STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013115	A. BUILDING: _____ B. WING _____	R-C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN AVENUE HOUSE	9833 W LINCOLN AVE MILWAUKEE, WI 53227

(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 08/08/2023, Surveyor completed a verification visit and 1 complaint survey at Lincoln Avenue House. One of 1 complaint was substantiated. One deficiency was identified. One of 1 deficiency was a repeat violation. See Statement of Deficiency (SOD) ND5D11, dated 06/08/2022. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
{M 436}	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure services specified in 1 (Resident 1) of 1 resident's individualized service plan (ISP) was provided. Resident 1 required 24-hour supervision and did not receive hourly safety checks as specified in his/her ISP. This resulted in Resident 1 eloping from the home. This is a repeat deficiency. See Statement of Deficiency ND5D11, dated 06/08/2022. Findings include: On 06/07/2023, the Department received a	{M 436}		

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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{M 436}	Continued From page 1 complaint alleging a resident crawled out of the window and staff were not completing hourly checks. On 08/08/2023, Surveyor reviewed Resident 1's file. Resident 1 was admitted on 02/16/2010. Resident 1 was diagnosed with Autism, mild mental retardation, and severe acute aggressive behavior problems. Resident 1's ISP, with a date of 02/07/2023 indicated "24-hour supervision is needed." Resident 1's "Special Alert Condition/At-Risk Behavior Assessment," which was a part of Resident 1's ISP, indicated Resident 1 had the potential to elope with a severity level of "moderate." Per Resident 1's Psychological/Behavioral Functioning, which was a part of Resident 1's ISP indicated, " ...Staff does complete hourly safety checks, entering/checking-in on third shift ..." On 08/08/2023, Surveyor reviewed client logs dated on 06/03/2023 and 06/04/2023. The client logs indicated hourly checks were not completed between 10:00 p.m. on 06/03/2023 to 11:00 a.m. on 06/04/2023 and 8:00 p.m. on 06/04/2023 to 8:00 a.m. on 06/05/2023. On 08/08/2023 at approximately 3:30 p.m., Surveyor interviewed Resident 1. Resident 1 acknowledged leaving the adult family home (AFH) through his/her window. Resident 1 affirmed not informing the caregiver on duty that he/she was leaving the home. Resident 1 disclosed the caregiver was not a "regular" caregiver who worked in the AFH. Resident 1 reported coming through the front door upon his/her return. Resident 1 denied the caregiver was aware he/she left the AFH. On 08/08/2023 at approximately 3:30 p.m.,	{M 436}		

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{M 436}	Continued From page 2 Surveyor interviewed House Manager A. House Manager A denied being aware of an incident in June 2023 where Resident 1 climbed out of his/her window. House Manager A reported a caregiver from a temporary (temp) agency worked the shift Resident 1 was said to have "climbed out of [his/her] window." House Manager A affirmed staff were to complete hourly checks on Resident 1 and the hourly checks were to be documented on the client logs. House Manager A reported Resident 1's window was equipped with a device where Resident 1 was able to open the window for ventilation, but not enough to where he/she was able to climb out of the window. On 08/08/2023 at approximately 4:00 p.m., Surveyor interviewed Director D. Director D denied being aware of an incident where Resident 1 climbed out of his/her window in June 2023. Director D denied an incident report was completed or submitted indicating an incident occurred on 06/04/2023. Director D reported on 02/19/2023, a new contract was completed with the temp agency requiring all caregivers from the temp agency to complete each client log prior to the end of his/her shift and stating all shifts were awake shifts and caregivers should not be sleeping. The provider did not provide hourly safety checks, entering/checking-in with Resident 1 on third shift.	{M 436}		