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 _____	C 07/31/2023

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 On 06/13/2023, Surveyors conducted a complaint investigation at Hampton Supportive Care. Eight deficiencies were identified. Two of the 8 deficiencies were repeat violations (see SOD YBO811, dated 02/03/2022). One complaint was substantiated. Census: 3	N 000		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not submit a written report to the department within 3 working days after 1 of 3 residents (Resident 1) eloped. Resident 1 eloped from the facility on 05/07/2022, 07/05/2022, 08/21/2022, 08/22/2022, 09/11/2022, 09/12/2022, 10/17/2022, 12/08/2022, 05/20/2023	N 163		

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

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N 163	Continued From page 1 and 05/31/2023. Findings include: On 06/05/2023, the Department received a complaint alleging Resident 1 was found 4.5 miles from the facility in a wheelchair with no identification. On 06/20/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/12/2021, with diagnosis of psychosis, bulimia nervosa, dysphagia, schizophrenia, right knee effusion, and hyperlipidemia. Resident 1's progress notes listed 10 incidents of elopement between 05/07/2022 -05/31/2023. On 06/20/2023, Surveyor reviewed department records and confirmed self-reports were not submitted when Resident 1's whereabouts were unknown on 05/07/2022, 07/05/2022, 08/21/2022, 08/22/2022, 09/11/2022, 09/12/2022, 10/17/2022, 12/08/2022, 05/20/2023 and 05/31/2023. On 06/28/2023, at 8:55 AM, Surveyor interviewed Administrator A. Administrator A stated Resident 1 left the building every day. When [Resident 1] was lost [he/she] would often show up at St. Joseph's hospital and they would call to have us come pick [him/her] up. Surveyor asked Administrator A if they were aware of the reporting requirement anytime a resident's whereabouts were unknown. Administrator A stated they thought this was unnecessary because the case manager had agreed to wait 24 hours before alerting anyone.	N 163		
N 220	83.17(2)(a) Employees screened for communicable disease.	N 220		

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N 220	Continued From page 2 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 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 ensure documentation was obtained from a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse indicating 1 of 1 employee was screened for clinically apparent communicable disease including tuberculosis (TB). Caregiver (F) was not screened for communicable disease including TB. Findings include: On 06/19/2023 at approximately 2:55 p.m., Surveyor reviewed Caregiver F's employee file. Caregiver F was hired on 07/26/2022. Caregiver F's file did not contain documentation indicating they were screened for communicable disease, including TB. On 06/19/2023 at 3:36 p.m., Surveyor interviewed Administrator A who confirmed there was no documentation indicating Caregiver F was	N 220		

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N 220	Continued From page 3 screened for clinically apparent communicable disease including TB.	N 220		
N 334	83.31(7)(a) Discharge information: facility information At the time of a resident ' s transfer or discharge, the CBRF shall inform the resident or the resident ' s legal representative and the resident ' s new place of residence that all of the following information is available in writing upon request: Facility information. The name and address of the CBRF, the dates of admission, and discharge or transfer, and the name and address of a person to contact for additional information. This Rule is not met as evidenced by: Based on interview and record review the provider did not maintain a record of facility information at the time of discharge for 16 of 16 residents. (Residents 1, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20). The name and address of the CBRF, the dates of admission, and discharge or transfer, and the name and address of a person to contact for additional information were not documented at time of resident relocations. Findings Include: On 06/28/2023, Surveyors interviewed Administrator A and requested a roster of discharged residents with discharge dates and new locations. Administrator A stated they were not in the country when residents were being moved out of the facility. Administrator A stated, "[Human Resources Director G] ... might have the dates and some of the facilities, but I don't know if she knows them all." Administrator A	N 334		

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N 334	Continued From page 4 agreed to gather the requested information and send it to surveyor's e-mail. As of 07/26/2023 no discharge roster had been provided.	N 334		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not involve the resident and the resident's legal guardian and case manager of the resident's managed care organization (MCO), in developing the individual service plan (ISP) for 1 of 1 resident reviewed (Resident 1). This is a repeat deficiency. See SOD YBO811, dated 02/03/2022.	N 387		

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N 387	Continued From page 5 Findings include: On 6/17/2023 at approximately 11:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/12/2021 with diagnosis of mental illness/psychosis, schizophrenia, bulimia and hyperlipidemia. Resident 1's ISP, dated 11/12/2021, had no signature of participants. On 06/22/2023 at 12:30 PM, Surveyor interviewed Case Manager (CM) C. CM C denied being invited to participate in the development of Resident 1's ISP and said there was no copy of the ISP in Resident 1's file. On 06/29/2023 at 2:00 PM, Surveyors interviewed Administrator A who stated, Resident 1 was enrolled with a MCO and had an assigned case manager, CM C, and a legal guardian, Legal Guardian (LG) B. Administrator A stated they were unable to get a response from Resident 1's guardian regarding ISP meetings and the case managers were always changing. "I had been leaving messages for the case manager who wasn't responding." "I think it was [a previous surveyor] who said if you can't get the people in there, get them on the phone. And so that's what I started doing just calling the people and telling them what the care plan was. And if they come then I would have them sign, but 9 times out of 10, when they were here, I wasn't. So, I did call."	N 387		
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	N 389		

