STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 11/05/2024, Surveyors concluded a verification visit, standard survey, and 3 complaint investigations at Latonya's House. Twelve deficiencies were identified. Four of the 12 deficiencies were repeat violations (see Statement of Deficiency SE4J12 dated 08/12/2021). Three complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 1	{M 000}		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure the Adult Family Home (AFH) and its operation complied with this chapter and all other laws governing the home and its operation. The licensee did not follow Department orders. The provider did not ensure all staff responsible for providing services to a resident received documented training with evidence in personnel records including the date/duration of training, the signature/qualification of the instructor and evidence of successful completion of the training.	M 216		

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
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 216	Continued From page 1 As a result of the verification visit, and 3 complaint investigations, a total of 12 violations have been issued. Four of the 12 violations were repeat deficiencies related to administration supervising daily operations. Three complaints were substantiated. Findings include: Latonya's House license became effective 04/29/2016, for 3 residents. On 10/18/2024, Surveyor reviewed Department records and identified the following: Licensee A was issued Statement of Deficiency (SOD) SE4J12 dated 08/21/2021, which included the following Special Orders: "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that LaTonyas House: 1. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., the licensee shall develop and implement corrective measures to ensure all service providers protect and promote each resident's right to live in a safe environment, and the home is clean and well-maintained. The licensee will provide training to all service providers on the corrective actions taken to resolve each environmental deficiency identified in Statement of Deficiency (SOD) SE4J12. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and	M 216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 216	Continued From page 2 evidence of successful completion of the training." On 10/31/2024 at 10:15 a.m., Surveyor requested special orders documentation to determine compliance for the verification visit for SOD SE4J12, dated 08/21/2021, from Administrator B. On 10/31/2024 at 3:40 p.m., Surveyors interviewed Director of Operations (DOO) E and Administrator B. Administrator B stated, "I did not even know about that." DOO E stated, "Because we don't have an area for an office here, we took things home. We don't know where everything is. We plan to eventually put an electronic filing system into place, so we know where things are." On 10/31/2024, Surveyors conducted a verification visit and 3 complaint investigations. As a result of the survey, 3 complaints were substantiated, and the following repeat deficiencies were identified: 88.04(2)(f) Health Screening For Staff 88.04(2)(h) Comply With Osha 88.05(4)(b)1 Fire Safety Smoke Detectors 88.10(3)(L) Safe Physical Environment	M 216		
{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	{M 232}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 232}	Continued From page 3 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 ensure 2 of 2 service providers were screened for illness detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse, or a physician assistant within 90 days before the start of providing service. This is a repeat deficiency. See Statement of Deficiency SE4J12, dated 08/12/2021. Findings include: On 10/31/2024, at 12:30 PM, Surveyors requested to see Caregiver L's and Caregiver M's files. Caregiver L was hired on 06/25/2018. Caregiver L's file contained evidence Caregiver L was screened for TB on 06/18/2018. Caregiver L's record showed no evidence Caregiver L had been screened for communicable diseases. Caregiver M was hired on 04/13/2016. Caregiver M's record showed no evidence Caregiver M was screened for TB or communicable diseases. On 10/31/2024, at approximately 3:35 PM, Surveyors interviewed Director of Operations (DOO) E. Surveyors inquired about Caregiver L's and Caregiver M's screening for communicable diseases including TB. DOO E stated, "I don't have it and I'm not sure why". When Surveyors inquired about Caregiver L's screening for communicable disease. DOO E reported s/he was screened however s/he was unable to locate the document reflecting a completed	{M 232}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 232}	Continued From page 4 communicable disease screening. When Surveyors inquired about Caregiver M's screening for communicable disease and TB. DOO E reported s/he could not locate Caregiver M's full employee file but believed Caregiver M was screened for TB and communicable disease prior to his/her hire date.	{M 232}		
{M 235}	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult family home shall comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 service providers (Caregivers L and M) received annual training in standard precautions as required in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens in 2022 and 2023. The OSHA standard requires the employer train each employee with occupational exposure, "At the time of initial assignment to tasks where occupational exposure may take place" per 1910.1030(g)(2)(ii)(A); and "At least annually thereafter," per 1910.1030(g)(2)(ii) (B). This is a repeat deficiency. See Statement of	{M 235}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 235}	Continued From page 5 Deficiency SE4J12, dated 08/12/2021. Findings include: On 10/31/2024, at 12:30 PM, Surveyors requested to review employee files. Review of employee files revealed the following: 1. Caregiver L began providing service on 06/25/2018. Caregiver L's record did not contain documentation of receiving annual training in standard precautions for the years 2022 and 2023. 2. Caregiver M began providing service on 04/13/2016. Caregiver M's record did not contain documentation of receiving annual training in standard precautions for the years 2022 and 2023. On 10/31/2024 at 3:35 PM, Surveyors interviewed Director of Operations (DOO) E and informed DOO E of the findings. DOO E reported s/he was aware of the code requirement for annual training in standard precautions but did not provide a reason of why the training did not occur annually.	{M 235}		
