STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018687	A. BUILDING: _____ B. WING _____	C 08/08/2024

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HILLCREST HOMES 75 LLC	1467 S 75TH ST WEST ALLIS, WI 53214

(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 From 08/01/2024 to 08/08/2024, Surveyor conducted 2 complaint investigations and an abbreviated survey at Hillcrest Homes 75 LLC, a CBRF in Milwaukee. Eighteen deficiencies were identified. One complaint was substantiated. One complaint was unsubstantiated. Census: 11	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a complete background check was completed for 1 of 3 employees reviewed. Caregiver C did not have background checks completed upon hire.	N 219		

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

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N 219	Continued From page 1 Findings include: On 08/01/2024 at approximately 9:00 a.m., Surveyor requested the employee records of Caregiver B, Caregiver C and Caregiver D from Administrator A. Administrator A explained employee records were not kept onsite and that s/he would need to follow up. According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete Caregiver Background Check, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check" letter from the Department of Health Service, also referred to as the Integrated Background Information System (IBIS). On 08/05/2024 at approximately 10:15 p.m., Surveyor received employee records from Administrator A that documented Caregiver C was hired on 04/08/2024. Caregiver C's record did not include a complete BID. Caregiver C's DOJ and IBIS were dated 08/05/2024, greater than 60 days after his/her date of hire. On 08/08/2024 at approximately 1:30 p.m., Surveyor interviewed Administrator A regarding employee background checks. Administrator A did not explain why Caregiver C's background check was incomplete.	N 219		
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 a licensed registered nurse indicating 3 of 3 employees reviewed had been screened for clinically apparent communicable disease, including tuberculosis. The provider did not have documentation to indicate Caregiver B, Caregiver C and Caregiver D had been tested for tuberculosis. Findings include: On 08/01/2024 at approximately 9:00 a.m., Surveyor requested the employee records of Caregiver B, Caregiver C and Caregiver D from Administrator A. Administrator A explained employee records were not kept onsite and that s/he would need to follow up. On 08/05/2024 at approximately 5:00 p.m., Surveyor received employee records from	N 220		

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N 220	Continued From page 3 Administrator A, which documented the following: - Caregiver B was hired on 10/23/2023. Caregiver B's record included a communicable disease screen, dated 10/12/2024, a date yet to occur, in 2 different spots on the document. The record did not include a tuberculosis test. - Caregiver C was hired on 04/08/2024. His/her record included a communicable disease screen, dated 02/05/2024. The record did not include a tuberculosis test. - Caregiver D was hired on 06/27/2024. His/her record included a communicable disease screen, dated 06/24/2024. The record did not include a tuberculosis test. Surveyor followed up with Administrator A on 08/06/2024 at 5:30 a.m. via e-mail, 1:21 p.m. via phone and 4:30 p.m. via phone requesting documentation of tuberculosis tests for Caregiver B, Caregiver C and Caregiver D. Administrator A stated, "Oh, I have those." Surveyor requested that Administrator A provide documentation on 08/06/2024. As of 08/08/2024 at 8:00 a.m., Surveyor had not received documentation of tuberculosis tests.	N 220		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or	N 243		

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N 243	Continued From page 4	N 243		

service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment.
Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment.
Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group.
Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 3 employees reviewed, obtained all training as required within

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N 243	Continued From page 5 90 days after starting employment. Caregiver B did not have training in resident rights, recognizing, preventing, managing and responding to challenging behaviors or client groups within 90 days after starting employment. Findings include: On 08/01/2024 at approximately 9:00 a.m., Surveyor requested the employee records of Caregiver B, Caregiver C and Caregiver D from Administrator A. Administrator A explained employee records were not kept onsite and that s/he would need to follow up. On 08/05/2024 at approximately 5:00 p.m., Surveyor received employee records, which documented the following concerns: Resident Rights The record for Caregiver B, hired 10/23/2023, indicated s/he completed resident rights training from 06/11/2024 to 06/14/2024, greater than 90 days after his/her date of hire. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for Caregiver B, hired 10/23/2023, indicated s/he completed challenging behaviors training from 06/11/2024 to 06/14/2024, greater than 90 days after his/her date of hire. Client Group The facility was licensed to provide care and services to residents within the client groups of terminally ill, emotionally disabled/mental illness,	N 243		

