STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	INITIAL COMMENTS On 08/26/2024, Surveyors completed a standard survey at Walk By Faith. As a result, 13 deficiencies were identified. One of 13 was a repeat violation (see Statement of Deficiency (SOD) U7GO11, dated 12/21/2021). Census: 3	M 000		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation indicating 4 of 4 staff had been screened for illnesses detrimental to residents by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service. House Manager B, Caregiver C, Caregiver D, and Caregiver E, were not screened for communicable diseases detrimental to residents. Findings include:	M 232		

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
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 232	Continued From page 1 On 08/26/2024, at 10:00AM, Surveyors reviewed staff records and identified the following: -House Manager B was hired 10/20/2021. House Manager B's record did not contain any evidence indicating House Manager B was screened for communicable diseases. -Caregiver C was hired 05/01/2024. Caregiver C's record did not contain any evidence indicating Caregiver C was screened for communicable diseases. -Caregiver D was hired 11/2023. Caregiver D's record did not contain any evidence indicating Caregiver D was screened for communicable diseases. -Caregiver E was hired 07/26/2024. Caregiver E's record did not contain any evidence indicating Caregiver E was screened for communicable diseases. On 08/26/2024, at 3:15 PM, Surveyors interviewed Licensee A. Licensee A reported s/he thought communicable disease screenings were for residents only. Licensee A reported s/he did not have communicable disease screenings completed for staff.	M 232		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents	M 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 244	Continued From page 2 served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 staff received 15 hours of training related to health safety and welfare, resident rights, first aid and fire safety, and treatment appropriate to residents prior to or within 6 months of starting to provide cares. Caregiver D did not receive training in health safety and welfare, resident rights, first aid and fire safety, and treatment appropriate to residents. Findings include: On 08/26/2024, at 10:00 AM, Surveyors reviewed staff records and identified the following: -Caregiver D was hired on 11/2023. Caregiver D's record did not contain evidence of training in health safety and welfare, first aid and fire safety, and treatment appropriate to residents prior to or within 6 months of starting to provide cares. On 08/26/2024, at 3:15 PM, Surveyors interviewed Licensee A. Licensee A reported House Manager B was responsible for completing the training. Licensee A reported s/he thought staff should complete residents' rights, challenging behaviors, house rules, fire safety and first aid during initial training. Licensee A reported s/he was unaware of all the topics which needed to be completed.	M 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 service provider (House Manager B) completed 8 hours of training related to health, safety, welfare, rights and treatment of residents for 2023. Findings include: On 08/26/2024, at 10:00 AM, Surveyors reviewed House Manager B's staff file. House Manager B was hired on 10/20/2021. In 2023, House Manager B received training in insulin delegation. House Manager B's record indicated s/he received 2 hours of continuing education in 2023. On 08/26/2024, at 3:15 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement for annual training. Licensee A did not offer a reason House Manager B's training was not completed.	M 246		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 332	Continued From page 4	M 332		

Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 1 of 2 floors was equipped with a fire extinguisher. The basement did not contain a fire extinguisher.

This is a repeat deficiency. See Statement of Deficiency (SOD) U7GO11, dated 12/21/2021.

Findings include:

On 08/26/2024, at 9:55 AM, Surveyors toured the facility and observed the basement was not equipped with a with a fire extinguisher.

