STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017676	A. BUILDING: _____ B. WING _____	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLS ADULT FAMILY HOME	6447 N 106TH MILWAUKEE, WI 53224

(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 08/08/2025 to 08/11/2025, Surveyor conducted a standard survey at Bills Adult Family Home. Two deficiencies were identified. Census: 1	M 000		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following: This Rule is not met as evidenced by: Based on observations, record review and interview, the provider did not ensure 1 of 2 residents' (Resident 1) Individual Service Plan (ISP) included all required information. Resident 1's ISP did not identify behaviors. Findings include: On 08/08/2025, Surveyor conducted a standard survey and identified the following: On 08/08/2025 at 8:50 AM, Surveyor interviewed Caregiver B. Caregiver B reported Resident 1 displayed property destruction, hallucinations, elopement, and verbal/physical aggression since admission. Caregiver B reported Resident 1's managed care organization asked the provider to start behavior tracking. Caregiver B showed Surveyor a large flat screen TV, Resident 1 ripped off the stand and in addition s/he put a	M 410		

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
	0017676	A. BUILDING: _____ B. WING _____	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLS ADULT FAMILY HOME	6447 N 106TH MILWAUKEE, WI 53224

(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 410	Continued From page 1	M 410		

hole in the drywall near the stairs. Caregiver B reported an incident where Resident 1 wandered off down the alley as s/he followed, and Resident 1 stated s/he was looking for their car/dog. Caregiver B stated Resident 1 had gotten physical with staff. Caregiver B stated staff will try to calm Resident 1 down by reminding him/her the provider was his/her temporary home and that his/her dog was being taken care of by his/her guardian.

Resident 1 was admitted on 06/02/2025 with diagnoses including Korsakoff's syndrome, depression, and post traumatic stress disorder. Resident 1 had a guardian. Resident 1's ISP with an unknown date did not identify his/her behaviors related to property destruction, hallucinations, elopement, and verbal/physical aggression.

Resident 1's pre-admission assessment dated 05/22/2025 documented:
"Behavior: 5-Needs prompting/assisting/encouragement to initiate personal care/activity due to behavior, including noncompliance, but not assistance once care/activity has begun. List any disruptive behaviors below and current approaches to manage: May yell, delusional conversation, Hulucination [sic], Destructible, talk to [him/her] and."

A review of Resident 1's daily behavior tracking for July and August 2025 showed the following behaviors displayed: property destruction, hallucinations, elopement, and verbal/physical aggression.

A review of Resident 1's hospital discharge summary dated 09/10/2024-06/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017676	A. BUILDING: _____ B. WING _____	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLS ADULT FAMILY HOME	6447 N 106TH MILWAUKEE, WI 53224

(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 410	Continued From page 2 documented: "[Resident 1] presented from home after being found by [his/her] tenant in confused an unkept state. A&Ox1 on arrival. Uncertain last known well time. Exam significant for nystagmus, unsteady gait, and severe confabulation, most concerning for Korsakoff's Syndrome ....Due to patient's inability to care for self [s/he] was not able to return home. Given lack of designated POA and appropriate insurance, [his/her] placement was complicated and [s/he] was hospitalized for several months awaiting guardianship and placement. Difficult to reorient verbally, therefore medications were optimized to help with agitation, irritability, and mood. Patient used to require 3 prns which were often not effective; also required restraints and a sitter. Behaviors improved and patient later became pleasant, calm and cooperative for long period of time. In past couple of months, [s/he] again started exhibiting agitation mostly related to inability to leave the hospital and return home. Medications were again reviewed and dosing adjusted. Psychiatry assisted and followed patient during the lengthy hospitalization." On 08/11/2025 at 12:31 PM, Surveyor interviewed Licensee A regarding the above concern. Licensee A reported Resident 1's admission was difficult as s/he came straight from the hospital. Licensee A confirmed Resident 1 displayed the above behaviors after Surveyor shared observations within the facility. Licensee A reported s/he has an upcoming meeting with Resident 1's managed care organization team regarding his/her behaviors and requesting additional support for Resident 1. Licensee A stated s/he would update Resident 1's ISP.	M 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017676	A. BUILDING: _____ B. WING _____	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLS ADULT FAMILY HOME	6447 N 106TH MILWAUKEE, WI 53224

(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 3	M 464		
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 2 of 2 residents reviewed. Findings include: On 08/08/2025, Surveyor reviewed resident records and identified the following: -Resident 1 was admitted to the facility on 06/02/2025. Resident 1's July and August 2025 medication administration record (MAR) indicated staff were administering Resident 1's medication. Resident 1's record did not contain a written order from a physician for the provider to administer medications prior to receiving medications. -Resident 2 was admitted to the facility on 02/03/2025 and discharged on 08/04/2025. Resident 2's July and August 2025 MAR indicated	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017676	A. BUILDING: _____ B. WING _____	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLS ADULT FAMILY HOME	6447 N 106TH MILWAUKEE, WI 53224

(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 4 staff were administering Resident 2's medication. Resident 2's record did not contain a written order from a physician for the provider to administer medications prior to receiving medications. On 08/11/2025 at 12:31 PM, Surveyor interviewed Licensee A regarding the above concern. Licensee A stated s/he was unaware of the requirement. Licensee A reported after the survey on 08/08, s/he had staff reach out to Resident 1's physician for a written order, which was obtained. Licensee A reported s/he created a form which will be used for any new residents.	M 464		