Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013808	A. BUILDING: _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNVALE HOME 4	**4714 N 58TH ST 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 10/31/2024, Surveyors conducted a complaint investigation at Sunvale Home 4, an Adult Family Home (AFH) in Milwaukee, WI. One deficiency identified. Complaint substantiated. Census: 4	M 000		
M 424	88.06(3)(f) REVIEW OF ISP 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 (Resident 1) reviewed had his/her individual service plan (ISP) reviewed every 6 months to determine continued appropriateness of the plan and to	M 424		

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
	0013808	A. BUILDING: _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNVALE HOME 4	4714 N 58TH ST 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 424	Continued From page 1 update the plan as necessary. Findings include: On 10/31/2024, Surveyors reviewed Resident 1's record and identified the following: - Resident 1 was admitted to the facility on 12/10/2012. Resident 1 had a legal guardian. - Resident 1's ISP was dated 09/12/2024. Resident 1's current ISP did not include his/her change of condition after his/her hospital/emergency room (ER) visit on 08/21/2024. Resident 1's after visit summary from Aurora Medical Center, dated 08/21/2024, stated the following: "- Discharge Diagnosis: Right ankle bimalleolar fracture. - Admitted on 07/31/2024 to Aurora Medical Center. - The following medical problems were addressed in hospital: - Right ankle bimalleolar fracture. This suspected to be traumatic however no definitive falls or trauma has been reported witnessed from group home. Patient has cognitive difficulty makes it difficult to obtain any history from him/her. - Patient was evaluated and treated here. - Orthopedic surgery has evaluated and treated him/her. Non operative treatment is recommended. - Nonweightbearing for 6-8 weeks recommended. - Will need continued PT/OT. - We have ruled out DVT (deep vein thrombosis) in the right lower extremity on duplex venous scan.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013808	A. BUILDING: _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNVALE HOME 4	4714 N 58TH ST 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 424	Continued From page 2 - Pain is well controlled currently. - Patient will follow-up with orthopedic surgery in 2 to 3 weeks as noted below. - Cerebral palsy/cognitive/physical and communication delay. Supportive care. - Mild leukocytosis. Resolved. ... No active source of infection currently. Likely was reactive. - Mild anemia is noted. His/Her baseline hemoglobin-around 12. S/He probably was hemoconcentrated on admission. With IV (intravenous) hydration his/her H&H (hemoglobin and hematocrit levels) came down. Encourage oral intake. No bleeding noted. Routine follow-up as an outpatient. "Patient was provided with the necessary supportive care needs and her disability. S/He is being discharged back to her CPRS in stable and improved condition. "Disposition: - Home with home health care." On 10/31/2024 at approximately 10:45 AM, Surveyors interviewed Licensee A. Licensee A stated Resident 1 utilized a hospital bed and hoyer from 08/21/2024 through 10/17/2024. Licensee A confirmed Resident 1's ISP dated 09/12/2024 was the most recent and was not updated with new interventions resulting from his/her broken limb.	M 424		