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N 243	Continued From page 6 irreversible dementia/Alzheimer's, advanced age, traumatic brain injury and developmentally disabled. The record for Caregiver B, hired 10/23/2023, indicated s/he completed client specific training from 06/11/2024 to 06/14/2024, greater than 90 days after his/her date of hire. Surveyor followed up with Administrator A on 08/06/2024 at 5:30 a.m. via e-mail, 1:21 p.m. via phone and 4:30 p.m. via phone requesting documentation of additional trainings completed as part of Caregiver B's orientation or exemptions. Administrator A stated s/he would provide follow up documentation. As of 08/08/2024 at 8:00 a.m., Surveyor had not received documentation of any additional trainings or exemptions for Caregiver B.	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of	N 247		

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N 247	Continued From page 7	N 247		

goals and interventions, service plan evaluation and review of progress.
Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring.
Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 3 employees obtained all task specific training.

Caregiver B and Caregiver C, who had responsibilities for providing assistance with activities of daily living, did not have training in the provision of personal care prior to assuming these duties.

Caregiver B and Caregiver C, who performed dietary duties, did not have training in dietary services within 90 days after assuming these job duties.

Findings include:

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N 247	Continued From page 8 On 08/01/2024 at approximately 8:20 a.m., Surveyor interviewed Caregiver B. Caregiver B stated all caregivers were responsible for assisting residents with personal cares and completing dietary tasks. On 08/01/2024 at approximately 9:00 a.m., Surveyor requested the employee records of Caregiver B, Caregiver C and Caregiver D from Administrator A. Administrator A explained employee records were not kept onsite and that s/he would need to follow up. On 08/05/2024 at approximately 5:00 p.m., Surveyor received employee records, which documented the following concerns: Provision of Personal Care The record for Caregiver B, hired 10/23/2023, and Caregiver C, hired 04/08/2024, did not contain evidence of training or evidence of meeting an exemption for personal care training. Dietary Training The record for Caregiver B, hired 10/23/2023, and Caregiver C, hired 04/08/2024, did not contain evidence of training or evidence of meeting an exemption for dietary training. Surveyor followed up with Administrator A on 08/06/2024 at 5:30 a.m. via e-mail, 1:21 p.m. via phone and 4:30 p.m. via phone requesting documentation of additional trainings completed as part of Caregiver B and Caregiver C's orientation or exemptions. Administrator A stated s/he would provide follow up documentation. As of 08/08/2024 at 8:00 a.m., Surveyor had not	N 247		

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N 247	Continued From page 9 received documentation of any additional trainings or exemptions for Caregiver B.	N 247		
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 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 individual service plans (ISP) reviewed was updated when there was a change in the resident's needs. Resident 1's ISP did not include his/her behaviors, room change, history of medication refusals and chronic wounds. Resident 1's ISP was not signed by Resident 1 or the managed care organization staff. Findings include: From 08/01/2024 to 08/08/2024, Surveyor conducted a complaint investigation alleging care concerns, such as medication mismanagement, changing resident rooms without agreement and	N 389		

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missing items.

On 08/01/2024 at approximately 10:00 a.m., Surveyor interviewed Administrator A regarding Resident 1's needs. Administrator A stated Resident 1 had behaviors Administrator A explained calling Resident 1 to the dining room, Resident 1 running out of cigarettes or asking Resident 1 for documentation after medical appointments would agitate Resident 1 causing him/her to cuss out staff. Administrator A stated Resident 1 would often say s/he had items missing "when [s/he] was having an episode." Administrator A stated Resident 1 had wounds on his/her lower extremities that limited his/her weightbearing status, so Resident 1 was moved from the upper level to the main level of the home. Administrator A stated Resident 1 had a history of refusing medications.

