STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014500	A. BUILDING: _____ B. WING _____	C 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT WAY FAMILY HOME (THE)	5157 NORTH 45TH STREET 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
M 000	INITIAL COMMENTS On 09/03/2024, Surveyors completed a standard survey and a complaint investigation at Right Way Family Home. As a result, 13 deficiencies were identified. One of 13 deficiencies is a repeat violation (see Statement of Deficiency (SOD) 7LEN13, dated 05/08/2019, and SOD 7LEN14, dated 06/24/2021). The complaint was unsubstantiated. Census: 3	M 000		
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 interview and record review, the provider did not obtain documentation indicating 2 of 2 staff had been screened for illnesses detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service. Caregiver D's and Caregiver E's records did not contain documentation indicating they had been illnesses	M 232		

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

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M 232	Continued From page 1 detrimental to residents including TB. Findings include: On 08/15/2024, at 10:00 AM, Surveyors requested employee files from Regional Director A. Regional Director A reported the employee files were at the office. Regional Director A reported staff were getting ready for the company banquet, so no one was at the office. Regional Director A reported s/he would send them over to Surveyors by the end of the day. On 08/15/2024, at 4:57 PM, Surveyors sent an email which requested Caregiver D's and Caregiver E's employee records to be sent to Surveyors by 10:00 AM on 08/16/2024. As of 09/03/2024, at 9:30 AM, no documentation had been received.	M 232		
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 complete the resident evacuation assessment within 3 days of admission for 2 of 2	M 344		

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M 344	Continued From page 2 residents. Resident 2's and Resident 3's records did not contain a completed evacuation assessment. Findings include: On 08/15/2024, at 09:1 5AM, Surveyors reviewed resident records and identified the following: -Resident 2 was admitted on 04/11/2024, with diagnoses including metastatic functional pancreatic cancer and osteoporosis vertebrae compression fractures. Resident 2's record did not contain an evacuation assessment. -Resident 3 was admitted on 04/27/2024, with diagnoses including autistic disorder, attention deficit hyperactivity disorder, and behavioral disorder. Resident 3's record did not contain an evacuation assessment. On 08/15/2024, at 10:30 AM, Surveyors interviewed Regional Director A. Regional Director A confirmed the evacuation assessments were to be completed immediately following placement. Regional Director A reported s/he would send Surveyors the documentation of the completed evacuation assessments for Resident 2 and Resident 3 by the end of the day. As of 09/03/2024, at 9:30 AM, no documentation had been received.	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	M 346		

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M 346	Continued From page 3 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 complete an annual evacuation assessment review for 1 of 1 resident reviewed who lived in the facility beyond one year. Resident 1 did not have an evacuation assessment completed in 2022, 2023, and 2024. Findings include: On 08/15/2024, at 9:55 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/01/2021, with diagnoses including, intellectual disability, seizures, and insomnia. Resident 1's record contained a Resident Evacuation Assessment, dated 04/02/2021. Resident 1's resident evacuation assessment was due to be reviewed on 04/2022, 04/2023, and 04/2024. Resident 1's record did not contain an annual evacuation assessment review for 2022, 2023, and 2024. On 08/15/2024, at 10:30 AM, Surveyors interviewed Regional Director A. Regional Director A confirmed the annual evacuation assessment reviews were to be completed annually. Regional Director A reported s/he would send Surveyors the documentation of the completed annual evacuation assessments for Resident 1 by the end of the day. As of 09/03/2024, at 9:30 AM, no documentation had been received.	M 346		

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M 348	Continued From page 4	M 348		
M 348	88.05(4)(d)2.c SEMI-ANNUAL FIRE DRILLS The licensee shall conduct semi-annual fire drills with all household members with written documentation of the date and the evacuation time for each drill maintained by the home. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure semi-annual fire drills were conducted with all household members with written documentation of the date and evacuation time for each drill for 1 of 2 years. Fire drills were not documented in 2023. Findings include: The facility was licensed on 04/30/2013 to serve 4 residents in the client groups of physically disabled, correctional clients, advanced aged, terminally ill, irreversible dementia/ Alzheimer's, developmentally disabled, alcohol/drug dependent, emotional disturbed/mental illness, and traumatic brain injury. On 8/15/2024, at 9:30 AM, Surveyor requested to review the facility's fire drills. Regional Director A provided Surveyors with documentation of fire drills conducted in 2022 and 2024. On 8/15/2023, at 10:30 AM, Surveyor interviewed Regional Director A, regarding the fire drills. Regional Director A reported fire drills were conducted in 2023 and the documentation was at the office. Regional Director A reported s/he would send Surveyors the documentation of the completed fire drills for 2023.	M 348		

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M 348	Continued From page 5 As of 09/03/2024, at 9:30 AM, no documentation had been received.	M 348		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident admitted to the facility was screened for communicable disease, including tuberculosis (TB), 90 days prior to admission or within 7 days after admission, for 2 of 2 residents. Resident 2 and Resident 3 were not screened for communicable disease. Resident 3's record did not contain documentation which indicated s/he was screened for TB. Findings include: -Resident 2 was admitted on 04/11/2024, with diagnoses including metastatic functional pancreatic cancer and osteoporosis vertebrae compression fractures. Resident 2's record did	M 380		