On 08/26/2024, at 3:15 PM, Surveyors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 332	Continued From page 5 interviewed Licensee A. Licensee A reported s/he was unaware of the code requirement requiring a fire extinguisher in the basement. Licensee A reported s/he would follow up with maintenance.	M 332		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete the resident evacuation assessment within 3 days of admission for 1 of 3 residents. Resident 2's resident evacuation assessment was completed 45 days after admission. Findings include: On 08/26/2024, at 10:00 AM, Surveyors reviewed resident records and identified the following: Resident 2 was admitted on 05/01/2024. Resident 2's record contained an evacuation assessment completed on 06/15/2024. Resident 2's resident evacuation assessment was completed 45 days after admission. On 08/26/2024, at 3:15 PM, Surveyors	M 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 344	Continued From page 6 interviewed Licensee A. Licensee A confirmed the evacuation assessments were to be completed within 3 days following placement. Licensee A confirmed s/he completed Resident 2's evacuation assessment on 06/15/2024. Licensee A confirmed Resident 2's evacuation assessment was late.	M 344		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an admission agreement was completed, dated, and signed by each resident, guardian or designated representative, and licensee, prior to admission for 2 of 3 residents. Resident 2 and Resident 3 did not have a signed service agreement with the provider. Findings include: On 08/26/2024, at 10:00 AM, Surveyors reviewed resident records and identified the following:	M 384		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 384	Continued From page 7 Resident 2 was admitted on 05/01/2024. Resident 2 had an activated power of attorney (POA). Resident 2's file did not contain an admission agreement. Resident 3 was admitted on 04/17/2023. Resident 3 had an activated POA. Resident 3's file contained an admission agreement. The admission agreement was unsigned. On 08/26/2024, at 3:15 PM, Surveyors interviewed Licensee A. Licensee A confirmed s/he was aware of the requirement. When Surveyor inquired who was responsible for completing the service agreements, Licensee A reported s/he was responsible. Licensee A reported s/he would ensure the paperwork was completed.	M 384		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written assessment and an individual service plan (ISP) were developed for 1 of 3 residents within 30 days after placement. Resident 2 did not have a written assessment, or an ISP completed within 30 days.	M 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 404	Continued From page 8 Findings include: On 08/26/2024, at 10:00 AM, Surveyors reviewed resident records and identified the following: Resident 2 was admitted on 05/01/2024. Resident 2's record did not contain a written assessment or an ISP. On 08/26/2024, at 3:15 PM, Surveyors interviewed Licensee A. Surveyors inquired who was responsible for completing the assessment and ISP, Licensee A reported s/he was not aware of the requirement and s/he was not completing assessments. Licensee A reported s/he was responsible for completing ISPs. Licensee A reported s/he would ensure the paperwork was completed.	M 404		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a statement of agreement with the Individual Service Plan (ISP) was dated and signed by all persons involved in developing the plan for 2 of 2 residents (Resident 1 and Resident 3). Findings include: On 08/26/2024, at 10:00 AM, Surveyors reviewed	M 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 420	Continued From page 9 resident records and identified the following: Resident 1 was admitted on 06/01/2023. Resident 1's ISP was dated 06/10/2024. Resident 1's face sheet identified Resident 1 had a managed care organization (MCO) case management team. Resident 1's was his/her own person. Resident 1's ISP was signed by Licensee A. Resident 1's ISP did not contain Resident 1's signature or MCO case management team signatures. Resident 3 was admitted on 04/17/2023. Resident 3's ISP was dated 08/12/2024. Resident 3's face sheet identified Resident 3 had a managed care organization (MCO) case management team. Resident 3' had an activated power of attorney (POA). Resident 3's ISP contained signatures from Licensee A and the MCO case management team signature. Resident 3's ISP was not signed by Resident 3's POA. On 08/26/2024, at 3:15 PM, Surveyors interviewed Licensee A. Licensee A confirmed resident's ISP needed to be signed by all parties in agreement with the plan. Licensee A reported s/he was unsure why Resident 1's and Resident 3's ISPs were not signed by all parties involved. Licensee A reported s/he would ensure all ISPs were signed by all parties.	M 420		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist.	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 458	Continued From page 10	M 458		

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure 1 of 3 resident's (Resident 1) prescription medication was securely stored. Resident 1's insulin pens were not securely stored in the kitchen refrigerator.

Findings include:

On 08/27/2024, at 9:40 AM, Surveyors toured the kitchen and observed a lock box in the refrigerator. The lock box contained a combination locking mechanism, which was not engaged. The lock box contained 3 boxes of Novolin insulin. Inside each box were 5 insulin pens. There also was a partial box which contained 3 insulin pens. The lock box also contained 2 loose insulin pens; therefore, a total of 20 insulin pens were unsecured in the lock box.

Surveyors observed residents moving freely around the facility.