On 08/01/2024 at approximately 10:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 resided at the provider's facility from 03/06/2024 to 07/10/2024. Resident 1 was his/her own decision maker. Resident 1's diagnoses included anxiety, depression and chronic foot wounds. Resident 1's record included multiple "After Visit Summaries," dated 03/17/2024 to 06/21/2024, documenting chronic foot wounds that required wound care. Resident 1's Medication Administration Record (MAR), dated 06/01/2024 to 07/10/2024, included many blank entries. Surveyor noted Resident 1's ISP, dated 05/29/2024, did not include the following information:

- Resident 1's behaviors or interventions for behaviors. The ISP stated, "Requires staff assistance to manage/redirect aggressive/combative behaviors when resident

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N 389	Continued From page 11 becomes agitated ... Desired Outcome: To have interventions in place that help alleviate behaviors." - Resident 1's room change, which resulted in Resident 1 transitioning from a private room to a semi-private room. A progress note, dated 04/22/2024, documented Resident 1 was not happy with the move. - Resident 1's chronic foot wounds, including who was responsible for the care of the wounds. - Signatures indicating Resident 1 and his/her managed care organization staff agreed with the plan. On 08/01/2024 at approximately 11:00 a.m., Surveyor interviewed Administrator A and discussed concerns that Resident 1's ISP did not appear updated. Administrator A acknowledged the behaviors could have been more detailed and that in the future s/he could document room changes. Administrator A stated Resident 1's health was difficult to keep up on since Resident 1 would often go to the doctor on his/her own and refuse to give the provider paperwork. Administrator A stated Resident 1 likely refused to sign the ISP and managed care organizations were not required to sign the ISP.	N 389		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately.	N 410		

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N 410	Continued From page 12 Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure resident refusal to take medication was documented in the record for 1 of 1 resident reviewed. Resident 1's medication administration record (MAR) included blank entries that did not document administration or refusal. Findings include: From 08/01/2024 to 08/08/2024, Surveyor conducted a complaint investigation alleging the provider had mismanaged a resident's medications. On 08/01/2024 at approximately 10:00 a.m., Surveyor interviewed Administrator A regarding Resident 1's needs. Administrator A stated Resident 1 had a history of refusing his/her medications. On 08/01/2024 at approximately 10:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 resided at the provider's facility from 03/06/2024 to 07/10/2024. Resident 1 was his/her own decision maker. Resident 1's MAR, dated 06/01/2024 to 07/04/2024, included the following occurrences when neither administration, nor refusal was documented:	N 410		

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- Amlodipine Besylate 10 milligrams (mg) prescribed daily at 8:00 a.m.: 27 of 34 entries were blank.
- Ascorbic Acid 500 mg prescribed daily at 8:00 a.m.: 30 of 34 entries were blank.
- Aspirin 81 mg daily prescribed daily at 8:00 a.m.: 25 of 34 entries were blank.
- Atorvastatin Calcium 50 mg prescribed daily at 8:00 a.m.: 24 of 34 entries were blank.
- Accu-Checks prescribed 3 times daily at 8:00 a.m., 4:00 p.m., and 8:00 p.m.: 46 of 102 entries were blank.
- Amlodipine 10 mg prescribed daily at 8:00 am.: 12 of 34 entries were blank.
- Clonidine .1 mg prescribed daily at 8:00 a.m.: 13 of 34 entries were blank.
- Clonidine .1 mg prescribed daily at 8:00 p.m.: 19 of 34 entries were blank.
- Januvia 100 mg 1 time prescribed daily at 8:00 a.m.: 10 of 34 entries were blank.
- Magnesium Oxide 400 mg prescribed daily at 8:00 a.m.: 8 of 34 entries were blank.
- Acetaminophen ER 650 mg prescribed 3 times daily at 8:00 a.m., 4:00 p.m. and 8:00 p.m.: 35 of 102 entries were blank.
- Pantoprazole 40 mg prescribed daily at 8:00 a.m. 7 of 34 entries were blank.
- Quetiapine 25 mg prescribed 3 times daily at 8:00 a.m., 4:00 p.m. and 8:00 p.m.: 31 of 102 entries were blank.
- Venlafaxine Extended Release (ER) 75 mg prescribed daily at 8:00 a.m.: 7 of 34 entries were blank.
- Lisinopril 5 mg prescribed daily at 8:00 a.m.: 8 of 34 entries were blank.
- Lantus Solostar 100 unit/ml 10 units prescribed daily at bedtime: 20 of 34 blank entries.