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N 389	Continued From page 6 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident's (Resident 1) Individual Service Plans (ISP) was reviewed annually as required. Resident 1's ISP was not reviewed or updated in 2022. Findings include: On 6/17/2023 at approximately 11:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/12/2021 with diagnosis of mental illness/psychosis, schizophrenia, bulimia and hyperlipidemia. Resident 1's record contained an ISP, dated 12/01/2021, which did not include signatures by Resident 1's legal guardian, Legal Guardian (LG) B, Case Manager (CM) C, Resident 1, or the provider. On 06/29/2023 at 2:00 PM, Surveyors interviewed Administrator A who confirmed the ISP, dated 12/01/2021, was the only ISP in Resident 1's record. Administrator A stated, they were unable to get a response from Resident 1's guardian regarding ISP meetings and the case managers were always changing.	N 389		

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N 419	Continued From page 7	N 419		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 4 of 4 medication storage areas were locked and the key was available only to personnel who passed medications. The room on the first floor, did not contain a door to securely store medications. Inside the room, medications were stored in a basket and in a refrigerator. On the second floor, medications were stored in a refrigerator which did not contain a locking mechanism. The medication cart keys were stored in a cupboard drawer. Residents were observed ambulating freely throughout the facility. Findings include: On 06/14/2023, at 9:15 AM, Surveyors observed a room, located behind the nurse's station, which did not have a door attached to the doorframe. Inside the room were 15 medication cards stored in a basket. There was a refrigerator which contained 29 insulin pens and 8 vials of medication. Surveyor did not observe a locking mechanism on the refrigerator. On the second floor, Surveyors observed a refrigerator, which contained 5 insulin pens. The refrigerator did not contain a locking mechanism. -First floor basket contained the following medications: Resident 5: 4 tablets of 5 milligrams (mg) cyclobenzaprine, 3 capsules of 5-500 mg turmeric, 4 tablets of 25 mg hydrochlorothiazide,	N 419		

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2 tablets of 75 mg pregabalin, 3 tablets of 75 mg clopidogrel, 2 tablets of 75 mg lisinopril, 2 capsules of 350 mg krill oil, and 1 tablet of 10 mg cetirizine.
Resident 6: 20 tablets of 600 mg gabapentin, 19 tablets of 8.6 mg Senexon-s, and 11 tablets of 4 mg tizanidine hydrochloride (HCL).
Resident 7: 1 capsule of 30 mg duloxetine
Resident 8: 4 tablets of 25 mg hydrochlorothiazide
Resident 9: 2 tablets of 500 mg metformin extended release (ER)
Resident 10: 16 capsules of 250 mg valproic acid

-First-floor refrigerator contained:
Resident 8: 1 Levemir insulin pen
Resident 11: 2 Novolog insulin pens, 6 Basaglar insulin pens, and 2 vials of Lantus insulin
Resident 12: 5 Lantus insulin pens and 9 Humalog insulin pens
Resident 13: 1 Lispro insulin pen and 5 vials of Lantus insulin
Unlabeled: 2 Basaglar insulin pens, 1 Lantus insulin pen and 1 vial of Lantus insulin

-Second-floor refrigerator contained:
Resident 8: 1 Levemir insulin pen and 4 dulaglutide injections

On 06/14/2023, at 9:30 AM, Surveyors observed Caregiver E open a cupboard drawer and grab the medication cart keys. Caregiver E passed residents' medications, locked the medication cart, and placed the keys back in the drawer. Surveyors observed residents ambulate freely throughout the facility.

On 06/14/2023, at approximately 10:10 AM, Surveyors interviewed Administrator A. Administrator A confirmed medications were to be

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N 419	Continued From page 9 securely stored. Administrator A reported the medications in the basket and the refrigerator were to be in a room adjacent to where the medications were found during the survey. Administrator A reported s/he was unsure why the medications and refrigerator were moved to a room that did not have a door. Administrator A reported staff were to always keep the medication keys on them.	N 419		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide services to manage behaviors that may be harmful to themselves or others for 1 of 1 (Resident 1) resident reviewed. The provider did not provide or arrange for services to manage Resident 1's elopement behavior. Resident 1 eloped from the facility on 05/07/2022, 07/05/2022, 08/21/2022, 08/22/2022, 09/11/2022, 09/12/2022, 10/17/2022, 12/08/2022, 05/20/2023, and 05/31/2023. From 05/31/2023 until 06/02/2023, Resident 1 was admitted to the hospital. Resident 1 was minimally responsive	N 433		

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N 433	Continued From page 10	N 433		

and did not have identification. Resident 1 stayed in the hospital because his/her identity was unable to be determined and Resident 1 was unable to care for himself/herself.

Findings include:

The provider is licensed to care for 36 residents in the client groups emotionally disturbed/mental illness, physically disabled, advanced aged and correctional clients.

On 06/05/2023, the Department received a complaint stating Resident 1 was found 4.5 miles from the facility in a wheelchair with no identification. Resident was admitted and remained in hospital from 05/31/2023 until 06/02/2023 while Resident 1's identity was confirmed.

