STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018931	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEADING MILWAUKEE ADULT FAMILY HOME	**4406 S 84TH STREET GREENFIELD, WI 53228**

(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 01/24/2024, Surveyor conducted a standard survey and complaint investigation. As a result, 9 deficiencies were identified. The complaint was unsubstantiated. Census: 2	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 interview and record review, the provider did not report to the Department, within 24 hours, a significant change in status for 1 of 1 resident. Resident 1 had 5 documented elopements where staff did not know the resident's whereabouts and the provider did not notify the Department. Findings include: On 01/24/2024, at 12:50 PM, Surveyor interviewed Lead Caregiver B. Lead Caregiver G reported Resident 1 had a history of elopements while residing at the facility. Lead Caregiver B reported when Resident 1 became upset, s/he	M 134		

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

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M 134	Continued From page 1 attempted to leave the facility. Surveyor asked Lead Caregiver B if s/he or the licensee had submitted self-reports to the Department. Lead Caregiver B reported s/he was not aware of the requirement. Lead Caregiver B reported s/he updated the guardian and care team. On 01/24/2024, at 4:00 PM, Surveyor reviewed the provider file and did not locate evidence of self-reports for Resident 1's 5 elopements. On 01/24/2024, at 4:10 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 06/12/2023. Resident 1's Behavior Tracking Forms Logs identified Resident 1 eloped, and staff did not know his/her whereabouts, on 06/21/2023, 06/30/2023, 07/18/2023, 07/26/2023, and 09/15/2023. On 01/26/2024, at 9:00 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was not aware of the requirement to report Resident 1's elopements to the Department. Licensee A reported the guardian and family care team were notified shortly after any elopement. Licensee A reported s/he would submit Resident 1's self-reports.	M 134		
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	M 232		

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M 232	Continued From page 2	M 232		

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 interview, the provider did not obtain documentation indicating 2 of 3 caregivers had been screened for illnesses detrimental to residents. Two of 3 caregivers' tuberculosis (TB) tests were not obtained within 90 days before the start of providing service.

Caregiver C was not screened for communicable disease and her/his TB test was obtained 302 days before the start of care.
Caregiver D was not screened for communicable disease and her/his TB test was obtained 43 days after the start of care.

Findings include:

On 01/24/2024, at 11:45 AM, Surveyor reviewed staff files and identified the following:

Caregiver C
Caregiver C was hired on 09/14/2023. Caregiver C's record did not contain a screening for illnesses detrimental to residents. Caregiver C's file contained a TB test, dated 11/16/2022, approximately 302 days before the start of care.

Caregiver D
Caregiver D was hired on 09/12/2023. Caregiver D's record did not contain a screening for illnesses detrimental to residents. Caregiver D's TB test was obtained on 10/25/2023, approximately 43 days after the start of providing care.

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M 232	Continued From page 3 On 01/26/2024, at 9:00 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was aware there was a timeline to obtain the health screening but did not know the exact timeframe. Licensee A reported s/he was not aware of the communicable disease screening, but was aware of the TB test requirement. Licensee A reported s/he would work with Lead Caregiver B and ensure all documentation was complete.	M 232		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by:	M 332		

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M 332	Continued From page 4 Based on observation and interview, the provider did not ensure 3 of 3 fire extinguishers were inspected annually. The fire extinguisher in the kitchen contained an inspection tag dated December 2019. The fire extinguishers in the basement and hallway had inspection tags dated September 2021. This is a repeat violation. See Statement of Deficiency LWDS11, dated 12/02/2021. Findings include: On 10/20/2022, at 10:15 AM, Surveyor observed the kitchen's fire extinguisher's inspection tag indicated the fire extinguisher was serviced in July 2022. The basement did not contain a fire extinguisher. On 01/24/2024, at 10:30 AM, Surveyor interviewed Lead Caregiver B. Lead Caregiver B reported s/he was unaware the fire extinguisher was not serviced in 2023. Lead Caregiver B reported s/he was unaware the basement required a fire extinguisher. On 01/26/2024, at 9:00 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was aware of the code requirement for annual inspections; however, was not clear why the fire extinguisher inspection was late. Licensee A reported s/he was not aware the basement required a fire extinguisher. Licensee A reported s/he had purchased on 01/25/2024 for the basement. Licensee A reported s/he would have the fire extinguisher inspected as soon as possible.	M 332		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE	M 336		

