STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017154	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HILLS WEST	5910 S 118TH ST HALES CORNERS, WI 53130

(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
N 000	Initial Comments On 05/20/2025, Surveyors completed a standard survey and 1 complaint investigation at Park Hills West. As a result, 8 deficiencies were identified. One complaint was unsubstantiated. Census: 20	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis (TB), within 90 days before the start of employment for 2 of 2 caregivers reviewed (Program Supervisor B and Caregiver C). Program Supervisor B's and Caregiver C's communicable disease screening was not signed by a physician, physician assistant, clinical nurse	N 220		

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

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N 220	Continued From page 1 practitioner or a licensed registered nurse. Findings include: On 05/20/2025, at 11:25 AM, Surveyor reviewed staff files and identified the following: Program Supervisor B was hired on 01/09/2025. Program Supervisor B's record contained the results of a TB test on 01/02/2025 signed by a medical assistant. The TB test was not signed by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse. Program Supervisor B's record did not contain evidence of a communicable disease screening. Caregiver C was hired on 07/13/2023. Caregiver C's record contained the results of a TB test on 01/02/2025 signed by a licensed practical nurse (LPN). The TB test was not signed by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse. Program Supervisor B's record did not contain evidence of a communicable disease screening. On 05/20/2025, at 3:10 PM, Surveyors interviewed Director of Operations (DOO) A. DOO A reported s/he was aware of the requirement for ensuring a completed TB test, but was unaware of who could sign the documents. DOO A reported they utilized Concentra for all TB testing for staff. DOO A reported s/he would speak with Concentra to ensure a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse signs the documents.	N 220		
N 420	83.37(3)(d) Medication storage: refrigeration Refrigeration. Medications stored in a common	N 420		

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N 420	Continued From page 2 refrigerator shall be properly labeled and stored in a locked box. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all medications were securely stored in the common refrigerator for 1 of 1 refrigerator. Resident 2's Glatopa injections were stored unsecured in the common refrigerator. Findings include: On 05/20/2025, at 10:54 AM, Surveyors observed the common refrigerator located in the basement of the facility. The door leading to the basement had a locking mechanism. The locking mechanism was not engaged. Two boxes labeled with Resident 2's information containing 60 Glatopa subcutaneous injections were in the door of refrigerator on the shelf. Medications were not stored in a locked box. There was no locking mechanism on the outside of the refrigerator. Surveyor observed residents moving freely around the facility. On 05/20/2025, at 3:10 PM, Surveyors interviewed Director of Operations (DOO) A. DOO A confirmed the code requirement. DOO A reported she was unaware of any medications not secured in lock boxes. DOO A reported the common refrigerator in the basement should be equipped with a lock box for medications. DOO A was informed the common refrigerator did not contain a lock box for medications during the facility tour. DOO A spoke with Program Supervisor B. Program Supervisor B reported the lock box was in her/his office.	N 420		

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N 499	Continued From page 3	N 499		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored in 7 of 7 areas. Findings include: The facility is licensed as a Class CNA (non-ambulatory) Community Based Residential Facility which may serve up to 20 advanced aged, emotionally disturbed/mentally ill, dementia, traumatic brain injury, physically disabled, terminally ill, and developmentally disabled residents. On 5/20/2025, at 9:01 AM, Surveyors entered the facility and observed the following: The nurses station desk had a can of Lysol disinfectant and a can of Febreze air freshener. The chair rail next to the laundry room had spray bottle labeled Pine-Sol and a spray bottle labeled bleach. The shower room on the northeast side of building had a bottle of Lysol toilet bowl cleaner on a shelf. The door to the shower room had a locking mechanism, the locking mechanism was not engaged. The storage room on the southwest side of the	N 499		

