Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018839	A. BUILDING: _____ B. WING _____	C 08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW WAY OF LIVING ADULT FAMILY HOME #2	4114 ST CLAIR STREET RACINE, WI 53402

(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 08/02/2024, Surveyor conducted a standard survey and 1 complaint investigation at New Way of Living Adult Family Home #2. One deficiency was identified. One complaint was substantiated. Census: 3	M 000		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure services specified in 3 of 3 resident's individual support plans (ISPs) were provided. One of 3 residents (Resident 4) required complete assistance with all activities of daily living including evacuation from the home in case of emergency. Two of 3 residents (Resident 2 and Resident 3) were under court orders to receive 24-hour supervision. Three of 3 residents were left unattended for approximately 30 minutes. Findings include: On 02/28/2024, the Department received a complaint stating law enforcement had been called to facility on 02/22/2024 and found it to be unstaffed. The police waited 30 minutes before	M 436		

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

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M 436	Continued From page 1 staff arrived at the home. Record Review -Police report, dated 02/22/2024, timestamped 15:24, stated the following: "[Police Officer D and E] went to 4114 St. Clair to ensure the group home was currently staffed. We made contact with [Resident 2] who advised that the staff had left the home without saying anything. Two other residents were identified as [Resident 3] and [Resident 4]. [Resident 3] advised that the staff member for the residence had been out of the home since three o'clock in the afternoon ...Approximately twenty minutes after our arrival [Caregiver B] a staff member, arrived at the residence. [Caregiver B] advised that [s/he] had been away from the residence for about thirty minutes trying to find [Resident 1]." On 08/02/2024, Surveyor reviewed resident records and identified the following: Resident 1's ISP, dated 3/20/2024, indicated Resident 1 was admitted to the facility on 10/12/2022 with a diagnosis of schizophrenia and bipolar disorder. Resident 1 was not under a court order for 24-hour supervision and often took walks in the neighborhood independently. Resident 2's ISP, dated 06/30/2024, indicated Resident 2 was admitted to the facility on 06/30/2022 with diagnoses including diabetes, short term memory loss, anxiety disorder, alcoholic hepatitis, alcoholic cirrhosis of the liver, and major depressive disorder. Resident 2 had a court order for 24-hour supervision since admission and had a moderate risk for wandering.	M 436		

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M 436	Continued From page 2 Resident 3's ISP, dated 06/30/2024, indicated Resident 3 was admitted to the facility on 06/06/2022 with diagnoses of chronic obstructive pulmonary disease and depression. Resident 3 had a court order for 24-hour supervision since admission. They required cuing assistance for all transfers and for evacuation from the home in case of emergency. Resident 4's ISP, dated 06/30/2023, indicated Resident 4 was admitted to the facility on 06/06/2022 with diagnoses of unspecified dementia which included behavioral disturbances and a seizure disorder. They required complete assistance with all activities of daily living including evacuation from the home in case of emergency. Interview On 08/02/2024 at approximately 11:45 AM, Surveyor interviewed Licensee A and Assistant Manager C. Assistant Manager C confirmed Residents 1, 2, 3, and 4 were living in the home at the time of the incident. Resident 2 and Resident 3 were under court orders to be supervised 24 hours each day. Resident 1 was technically their own person and often went out walking on their own. On this occasion, Resident 1 was upset when they left the home for a walk. [Caregiver B] was concerned that Resident 1 did not have shoes or coat on when they went outside so s/he went out to find them, leaving the other residents alone. Licensee A stated, "Staff have all been retrained to contact management for assistance and never leave residents in the home unattended."	M 436		