On 08/01/2024 at approximately 11:00 a.m., Surveyor reviewed concern with Administrator A

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N 410	Continued From page 14 that Resident 1's MAR included several blank entries that did not indicate whether medications were administered or refused. Administrator A acknowledged the blank entries and stated the provider had recently gone through re-training related to medications. Administrator A stated the blank entries would have been refusals.	N 410		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed had his/her medication administration accurately recorded. Resident 1 had medications documented as administered that were not available for administration. Findings include: From 08/01/2024 to 08/08/2024, Surveyor conducted a complaint investigation alleging the provider had mismanaged a resident's	N 415		

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N 415	Continued From page 15	N 415		

medications.

On 08/01/2024 at approximately 10:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 resided at the provider's facility from 03/06/2024 to 07/10/2024. Resident 1 was his/her own decision maker. Resident 1's medication administration record (MAR), dated 06/01/2024 to 07/04/2024, included the following occurrences when medications were documented as administered outside of the prescribed duration:

- Amoxicillin/K Clavulanic acid 875/125 - Take 1 tablet every 12 hours for 10 days (04/02/2024 to 04/12/2024) was documented as administered 3 times from 06/01/2024 to 07/04/2024.
- Amoxicillin/K Clavulanic acid 875/125 - Take 1 tablet every 12 hours for 7 days (05/20/2024 - 05/27/2024): was documented as administered 3 times from 06/01/2024 to 07/04/2024.
- Ciprofloxacin Hydrocortisone (ear drop) - Instill 4 drops in left ear twice daily for 10 days (04/18/2024 - 04/28/2024) was documented as administered 2 times from 06/01/2024 to 07/04/2024.
- Ciprofloxacin 500 mg - Take 1 tablet twice daily for 5 days (04/19/2024 - 04/23/2024) was documented as administered 11 times from 06/01/2024 to 07/04/2024.
- Linezolid 600 mg take 1 tablet daily at 8:00 a.m. for 5 days (04/19/2024 - 04/23/2024) was documented as administered 8 times from 06/01/2024 to 07/04/2024.
- Linezolid 600 mg 1 tablet twice daily for 10 days (05/22/2024 - 06/01/2024) was documented as administered 8 times after the prescribed duration.
- Doxycycline Monohydrate 100 mg - Take 1 capsule twice daily for 10 days (04/02/2024 - 04/12/2024) was documented as administered 3

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times from 06/01/2024 to 07/04/2024.
- Ciprofloxacin/Dexamethasone .3/.1% OT - Instill 4 drops into left ear times 10 days (04/30/2024 - 05/10/2024) was documented as administered 7 times from 06/01/2024 to 07/04/2024.
- Ondansetron 4 mg - Take 1 tablet every 6 hours from 06/01/2024 to 06/04/2024 was documented as administered 7 times after 06/04/2024.
- Potassium Chloride Extended Release 20 milliequivalents (meq) - Take 1 tablet twice daily for 5 days (06/01/2024 - 06/06/2024) was documented as administered 5 times after 06/06/2024.
- Naproxen 500 mg - Take 1 tablet 2 times daily with meals (06/24/2024 - 07/04/2024) had 5 blank entries during prescribed duration.
- Doxycycline 100 mg - Take 1 capsule twice daily for 7 days (06/21/2024 - 06/28/2024) was documented as administered only 2 times during the duration. All other entries during duration blank. The MAR included one documentation of this medication as administered after prescribed duration.