M 290	88.05(3)(e)2.b INSPECTIONS-GAS FURNACE A gas furnace shall be inspected and serviced every 3 years by a heating contractor or local utility company. This Rule is not met as evidenced by: Based on record review and interview, the facility did not ensure the gas furnace was inspected by	M 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 290	Continued From page 6 a heating contractor of local utility company at least every 3 years for 1 of 1 furnace. Findings include: On 10/31/2024, Surveyors requested to review facility's most recent furnace inspection. Director of Operations (DOO) E could not locate a furnace inspection. On 10/31/2024, at approximately 3:35 PM, Surveyors interviewed DOO E and Administrator B. DOO E and Administrator B indicated they would obtain the most recent furnace inspection and provide it to the department by 11/01/2024. As of 11/01/2024 Surveyors did not receive any supporting documentation of the furnace inspection.	M 290		
{M 334}	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement.	{M 334}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 334}	Continued From page 7 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a smoke detector was installed and working in 1 of 5 required locations. One of 3 resident bedrooms had a chirping smoke detector. This is a repeat deficiency. See Statement of Deficiency SE4J12, dated 08/12/2021. Findings include: On 10/31/2024, at approximately 9:30 AM, Surveyors toured the home and observed an empty bedroom to contain a mounted smoke detector on the ceiling of the bedroom The smoke detector was observed to chirp continuously. The smoke detector chirped throughout the duration of the survey from approximately 9:30 AM until Surveyors exited the facility at 4:15 PM. On 10/31/2024 at 3:35 PM, Surveyors interviewed Director of Operations (DOO) E. DOO E confirmed the bedroom smoke detector needed to be replaced. DOO E reported the smoke detector was a 10-year smoke detector and the whole unit needed to be replaced. DOO E reported the 10-year smoke detectors do not last 10 years. DOO E could not confirm how long the smoke detector had been chirping. Surveyors informed DOO E of how long the smoke detector had been chirping during the survey. DOO E reported maintenance would change the smoke detector.	{M 334}		
M 386	88.06(2)(c) SERVICE AGREEMENT REQUIREMENTS	M 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 386	Continued From page 8 A service agreement shall specify all of the following: This Rule is not met as evidenced by: Based on record review and interview, the provider did not acquire a service agreement for each resident admitted to the home for 2 of 2 residents containing the following: names of the parties to the agreement, the services that will be provided and a description of each, charges for room and board and services and any other applicable expenses, frequency and amount of payment, policy on refunds, how personal funds will be handled, conditions for transfer or discharge and the assistance a licensee will provide in relocating a resident, and a statement indicating that the resident rights and grievance procedure had been explained to the resident, resident's guardian or designated representative. Resident 4 and Resident 5 did not have service agreements with the provider. Findings include: On 10/31/2024, at 10:00 AM, Surveyors reviewed resident records. The following was identified: -Resident 4 was admitted on 07/01/2023. Resident 4 had a guardian. Resident 4's file did not contain a service agreement that included: names of the parties to the agreement, the services that will be provided and a description of each, charges for room and board and services and any other applicable expenses, frequency and amount of payment, policy on refunds, how personal funds will be handled, conditions for	M 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 386	Continued From page 9 transfer or discharge and the assistance a licensee will provide in relocating a resident. Surveyors observed the resident rights and grievance procedure signed by Care Manager (CM) N and Director of Operations (DOO) E, dated 07/01/2023. Guardian O did not sign the resident rights and grievance procedure. -Resident 5 was admitted on 10/17/2024. Resident 5's record did not contain a service agreement. On 10/31/2024, at 3:50 PM, Surveyors interviewed Administrator B and DOO E regarding the missing information. DOO E reported they were, "good at patient care and bad at paperwork."	M 386		
M 408	88.06(3)(c) ASSESSMENT IDENTIFY NEEDS & ABILITIES The assessment shall identify the person's needs and abilities in at least the areas of activities of daily living, medications, health, level of supervision required in the home and community, vocational, recreational, social and transportation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not reassess 1 of 1 resident to identify the needs and abilities in the areas of	M 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 408	Continued From page 10	M 408		

medication administration. Resident 4 required increased assistance with monitoring blood sugars and administering insulin after hospitalization.