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N 499	Continued From page 4 building had a locking mechanism. The locking mechanism was not engaged. Inside the closet was a can of Raid Max bed bug and flea killer, 2 cans of Raid ant and roach killer, 3 spray cans of Weiman stainless steel polish, 1 bottle of CSI Magic stain eliminator, a can of Sprayway glass cleaner, a bottle of Pine-Sol, 2 bottles of Lysol toilet bowl cleaner, 5 bottles of Lysol disinfectant spray, 3 cans of Febreze air freshener, and a can of Pledge multisurface cleaner spray. The laundry room of the building had a locking mechanism. The locking mechanism was not engaged. Inside the laundry room was a bottle of Pine-Sol, a can of Sprayway glass cleaner, and 2 bottles of Clorox bleach. The kitchen was an open concept, there was no door. The cabinet under the sink contained, 1 bottle of Palmolive dish detergent, 1 bottle of Cascade complete dishwasher detergent, 1 can of Sprayway oven cleaner, 1 can of Sprayway glass cleaner, and 1 bottle of Weiman stainless steel polish. Surveyor observed residents moving freely throughout the facility. On 05/20/2025, at 3:10 PM, Surveyors interviewed Director of Operations (DOO) A. DOO A confirmed the code requirement. DOO A reported s/he thought the issues with the unsecured chemicals circled back to not having housekeeping staff. DOO A reported s/he would talk with staff.	N 499		
N 521	83.47(1)(c) Safety requirements: no safe evacuation	N 521		

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N 521	Continued From page 5 If a resident cannot be safely evacuated from their bedroom as determined by the CBRF ' s assessment, the CBRF shall instruct the resident to remain in the resident ' s bedroom and the CBRF shall meet all of the following requirements: 1. Be sprinklered as required under s. HFS 83.48(8). 2. Notify the local fire department and identify the specific residents using point of rescue, and provide an up-to-date floor plan identifying where those resident rooms are located. 3. Have vertical smoke separation between all floors. 4. Have 24 hour awake qualified resident care staff. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide the fire department a floor plan which informed the department of residents who were a point of rescue and where they were located in the facility. This had the potential to affect 20 of 20 residents. Findings include: On 05/20/2025, at 11:20 AM, Surveyors reviewed the facility safety files with Director of Operations (DOO) A and identified the following: 2025 01/14/2025 at 4:00 PM, Evacuation time 3 minutes 19 seconds. "Residents were evacuated to meeting area [sic] Residents that were in bed sheltered in place." 04/20/2025 at 9:00 AM, Evacuation time 3 minutes 21 seconds. "All residents that were up evacuated to meeting area, residents that were still in bed sheltered in place."	N 521		

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N 521	Continued From page 6 2024 01/19/2024 at 8:55 AM, evacuation time 3 minutes 24 seconds. "All residents that are ambulatory evacuated to meeting area with staff [sic] all residents non-ambulatory sheltered in place in their rooms with windows and doors closed." 07/14/2024 at 8:45 AM, evacuation time 3 minutes 16 seconds. "All ambulatory residents evacuated to designated meeting area with staff [sic] all non-ambulatory residents sheltered in place with windows and doors closed." 10/09/2024 at 9:10 AM, evacuation time 3 minutes 27 seconds. "Residents were evacuated to meeting area. Residents that were still in bed sheltered in place." 2023 01/13/2023 at 5:15 PM, evacuation time 3 minutes 42 seconds. "All ambulatory residents evacuated to designated meeting area with staff. All non-ambulatory resident sheltered in place in their rooms with door closed." 04/01/2023 at 9:00 AM, evacuation time 3 minutes 25 seconds. "All residents evacuated along with staff to meeting area [sic] all non-ambulatory residents sheltered in place with window [sic] and doors closed." 07/01/2023 at 5:00 PM, evacuation time 3 minutes 50 seconds. "All residents evacuated to meeting area. All non-ambulatory people sheltered in place [sic] windows closed."	N 521		

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N 521	Continued From page 7 10/10/2023 at 8:30 AM, evacuation time 3 minutes 49 seconds. "All residents evacuated to meeting area [sic] non-ambulatory residents sheltered in place [sic] windows closed [sic] doors closed." On 05/20/2025, at 12:29 PM, Surveyors reviewed the facility's disaster preparedness plan. The facility's procedure in the event of a fire was to take the following actions: "Remove residents in immediate danger. Inform every one [sic] of the fire, call 911 immediately (skip this step if fire alarms activated-this is monitored externally and fire department will get alerted) and provide facility's address. Contain the fire if possible by closing all doors and windows to stop the spread of the fire. If the fire is small enough to be extinguished with a fire extinguisher, do so. Evacuate all residents in the building and meet at the pre-determined [sic] meeting place. Account for the whereabouts of all residents and staff." On 05/20/2025, at 3:10 PM, Surveyors interviewed DOO A. DOO A reported s/he was unaware of the requirement. DOO A reported residents were to shelter in place during sleeping hours. Surveyors indicated on the fire drills; all non-ambulatory residents were being sheltered in place. DOO A acknowledged Surveyors concerns.	N 521		