On 08/26/2024, at 9:40 AM, Surveyors reviewed Resident 1's physician orders, dated 05/25/2023. Resident 1's physician orders indicated Resident 1 was prescribed Novolin 100 units/milliliter (ml).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 458	Continued From page 11 On 05/23/2024, at 3:15 PM, Surveyors interviewed Licensee A. Licensee A confirmed prescription medications should have been securely stored. Licensee A reported all staff completed training on medications to ensure compliance with the code requirements.	M 458		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a written order from the physician who prescribed medications to the resident, stating who can administer the medications for 3 of 3 residents. Resident 1's, Resident 2's and Resident 3's records did not contain a written order identifying who could administer medications. Findings include: On 08/26/2024, at 10:00 AM, Surveyors reviewed resident records and identified the following:	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 464	Continued From page 12 -Resident 1 was admitted on 06/01/2023 with diagnoses including dementia, diabetes, and hypertension. Resident 1's record contained an "Authorization to Dispense" which stated, "The above- named patient is currently residing in, or moving into, an Adult Family Home. There must be a written order from the physician allowing the Adult Family Home Provider to administer or assist a resident administering any prescription and/or over the counter medication... Patient requires medication administration by the adult family care provider." Resident 1's authorization to dispense was not signed by a physician. Resident 1's record did not include a physician's order stating who could administer Resident 1's medications. -Resident 2 was admitted on 05/01/2024 with unknown diagnoses. Resident 2's record contained an "Authorization to Dispense" which stated, "The above- named patient is currently residing in, or moving into, an Adult Family Home. There must be a written order from the physician allowing the Adult Family Home Provider to administer or assist a resident administering any prescription and/or over the counter medication... Patient requires medication administration by the adult family care provider." Resident 2's authorization to dispense was not signed by a physician. Resident 2's record did not include a physician's order stating who could administer Resident 2's medications. -Resident 3 was admitted on 04/17/2023 with diagnoses including dementia, depression, stage 3 kidney disease, hypertension, and post-traumatic stress disorder. Resident 3's record contained an "Authorization to Dispense" which stated, "The above- named patient is currently residing in, or moving into, an Adult	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 464	Continued From page 13 Family Home. There must be a written order from the physician allowing the Adult Family Home Provider to administer or assist a resident administering any prescription and/or over the counter medication... Patient requires medication administration by the adult family care provider." The authorization to dispense was electronically signed by a physician on 05/28/2023 which was 41 days after admission. Surveyors reviewed Resident 3's medication administration record, dated 04/18/2023 through 05/18/2023, which indicated Resident 3 received prescription medications during this time. On 08/26/2024, at 3:15 PM, Surveyors interviewed Licensee A. Licensee A confirmed the requirement to have a written order indicating who can pass resident prescription medications. Licensee A confirmed Resident 3's authorization to dispense medications was late. Licensee A reported s/he had Resident 1 and Resident 2's signed authorizations but was unsure of where they were. Licensee A confirmed all residents required assistance administering medications.	M 464		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 3 of 3 residents' (Resident 1,	M 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 482	Continued From page 14 Resident 2, and Resident 3) records contained all required information and were maintained in a secure location within the home. Findings include: On 08/26/2024, at 10:00 AM, Surveyors reviewed resident records and identified the following: - Resident 1 was admitted on 06/01/2023. Resident 1's record did not contain the following documents: Admission health exam Tuberculosis screening (TB) Medications written order - Resident 2 was admitted on 05/01/2024. Resident 2's record did not contain the following documents: Admission health exam TB screening Medications written order Individual Service Plan (ISP) Physician Information Service Coordinator -Resident 3 was admitted on 04/17/2023. Resident 3's record did not contain the following documents: Admission health exam Tuberculosis screening (TB) Medications written order On 08/26/2024, at 3:15 PM, Surveyors interviewed Licensee A. Licensee A reported everything was in the files last week. Licensee A reported s/he believes someone took things out	M 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 482	Continued From page 15 of the files. Licensee A reported s/he needs to get the rest of Resident 2's file from his/her other home.	M 482		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses contraband. The resident shall be present for the search. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each resident had physical privacy in living arrangements for 3 of 3 residents residing in the home. There were electronic video monitoring cameras which showed the kitchen, living room, and outdoor seating areas. Findings Include: On 08/27/2024, at 9:30 AM, Surveyors observed 2 cameras in the facility. There was a camera located above the entrance door of the living room. There was a camera located in the kitchen. Surveyors observed a computer screen, located in the dining room, which showed the views of the	M 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 550	Continued From page 16 camera as follows: The camera located above the entrance door of the living room showed the living room and part of the dining room. The camera located in the kitchen showed the entire kitchen, and the entrance to the hallway which led to the bathroom and residents' rooms. A camera was located on the front of the house. The camera view showed the front door and seating area. Resident 2 was viewed sitting outside. A camera was located on the back end of the house which showed an outdoor seating area. On 08/27/2024, 3:15 PM, Surveyors interviewed Licensee A regarding the use of the cameras. Licensee A reported the camera in the living room was for the time clock. Licensee A reported the camera in the kitchen was for the medication closet. Licensee A reported the camera's outside were for the doors. When Surveyors inquired about resident privacy, Licensee A reported s/he would move the cameras.	M 550		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 570	Continued From page 17 hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe physical environment for 3 or 3 residents. The hot water temperature in the residents' bathroom was 153.1° Fahrenheit (F). The dryer duct was not connected at the bottom of the dryer and the wall vent. Findings include: Example 1 On 08/26/2024, at 9:50 AM, Surveyors tested the water temperature in the residents' bathroom sink faucet. The water temperature was 153.1°F. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g. second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017) On 08/26/2024, at 3:15 PM, Surveyors interviewed Licensee A. Licensee A reported s/he	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017161	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALK BY FAITH AFH	3603 N 13TH ST MILWAUKEE, WI 53206

(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 570	Continued From page 18 was aware of the code requirement. Licensee A reported the water was tested monthly. Licensee A reported s/he would follow up with maintenance. Example 2 On 08/26/2024, at 9:55 AM, Surveyors observed the basement clothes dryer. The dryer duct was disconnected at the bottom of the dryer and at the wall vent. Surveyors observed the basement walls and ceiling were covered in a thick dust like substance consistent with dryer lint. The thick dust like substance hung from the ceiling and walls from what appeared to be spider webs. On 08/15/2024, at 3:15 PM, Surveyors interviewed Licensee A. Licensee A reported s/he was aware of the dryer duct being disconnected. Licensee A reported she instructed the staff to not use the dryer until it was fixed. Licensee A reported s/he would follow up with maintenance.	M 570		