On 08/01/2024 at approximately 10:45 a.m., Surveyor interviewed Caregiver B regarding medications prescribed for specified intervals. Caregiver B stated documentation errors do occur if the medications were not added to the MAR when the medication was prescribed or taken out of the MAR after the prescribed interval was complete.

On 08/01/2024 at approximately 11:00 a.m., Surveyor interviewed Administrator A. Surveyor shared medication documentation concerns with Administrator A. Administrator A stated the provider had just completed re-training regarding medication management.

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N 419	Continued From page 17	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 all medications were kept locked with the key available only to personnel identified by the provider. The provider's medication cabinet was left unlocked, and medications were observed accessible to residents and visitors in the provider's office. Findings include: The provider is licensed to serve up to 14 residents with diagnoses of terminally ill, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced age, traumatic brain injury and developmentally disabled. On 08/01/2024 at approximately 8:30 a.m., Surveyor toured the provider's facility. Surveyor observed the provider's medication cabinet, located in the dining room, was unlocked. Surveyor observed 2 grocery bags full of medications, including Risperidone, Spironolactone, Vitamin D-2, Atorvastatin, Trazadone, Jardiance, on the ground and a bottle of Haloperidol 2 mg/ml on the counter in the provider's office. The office door was kept wide open as it led to an emergency exit and was accessible to residents and visitors. On 08/01/2024 at approximately 1:00 p.m., Surveyor reviewed concern with Administrator A that medications were observed unsecured and	N 419		

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N 419	Continued From page 18 accessible while Surveyor was present. Administrator A instructed Caregiver B to ensure all medications were kept locked.	N 419		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure they provided medication administration appropriate to 1 of 2 residents reviewed. Resident 4 did not have all of his/her prescribed medications available to him/her. Findings include: On 08/01/2024 at approximately 10:00 a.m., Surveyor observed the provider's medication cabinet and reviewed Resident 4's physician orders. Resident 4 had a physician order for Oxycodone 10 milligrams (mg) (Start Date: 06/06/2024) every 6 hours as needed for pain and Polyethylene Glycol 3350 (Start Date: 03/18/2024) 17 grams (g) daily. Surveyor noted neither of these medications were available in the medication cart. Surveyor discussed concern with	N 432		

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N 432	Continued From page 19 Administrator A and Caregiver B that Oxycodone and Polyethylene Glycol 3350 were not in the provider's medicine cabinet. Caregiver B confirmed the medications were unavailable and Administrator A stated the medications had been discontinued. Surveyor requested documentation of the discontinue orders. As of 08/08/2024 at 8:00 a.m., Surveyor had not received documentation indicating Resident 4's Oxycodone and Polyethylene Glycol 3350 had been discontinued.	N 432		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a weekly menu was prepared and available to 11 of 11 residents. Findings include: On 08/01/2024 at approximately 8:30 a.m., Surveyor toured the provider's facility. Surveyor was unable to locate a menu to indicate what meals would be served for the day or week. On 08/01/2024 at approximately 9:00 a.m., Surveyor interviewed Caregiver B. Caregiver B	N 450		

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N 450	Continued From page 20 stated residents had already eaten breakfast. Surveyor asked Caregiver B if the provider had a menu. Caregiver B showed Surveyor a menu that listed Friday dinner through Tuesday lunch. Surveyor noted the meals for 08/01/2024, a Thursday, were not listed. Surveyor asked Caregiver B how s/he knew what s/he would be serving for lunch. Caregiver B stated s/he planned to serve pot pies for lunch based on what the facility had available and that s/he would verbally inform residents.	N 450		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored under sanitary	N 452		

