STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016521	A. BUILDING: _____ B. WING _____	R-C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLAGG STREET MANOR III	8608 WEST BENDER ROAD 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 07/19/2023, Surveyor concluded a standard survey, verification visit, and a complaint investigation at Flagg Street Manor III. Eleven deficiencies were identified. Seven of the 11 deficiencies were repeat violations (see SOD ZEZF11, dated 09/10/2021). One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 2	{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 record review and interview, the licensee did not ensure the home and its operation complied with all governing laws. During the standard survey, verification visit and complaint investigation, 11 deficiencies were identified. The licensee did not follow Department orders. The licensee did not develop staff training to address allegations of caregiver misconduct. The provider did not ensure 4 of 4 caregivers (Caregiver C, Caregiver K, Caregiver L, and Caregiver M) received training in caregiver misconduct within 45 days of 01/28/2022. On 07/05/2021, Surveyor conducted a standard	{M 216}		

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

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{M 216}	Continued From page 1 survey, verification visit, and a complaint investigation. As a result of this verification visit, a total of 11 violations were issued. Seven of the 11 violations were repeat deficiencies. This requirement is being cited for a second time. See Statement of Deficiency ZEZF11, dated 09/10/2021. Findings include: Flagg Street Manor III was licensed 03/02/2017 as a non-ambulatory adult family home to serve up to 3 residents within the client groups: advanced aged, developmentally disabled, physically disabled, emotionally disturbed/mental illness, terminally ill and traumatic brain injury. Eleven violations, including this violation, were identified during the time of the survey. The following deficiencies were identified: 88.04(2)(a) Responsibilities 88.04(2)(g) Health Screening for Staff 88.04(5)(b) Training- 8 hours Annually 88.05(4)(d)1 Fire Safety Evacuation Plan 88.05(4)(d)2a Fire Evacuation Plan Review 88.05(4)(d)2b Fire Evacuation Annual Evaluation 88.06(3)(c) Assessment Identify Needs & Abilities 88.06(3)(f) Review of ISP 88.09(1)(d) Resident Records Requirements 88.09(1)d Resident Records Retained 50.065(4m)(c) Complete Background Information Disclosure In addition, on 06/23/2023, Surveyor reviewed Department records and identified the following: On 01/28/2022, Statement of Deficiency (SOD) ZEZF11 and Notice and Order letter was sent	{M 216}		

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{M 216}	Continued From page 2 certified mailed. The Notice and Order letter included the following: Order to Comply with Requirements- Special Orders 1.Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., 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. The licensee shall ensure that residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. Upon learning of an incident of alleged misconduct, the licensee shall take whatever steps are necessary to ensure that residents are protected from subsequent episodes of misconduct while a determination on the matter is pending. The licensee will develop (or review/revise) a procedure and staff training to address: Allegations of Caregiver Misconduct. - For any allegation of caregiver misconduct, the licensee shall immediately take steps to ensure the safety of all residents, conduct an investigation, and maintain documentation of any investigation; - The licensee shall report to the department an allegation of client abuse, neglect or misappropriation of client property committed by any person employed by the entity when the licensee has reasonable cause to believe it has sufficient evidence, or another regulatory authority could obtain the evidence, to show the alleged incident occurred and the licensee has	{M 216}		

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{M 216}	Continued From page 3	{M 216}		

reasonable cause to believe the incident meets or could meet the definition of abuse, neglect or misappropriation. Caregiver misconduct investigations will be reviewed in accordance with the department's reporting requirements and reported if necessary. The Caregiver Manual is available as a reference at: https://www.dhs.wisconsin.gov/publications/p0/p00038.pdf.

The manager and each service providers will receive training regarding the facility's written procedures required by Order #1. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training.

A copy of the written procedure required for Order #1 will be made available to department representatives upon request.

2.Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for each resident with a copy of Statement of Deficiency (SOD) #ZEZF11, and a copy of the Notice and Order letter for each. The licensee shall retain evidence, acceptable to the Department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the Department representatives upon request.

On 07/05/2023, Surveyor conducted a verification visit to determine if the training violation identified

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{M 216}	Continued From page 4 in SOD ZEZF11 was corrected. Based on interview and record review, the provider did not ensure 4 of 4 caregivers sampled (Caregiver C, Caregiver K, Caregiver L and Caregiver M) received training in caregiver misconduct within 45 days of 01/28/2022. On 07/19/2023 at approximately 12:05 p.m., Surveyor interviewed Co-Licensee D and Co-Licensee E. Co-Licensee D reported s/he was aware of the code requirements. Co-Licensee D acknowledged the deficiencies. Co-Licensee D stated s/he knew a surveyor would be coming back to do a verification visit. Co-Licensee D stated, "We started to review the records to make ensure all the documentation was completed. We trusted our managers. We will make sure it gets done."	{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 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 staff interview, the provider did not obtain documentation that 3 of 3	{M 232}		