Resident 4 was hospitalized from 05/28/2024-06/12/2024 due to Diabetic Keto Acidosis with a blood glucose level greater than 700. Resident 4 was intubated from 5/28/2024-5/31/2024. Resident 4 was discharged back to facility on 06/12/2024. Resident 4's file did not contain an updated assessment to include assistance with monitoring blood sugars and administering insulin after hospitalization.

Findings include:

On 10/15/2024, the department received complaints alleging Resident 4 was staffed 1:1 and his/her cares were not monitored properly. Resident 4 required close supervision due to diabetes.

On 10/22/2024, Surveyors reviewed Resident 4's complete MCO file. Resident 4's Long Term Care Functional Screen (LTCFS) dated 06/07/2022, indicated Resident 4 had a history of pulling his/her own hair and hitting his/her head. Resident 4 had 1:1 staffing. Resident 4's file did not indicate Resident 4 had a diagnosis of diabetes mellitus.

Resident 4's LTCFS dated 07/03/2024, indicated, "Edit made (to LTCFS) due to new diagnosis of diabetes and blood sugar checks 4x/day along with insulin up to 4x/day...Diagnoses. Endocrine/Metabolic. 1. Diabetes Mellitus."

On 10/31/2024, at 10:00 a.m., Surveyors reviewed Resident 4's record. Resident 4 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 408	Continued From page 11	M 408		

admitted on 07/01/2023. Resident 4 was admitted with diagnoses including autism, anxiety disorder, nocturnal enuresis, intermittent explosive disorder, behavioral and emotional disorder. Resident 4 had a guardian.

Resident 4's initial assessment, dated 06/16/2023, under current medical diagnosis, did not identify that Resident 4 had a diagnoses of diabetes mellitus.

On 10/31/2024 at 9:05 a.m., Surveyors interviewed Caregiver L, who stated, "[Resident 4] just moved out. We helped him/her with his/her medications including blood sugars and insulin. S/He had diabetes mellitus."

On 10/31/2024, at approximately 9:35 a.m., Surveyors interviewed Director of Operations (DOO) E regarding Resident 4's services. DOO E reported Resident 4 was just diagnosed with diabetes in June 2024. S/He was sluggish, would not eat, so the staff sent him/her out to the hospital. S/He was gone for approximately two weeks.

On 10/31/2024 at 3:10 p.m., Surveyors interviewed Administrator B, who stated, "I did not do a new assessment on [Resident 4] when s/he got out of the hospital."

On 11/05/2024, at approximately 1:45 p.m., Surveyor interviewed Care Manager (CM) P regarding Resident 4's 05/28/2024-06/12/2024 hospitalization. CM P confirmed Resident 4 was hospitalized from 05/28/2024-06/12/2024 due to Diabetic Keto Acidosis with a blood glucose level greater than 700. Resident 4 was intubated from 5/28/2024-5/31/2024. Resident 4 was discharged back to facility on 06/12/2024, with a new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 408	Continued From page 12 diagnosis of diabetes. Resident 4 required blood sugar checks four times a day along with insulin up to four times a day. CM P confirmed Resident 4 returned to facility on 06/12/2024. Cross Reference: N0412 DHS 88.06(3)(d)1 Description of Services	M 408		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's Individual Service Plan (ISP) included a description of services staff were to implement to manage behaviors for 1 of 1 resident. Resident 4's individual service plan (ISP) did not include a description of a safety plan to address self-injurious behaviors, violent behaviors and wandering. Resident 4 received 1:1 staffing from his/her Managed Care Organization (MCO) from 07/01/2023 to 10/27/2024 due to physical aggression towards self and others. The ISP did not address Resident 4's need for supervision from caregivers or a plan to manage the behaviors when they occurred. Findings include: On 10/15/2024, the department received	M 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 412	Continued From page 13	M 412		

complaints alleging Resident 4 only had a bed in his/her room; all his/her personal belongings were gone. Complaint indicated Resident 4 was staffed 1:1 and his/her care was not monitored properly.