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N 452	Continued From page 21 conditions for the prevention of food borne illnesses. There was food not dated or dated greater than 2 weeks ago which had not been removed from the refrigerator. This had the potential to affect 11 of 11 residents residing in the facility. Findings include: On 08/01/2024 at approximately 8:30 a.m., Surveyor toured the provider's facility. Surveyor observed he following: - 4 hot dogs and a hamburger that was not dated in the refrigerator. - Chili dated 07/10/2024 and labeled "Resident's Lunch." - Lunch meat (ham), dated 07/15/2024 On 08/01/2024 at approximately 12:00 p.m., Surveyor reviewed observation of food not dated or dated greater than 2 weeks ago in the provider's refrigerator with Administrator A. Administrator A immediately reminded Caregiver B to ensure they were dating all food and disposing of expired foods. Foodsafety.gov indicates leftovers (cooked meat or poultry) and soups or stews (vegetable or meat added) are good for 3-4 days refrigerated and opened lunch meat is good for 3 to 5 days refrigerated. (Source: FoodSafety.gov, Cold Food Storage Chart, September 19, 2023, https://www.foodsafety.gov/food-safety-charts/cold-food-storage-charts (retrieval date - August 4, 2024).)	N 452		
N 481	83.43(1) Environment safe, clean, and comfortable	N 481		

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N 481	Continued From page 22 Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was safe, clean, comfortable and homelike. The provider's facility temperature was 82 degrees F and higher, appliances were covered in grease and the dining room was equipped with a "dummy" camera. This affected 11 of 11 residents residing in the facility. Findings include: On 08/01/2024, Surveyor toured the provider's facility and observe the following concerns: Example 1 - Temperature: At approximately 8:30 a.m., Surveyor observed the temperature in the upper level, which had resident bedrooms, ranged from 85.1 degrees F to 88 degrees F. Surveyor observed Resident 4, Resident 2 and Resident 3 did not have air conditioning units in their rooms. Surveyor observed the temperature in the dining room, located on the main floor, was 82 degrees F. At approximately 9:00 a.m., Surveyor interviewed Administrator A regarding the temperatures throughout the facility. Administrator A stated some residents had window air conditioning units in their rooms to keep them comfortable, but Resident 2 and Resident 3 had chosen not to	N 481		

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have units. Residents were supplied with fans. Caregiver B stated Resident 4 no longer had an air conditioning unit because the unit kept blowing a fuse, so Resident 4 needed to change rooms. Administrator A stated s/he was unsure why the dining room was so warm. Administrator A tried to adjust the air conditioning unit in the dining room but was unsuccessful. The temperature remained approximately 82 degrees F from 8:30 a.m. to approximately 1:00 p.m.

Example 2 - Grease Build Up:

At approximately 8:30 a.m., Surveyor toured the provider's kitchen and noticed grease build up on the appliances.

At approximately 9:00 a.m., Surveyor showed Administrator A the grease build up on the appliances. Administrator A instructed caregivers to clean the kitchen.

Example 3 - Camera:

At approximately 8:30 a.m., Surveyor observed a camera in the dining room, pointed at tables used by residents.

At approximately 10:20 a.m., Surveyor interviewed Administrator A regarding the camera. Administrator A stated the camera was a "dummy camera" and not really functioning, but the purpose was to make caregivers think they were being recorded while administering medications. Surveyor explained concern that residents would also then feel like they were being recorded while in their own home.