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{M 232}	Continued From page 5 staff reviewed had been screened for communicable disease, including tuberculosis (TB), within 90 days before the start of providing service. Caregiver K was screened for tuberculosis (TB); however, the screening was completed 4.5 months after hire. Caregiver L and Caregiver M had been working in the facility and providing cares to residents without having had a baseline TB test as a part of the communicable disease screening. This requirement is being cited for a second time. See Statement of Deficiency ZEZF11, dated 09/10/2021. Findings include: On 07/05/2023 at 1:15 p.m., Surveyor reviewed employee records and found the following: Caregiver K was hired on 10/26/2021. Caregiver K's file contained a communicable disease screen, dated 03/14/2022, almost 4.5 months after hire and not within the 90 days before the start of employment. Caregiver K's record did not contain a screening for other illnesses detrimental to residents, including tuberculosis, within 90 days before the start of providing service. Caregiver L was hired 06/21/2022. Caregiver L's record did not contain a TB skin test or a screening for other illnesses detrimental to residents, including tuberculosis, within 90 days before the start of providing service. Caregiver M's date of hire was 06/16/2023. Caregiver M's record did not contain a TB skin test or a screening for other illnesses detrimental to residents, including tuberculosis within 90 days before the start of providing service.	{M 232}		

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{M 232}	Continued From page 6 On 07/06/2023 at 1:15 p.m., Surveyor interviewed Caregiver L and asked if documentation of screening for tuberculosis had been completed. Caregiver L stated Co-Licensee E was unable to find documentation that s/he completed a TB test. S/He thought s/he gave the paperwork to Lead Caregiver A but could not be certain. On 07/06/2023, at 2:25 p.m., Surveyor interviewed Co-Licensee D who reported s/he thought Former Manager N took care of the employee files including TB skin tests and screenings for other illnesses. Co-Licensee D stated Former Manager N was no longer employed at facility. On 07/06/2023 at 3:25 p.m., Surveyor gave Co-Licensee E until 07/06/2023 at 6:00 p.m. to provide any remaining documentation. As of 07/11/2023 at 12:25 p.m., no further information was provided. On 07/19/2022 at approximately 10:45 a.m., Surveyor interviewed Co-Licensee D and Co-Licensee E. Co-Licensee E reported s/he was aware of the code requirement. Co-Licensee E acknowledged the deficiency. Co-Licensee E stated, "Our former manager was in charge of overseeing the TB and communicable disease [screenings] for staff. I was overseeing him/her. I was late in reviewing his/her work and found things were not getting done. We will make sure it gets done."	{M 232}		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service	M 246		

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M 246	Continued From page 7 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 2 of 2 caregivers (Caregiver K and Caregiver L) completed resident rights training and 8 hours of annual training approved by the licensing agency related to the health, safety, welfare, rights, and treatment of residents served in the facility. Findings include: On 07/05/2023 at 1:15 p.m., Surveyor reviewed caregiver records and identified the following: Caregiver K was hired on 10/26/2021. Caregiver K's record did not contain evidence of training in resident rights or 8 hours of continuing education for the year 2022. Caregiver L was hired 06/21/2022. Caregiver L's record did not contain evidence of training in resident rights or 8 hours of continuing education for the year 2022. On 07/05/2023, at 8:45 a.m., Surveyor interviewed Caregiver K who stated, "I didn't have any training last year. Not even resident rights." On 07/06/2023, at 1:15 p.m., Surveyor	M 246		

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M 246	Continued From page 8 interviewed Caregiver L who stated, "I only had lift training with [Lead Caregiver A]. Nothing else last year." On 07/06/2023, at 2:25 p.m., Surveyor interviewed Co-Licensee D, who reported s/he did not go through the 8 hours of annual training or resident rights training with his/her staff in 2022. Co-Licensee D reported s/he thought that Former Manager N was taking care of all the trainings and was keeping documentation in the employees' files. Co-Licensee D stated Former Manager N was no longer employed at the facility. Co-Licensee D informed Surveyor that all trainings were kept in the employee files. On 07/19/2022 at approximately 10:45 a.m., Surveyor interviewed Co-Licensee D and Co-Licensee E. Co-Licensee E reported s/he was aware of the code requirements. Co-Licensee E acknowledged the deficiency. Co-Licensee E stated, "We have a training website for the caregivers to watch videos and print certificates upon completion. I never set it up. We will make sure it gets done."	M 246		
{M 342}	88.05(4)(d)1 FIRE SAFETY EVACUATION PLAN The licensee shall have a written plan for the immediate and safe evacuation of all occupants of the home in the event of a fire. The plan shall identify an external meeting place. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not have a written plan for the immediate and safe evacuation of all occupants of the home in the event of a fire or	{M 342}		

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{M 342}	Continued From page 9 natural disaster. Resident 1 required the use of a Hoyer and required full assistance to evacuate building. This requirement is being cited for a second time. See Statement of Deficiency ZEZF11, dated 09/10/2021. Findings include: On 07/05/2023, at 12:58 p.m., Surveyor reviewed fire escape route posted in kitchen and noted there was no meeting place indicated on diagram. On 07/05/2023 Surveyor reviewed Resident 1's records. Resident 1 was admitted to the home 03/15/2021. Resident 1's Individual Service Plan (ISP), dated 09/17/2021, identified Resident 1 required 24-hour supervision. Resident 1's 6-month assessment, dated 02/16/2022, identified Resident 1 required full assistance to evacuate the building, and in an event of a fire, the resident's room door was to be closed and a towel placed under the door. Resident 1 had diagnoses including traumatic brain injury (TBI), stroke, and hypertension. Resident 1 had a guardian. Surveyor reviewed protective services/placement annual report from 05/05/2023 stating Resident 1 had right sided paralysis. Resident 1's record did not contain evidence indicating an annual evaluation evacuation assessment was completed in 2022. Interviews: On 07/05/2023 at 10:00 a.m., Surveyor interviewed Lead Caregiver A (LC A). Surveyor asked LC A what the facility's evacuation plan was. LC A told Surveyor, "I do not know what the evacuation plan is or if we have a written plan. Co-Licensee D may know but I don't know."	{M 342}		