On 10/22/2024, Surveyors reviewed Resident 4's complete MCO file. Resident 4's Long Term Care Functional Screen (LTCFS) dated 06/07/2022, indicated Resident 4 had a history of pulling his/her own hair and hitting his/her head. Resident 4 had 1:1 staffing.

Resident 4's LTCFS dated 07/02/2024, indicated, "Resident 4 was at risk of wandering both day and night. Without 1:1 staff, s/he would likely wander from the home with no sense of safety. Resident 4 had a history of pulling his/her own hair (pulling patches out), scratching/clawing himself/herself and hitting his/her head but this has reduced with current supports. Resident 4 had 1:1 staffing and needed interventions several times per week. Resident 4 required interventions throughout the day (5+) and included 24/7 1:1 staffing at home (and 2:1 in vehicles) due to physical aggression towards others."

On 10/31/2024, at 10:00 a.m., Surveyors reviewed Resident 4's record. Resident 4 was admitted on 07/01/2023. Resident 4 was admitted with diagnoses including autism, anxiety disorder, nocturnal enuresis, intermittent explosive disorder, behavioral and emotional disorder. Resident 4 had a guardian.

Resident 4's ISP, dated 07/01/2023, did not identify Resident 4's level of supervision. Resident 4's ISP identified Resident 4 exhibited behaviors and stated, " . . . S/He will become very physically aggressive with staff (hit, kicks, scratch, pinch, throw objects) at that time s/he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 412	Continued From page 14 usually makes a very loud noise ... S/He also will throw his/her clothes away with no warning and staff must remove them from the garbage without [Resident 4] seeing them or this will cause an outburst. Mental Health Comments ...[Resident 4] will sometimes scratch himself/herself, s/he's resistant to cares, [Resident 4] has nights where s/he don't [sic] sleep at all." Under General Health, Surveyors read, "Diet/Nutrition: Regular,,, Health History ...[Resident 4] has no known health concerns or problems at this time." Surveyors observed Resident 4's ISP signed by Care Manager (CM) N and Director of Operations (DOO) E on 07/01/2023. Guardian O did not sign Resident 4's ISP. - Resident 4's record did not include strategies for teaching appropriate coping skills or inform staff what coping skills should have been practiced when Resident 4 had behaviors in general and when throwing away personal belongings. - Resident 4's record did not indicate Resident 4 had 1:1 staff assigned to him/her and how they would monitor his/her self-injurious behaviors behavior. - Resident 4's record did not identify ways for Resident 4's staff to redirect Resident 4 when having various behaviors identified. - Resident 4's ISP did not identify any interventions to assist Resident 4 with calming him/herself before his/her behavior became a crisis. Resident 4's record did not contain evidence that a 6-month ISP review was conducted by Licensee, Resident 4's guardian and Resident 4's care manager.	M 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 412	Continued From page 15 Resident 4's ISP, dated 07/01/2024, did not identify Resident 4's level of supervision. Resident 4's ISP identified Resident 4 exhibited behaviors and stated, " . . . S/He will become very physically aggressive with staff (hit, kicks, scratch, pinch, throw objects) at that time s/he usually makes a very loud noise ... S/He also will throw his/her clothes away with no warning and staff must remove them from the garbage without [Resident 4] seeing them or this will cause an outburst. Mental Health Comments ...[Resident 4] will sometimes scratch himself/herself, s/he's resistant to cares, [Resident 4] has nights where s/he don't [sic] sleep at all." Under General Health, Surveyors read, "Diet/Nutrition: Regular,,, Health History ...[Resident 4] has no known health concerns or problems at this time. Surveyors observed Resident 4's ISP signed by DOO E on 07/01/2024. Guardian O did not sign Resident 4's ISP. - Resident 4's record did not include strategies for teaching appropriate coping skills or inform staff what coping skills should have been practiced when Resident 4 had behaviors in general and when throwing away personal belongings. - Resident 4's record did not indicate Resident 4 had 1:1 staff assigned to him/her and how they would monitor his/her self-injurious behaviors behavior. - Resident 4's record did not identify ways for Resident 4's staff to redirect Resident 4 when having various behaviors identified. - Resident 4's ISP did not identify any interventions to assist Resident 4 with calming him/herself before his/her behavior became a	M 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 412	Continued From page 16 crisis. Resident 4's pre-admission assessment, dated 06/16/2023, did not identify Resident 4 needed a safety plan to address self-injurious behaviors, violent behaviors and wandering both day and night or 1:1 care. On 10/31/2024 at 9:05 a.m., Surveyors interviewed