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N 499	Continued From page 24	N 499		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic chemicals were kept secured. Findings include: The provider is licensed to serve up to 14 residents with diagnoses of terminally ill, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced age, traumatic brain injury and developmentally disabled. On 08/01/2024 at approximately 8:30 a.m., Surveyor toured the provider's facility and observed the following: - Cleaner with Bleach (Label - CAUTION: IRRITANT. MAY IRRITATE EYES). - Roach & Ant Aerosol (Label - CAUTION: Harmful if swallowed or absorbed through skin). - Hot Shot Kitchen Bug Cleaner (Label - CAUTION: Avoid contact with skin, eyes and clothing). - Fabuloso (Label - CAUTION: Keep out of reach of children). On 08/01/2024 at approximately 1:00 p.m., Surveyor discussed concern with Administrator A that toxic chemicals were accessible throughout the home. Administrator A immediately instructed Caregiver B to ensure toxic chemicals were	N 499		

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N 499	Continued From page 25 locked up.	N 499		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the heating system was serviced at least once every 3 years and that documentation was maintained and available. The provider did not have record of the most recent furnace inspection. Findings include: On 08/01/2024 at approximately 12:00 p.m., Surveyor toured the provider's basement with Administrator A. Surveyor observed the facility's heating system and requested a copy of the most recent inspection from Administrator A. Administrator A stated s/he would follow up with Surveyor with documentation by the end of the day.	N 504		

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N 504	Continued From page 26 On 08/01/2024 at approximately 1:00 p.m., Surveyor interviewed Administrator A and shared that s/he had not received documentation of a heating system inspection. Administrator A stated s/he provided Surveyor with the environmental records s/he was able to locate. Surveyor corresponded with Administrator A requesting documentation of a heating system inspection on the following dates via the following means: - 08/02/2024 at 10:14 a.m. phone call, 10:16 a.m. e-mail, 10:48 e-mail and 12:05 p.m. e-mail. - 08/05/2024 at 11:38 a.m. phone call, 1:08 p.m. phone call, 7:37 p.m. phone call and 7:45 p.m. e-mail. - 08/06/2024 at 5:30 a.m. e-mail, 1:21 p.m. phone call and 4:30 p.m. phone call. As of 08/08/2024 at 8:00 a.m., Surveyor had not received documentation of a heating system inspection.	N 504		
N 532	83.47(4)(b) Fire extinguishers: locations. A fire extinguisher shall be mounted on a wall or a post or in an unlocked wall cabinet used exclusively for that purpose. Fire extinguishers shall be clearly visible. The route to the fire extinguisher shall be unobstructed and the top of the fire extinguisher shall not be over 5 feet high. The extinguisher shall not be tied down, locked in a cabinet or placed in a closet or on the floor. Fire extinguishers on upper floors shall be located at the top of each stairway. Extinguishers shall be located so the travel distance between extinguishers does not exceed 75 feet. The extinguisher on the kitchen floor level shall be	N 532		

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N 532	Continued From page 27 mounted in or near the kitchen. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 3 of 4 fire extinguishers were mounted on a wall or stored in an unlocked cabinet. Findings include: On 08/01/2024 at approximately 8:30 a.m., Surveyor toured the provider's facility and observed 3 fire extinguishers on the 1st and 2nd floor sitting on the floor rather than being mounted to the wall. On 08/01/2024 at approximately 12:30 p.m., Surveyor reviewed concern with Administrator A that fire extinguishers were observed sitting on the floor. Administrator A turned to Caregiver B and stated, "Can you go hang the fire extinguishers back up?" Caregiver B then explained to Administrator A that the mounts were broken.	N 532		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the fire detection system was maintained in accordance with NFPA 72	N 538		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018687	A. BUILDING: _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HOMES 75 LLC	1467 S 75TH ST WEST ALLIS, WI 53214