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M 336	Continued From page 5 The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the facility's smoke detectors were tested on a monthly basis. There was no evidence the smoke detectors were tested between August 2022- December 2022 and in December 2023. Findings include: On 01/24/2024, at 12:00 PM, Surveyor reviewed the facility safety files. There was no evidence of smoke detector testing between August 2022 and December 2022 and in December 2023. On 01/24/2023, at 12:10 PM, Surveyor interviewed Lead Caregiver B. Lead Caregiver B confirmed the smoke detectors were not tested between August 2022 and December 2022 as there were no residents. Lead Caregiver B reported the task was shared. Lead Caregiver B was unsure why the smoke detectors were not tested in December 2023. On 01/26/2024, at 9:00 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was not aware the smoke detectors required testing when the home was empty and in 12/2023. Licensee A	M 336		

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M 336	Continued From page 6 reported the task was collaborative amongst staff. Licensee A reported s/he would implement a plan to ensure monthly testing was completed as required.	M 336		
M 338	88.05(4)(c)1 EXITING FROM THE FIRST FLOOR Exiting from the first floor. The first floor of the home shall have at least 2 means of exiting which provides unobstructed access to the outside. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home had at least 2 means of exiting which provided unobstructed access to the outside in 1 of 2 exits. The patio door exit, identified as an emergency exit, contained a bar lock in the track which prevented the door from opening. The stairs and walkway from the patio were not shoveled. Findings include: On 01/24/2024, at 11:25 AM, Surveyor observed the patio door contained a bar lock in the track which prevented the door from opening. The exterior stairs were covered in snow as well as the surrounding area of the back door. There was no pathway from the patio exit leading away from the home. A review of the U.S. Department of Commerce National Oceanic and Atmospheric Administration (NOAA) historical precipitation data extracted on 01/24/2024, there was 16.5 inches of snow or ice	M 338		

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M 338	Continued From page 7 on the ground in the area where the facility is located. Between January 1, 2024, and January 20, 2024, the area where the facility was located received 16.5 inches of snow. (Source: National Weather Service, Climate Data, https://www.weather.gov/wrh/climate?wfo=mkx (retrieval date- 01/24/2024).) On 01/24/2024, at 11:30 AM, Surveyor interviewed Lead Caregiver B. Lead Caregiver B confirmed the patio door was an emergency exit. Lead Caregiver B reported either a hired company or staff removed any snow. Lead Caregiver B did not provide an answer when Surveyor asked why the snow at the emergency exit was not removed. On 01/26/2024, at 9:00 AM, Surveyor interviewed Licensee A. Licensee A reported s/he had attempted to have several snow removal providers; however, they did not show up. Licensee A reported the snow had been removed and s/he would ensure timely removal in the future.	M 338		
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.	M 408		

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M 408	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written was completed and for 2 of 2 residents within 30 days after placement. Resident 1's and Resident 2's records did not contain a written assessment. Findings include: On 01/24/2024, at 11:45 AM, Surveyor reviewed resident records and identified the following: -Resident 1 was admitted on 06/12/2023, with diagnoses including anxiety, autism, and mood disorders. Resident 1's record did not contain a written assessment. -Resident 2 was admitted on 04/14/2023, with diagnoses including intellectual disability, diabetes, and seizure disorder. Resident 2's record did not contain a written assessment. On 01/24/2024, at 12:00 PM, Surveyor interviewed Lead Caregiver B. Lead Caregiver B reported s/he was not aware a written assessment was required. On 01/26/2024, at 9:00 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was unaware the admission assessments were not completed. Licensee A reported s/he would work with staff to ensure admission assessments were completed.	M 408		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall	M 410		

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M 410	Continued From page 9 contain at least the following: This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 1 resident's Individual Service Plan (ISP) included all required information. Resident 1's ISP did not include the following: 1. A description of the services the licensee will provide to meet assessed needs. 2. Identification of the level of supervision required in the home and community. 3. Description of service provided by outside agencies. 4. A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. Findings include: On 01/24/2023, at 11:45 AM, Surveyor interviewed Lead Caregiver B and requested Resident 1's ISP. Lead Caregiver B reported s/he would provide the documents via electronic mail (email). Lead Caregiver B reported Resident 1 was an elopement risk and had behaviors. On 01/24/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 06/12/2023, with diagnoses including fetal alcohol syndrome, reactive attachment disorder, attention deficit and hyperactivity disorder (ADHD), conduct disorder, anxiety, and unspecified mood (affective) disorder. Resident 1's ISP was not available on site for review and was provided by	M 410		