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N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure quarterly fire drills were conducted for 1 of 2 years (2024). A nighttime drill was not documented in 2023 and 2024. Findings include: On 05/20/2025, at 11:20 AM, Surveyors reviewed the facility safety files with Director of Operations (DOO) A. Surveyor did not review evidence of a completed fire drill during the 2nd quarter of 2024. Surveyors were unable to establish compliance with a drill which simulates the conditions of usual sleeping hours.	N 525		

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N 525	Continued From page 9 On 05/20/2025, at 3:10 PM, Surveyors interviewed DOO A. DOO A confirmed the code requirement. DOO A reported s/he was unsure if a simulated drill was completed for 2023 and 2024. DOO A reported Program Supervisor B was responsible for ensuring drills were completed.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster drills were conducted semi-annually for 2 of 2 years. There were no other emergency or disaster drills conducted in 2023 or 2024. Findings include: On 05/20/2025, at 11:20 AM, Surveyors reviewed the facility safety files with Director of Operations (DOO) A. The safety files did not contain evidence of other emergency or disaster drills for 2023 and 2024. On 05/20/2025, at 3:10 PM, Surveyors interviewed DOO A. DOO A confirmed the code requirement. DOO A reported s/he did not find the drills. DOO A reported s/he was unsure if the drills were completed.	N 526		
N 617	83.55(6)(b) Bath and toilet areas: water temperature	N 617		

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N 617	Continued From page 10 The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: The facility is licensed as a Class CNA (non-ambulatory) Community Based Residential Facility which may serve up to 20 advanced aged, emotionally disturbed/mentally ill, dementia, traumatic brain injury, physically disabled, terminally ill, and developmentally disabled residents. On 05/20/2025, at 9:30 AM Surveyors toured the facility and observed the following: Resident 1's bathroom water temperature was 119.5 degrees F. Resident 3's bathroom water temperature was 121.3 degrees F. Resident 4 and Resident 5 had a shared bedroom. The bathroom water temperature was 122.9 degrees F. On 05/20/2025, at 9:30 AM, Surveyors interviewed Director of Operations (DOO) A who confirmed the code requirement. DOO A was informed the bathroom sink temperatures exceeded 115 degrees F. DOO A reported the temperatures were monitored by the night shift	N 617		

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N 617	Continued From page 11 staff. DOO A reported s/he would have the water temperature adjusted.	N 617		
N 631	83.59(1)(a) Class AS, ANA, CS, CNA 2 grade level exits All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Class AS, class ANA, class CS and class CNA CBRFs shall have at least 2 grade level or ramped exits to grade. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 2 of 5 exits were ramped to grade. Findings include: This facility was issued a Class CNA (non-ambulatory) Community Based Residential Facility license on 07/13/2018, to serve residents whose primary diagnoses are in the client groups of advanced aged, developmentally disabled, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, physically disabled, terminally ill, and traumatic brain injury. On 05/20/2025, at 9:20 AM, Surveyors toured the facility and observed the following: In the dining room, there was a door, which led to a wood deck. The deck led to a wood ramp,	N 631		

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N 631	Continued From page 12 which led to a concrete patio. From the wood deck to the ramp, there was a drop of 1 inch. From the wood ramp to the concrete patio, there was a 0.5-inch lift. In the activity area, there was a door which led to a concrete patio. The doorframe of the door was approximately 0.75-inch rise from the activity room to the threshold, and a 0.75-inch drop from the threshold to the patio. On 05/20/2025, at 12:29 PM, Surveyors reviewed the facility's emergency evacuation routes from the emergency plans. The floor plan outlined in red the emergency routes. The door from the dining room to the wood deck, down the ramp to the patio was identified as an emergency route. The door from the activity area to the patio was also identified as an emergency route. On 05/20/2025, at 3:10 PM, Surveyors interviewed Director of Operations (DOO) A. DOO A confirmed the code requirement. DOO A reported s/he had discussed the concerns with the owner in the past. DOO A reported s/he was unaware the 2 exits Surveyors identified were emergency routes in the emergency plan.	N 631		