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{M 342}	Continued From page 10 On 07/05/2023 at 10:05 a.m., Surveyor requested a copy of the facility's written plan for the immediate and safe evacuation of all residents in the event of a fire. Surveyor did not receive copy of written evacuation plan. On 07/05/2023 at 3:10 p.m., Surveyor interviewed Resident 1, who told Surveyor s/he, "doesn't get up at all." Surveyor asked Resident 1 if s/he had to get up, how did staff assist. Resident 1 stated, "They use that thing." Resident 1 pointed at the Hoyer Lift in his/her room next to the television. On 07/05/2023 at 2:35 p.m., Surveyor interviewed Caregiver K, who told Surveyor that Resident 1 was bed-bound, and that Resident 1 required a Hoyer Lift to get out of bed. Caregiver K explained in the event of a fire, "We are supposed to put him/her in his/her Hoyer lift and wheel him/her out into the street, away from the house." Surveyor asked Caregiver K if there was a designated meeting place. Caregiver K believed it was outside in the street. Caregiver K was unable to locate a written safe evacuation plan in the facility for Surveyor to review. On 07/06/2023 at 1:20 p.m., Surveyor discussed findings with Co-Licensee D, who stated they tell caregivers what to do during orientation. Caregivers could also reference the residents Individualized Service Plans (ISPs). Surveyor shared the different interview responses from LC A and Caregiver K with Co-Licensee D, who responded, "I can't help it if the caregivers don't read the ISPs and know what to do for the residents." Surveyor informed Co-Licensee D Resident 1's and Resident 2's ISPs and resident evacuation assessments had not updated since 2021. Co-Licensee D stated s/he thought LC A	{M 342}		

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{M 342}	Continued From page 11 and Former Manager N were taking care of orientating of the caregivers. Co-Licensee D confirmed s/he was responsible for updating resident ISP's. On 07/06/2023 at 3:25 p.m., Surveyor gave Co-Licensee E until 07/06/2023 at 6:00 p.m. to provide written plan for the immediate and safe evacuation of all occupants of the home in the event of a fire or natural disaster. As of 07/11/2023 at 12:25 p.m., no further information was received. On 07/19/2022 at approximately 10:40 a.m., Surveyor interviewed Co-Licensee D and Co-Licensee E. Co-Licensee E reported s/he was aware of the code requirements. Co-Licensee E acknowledged the deficiency. Co-Licensee D stated, "I went through the plan with the staff again. I don't know why the caregivers don't remember. The written plan is supposed to be posted next to the fire evacuation map. We will hang it back up and retrain the care staff." Cross Reference N0346 88.05(4)(d)2b Fire Evacuation Annual Evacuation.	{M 342}		
{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.	{M 344}		

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{M 344}	Continued From page 12	{M 344}		

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure 1 of 1 resident (Resident 3) was evaluated immediately upon admission for evacuation time, using the Department's form.

This requirement is being cited for a second time. See Statement of Deficiency ZEZF11, dated 09/10/2021.

Findings include:

On 07/05/2023 at 11:30 a.m., Surveyor requested to review Resident 3's record.

Resident 3 was admitted to the home on 10/11/2021. Resident 3 was discharged on 10/17/2022. Resident 3's record did not contain evidence the initial fire evacuation evaluation was completed upon admission for Resident 3's evacuation time.

Resident 3's managed care organization (MCO) assessment, dated 08/23/2022, read, "Living Environment: [Resident 3] needs assistance from another person in an emergency. In the event of an emergency that required evacuation [sic] [Resident 3] would need assistance in order to leave the apartment (facility) in a save [sic] and quick manner."

Interview:

On 07/05/2023 at 11:30 a.m., Surveyor requested to review the initial fire evacuation evaluation form for Resident 3 from Lead Caregiver (LC) A . LC A stated that s/he did not know where his/her file was. On 07/05/2023 at 1:20 p.m., LC A told

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{M 344}	Continued From page 13 Surveyor, "I could not find Resident 3's file anywhere at the office." On 07/06/2023, at 1:25 p.m., Surveyor interviewed Co-Licensee D who reported, "We just don't have any records on Resident 3. The only thing we have is what is in ECP (electronic health record software). The only guess I have is that the paper file got packed up with his/her things when they got picked up after s/he passed away." Surveyor gave Co-Licensee D until 07/06/2023 at 6:00 p.m. to provide any requested documentation. As of 07/11/2023 at 12:25 p.m., no further information was received.	{M 344}		
{M 346}	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 2 of 2 residents were evaluated annually for evacuation time, using the Department's form (Resident 1 and Resident 2). This requirement is being cited for a second time. See Statement of Deficiency ZEZF11, dated 09/10/2021.	{M 346}		