(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 538	Continued From page 28 National Fire Alarm Code. The provider did not have documentation to indicate the deficiency identified during a fire detection system inspection was addressed. Findings include: On 08/01/2024 at approximately 9:00 a.m., Surveyor requested the provider's environmental records, including the most recent fire detection system inspection, from Administrator A. On 08/01/2024 at approximately 1:00 p.m., Administrator A provided Surveyor with documentation of an inspection, dated 10/17/2023, with a listed deficiency stating "Found Pull Station in basement exit that looks abandoned. Device will need to get replaced and wired." Surveyor requested follow up of the deficiency. Administrator A stated s/he would follow up with Surveyor. Surveyor corresponded with Administrator A requesting follow up of the fire detection inspection on the following dates via the following means: - 08/02/2024 at 10:14 a.m. phone call, 10:16 a.m. e-mail, 10:48 e-mail and 12:05 p.m. e-mail. - 08/05/2024 at 11:38 a.m. phone call, 1:08 p.m. phone call, 7:37 p.m. phone call and 7:45 p.m. e-mail. - 08/06/2024 at 5:30 a.m. e-mail, 1:21 p.m. phone call and 4:30 p.m. phone call. As of 08/08/2024 at 8:00 a.m., Surveyor had not received documentation to indicate follow up of the 10/17/2023 fire detection system with an identified deficiency was addressed.	N 538		

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 558	Continued From page 29	N 558		
N 558	83.48(8)(b) Sprinkler system installation and maintenance Installation and maintenance. 1. All sprinkler systems shall be installed by a state licensed sprinkler contractor. All sprinkler systems shall be maintained, inspected and tested at least annually or at intervals determined by the requirements in NFPA 25. 2. In facilities with sprinklers, sprinkler heads shall be placed at the top of each linen or trash chute and in the rooms where the chutes terminates. 3. The sprinkler system flow alarm shall be connected to the CBRF ' s fire alarm system. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the sprinkler system was inspected at least annually for 1 of 1 year. The provider was unable to provide evidence any sprinkler inspections in the past year. Findings include: On 08/01/2024 at approximately 9:00 a.m., Surveyor requested environmental records, including the most recent sprinkler system inspection, from Administrator A. Administrator A stated s/he did not have any environmental records onsite at the facility. On 08/02/2024 at approximately 11:45 a.m., Surveyor received an invoice from Administrator A that indicated a service call was made to the provider's facility for a leak in the sprinkler system on 07/09/2023. Surveyor did not receive documentation indicating the provider's sprinkler system had been inspected in the past year.	N 558		

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HILLCREST HOMES 75 LLC	1467 S 75TH ST WEST ALLIS, WI 53214

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N 558	Continued From page 30 On 08/05/2024 at approximately 1:00 p.m., Surveyor interviewed Administrator A. Administrator A stated s/he reached out to the provider's vendor for a copy of the most recent inspection but did not receive any further documentation. Administrator A was unable to provide Surveyor with the date of the most recent inspection. As of 08/08/2024 at 8:00 a.m., Surveyor had not received documentation indicating a sprinkler system inspection was completed in the past year.	N 558		
N 636	83.59(1)(f) Exit passageways, stairways: width maintained All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exit passageways and stairways to outside exits shall be at least 36 inches in width and maintained clear and unobstructed at all times. Exit passageways and stairways to outside exits shall be at least 32 inches in width in facilities licensed on or before the effective date of this section. In existing large facilities, the minimum corridor width shall be at least 4 feet. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all exit passageways were unobstructed at all times. An emergency exit on the provider's upper level was tied shut. Findings include:	N 636		

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N 636	Continued From page 31 On 08/01/2024 at approximately 8:30 a.m., Surveyor toured the provider's facility with Caregiver B. Surveyor observed a door, identified as an emergency exit, on the upper level of the home had a string tying the door handle to a railing on the wall. The string prevented the door from being opened. On 08/01/2024, at approximately 8:30 a.m., Surveyor interviewed Caregiver B and why the door was tied shut. Caregiver B stated s/he did not know why. On 08/06/2024 at approximately 5:30 a.m., Surveyor emailed Administrator A requesting follow up as to why the upper-level emergency exit was tied shut. As of 08/08/2024 at 8:00 a.m., Surveyor had not received a response from Administrator A regarding the upper-level emergency exit.	N 636		