On 6/17/2023 Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/12/2021 with diagnosis of mental illness/psychosis, schizophrenia, bulimia and hyperlipidemia. Resident 1's progress notes documented the following elopements: 05/07/2022, 07/05/2022, 08/21/2022, 08/22/2022, 09/11/2022, 09/12/2022, 10/17/2022, 12/08/2022, 05/20/2023, and 05/31/2023. Resident 1's assessment, dated 03/13/2023, stated, "...leaves facility without informing caregivers."

Resident 1's individual service plan (ISP), dated 12/01/2021, and unsigned by participants involved in planning, listed the following under frequency of service and service provided:

"Encourage resident to inform staff when [Resident 1] leaves facility. Notify RN (registered nurse) administrator if resident does not return to

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N 433	Continued From page 11 facility within 24 hours ..." The ISP listed the following under the goal/outcome column: "Resident will inform staff of whereabouts at all times." The ISP listed the following under the service provider responsible column: "To maintain level of contact within the community." On 06/14/2023 at approximately 11:00 AM, Surveyors interviewed Administrator A who stated, "Resident 1 comes and goes as s/he pleases. When s/he doesn't return, I call his/her case manager and they generally say if s/he doesn't return within 24 hours, I should call the guardian and let them know." On 06/22/2023 at approximately 12:30 PM, Surveyors interviewed Case Manager (CM) C. CM C reported s/he was Resident 1's managed care organization case manager. CM C confirmed Resident 1 was in the hospital for 3 days because Resident 1 did not have identification, and the hospital staff were unable to find Resident 1's responsible party. CM C confirmed Resident 1 should not have been in the community unsupervised. On 06/19/2023 at 9:00 AM, Surveyor called Guardian B for an interview. Surveyor left a voicemail message requesting a return call. On 06/22/2023, at 11:30 AM, Surveyor called Guardian B for an interview. Surveyor left a voicemail message requesting a return call. As of 07/31/2023, Surveyors did not receive a return call from Guardian B.	N 433		

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N 433	Continued From page 12 On 06/29/2023 at 2:00 PM, Surveyors interviewed Administrator A and Licensee H. Surveyors asked if Resident 1 had a guardian and, if so, what type of guardianship it was. Administrator A stated, "[I do not know] ...not off the top of my head. It might be in the chart. But I know that the guardian is aware that s/he comes and goes. I was calling him/her every time s/he left back when I first started. I was calling [them] and calling the case manager and the police and everything. The guardian said I don't need to call, and I don't need to do anything unless s/he's been gone 24 hours." Surveyors asked if this 24-hour waiting period was a written directive. Administrator A stated it was not. Administrator A reported Resident 1 eloped frequently. The police would assess him/her and identify s/he needed medical attention and took him/her to the emergency room closest to his/her home. That hospital knew him/her due to frequent visits and would call Administrator A to pick up Resident 1. Administrator A reported Guardian B, Resident 1's guardian, called Administrator A on 06/02/2023 and informed him/her Resident 1 was in the hospital and s/he was unable to identify him/her. Administrator A reported Guardian B did not know what Resident 1 looked like (because s/he was a newly assigned corporate guardian), so Guardian B needed Administrator A to confirm Resident 1's identity. Administrator A confirmed there were no other interventions to manage Resident 1's elopement behavior other than what was listed in his/her ISP. SUMMARY Resident 1 eloped from the facility without identification. Resident 1's ISP did not include interventions for Resident 1's elopements and interventions needed to keep Resident 1 safe in	N 433		

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N 433	Continued From page 13 the community. Resident 1's ISP was not signed by Resident 1's case manager, guardian, or facility staff who participated in planning. Resident 1 had a history of being found within the community where s/he lived and went to a specific hospital for evaluation when located by the police. That hospital knew Resident 1 and knew to call Administrator A for identification and to pick him/her up from the hospital to take him/her back to the facility. On 05/31/2023, Resident 1 eloped and was found in a different area of town and was taken to a different hospital where hospital staff were unable to identify him/her. Resident 1 stayed in the hospital until identification could be made on 06/02/2023. Resident 1's case manager reported Resident 1 should not have been in the community unsupervised, which was inconsistent with Resident 1's ISP and information provided by Administrator A.	N 433		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s.	N 454		

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 _____	C 07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 454	Continued From page 14 DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 454	Continued From page 15 the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure resident record was maintained for 1 of 1 resident record reviewed. Resident 1's record did not include documentation of court ordered guardianship. This is a repeat deficiency. See Statement of Deficiency YBO811, dated 02/03/2022. Findings include: On 6/17/2023 at approximately 11:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/12/2021 with diagnosis of mental illness/psychosis, schizophrenia, bulimia and hyperlipidemia. Resident 1's record did not contain guardianship documentation. On 06/29/2023 at 2:00 PM Surveyors interviewed Administrator A who confirmed they did not have a copy of Resident 1's guardianship document in the resident record. Administrator A agreed to reach out to Case Manager C for a copy and send it to surveyor's e-mail. As of 07/26/2023 the documentation had not been received.	N 454		