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M 380	Continued From page 6 not contain evidence of Resident 2 having been screened for communicable disease. -Resident 3 was admitted on 04/27/2024, with diagnoses including autistic disorder, attention deficit hyperactivity disorder, and behavioral disorder. Resident 3's did not contain evidence of Resident 3 having been screened for communicable disease, including TB. On 8/15/2024, at 11:15 AM, Surveyors interviewed Registered Nurse (RN) C. RN C reported s/he was not aware residents needed to be screened for communicable diseases along with TB. RN C reported residents were screened for TB and covid upon admission.	M 380		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written assessment and an individual service plan (ISP) were developed for 2 of 2 residents within 30 days after placement. Resident 2 and Resident 3 did not have a written assessment, or an ISP completed within 30 days. Findings include:	M 404		

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M 404	Continued From page 7 On 08/15/2024, at 09:1 5AM, Surveyors reviewed resident records and identified the following: -Resident 2 was admitted on 04/11/2024, with diagnoses including metastatic functional pancreatic cancer and osteoporosis vertebrae compression fractures. Resident 2's record did not contain written assessment, or an ISP. -Resident 3 was admitted on 04/27/2024, with diagnoses including autistic disorder, attention deficit hyperactivity disorder, and behavioral disorder. Resident 3's record did not contain written assessment, or an ISP. On 08/15/2024, at 9:40 AM, Surveyors interviewed Regional Director A. Regional Director A reported Resident 2's and Resident 3's ISPs were at the office. Regional Director A reported s/he would send Surveyors the documentation of the completed ISPs for Resident 2 and Resident 3. On 08/15/2024, at approximately 10:45 AM, Surveyors interviewed Licensee B. Licensee B reported s/he thought they had 6 months to complete the ISPs. Licensee B reported stated, "Oh we may have to get on the same page." As of 09/03/2024, at 9:30 AM, no documentation had been received.	M 404		
M 406	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the	M 406		

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M 406	Continued From page 8 licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This Rule is not met as evidenced by: Based on record review and interview, the facility did not ensure 1 of 1 resident's individual service plans (ISPs) were developed, signed, and dated by all persons involved in developing the plan. Resident 1's was not signed by his/her guardian. Findings include: On 08/15/2024, at 9:55 AM, Surveyors reviewed Resident 1's records. Resident 1 was admitted to the facility on 04/01/2021, with diagnoses including, intellectual disability, seizures, and insomnia. Resident had a court appointment guardian. Resident 1's ISP dated 06/24/2021, had a review date of 04/16/2024. Resident 1's ISP was signed by Resident 1's case manager and Resident 1's Registered Nurse (RN) case worker. Resident 1's ISP was not signed by Resident 1's guardian. On 08/15/2024, at approximately 9:45 AM, Surveyors interviewed Regional Director A. Regional Director A confirmed the code requirement. Regional Director A did not offer a reason Resident 1's ISP was not signed by Resident 1's guardian.	M 406		
M 424	88.06(3)(f) REVIEW OF ISP	M 424		

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M 424	Continued From page 9 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 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 1 of 1 resident's individual service plans (ISPs) were reviewed at least every 6 months. Resident 1's ISP was due to be reviewed 12/24/2021, 06/24/2022,12/24/2022, 06/24/2023, and 12/24/2023. Residents 1's record did not contain any documentation of the ISP reviews. Findings include: On 08/15/2024, at 9:55 AM, Surveyors reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/01/2021, with diagnoses including, intellectual disability, seizures, and insomnia. Resident 1's current ISP was dated 06/24/2021, with a review date of 04/16/2024. Resident 1's ISP was due to be reviewed	M 424		

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M 424	Continued From page 10 12/24/2021, 06/24/2022,12/24/2022, 06/24/2023, and 12/24/2023. Residents 1's record did not contain any documentation of the ISP reviews. On 08/15/2024, at 9:40 AM, Surveyors interviewed Regional Director A. Regional Director A reported Resident 1's ISP reviews were at the office. Regional Director A reported s/he would send Surveyors the documentation of the completed ISP reviews for Resident 1. As of 09/03/2024, at 9:30 AM, no documentation had been received.	M 424		
M 446	88.07(2)(b)4 RECORD OF MEDICAL VISITS AND REPORTS Keeping a current record of all medical visits, reports and recommendations for a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure they obtained a record of all medical visits and reports for 1 of 1 resident. Resident 2 was seen in the emergency room and admitted to the hospital and there were no reports included in her/his record. Findings include: On 08/15/2024, at 9:15 AM, Surveyors reviewed Resident 2's record. Resident 2 was admitted on 04/11/2024. Resident 2's record did not include a record of emergency room or hospital after visit summary. On 08/15/2024, at 9:30 AM, Surveyors reviewed	M 446		

