STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016910	A. BUILDING: _____ B. WING _____	R-C 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIL VIENNA	10136 W VIENNA AVE WAUWATOSA, WI 53222

(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 05/22/2026, Surveyor completed a complaint, verification visit, and standard survey at HIL Vienna. As a result, all previous deficiencies were corrected. Two new deficiencies were identified. One of 1 complaint was substantiated. Census:4	{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 2) of 2 residents' individual service plan (ISP) was followed. Resident 2's ISP indicated Resident 2 received supervision during all mealtimes to manage Resident 2's impulsiveness around food. It was suspected Resident 2 may have used his/her hands to obtain additional food in a pot that was filled with hot water resulting in Resident 2's hands being burned. Findings include: On 05/06/2026, the department received a complaint regarding injuries of an unknown source.	M 436		

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

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M 436	Continued From page 1 On 05/20/2026 at approximately 10:00 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the adult family home on 09/19/2019. Resident 2's individualized service plan (ISP), dated with a review date of 10/10/2025 indicated, " ...Eating Current Status: [Resident 2] requires hands-on assistance during mealtimes ...[Resident 2] is supervised at all mealtimes to ensure healthy eating habits. To help manage impulsivity around food ...Frequency of Service & Service Provided ...Staff are present at all mealtimes to ensure that [Resident 2] is safe ..." On 05/20/2026 as Surveyor reviewed Resident 2's record, Surveyor also reviewed Resident 2's "After Visit Summary," dated 04/16/2026, 04/17/2026, and 04/23/2026. "After Visit Summary," dated 04/16/2026 indicated Resident 2's "Reason for Visit" was "burn." Resident 2's "Diagnosis" was "burn." Resident 2 was instructed to follow-up with the burn clinic. "After Visit Summary," dated 04/17/2026 indicated Resident 2 was seen for a "Burn Initial Visit." Resident 2 was instructed to "keep dressings clean, dry and intact." "After Visit Summary," dated 04/23/2026 indicated Resident 2 was seen for "Patrial thickness burn of back left hand, initial encounter and Partial thickness burn of multiple sites of right hand, initial encounter." Resident 2 was referred to home health with instructions to, "Please evaluate [Resident 2] for admission Home Health. RN (Registered Nurse) for skilled wound care to bilateral hands q (every) other day. Wash hands with soap and water. Apply aquaphor ointment to all areas of both hands and cover open areas with xerform gauze and secure with isotoner gloves ..."	M 436		

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M 436	Continued From page 2 On 05/22/2026 at approximately 8:52 AM, through electronic mail (e-mail) correspondence with Senior Quality Assurance and Compliance Specialist J, Surveyor received an "updated attestation letter" form. The updated attestation letter titled "[Resident 2] - Injury of Unknown Source Allegation Review Attestation" stated the following: " ...On April 16, 2026, at 6:58 a.m., a Direct Support Professional (DSP) contacted the HIL Call Center to report that while assisting Vienna client [Resident 2] with getting up and ready for day program, the DSP observed that both of [Resident 2's] hands and fingers were red, with skin peeling. The Call Center subsequently notified the Client Services Manager (CSM) of the reported injury. [Resident 2] was then transported to the emergency room for evaluation. "[Resident 2] reported to the CSM that [he/she] injured [his/her] hand on a stove. While being evaluated in the emergency department, [Resident 2] stated that [he/she] spilled a substance on [him/herself]. The emergency department physician referred [him/her] to a burn clinic for further evaluation. [Resident 2] was seen at the burn clinic on April 17, 2026. The treating medical provider documented concern that the injury was consistent with a water-related burn, with an estimated timeframe of occurrence approximately 4-12 hours prior to the onset of skin peeling. "Upon becoming aware of the incident, HIL-Vienna promptly implemented measures to prevent further injury to the client. A comprehensive internal investigation into the injury of unknown origin was conducted by an investigator ...who is trained in	M 436		