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{M 346}	Continued From page 14 Findings include: On 07/05/2023 at 11:05 a.m., Surveyor reviewed resident records. The following was identified: Example 1: Resident 1 was admitted to the facility on 03/15/2021. Surveyor observed fire evacuation evaluation form dated 03/20/2021. Resident 1's record did not contain a fire evacuation evaluation form for 2022. Example 2 Resident 2 was admitted to the facility on 07/26/2017. Surveyor observed fire evacuation evaluation form dated 10/24/2017. Resident 2's record did not contain a fire evacuation evaluation form for 2022. Interview: On 07/05/2023 at 10:15 a.m., Surveyor Lead Caregiver (LC) A. LC A provided a fire evacuation evaluation form dated 03/20/2021. LC A stated, "2022 is not in the file...Co-Licensee E did the last one." On 07/05/2023 at 12:35 p.m., Surveyor interviewed Co-Licensee D, who provided fire evacuation evaluation form dated 10/24/2021. Co-Licensee D stated, "2022 is not in the file. I'm not sure where it is. I'll have to ask my partner." On 07/05/2023 at 10:35 a.m., Co-Licensee D provided Resident 1 and Resident 2's records to Surveyor. Co-Licensee D confirmed resident records were complete and updated. On 07/19/2022 at approximately 10:58 a.m., Surveyor interviewed Co-Licensee D and	{M 346}		

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{M 346}	Continued From page 15 Co-Licensee E. Co-Licensee D reported s/he was aware of the code requirements. Co-Licensee D stated, "I updated those after the last survey in 2021, but nothing has changed with Resident 1 and Resident 2. I have not done anything with the evacuation forms since. I guess we filled the documents out wrong. Now we know."	{M 346}		
{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 assess 1 of 1 resident to identify the needs and abilities in the areas of activities of daily living and level of supervision required in the home and community. Resident 3's assessment and Individualized Service Plan (ISP) did not identify Resident 3 had a colostomy bag, destructive/abusive behaviors including substance abuse, or the need for emergency evacuation assistance due to right leg amputation. Resident 3 had 1:1 staffing in place from his/her Managed Care Organization (MCO) from 05/27/2022 to 07/31/2022 due to behaviors. The assessment and ISP did not address	{M 408}		

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{M 408}	Continued From page 16	{M 408}		

Resident 3's need or level of supervision from caregivers when behaviors occurred.

This requirement is being cited for a second time. See Statement of Deficiency ZEZF11, dated 09/10/2021.

Findings include:

On 07/06/2023, Surveyor evaluated Resident 3 electronic medical records and the following was identified:

Resident 3 was admitted to the facility on 10/11/2021 with diagnoses that included substance use- alcohol abuse, amputation-left foot-toes 1-5, atherosclerosis, amputation - right leg phantom limb pain, colostomy, and hypotension (low blood pressure). Resident 3 was his/her own decision maker.

Resident 3's initial assessment, dated 10/11/2021, did not identify Resident 3 had a colostomy bag, destructive/abusive behaviors including substance abuse, or need for emergency evacuation assistance due to right leg amputation.

Resident 3's Individual Service Plan (ISP), dated 10/11/2021, did not identify Resident 3 had a colostomy bag, destructive/abusive behaviors including substance abuse, or the need for emergency evacuation assistance due to right leg amputation.

Resident 3's observation notes read:

On 03/01/2022, Caregiver C wrote, " ...Resident 3 makes me feel very uncomfortable at times s/he be trying to come on to me an [sic] i really feel

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{M 408}	Continued From page 17	{M 408}		

very uncomfortable when Resident 3 come [sic] to me inappropriate. Resident 3 also started to role [sic] pass me and touch on me as well. I told Resident 3 s/he got one more time to touch me [sic] I'm going to call management and the boss. Resident 3 also been on his/her phone talking about s/he wants to buy (sex) and telling his/her family to come over and bring him/her what s/he asked for as well. Resident 3 also was using profanity towards [sic] sstaff after redirecting him/her about sex . [sic] and what s/he'll do to me and offering me to come to his/her bedroom."

On 09/23/2022, Lead Caregiver A wrote, "res (resident) was gone out with his/her family members when staff arrived this evening. res shortly came back to FSM4 (Flagg Street Manor III) and res [sic] was communicating with staff a short time. res [sic] then went to [his/her] bedroom and started slurring with [his/her] words and res [sic] was talking about s/he ate something at a family member [sic] house and s/he felt sick and numb and feel that s/he can't feel [his/her] right side. res [sic] scream staff name and said s/he feel like s/he was having a stroke so staff call the ambulance and fire department. AS RES VITIAL [SIC] WAS BEING CHECK [sic] RES GLUCOSE DROP UNDER 20 DUE TO RES DRINKING AT HIS/HER FAMILY MEMBER HOUSE. RES HAD A BOTTLE OF LIQUOR INSIDE HIS/HER BED WHEN AMBULANCE CAME AND RES WAS ASKED WHY DID S/HE BRING A BOTTLE OF LIQUOR INSIDE THE FACILITY AND RES STATED S/HE DIDN'T KNOW IT WAS IN HERE AND S/HE STATED S/HE DID'NT BRING IT IN THE FACILITY. RES CONTINUE [SIC] SAY S/HE DID'NT [sic] DRINK AND BRING IT IN THE FACILITY BUT S/HE DID [sic] IT WAS INSIDE OF HIS/HER BED. STAFF TOOK LIQUOR AND