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M 410	Continued From page 10	M 410		

Licensee A via email. Resident 1's record included a behavioral support plan (BSP) and behavior tracking logs (BTL). Resident 1's BSP, dated 07/31/2023, identified Resident 1 had behaviors including property destruction, self-injurious behaviors, physical and verbal aggression. Resident 1's BTLs, beginning 06/12/2023 through 08/28/2023, indicated Resident 1 was physically and verbally aggressive with staff, destroyed property, and expressed suicidal ideation. Resident 1's BTL, dated 08/19/2023, indicated Resident 1's bedroom windows contained security bars. Resident 1's ISP, dated 06/19/2023, was provided via email by Licensee A. Resident 1's ISP did not identify Resident 1 had a BSP. Resident 1's ISP did not identify Resident 1 had behaviors including verbal and physical aggression, suicide ideation, and had security bars on their bedroom windows. The ISP did not identify Resident 1 required 2:1 staffing, and s/he took part in a work program 6 hours per week. Resident 1's ISP, dated 06/19/2023, contained Licensee A's signature and no other signatures.

On 01/25/2024, at 11:45 AM, Surveyor interviewed Family Care Registered Nurse (FCRN) E. FCRN E reported Resident 1 had 2:1 staffing due to behaviors. FCRN E reported Resident 1 attended a work program with a job coach up to 6 hours per week. Surveyor asked if s/he was involved in Resident 1's ISP development. FCRN E reported s/he was not.

On 01/26/2024, at 9:00 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was not aware Resident 1's ISP did not accurately reflect her/his required services. Licensee A reported s/he would work with staff to ensure the ISPs were accurate and included all services required

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M 410	Continued From page 11 and include additional parties involved in Resident 1's supports. Licensee A confirmed s/he did not include other parties or obtain any other signatures.	M 410		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation, and interview, the provider did not ensure water temperatures were kept at a safe temperature for 1 of 1 resident bathroom. The hot water temperature in the resident bathroom was 144° Fahrenheit (F). Findings include: This AFH was licensed by the Department, effective 07/26/2022, to admit up to 3 residents in the client groups of developmentally disabled, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, and traumatic brain injury. On 01/24/2024, at 11:20 AM, Surveyor and	M 570		

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M 570	Continued From page 12 Caregiver B tested the hot water temperature of faucet in the resident's bathroom. The water temperature was 144° F. Residents were observed utilizing the bathroom unsupervised. Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017.) On 01/24/2024, at 11:25 AM, Surveyor interviewed Caregiver B regarding the hot water in the resident bathroom. Caregiver B reported staff conducted water temperature checks. Caregiver B reported s/he was unaware the water temperature was 144° F. On 01/26/2024, at 9:00 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was unaware of the hot water temperature. Licensee A reported s/he would have the temperature corrected as soon as possible.	M 570		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search	Z 012		

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Z 012	Continued From page 13 under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions. This Rule is not met as evidenced by: Based on record review and interview, the provider did not attempt to obtain an out-of-state criminal record search for 2 of 2 employees reviewed. Caregiver B's and Caregiver C's employee files did not contain an out of state background check or evidence an attempt was made to retrieve the information. Findings include: On 01/24/2024, at 11:45 AM, Surveyor reviewed employee files and identified the following:	Z 012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018931	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEADING MILWAUKEE ADULT FAMILY HOME	**4406 S 84TH STREET GREENFIELD, WI 53228**

(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
Z 012	Continued From page 14 Caregiver B was hired on 04/05/2023. Caregiver B's Background Information Disclosure (BID), dated 10/05/2022, identified s/he resided in California from 1996-2022. The file did not contain an out of state background check or evidence an attempt was made to retrieve the information. Caregiver C was hired on 09/14/2023. Caregiver C's BID, dated 09/06/2023, identified s/he resided in Virginia from 06/2022-06/2023. The file did not contain an out of state background check or evidence an attempt was made to retrieve the information. On 01/26/2024, at 9:00 AM, Surveyor interviewed Licensee A regarding out of state background checks. Licensee A was unaware of the requirement to obtain out of state background checks for employees who resided out of state within the previous 3 years. Licensee A confirmed s/he did not attempt to retrieve an out of state background check for Caregiver B and Caregiver C. Licensee A reported Lead Caregiver B was initially hired in 10/2022; however, there were no residents until 04/2023. Licensee A reported s/he would obtain the out of state background checks.	Z 012		