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M 436	Continued From page 3 regulatory-compliant misconduct investigations ...The investigative process includes gathering and reviewing relevant information, interviewing involved parties and witnesses when applicable, evaluating corroborating evidence, and documenting investigative findings ...Based on the interviews conducted, staff reported they were unaware of how [Resident 2] sustained [his/her] injury and did not witness the incident. [Resident 2] stated that [he/she] injured [his/herself] on the stove, and the burn specialist advised that the injuries were consistent with a water-related burn. It was further determined that [Resident 2's] dinner on 4/15/2026, consisting of hot dogs, had been prepared in water on the stove. It is possible that [Resident 2] reached into the pot to obtain additional hot dogs, resulting in the burn injury ...[Resident 2's] ISP has since been updated to include additional safeguards and supervision strategies to promote [his/her] safety and address food-seeking behaviors."	M 436		
Z 053	DHS 13.05 (2) CLIENT PROTECTION ENTITY'S RESPONSIBILITY TO PROTECT CLIENTS. Upon learning of an incident of alleged misconduct, an entity shall take whatever steps are necessary to ensure that clients are protected from subsequent episodes or misconduct while a determination on the matter is pending.	Z 053		

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Z 053	Continued From page 4 This Rule is not met as evidenced by: Based on interview and record review, the entity did not have written evidence of a timely and thorough investigation into a suspected incident of misconduct to ensure 1 (Resident 2) of 1 resident was protected from subsequent episodes of misconduct while a determination on the matter was pending. Surveyor could not confirm the provider completed or documented a timely and thorough internal investigation when Resident 2 sustained a partial thickness burn of the back of the left-hand, and a partial thickness burn of multiple sites to the right-hand from an unknown source. Findings Include: The facility was licensed on 01/24/2018, as a 4-bed ambulatory adult family home (AFH). The AFH serves residents who may receive public funding and/or diagnosed with a developmental disability and emotionally disturbed/mental illness. On 05/06/2026, the department received a complaint regarding injuries of an unknown source. "An injury of unknown source should be classified as an "injury of unknown source" when all of the following conditions are met: o The source of the injury was not observed by any person. OR o The source of the injury could not be explained by the resident. AND o The injury is suspicious because of the extent	Z 053		

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of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time."

In addition, according to Publication 00038 (10/2025) Wisconsin Background Check And Misconduct Investigation Program Manual for Entities Regulated by the Division of Quality Assurance " ...All entities regulated by DQA (Division of Quality Assurance) must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include:

o Collecting and preserving any physical and documentary evidence including videos;
o Interviewing alleged victims and witnesses;
o Collecting other corroborating/disproving evidence;
o Involving other regulatory authorities who can assist (e.g., local law enforcement, elder abuse agency, Adult Protective Service agency, DQA, Board on Aging Ombudsmen, Client Right's Specialist, etc.); and
o Documenting each step taken during the internal investigation ...

"An entity's internal investigation will assist in determining if an incident must be reported to DQA. If the incident is reported to DQA, the entity's internal investigation becomes part of the DQA caregiver misconduct investigation." Publication 00038 indicated an internal investigate report provides:

"o A record of the entity's internal investigator's activities and findings so that nothing is left to

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memory
o A permanent official record of the entity's internal investigator's actions, observations, and discoveries
o A basic reference of the case
o Information on what has been done concerning the case
o A basis for deciding further action
o A method to communicate the findings of the case
o Information that can be evaluated and analyzed to detect and identify patterns of
Conduct ..."

Publication 00038 reported the basic "elements of the entity report," should contain the following:

" ...1. Individuals Involved (Who)
Include all persons who are connected in any way with the incident under investigation:
o Resident, client, or patient
o Complainant
o Suspect or accused person
o Witness
o Any others with first-hand knowledge
Identify each person separately in such a manner that he/she cannot be confused with any other individual, including:
o Legal name - first, middle, last
o Names used - nicknames
o Title, position, place of employment
o Gender, race
o Date of birth
o Social security number
o Full address
o Telephone number
2. Description (What)
Describe the incident in a precise and accurate manner.
o Document observable facts.

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o Photograph injuries, bruises, skin tears, etc.
o Obtain statements of witnesses.
3. Timeframe (When)
Attempt to establish the date and time of the incident.
4. Location (Where)
Include the specific location of all persons and things that are related to the offense or incident, including:
o Specific location of room, using room numbers, wings
o Specific location of objects in the space
o Noise
o Location of furnishings
o Type of furnishings
o Clothing of victim
Document physical findings using diagrams, sketches, and photographs, as appropriate.
5. Effect on the Client or Client's Reaction
6. How the Incident Occurred ..." (DQA Publication-00038, Wisconsin Background Check And Misconduct Investigation Program Manual for Entities Regulated by the Division of Quality Assurance - State of Wisconsin Department of Health Services Division of Quality Assurance Office of Caregiver Quality, October 2025, pp. 37-40).