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{M 408}	Continued From page 18 PULL IKT [sic] DOWN THE SINK AND THREW THE BOTTLE AWAY [sic] OUTDOORS GARBAGE CAN. RES THEN WAS TAKEN TO THE COMMUNITY MEMORIAL HOSPITAL AFTER BEING SERVED SNACKS AND DINNER AND ADMINISTERED MEDICATION." Resident 3's MCO semi-annual nurse assessment, dated 08/16/2022, read, "Gastrointestinal: Member reports having bm coming from rectum despite having a colostomy bag." Resident 3's MCO assessment, dated 08/23/2022, read, "Living Environment: Resident 3 needs assistance from another person in an emergency. In the event of an emergency that required evacuation [sic] Resident 3 would need assistance in order to leave the apartment (facility) in a save [sic] and quick manner ... Substance abuse/dependence: on 8/27/2021 [sic] reported that Resident 3 consumes 2 quarts of alcohol/day with members of his/her previous household. Medical professionals informed him/her of the harm s/he is causing to his/her health. Potential indicators of current abuse/dependence or concerns; high tolerance; hiding and minimizing; network of friends who abuse alcohol or substances; health problems. Goals: .... In the next 6 months, Resident 3 will attend all PT (physical therapy) appointments and complete all recommended therapies and strengthening exercises to help him/her further adapt to the use of his/her prosthetic leg, so that s/he no longer requires his/her motorized wheelchair." Resident 3's MCO care plan dated 09/01/2022 indicated Flagg Street Manor III was responsible for interventions and goals with a start date of	{M 408}		

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{M 408}	Continued From page 19 10/11/2021 and end date of 02/28/2023. Resident 3's MCO visit/observation notes read: On 12/08/2021, former Registered Nurse Care Manager (RN CM) R wrote, "Communicated with [Co-Licensee E] ... [Co-Licensee E] explained that member continues to abuse alcohol 2 to 3 days a week and when member is intoxicated s/he makes accusations against staff which are not accurate. [Co-Licensee E] stated members family brings member alcohol and member will go around the corner in his/her power wheelchair and returns to AFH intoxicated. AFH staff monitor member closely when s/he returns intoxicated. [Co-Licensee E] has told family members not to bring alcohol to the house but they continue to do so. [Co-Licensee E] has discussed with member and has told him/her if alcohol is found in the AFH s/he will no longer be able to live there. [Co-Licensee E] stated member is apologetic the following day for his/her disrespectful behavior toward staff when s/he is intoxicated." On 05/19/2022, Care Manager (CM) Q wrote, "[Co-Licensee E] reported that member's sexualized comments to staff and others have continued and are making people increasingly uncomfortable. S/He requested that IDT address this matter with member as [Co-Licensee E] attempts have only had only temporary impacts on member's behavior. If member's behaviors continue, [Resident 3] may be asked to leave AFH." On 05/19/2022, Care Manager (CM) Q wrote, "Request to be done for 1 on 1 supervision for member by staff during waking hours (16 hrs/day). 30-day notification received to locate alternate living arrangements for member."	{M 408}		

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{M 408}	Continued From page 20 On 05/19/2022, Care Manager (CM) Q wrote, "[Co-Licensee E] reported that member's family brought firearms and alcohol to AFH yesterday, and a member also reported to have shown a weapon to a member of AFH staff. Staff reported member told him/her not to worry because s/he had his/her back, and then showed him/her the handgun. Member was reported to be under the influence of alcohol at the time. Staff reached out to IDT for assistance as they are unsure how to proceed." On 06/15/2022, Care Manager (CM) Q wrote, "Face to face with [Co-Licensee E] and [Resident 3] ... [Co-Licensee E] explained to member that the goal of him/her continuing to live at AFH is to get better and succeed, but that staff cannot help him/her if s/he is not going to help him/herself, such as his/her continued alcohol usage. [Co-Licensee E] stated that s/he would not want to have to ask member to leave and/or go to another AFH, but that is what will happen if member does not correct these issues. Member appeared understanding and receptive during meeting, and [Resident 3] accepted some responsible [sic] for his/her actions, both at and away from AFH. Member acknowledged this and stated s/he would do better as s/he likes it there and does not want to have to leave. At this time, [Co-Licensee E] will not push the 30-day notification at this time and will not ask that alternate living arrangements be made for member but would prefer 1 on 1 remain in place for 16 hours (waking) for now." Interviews On 07/05/2023 at 10:30 a.m., Surveyor interviewed Lead Caregiver (LC) A who stated,	{M 408}		

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{M 408}	Continued From page 21 "[Resident 3] had low blood sugar one night. S/He went to the hospital and died." Surveyor asked Lead CG A what services were provided to Resident 3. "We fed him/her, gave him/her medication and helped with his/her laundry. That's about it." On 07/06/2023, at 1:25 p.m., Surveyor interviewed Co-Licensee D who reported, "We just don't have any records on Resident 3. The only thing we have is what is in ECP (electronic health record software). The only guess I have is that the paper file got packed up with his/her things when they got picked up after s/he passed away. I really don't know much about this resident without a paper file." On 07/14/2023, at 12:25 p.m., Surveyor interviewed CM Q, who reported, "Resident 3's diagnosis was alcohol abuse. S/He needed help with all care needs because s/he was wheelchair bound due to right leg amputation. S/He also had a colostomy bag." CM Q explained Resident 3 had one on one caregivers from the MCO from 05/27/2022 to 07/31/2022 due to his/her destructive/abusive behaviors coupled with his/her substance abuse. CM Q described, "Resident 3 would go on home visits and return inebriated. His/Her behavior became inappropriate, hitting on the staff, requesting that s/he would pay them for sexual services. S/He also did not manage his/her cigarettes appropriately. There was a time when s/he threw his cigarette butt into a bush, and it started on fire. The interventions that the provider put in place were to remind him/her that there was no alcohol on site, the caregivers would search his/her bag and upon arriving back to the	{M 408}		

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{M 408}	Continued From page 22	{M 408}		

facility, the staff would check his/her belongings and dump the liquor out, if they find it. After the bush fire, the provider put away his/her lighter."