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M 446	Continued From page 11 staff communication book. The staff communication book reported on 07/20/2024, Resident 2 had maggots and parasites in her/his wound on her/his foot. Resident 2 was sent to the hospital on 07/20/2024. Resident 2 returned from the hospital on 07/24/2024. On 08/15/2024, at 11:15 AM, Surveyors interviewed Regional Director A and Registered Nurse (RN) C. Regional Director A reported RN C had the copy of Resident 2's hospital discharge paperwork. RN C reported s/he did not have the copy of Resident 2's discharge paperwork as it was not in his/her mailbox. RN C reported s/he did not know where the paperwork was.	M 446		
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 and interview the provider did not ensure medications were destroyed when expired for 1 of 3 residents. Resident 1's medication container contained expired medications.	M 458		

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M 458	Continued From page 12 This is being cited for a third time. See Statement of Deficiency (SOD) 7LEN13, dated 05/08/2019, and SOD 7LEN14, dated 06/24/2021. Findings include: On 08/15/2024 at 10:00 AM, Surveyors observed the medication closet. Resident 1's medication container contained the following expired medications: Antacid chew 500 milligrams (mg) expired 04/25/2024. Aspercreme Lidocaine 4% patches expired 03/31/2022. Refresh tears 0.5% solution expired 06/08/2024. Antacid 20 mg/ 5 milliliters (ml) expired 04/26/2024. On 08/15/2024, at 10:30 AM, Surveyors interviewed Regional Director A. Regional Director A reported the nurses were responsible for ensuring expired medications are disposed of. Regional Director A reported there were 3 nurses who worked for the company so there was no reason for expired medications to be in the facility. Regional Director A reported s/he would speak with the nurses to ensure all expired medications were disposed of.	M 458		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access.	M 482		

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M 482	Continued From page 13 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 3 of 3 residents' (Resident 1, Resident 2, and Resident 3) records contained all required information and were maintained in a secure location within the home. Findings include: On 08/15/2023, at 9:15 AM, Surveyors reviewed resident records and identified the following: - Resident 1 was admitted to the facility on 04/01/2021. Resident 1's record did not contain the following documents: Admission health exam Communicable disease screening - Resident 2 was admitted on 04/11/2024. Resident 1's record did not contain the following documents: Communicable disease screening Current Individual Service Plan (ISP) Evacuation Evaluation -Resident 3 was admitted on 04/27/2024. Resident 3's record did not contain the following documents: Communicable disease screening and tuberculosis screening Admission Assessment Evacuation Evaluation Admission Health Exam ISP	M 482		

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M 482	Continued From page 14 On 08/15/2024, at 9:40 AM, Surveyors interviewed Regional Director A. Regional Director A reported the documentation was at the office. When Surveyors inquired why the resident documentation was not in the home, Regional Director A reported it used to be kept in the home, but systems had changed, and some paperwork was kept at the office.	M 482		
M 530	88.09(2)(a)8 TRAINING DOCUMENTATION Documentation of successful completion of the training requirements under HSS 88.04(5). This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain and keep up to date a personnel record for each service provider which included documentation of successful completion of the training requirements under s. DHS 88.04(5) for 2 of 2 employees reviewed (Caregiver D and Caregiver E). Caregiver D's and Caregiver E's records did not contain evidence of orientation training and 8 hours of annual training for 2022 and 2023. DHS 88.04(5)(b) states "(5) TRAINING. (b) Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received." Findings include:	M 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014500	A. BUILDING: _____ B. WING _____	C 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT WAY FAMILY HOME (THE)	5157 NORTH 45TH STREET 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
M 530	Continued From page 15 On 08/15/2024, at 10:00 AM, Surveyors requested to review employee files. Regional Director A reported the employee files were at the office. Regional Director A reported staff were getting ready for the company banquet, so no one was at the office. Regional Director A reported s/he would send them over to Surveyors by the end of the day. On 08/15/2024, at 4:57 PM, Surveyors sent an email which requested Caregiver D's and Caregiver E's employee records to be sent to Surveyors by 10:00 AM on 08/16/2024. As of 09/03/2024, at 9:30 AM, no documentation had been received.	M 530		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe physical environment for 3 or 3 residents. The hot water temperature in the residents' bathroom was 132.4° Fahrenheit (F).	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014500	A. BUILDING: _____ B. WING _____	C 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 570	Continued From page 16 The dryer vent consisted of flexible vent material. Findings include: Example 1 On 08/15/2024, at 9:14 AM, Surveyors tested the water temperature in the residents' bathroom sink faucet. The water temperature was 132.4°F. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g. second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017) On 08/15/2024, at 10:30 AM, Surveyors interviewed Regional Director A. Regional Director A reported s/he was aware of the code requirement. Regional Director A reported s/he would follow up with maintenance. Example 2 On 08/15/2024, at 9:38 AM, Surveyors observed the basement clothes dryer venting was made of a flexible material rather than rigid metal. On 08/15/2024, at 10:30 AM, Surveyors interviewed Regional Director A. Regional	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014500	A. BUILDING: _____ B. WING _____	C 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT WAY FAMILY HOME (THE)	**5157 NORTH 45TH STREET 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
M 570	Continued From page 17 Director A reported s/he was aware the dryer vent should be of rigid metal. Regional Director A reported s/he would follow up with maintenance.	M 570		