter, indicating the biennial report and license fee were past due. The notice indicated if the biennial report and license fee were not received by 10/30/2024, the Division of Quality Assurance will proceed with enforcement action, which may include license revocation.<br><br>On 09/17/2024, the department received a confirmation of delivery.<br><br>On 01/08/2025 at 9:40 AM, Person C sent an email to Regional Director D (Bureau of Assisted Living Regional Director) asking about the status of the Change of Ownership (CHOW) with the plan for Administrator B become licensee.<br><br>On 01/08/2025 at 10:28 AM, Regional Director D sent the following reply, "(Administrator B) was informed yesterday during the [onsite survey] exit conference that the verification survey conducted in December cleared all the citations. (Person C) and (Administrator B) should receive receipt of that via email within the next day or two... (Regional Director D) also will check with our office to determine if there are any other outstanding fees under the current license that would need to be settled prior to the CHOW to occur. If any fees are outstanding, (Person C) and (Administrator B) will be notified of those fees. They would need to be paid prior to the CHOW."<br><br>On 01/08/2025, the department sent a fourth notice to Administrator B and Person C by email, indicating the biennial report and license fee were past due. The notice indicated if the biennial report and license fee were not received by | N 141 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310631 | A. BUILDING: _____ B. WING _____ | 02/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **HAMPTON SUPPORTIVE CARE** | **4615 W HAMPTON AVE 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 141 | Continued From page 2<br>10/30/2024, the Division of Quality Assurance will proceed with enforcement action, which may include license revocation.<br><br>On 02/10/2025, Surveyor reviewed department records and found no evidence a biennial report and license fees were received from the provider. | N 141 | | |