On 07/19/2022 at approximately 11:20 a.m., Surveyor interviewed Co-Licensee D and Co-Licensee E. Co-Licensee D reported destructive/abusive behaviors including substance abuse behaviors were not known upon admission assessment. "We knew about the colostomy bag and his amputation. Since s/he took care of his/her own colostomy bag, we did not put it on the assessment."

Co-Licensee D explained, "Resident 3 began displaying challenging behaviors after 4-5 months of living in the home. [S/He] began coming home drunk, drinking in the home, and having sexualized behaviors towards the staff. We did receive extra staff from the MCO. Resident 3 had a smoking incident where s/he through a cigarette butt into a dry bush and it caught fire. Co-Licensee D explained, "Our intervention was to have him use a different ashtray and smoke away from the house."

Surveyor asked when Resident 3 was reassessed to reflect new behaviors and caregiver interventions. Co-Licensee D stated Resident 3 was reassessed multiple time, but never in writing. Co-Licensee E explained, "People knew verbally how to care for him/her. Nothing was in writing."

Co-Licensee D and Co-Licensee E acknowledged the deficiency. Co-Licensee D stated, "It was a verbal thing. I understand. If it wasn't written, it wasn't done."

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M 424	Continued From page 23	M 424		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure each resident's Individual Service Plan (ISP) was reviewed at least once every 6 months or when residents' needs or preferences changed substantially for 3 of 3 residents reviewed (Resident 1, Resident 2, and Resident 3), Resident 1's ISP was not updated at least every 6 months with a change in needs regarding refusal of cares. Resident 2's ISP was not updated at least every 6 months with a change in needs regarding transferring with a mechanical lift. Resident 3's ISP was not updated when s/he displayed change in behaviors resulting in 1:1 staffing from 05/27/2022 to 07/31/2022.	M 424		

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M 424	Continued From page 24 Findings include: Example 1 On 07/05/2023 at 3:15 p.m., Surveyor observed Resident 1, in his/her bed. His/Her hair was greasy, and fingernails were dirty and long. Surveyor asked Resident 1 when s/he showered last. Resident 1 could not recall. On 07/05/2023, at 10:30 a.m., Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 03/15/2021. According to Resident 1's face sheet, Resident 1 had history of traumatic brain injury/stroke and hypertension. Surveyor observed protective placement paperwork dated 07/28/2021. Resident 1 had a guardian. Resident 1's ISP, dated 09/17/2021, was not updated to reflect Resident 1's behavior which included refusal of care. Resident 1's protective services/placement annual report from 05/05/2023 stated, "Resident 1 is full care and requires significant encouragement to accept assistance; s/he is often verbally and physically resistant (yelling, swearing, name calling, striking out). At the Department visit, Resident 1 was found to have long, untrimmed fingernails. His/Her hands were dirty and his/her hair greasy." On 07/05/2023 at 2:35 p.m., Surveyor interviewed Caregiver K, who told Surveyor that Resident 1 refused cares often. Caregiver K stated, "We are told to let him/her be if s/he refuses. It's his/her choice." On 07/06/2023 at 9:40 a.m., Surveyor interviewed	M 424		

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M 424	Continued From page 25 Corporate Guardian (Guardian) O who reported s/he had been working with Resident 1 for nine months and had witnessed a slow decline in his/her health. Guardian O recalled Resident 1 had emergency room visits on 05/16/2023, 05/19/2023, and 05/29/2023 and the facility never informed him/her. "I found out when the hospital called me." Guardian O stated, "I have never received an ISP from the facility. I am lucky if I can get a monthly update. On 03/20/2023, a case manager from my office called the facility looking for an update on [Resident 1]. [Lead Caregiver A] answered the phone and told our case manager, 'Why you not calling your people. Why you always bothering me.' Then s/he hung up. We documented it in Resident 1's file. We are looking for new placement." On 07/06/2023, at 2:10 p.m., Surveyor interviewed Co-Licensee D, who reported Resident 1 had not had a change in condition. It was more like a change in behavior. Co-Licensee D requested a second caregiver from the managed care organization (MCO) in 2021 because Resident 1 needed so much assistance with turning, activities of daily living (ADLs), and cleaning his/her room. Resident 1 was combative, which made caring for him/her difficult. Example 2 On 07/05/2023, at 10:30 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the home on 07/26/2017. According to Resident 2's face sheet, Resident 2 had diagnoses including depression, multiple sclerosis, and dementia. Resident 2 was his/her own decision maker. Resident 2's ISP, dated 09/21/2021, did not provide information related to how Resident 2 required the use of a Hoyer lift for transfers.	M 424		