On 05/20/2026 at approximately 10:00 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the adult family home on 09/19/2019. Resident 2's individualized service plan (ISP), dated with a review date of 10/10/2025 indicated Resident 2 needs assistance with self-direction, and is not capable of self-supervision. In addition, Resident 2 relies on assistance from facility staff for all activities of daily living (ADLs). More specifically, Resident 2 requires "total assistance with bathing." Lastly, Resident 2's ISP indicated, " ...[Resident 2] has

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the capacity to express is [he/she] is in pain. Since admission, [Resident 2] has been able to inform staff of when [he/she] is in pain. At times [Resident 2] will show signs of pain by crying or wincing ..." Resident 2's record included a document titled "[Resident 2] - Injury of Unknown Source Allegation Review Attestation." The document stated the following:

"On April 16, 2026, at 6:58 a.m., a Direct Support Professional (DSP) contacted the HIL Call Center to report that while assisting Vienna client [Resident 2] with getting up and ready for day program, the DSP observed that both of [Resident 2's] hands and fingers were red, with skin peeling. The Call Center subsequently notified the Client Services Manager (CSM) of the reported injury. [Resident 2] was then transported to the emergency room for evaluation.

"[Resident 2] reported to the CSM that [he/she] injured [his/her] hand on a stove. While being evaluated in the emergency department, [Resident 2] stated that [he/she] spilled a substance on [him/herself]. The emergency department physician referred [him/her] to a burn clinic for further evaluation. [Resident 2] was seen at the burn clinic on April 17, 2026. The treating medical provider documented concern that the injury was consistent with a water-related burn, with an estimated timeframe of occurrence approximately 4-12 hours prior to the onset of skin peeling.

"During the review, the following people were interviewed:
[Direct Support Professional B]
[Direct Support Professional C]
[Direct Support Professional D]

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Z 053	Continued From page 9 [Direct Support Professional E] [Employee Support Specialist F] [Service Coordinator G] "Based on the interviews conducted, I cannot substantiate that misconduct occurred ..." On 05/20/2026 as Surveyor reviewed Resident 2's record, Surveyor also reviewed Resident 2's After Visit Summary, dated 04/16/2026, 04/17/2026, and 04/23/2026. After Visit Summary, dated 04/16/2026, indicated Resident 2's "Reason for Visit ...burn ...diagnosis ...burn." Resident 2 was instructed to follow-up with the burn clinic. After Visit Summary, dated 04/17/2026, indicated Resident 2 was seen for a "Burn Initial Visit." Resident 2 was instructed to "keep dressings clean, dry and intact." After Visit Summary, dated 04/23/2026, indicated Resident 2 was seen for "Partial thickness burn of back left hand, initial encounter and Partial thickness burn of multiple sites of right hand, initial encounter." Resident 2 was referred to home health with instructions to, "Please evaluate [Resident 2] for admission Home Health. RN (Registered Nurse) for skilled wound care to bilateral hands q (every) other day. Wash hands with soap and water. Apply aquaphor ointment to all areas of both hands and cover open areas with xerform gauze and secure with isotoner gloves ..." On 05/20/2026 at approximately 11:00 AM, Surveyor interviewed Regional Director H. Regional Director H confirmed Resident 2's injuries of unknown source reached the level of reporting the incident to the department. Regional Director H provided Surveyor with documents that indicated an electronic mail (e-mail) was sent to the regional office on 04/16/2026 at 7:15 PM reporting Resident 2's	Z 053		

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injuries of an unknown source and not the Office of Caregiver Quality. The self-report stated, " ... DHS 88.03(5)(e)(1) A significant change in a resident's status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death Department ...On April 16, 2026, at approximately 7:30 AM, staff observed that [Resident 2's] hands appeared red and as if the skin was peeling. [Resident 2] reported that [he/she] had sustained a burn from contact with a stove. HIL management transported [Resident 2] to Froedtert Hospital for medical evaluation.

Upon arrival at the Emergency Department, the attending physician conducted a physical examination and ordered appropriate diagnostic testing. [Resident 2] received a Tetanus shot, and [his/her] hands were cleaned and dressed. [He/She] was discharged home with instructions to follow up at a burn clinic ..."

