

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015115	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/07/2023
NAME OF PROVIDER OR SUPPLIER ROOMS R US ADULT FAMILY HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3850 N 27TH STREET MILWAUKEE, WI 53216		
(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 09/07/2023, Surveyor completed 2 complaint surveys at Rooms R Us Adult Family Home LLC. One of the 2 complaints was substantiated. One of the 2 complaints was unsubstantiated. Two deficiencies were identified. Census: 1	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department, within 24 hours, when 1 (Resident 1) of 4 residents reviewed eloped and was reported missing. Resident 1 was reported missing to the Milwaukee Police Department on 08/07/2023. Resident 1 was found by Milwaukee Police Department on 08/29/2023. Findings include: On 08/28/2023, the Department received a complaint alleging a resident eloped from the	M 134		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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M 134	Continued From page 1 facility. On 09/05/2023, Surveyor completed a review of the Department facility folder. Surveyor did not observe any self-reports submitted to the Department in 2023. On 09/05/2023, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted on 05/28/2021. -Resident 1 was diagnosed with schizophrenia, type 2 diabetes, history of alcohol abuse, unspecified mood (affective) disorder, and anxiety. -Surveyor reviewed an incident report dated, 08/07/2023, at 1:44 p.m., and written by Caregiver B which stated, "I was completing my afternoon routine tasks cleaning up the kitchen after lunch. [Resident 1] was sitting at the kitchen table while I was cleaning. I needed to go to the restroom, so I went to the bathroom. I was in the restroom for about 10 minutes when I returned to the kitchen, [he/she] was gone. I checked [his/her] bedroom [he/she] was not there I noticed the back kitchen door open. Immediately notify [sic] the owner [Licensee A] that [Resident 1] had walked out [sic] [he/she] told me [he/she] was sending staff over to help me look for [him/her] and I started my search looking for [him/her]. I walked down the alley calling [his/her] name asking by standers [sic] have they seen [him/her] to no avail. Me and my coworker search [sic] all day I went and made a police report and describe what [he/she] was wearing at the time of [his/her] elopement ..." On 09/07/2023, Surveyor reviewed police records from the Milwaukee Police Department. Reports indicated on 08/26/2023 at 9:09 p.m., Resident 1 was reported missing. Police report with a case	M 134		

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M 134	Continued From page 2 number of 232380156 and other event number of 23-MP-2145 stated, "...on Monday, August 7, 2023, [Caregiver B] reported [Resident 1] missing ..." Police report with a case number of 232380156 and other event number of 23-MP-2145.006 stated, "This report is being written by [Police Officer (PO) C]. On Tuesday, August 29th, 2023, I was assigned to squad 5341 with [PO D]. At approximately 5:32 a.m. we were instructed by dispatch to go assist District 1 in the downtown Milwaukee area to help locate a critical missing subject ...At approximately 6:20 a.m., we changed locations to 612 W Wisconsin Ave to look for [him/her]. At approximately 6:41 a.m. we located [Resident 1] in the lobby of that address ...We conveyed [Resident 1] back to 3850 N 27th St. and the owner was there. The owner of the group home was identified as [Licensee A]. [Licensee A] walked [Resident 1] into the location ..." On 09/06/2023 at 8:20 p.m., through e-mail correspondence with Licensee A, Licensee A affirmed a self-report was not submitted to the Department regarding the unknown whereabouts for Resident 1. Licensee A stated, "...I was not aware one needed to be completed ..." On 09/07/2023, Surveyor received a completed self-report from Licensee A regarding the above incident.	M 134			
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.	M 436			

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M 436	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide services specified in 1 (Resident 1) of 1 resident's behavior support plan (BSP) that was the licensee's responsibility. Resident 1 did not receive the required supervision as specified in his/her BSP and eloped from the facility. Findings include: On 08/28/2023, the Department received a complaint alleging a resident eloped from the facility. On 09/05/2023, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted on 05/28/2021. -Resident 1 was diagnosed with schizophrenia, type 2 diabetes, history of alcohol abuse, unspecified mood (affective) disorder, and anxiety. -Resident 1's behavior support plan (BSP), dated 06/28/2023, stated, " ... [Resident 1] will attempt to elope day or night. [He/She] needs continuous line-of sight supervision ..." -Surveyor reviewed an incident report dated on 08/07/2023 at 1:44 p.m. and written by Caregiver B. The report stated, "I was completing my afternoon routine tasks cleaning up the kitchen after lunch. [Resident 1] was sitting in the kitchen table while I was cleaning. I needed to go to the restroom, so I went to the bathroom. I was in the restroom for about 10 minutes when I returned to	M 436			

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M 436	Continued From page 4 the kitchen, [he/she] was gone I checked [his/her] bedroom [he/she] was not there I noticed the back kitchen door open. Immediately notify [sic] the owner [Licensee A] that [Resident 1] had walked out [sic] [he/she] told me [he/she] was sending staff over to help me look for [him/her] and I started my search looking for [him/her]. I walked down the alley calling [his/her] name asking by standers [sic] have they seen [him/her] to no avail. Me and my coworker search [sic] all day I went and made a police report and describe what [he/she] was wearing at the time of [his/her] elopement ..." On 09/07/2023, Surveyor contacted Licensee A via telephone and left a voice mail 12:15 p.m. and 4:06 p.m. asking to return Surveyor's phone call to complete an exit interview. On 09/07/2023 at 12:17 p.m., Surveyor e-mailed Licensee A asking that he/she contact the Surveyor to complete an exit interview. On 09/08/2023 at 8:01 a.m., Surveyor left another voice mail for Licensee A. As of 09/08/2023 at 2:35 p.m., Surveyor has not received a return phone call from Licensee A to complete an exit interview. At the time Resident 1 eloped, no staff was available to provide continuous line-of sight supervision.	M 436		