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M 424	Continued From page 26 Resident 2's ISP was due for review in 03/2022, 09/2022, and 03/2023 and the ISP was not reviewed and/or updated. Example 3 On 07/05/2023, at 10:30 a.m., Surveyor reviewed Resident 3's record and identified the following: Resident 3 was admitted to the facility on 10/11/2021 with diagnoses including substance use- alcohol abuse, amputation-left foot-toes 1-5, atherosclerosis, amputation - right leg phantom limb pain, colostomy, and hypotension (low blood pressure). Resident 3 was his/her own decision maker. Surveyor reviewed Resident 3's initial assessment, dated 10/11/2021, did not identify Resident 3 had a colostomy bag, destructive/abusive behaviors including substance abuse, or need for emergency evacuation assistance due to right leg amputation. Surveyor reviewed Resident 3's Individual Service Plan (ISP), dated 10/11/2021, did not identify Resident 3 had a colostomy bag, destructive/abusive behaviors including substance abuse, or the need for emergency evacuation assistance due to right leg amputation. Resident 3's facility observation notes read: On 03/01/2022, Caregiver C wrote, " ...Resident 3 makes me feel very uncomfortable at times s/he be trying to come on to me an [sic] i really feel very uncomfortable when Resident 3 come [sic] to me inappropriate. Resident 3 also started to	M 424		

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M 424	Continued From page 27	M 424		

role [sic] pass me and touch on me as well. I told Resident 3 s/he got one more time to touch me [sic] I'm going to call management and the boss. Resident 3 also been on his/her phone talking about s/he wants to buy (sex) and telling his/her family to come over and bring him/her what s/he asked for as well. Resident 3 also was using profanity towards [sick] sstaff after redirecting him/her about sex . [sic] and what s/he'll do to me and offering me to come to his/her bedroom."

Surveyor reviewed Resident 3's MCO visit/observation notes:

On 12/08/2021, former Registered Nurse Care Manager (RN CM) R wrote, "Communicated with [Co-Licensee E] ... [Co-Licensee E] explained that member continues to abuse alcohol 2 to 3 days a week and when member is intoxicated s/he makes accusations against staff which are not accurate. [Co-Licensee E] stated members family brings member alcohol and member will go around the corner in his/her power wheelchair and returns to AFH intoxicated. AFH staff monitor member closely when s/he returns intoxicated. [Co-Licensee E] has told family members not to bring alcohol to the house but they continue to do so. [Co-Licensee E] has discussed with member and has told him/her if alcohol is found in the AFH s/he will no longer be able to live there. [Co-Licensee E] stated member is apologetic the following day for his/her disrespectful behavior toward staff when s/he is intoxicated."

On 05/19/2022, Care Manager (CM) Q wrote, "[Co-Licensee E] reported that member's sexualized comments to staff and others have continued and are making people increasingly uncomfortable. S/He requested that IDT address this matter with member as [Co-Licensee E]

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M 424	Continued From page 28 attempts have only had only temporary impacts on member's behavior. If member's behaviors continue, [Resident 3] may be asked to leave AFH." On 07/05/2023, at 10:30 a.m., Surveyor interviewed Caregiver K, who reported Resident 2 did not get up very often. When s/he did they used the mechanical lift. Resident 2 did not ambulate any longer. 07/05/2023 at 12:30 p.m., Surveyor interviewed Co-Licensee D who stated, "Resident 2 cannot sign his/her own documents, so I just wrote in his/her name. Resident 2 does not understand anymore, her cognition is bad." On 07/19/2022 at approximately 11:20 a.m., Surveyor interviewed Co-Licensee D and Co-Licensee E. Licensee E stated, "I thought that we could use the MCO's member centered plan for Resident 1 and Resident 2 for our staff. I made a mistake." Co-Licensee D reported Resident 3 did not display destructive/abusive behaviors including substance abuse upon admission assessment. Surveyor asked when Resident 3 was reassessed to reflect new behaviors and caregiver interventions. Co-Licensee D stated Resident 3 was reassessed multiple times, but never in writing. Co-Licensee E explained, "People knew verbally how to care for him/her. Nothing was in writing.	M 424		
{M 488}	88.09(1)(d) RESIDENT RECORDS REQUIREMENTS A resident's record shall include all	{M 488}		

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{M 488}	Continued From page 29 of the following: This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not maintain 2 of 2 resident records (Resident 1 and Resident 2). This requirement is being cited for a second time. See Statement of Deficiency ZEZF11, dated 09/10/2021. Findings include: On 07/05/2023 at 10:55 a.m., Surveyor reviewed Resident 1's and Resident 2's records and found the following: Resident 1 was admitted to the facility on 03/15/2021. Resident 1's record did not contain a signed service agreement. Resident 2 was admitted to the facility on 07/26/2017. Resident 2's record did not contain the following required information: signed service agreement, 2021 and 2022 annual health examinations, authorization to control funds, or a statement indicating the resident rights and grievance procedures had been provided and explained. On 07/05/2023 at 12:30 p.m., Surveyor interviewed Co-Licensee D who stated, "Resident 2 cannot sign his/her own documents, so I just wrote in his/her name. Resident 2 does not understand anymore, [his/her] cognition is bad." On 07/06/2023 at 9:40 a.m., Surveyor interviewed Corporate Guardian (Guardian G) O, who stated s/he had been working with Resident 1 for nine	{M 488}		