Caregiver L, who stated, "When [Resident 4] got behavioral, we just brought him/her to another room to calm him/her down or talked to him/her." Surveyors asked if there were other interventions to assist Resident 4 with calming him/herself before his/her behavior got bad. Caregiver L stated, "We just talk calm to him/her and listen." On 10/31/2024 at 10:30 a.m., Surveyors interviewed Director of Operations (DOO) E and Administrator B. DOO E stated, "I kept record of [Resident 4]'s health and communication through text messaging. I never thought to tell [Guardian O] [Resident 4] was throwing his/her things away, which started when s/he moved in. [Resident 4] would put things away, out of his/her sight. Sometimes under his/her bed, in his/her closet, sometimes into the garbage. That behavior was on the ISP." Surveyors asked what behavioral interventions were written in ISP for staff, Administrator B stated, "We used a soft re-direction." On 10/31/2024 at 3:00 p.m., Surveyors interviewed Administrator B. Administrator B stated, "I did not do a new ISP for [Resident 4] when s/he got out of the hospital." On 10/31/2024 at 3:10 p.m., Surveyors interviewed DOO E and Administrator B.	M 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 412	Continued From page 17 Administrator B confirmed Resident 4's ISP stated if s/he puts his/her things in the trash, the staff is supposed to retrieve it. Administrator B stated, "As much as we could, we got the things out of the trash." Surveyors asked how s/he did that when s/he has 1:1 staffing. Administrator B stated, "I just don't know what happened." Cross Reference: N0408 DHS 88.06(3)(c) Assessment Identify Needs and Ability	M 412		
M 446	88.07(2)(b)4 RECORD OF MEDICAL VISITS AND REPORTS Keeping a current record of all medical visits, reports and recommendations for a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure they obtained a record of all medical visits and reports for 1 of 1 resident. Resident 4 was hospitalized from 05/28/2024-06/12/2024. Resident 4's file did not contain medical visits, reports, and recommendations from 05/28/2024-06/12/2024 hospitalization in his/her record. Findings include: On 10/31/2024, at 10:00 a.m., Surveyors reviewed Resident 4's record. Resident 4 was admitted on 07/01/2023. Resident 4 was admitted with diagnoses including autism, anxiety disorder, nocturnal enuresis, intermittent explosive disorder, behavioral and emotional disorder. Resident 4 had a guardian. Resident 4's record did not include a record of hospitalization from 05/28/2024-06/12/2024 and reports.	M 446		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 446	Continued From page 18 On 10/31/2024, at approximately 9:35 a.m., Surveyors interviewed Director of Operations (DOO) E regarding Resident 4's services. DOO E reported Resident 4 was just diagnosed with diabetes in June 2024. S/He was sluggish, would not eat, so the staff sent him/her out to the hospital. S/He was gone for approximately two weeks. On 10/31/2024, at approximately 1:00 p.m., Surveyors requested Resident 4's hospitalization documentation from 05/28/2024-06/12/2024. Administrator B stated s/he did not know where the paperwork was. Administrator B stated, "What is supposed to be in a resident file?" On 10/31/2024, at approximately 1:00 p.m., Surveyors interviewed DOO E. DOO E stated, "I did not document any of it. It was all just a bunch of telephone calls and emails. I called the physician and asked him/her to send his/her notes." DOO E stated, "I don't know why I don't have the paperwork." Administrator B confirmed s/he did not have medical visits, reports, and recommendations from Resident 4's 05/28/2024-06/12/2024 hospitalization. On 10/31/2024 at 3:00 p.m., Surveyors interviewed Administrator B, who stated, "We sent all the paperwork over to the doctor. We don't have any of it." On 11/05/2024, at approximately 1:45 p.m., Surveyor interviewed Care Manager (CM) P regarding Resident 4's 05/28/2024-06/12/2024 hospitalization. CM P confirmed Resident 4 returned to facility on 06/12/2024.	M 446		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 530	Continued From page 19	M 530		
M 530	88.09(2)(a)8 TRAINING DOCUMENTATION Documentation of successful completion of the training requirements under HSS 88.04(5). This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain and keep up to date a personnel record for each service provider which included documentation of successful completion of the training requirements under s. DHS 88.04(5) for 1 of 2 employees reviewed (Caregiver M). Caregiver M's records did not contain evidence of orientation training and 8 hours of annual training for 2022 and 2023. DHS 88.04(5)(b) states "(5) TRAINING. (b) 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." Findings include: On 10/31/2024, at 12:30 PM, Surveyors requested to review employee files. Director of Operations (DOO) E reported the employee files were at the office. DOO E obtained Caregiver M's employee file. Caregiver