On 05/20/2026 at approximately 12:00 PM, Surveyor requested to review the provider's internal investigation documents related to Resident 2's injuries of an unknown source. At approximately 12:20 PM, Surveyor was informed by Area Director I and provided Surveyor with an e-mail from Senior Quality Assurance and Compliance Specialist J that indicated the provider's internal investigation documents were "subject to the quality assurance confidentialy privilege pursuant to Wisconsin statue 146.38. It was generated for the sole purpose of improving the quality services provided to our clients. It may not be reproduced or disseminated beyond the members of the Company's Quality Assurrance committee..."

On 05/20/2026 at approximately 12:40 PM,

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Z 053	Continued From page 11 Surveyor interviewed Service Manager Coordinator K. Service Manager Coordinator K confirmed he/she was the individual who transported Resident 2 to the emergency room on 04/16/2026 after Resident 2's hands were observed to be red and peeling. Service Manager Coordinator K disclosed Direct Support Professional B and Direct Support Professional C was at the adult family home upon Resident 2's arrival on 04/15/2026. Service Manager Coordinator K reported Direct Support Professional D worked third shift, and was the individual who observed the injuries to Resident 2's hand on 04/16/2026. Service Manager Coordinator K could not confirm details surrounding the time Resident 2 returned home to the adult family home from day program on 04/15/2026 until Direct Support Professional D identified the injuries to Resident 2's hand. Service Manager Coordinator K confirmed Resident 2 had the ability to express if he/she were in any pain on 04/15/2026 and 04/16/2026. On 05/21/2026 at approximately 11:44 AM through e-mail correspondence with Senior Quality Assurance and Compliance Specialist J, the following was stated from Executive Director L, " ...First, I understand the Department's point of view that it is difficult for them to establish that a thorough investigation was conducted without additional information regarding the investigation. We should seek an alternate solution to deliver this outcome ... It seems counter intuitive that a Provider could refuse the provision of a document to a licensing body or funding entity. However, HIL has consistently prevailed without exception on this issue because we are able to withhold these types of documents for which we have established privilege under the law ...While we will not be submitting our investigation notes nor	Z 053		

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the complete file on the matter of the injury we investigated, we are able to provide related policies on our investigative process and can verbally outline how we proceeded with this investigation ... Under the advisement of legal counsel, our organization does not release investigation notes to DQA is because the Department will not redact these records thereby leaving those records vulnerable to discovery ..."

On 05/21/2026 at approximately 2:30 PM, through e-mail correspondance, Surveyor asked Senior Quality Assurance and Compliance Specialist J, "Are there any other documents, other than the attestation letter that can be provided to the department that indicates that the basic information/elements were obtained while completing the investigation into [Resident 2's] injuries from an unknown source?"

On 05/22/2026 at approximately 8:52 AM, Surveyor received an "updated attestation letter" from Senior Quality Assurance and Compliance Specialist J. The updated attestation letter included, " ...Upon becoming aware of the incident, HIL-Vienna promptly implemented measures to prevent further injury to the client. A comprehensive internal investigation into the injury of unknown origin was conducted by an investigator ...who is trained in regulatory-comliant misconduct investigations ...The investigative process includes gathering and reviewing relevant information, interviewing involved parties and witnesses when applicable, evaluating corroborating evidence, and docuemnting investigative findings ...Based on the interviews conducted, staff reported they were unaware of how [Resident 2] sustained [his/her] injury and did not witness the incident. [Resident 2] stated that [he/she] injured [his/herself] on the

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HIL VIENNA	10136 W VIENNA AVE WAUWATOSA, WI 53222

(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
Z 053	Continued From page 13 stove, and the burn specialist advised that the injuries were consistent with a water-related burn. It was further determined that [Resident 2's] dinner on 4/15/2026, consisting of hot dogs, had been prepared in water on the stove. It is possible that [Resident 2] reached into the port to obtain additional hot dogs, resulting in the burn injury ..." The updated attestation letter did not include the following to indicate the basic elements/information were collected for the internal investigation: documentation of observable facts, such as statements of witnesses, specific locations of all individuals or things related to the incident, and the resident's reaction(s) of when the incident may have been suspected to have occurred. Surveyor could not confirm if the provider documented or completed a timely and thorough investigation into Resident 2's injury of an unknown source as Surveyor was not able to confirm that the basic elements of an internal investigation were completed.	Z 053		