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{M 488}	Continued From page 30 months and has never received any documentation or requests for signatures from the licensee. On 07/19/2022 at approximately 11:40 a.m., Surveyor interviewed Co-Licensee D and Co-Licensee E. Co-Licensee D explained to come into compliance, they developed folders with tabs indicating what needed to be in the resident file. Co-Licensee E stated, "Our former manager was in charge of organizing the resident files. I was in charge of overseeing him/her. We will make sure the files are updated."	{M 488}		
M 512	88.09(1)(e) RESIDENT'S RECORD RETENTION The licensee shall retain a resident's record for at least 7 years after the resident's discharge. The record shall be kept in a secure, dry place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 (Resident 3) of 3 resident records reviewed were retained for at least 7 years after the resident's discharge. Findings include: On 07/05/2023 at 10:25 a.m., Co-Licensee D reported Resident 3's closed records were offsite at the company office. 07/05/2023 at 12:55 p.m., Co-Licensee D reported Lead Caregiver A was looking for Resident 3's file at the office. Co-Licensee D stated, "We can't seem to find it anywhere." On 07/06/2023, at 1:25 p.m., Surveyor	M 512		

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M 512	Continued From page 31 interviewed Co-Licensee D who reported, "We just don't have any records on Resident 3. The only thing we have is what is in ECP (electronic health records software). The only guess I have is that the paper file got packed up with his/her things when they got picked up after s/he passed away. I really don't know much about this resident without a paper file." On 07/19/2022 at approximately 11:05 a.m., Surveyor reviewed code requirement with Co-Licensee D and Co-Licensee E. Co-Licensee D acknowledged, "The resident file should have been locked up." Co-Licensee D acknowledged an understanding of the requirements and stated, "We will work on this."	M 512		
Z 024	50.065(4m)(c) COMPLETE BACKGROUND INFORMATION DISCLOSURE If the background information form completed by a person under sub. (6) (am) indicates that the person is not ineligible to be employed or contracted with for a reason specified under par. (b) 1. to 5., an entity may employ or contract with the person for not more than 60 days pending the receipt of the information sought under sub. (2) (b). If the background information form completed by a person under sub. (6) (am) indicates that the person is not ineligible to be permitted to reside at an entity for a reason specified in par. (b) 1. to 5. and if an entity otherwise has no reason to believe that the person is ineligible to be permitted to reside at an entity for any of these reasons, the entity may permit the person to reside at the entity for not more than 60 days pending receipt of information sought under sub. (2) (am). An entity shall	Z 024		

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Z 024	Continued From page 32 provide supervision for a person who is employed or contracted with or permitted to reside as permitted under this paragraph. This Rule is not met as evidenced by: Based on record review and staff interview, the adult family home (AFH) did not ensure all required completed department background information forms for 1 of 3 staff were retained to ensure prompt retrieval for inspection to comply with applicable federal and state confidentiality laws. A completed background check includes a Department of Justice (DOJ) report, an Integrated Background Information System (IBIS) letter from the department, and a Background Information Disclosure (BID) form. Findings include: Flagg Street Manor III was licensed 03/02/2017 to serve up to 3 residents within the client groups: advanced aged, developmentally disabled, physically disabled, emotionally disturbed/mental illness, terminally ill and traumatic brain injury. On 07/05/2023 and 07/06/2023, Surveyor reviewed the following staff files. The following was identified: Caregiver K was hired 10/26/2021. Caregiver K completed a BID form on 04/25/2022, almost 7 months after Caregiver K began employment. The report of findings from the Department of Regulation and Licensing was dated 07/05/2023. The Department of Justice (DOJ) report form was	Z 024		

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Z 024	Continued From page 33 dated 07/05/2023. Caregiver L was hired 06/21/2022. Caregiver L completed a BID form on 07/05/2023, over 1 year after Caregiver L began employment. The report of findings from the Department of Regulation and Licensing was dated 07/06/2023. The Department of Justice (DOJ) report form was dated 07/06/2023. Caregiver M was hired 06/16/2023. Caregiver M's file did not contain a BID form. The report of findings from the Department of Regulation and Licensing was dated 06/21/2023. The Department of Justice (DOJ) report form was dated 06/21/2023. On 7/06/2023 at 1:15 p.m., Surveyor interviewed Caregiver L who stated, "I filled out my employment paperwork yesterday. I wrote up and signed my application for employment, my background check, the orientation form, and I brought them a copy of my social security card and ID. I signed all of it with yesterday's date of 07/05/2023." On 7/06/2023 at 2:25 p.m., Surveyor interviewed Licensee D, who stated, "I know that we did these background checks. We just can't seem to find them. They could be anywhere. So, for some of them, we just ran them right away. Former Manager N said s/he was taking care of these things and I believed him/her. I should have checked his/her work." On 07/19/2022 at approximately 12:05 p.m., Surveyor reviewed code requirement with Co-Licensee D and Co-Licensee E. Co-License E acknowledged, "The caregiver background checks were ultimately my mistake. I was not	Z 024		

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Z 024	Continued From page 34 overseeing the manager." Co-Licensee D acknowledged an understanding of the requirements and stated, "We will work on this."	Z 024		