M's start date was 04/13/2016. Surveyors observed the file to contain a document dated 05/20/2016. The document indicated Caregiver M was missing trainings in fire safety, first aid and choking, standard precautions, medication administration, challenging behaviors, residents' rights, and physical restraints. Caregiver M's file did not	M 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 530	Continued From page 20 contain did not contain evidence of orientation training and 8 hours of annual training for 2022 and 2023. On 10/31/2024, at 3:35 PM, Surveyors interviewed DOO E. DOO E reported s/he did not know where the supporting training documents were for Caregiver M. DOO E reported s/he could not provide the requested documents as s/he could not locate the full file for Caregiver M.	M 530		
{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 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 environment free from environmental hazards. This had the potential to affect 1 of 1 resident. This is a repeat deficiency. See Statement of Deficiency SE4J12, dated 08/12/2021. Findings include:	{M 570}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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 570}	Continued From page 21 On 10/31/2024, at approximately 9:30 AM, Surveyors toured the facility with Administrator B and observed water on the basement floor in front of the furnace and water heater approximately 5 feet wide and 10 feet long. Surveyors observed a black substance along the lower basement walls extending from the electrical boxes to the basement floor. Surveyors observed white trash bags filled with garbage hanging on the left and right side of the dryer. Surveyors noticed a pungent smell coming from the garbage bags. On 10/31/2024 at 3:35 PM, Surveyors interviewed Director of Operations (DOO) E and Administrator B regarding the conditions observed in the basement. Administrator B reported s/he was unaware of the water and the garbage in the basement. Administrator B reported sometimes water entered the basement after a heavy rain. Administrator B could not identify the black substance on the basement wall. DOO E reported having plumbing services recently. DOO E reported s/he did not know why garbage bags were in the basement. Surveyors requested documentation of services provided by the plumber. DOO E reported s/he would provide documentation by 11/01/2024 via email. As of 11/01/2024 Surveyors did not receive any supporting documentation of plumbing services.	{M 570}		
Z 022	50.065(3)(b) COMPLETE BACKGROUND CHECK PROCESS Every 4 years or at any other time within that period that an entity considers appropriate, the	Z 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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
Z 022	Continued From page 22 entity shall request the information specified in sub. (2) (b) 1. to 5. for all caregivers of the entity. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a complete caregiver background check (CBC) was completed for 2 of 2 caregivers (Caregivers L and M) reviewed. At minimum, a CBC contains 3 parts: 1) Background information disclosure form (BID), 2) Criminal history report from the Department of Justice (DOJ) 3) A report from the Department of Health Services integrated background information system (IBIS) Findings include: The provider is licensed to care for up to 3 residents within the following client groups: irreversible dementia/Alzheimer's disease, terminally ill, physically disabled, developmentally disabled, emotionally disturbed/mental illness, and advanced aged. On 10/31/2024, at 12:30 PM, Surveyors reviewed Caregiver L's and M's employee records. Caregiver L's date of hire was 06/25/2018.	Z 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016069	A. BUILDING: _____ B. WING _____	R-C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATONYAS HOUSE	8030 WEST SHERIDAN AVE 1E 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
Z 022	Continued From page 23 Caregiver L's record contained the DOJ, IBIS, and BID from the date of hire. The record did not contain any of the three necessary parts of the four-year background check due June of 2022. Caregiver M's date of hire was 04/13/2016. Caregiver M's record did not contain the initial DOJ, IBIS, and BID from the date of hire. The record did not contain any of the three necessary parts of the four-year background check due April of 2024. On 10/31/2024, at 12:30 PM, Surveyors interviewed and asked Director of Operations (DOO) E if s/he could locate the background checks for Caregiver L and Caregiver M. DOO E reported s/he could not locate the initial background check information for Caregiver M. DOO E reported s/he was not aware caregiver background checks needed to be completed every 4 years. Surveyors gave DOO E until 11/1/2024 by 5:00 p.m. to provide further background information for Caregiver L and Caregiver M. Surveyors did not receive any further background check information from DOO E.	Z 022		