STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017981	A. BUILDING: _____ B. WING _____	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS HAVEN LLC	2205 WEST BURNHAM STREET MILWAUKEE, WI 53204

(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 05/22/2024, Surveyor completed a standard licensing survey and three complaint investigations at Helping Hands Haven LLC. Thirteen deficiencies were identified. One of 13 was a repeat violation (see Statement of Deficiency V9HK11, dated 01/12/2022). One complaint was substantiated. Two complaints were unsubstantiated. Census: 2	M 000		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or	M 114		

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

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M 114	Continued From page 1 property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 service providers had complete background checks. Caregiver C, Caregiver D, Caregiver E and Caregiver F did not have complete background checks. A complete background check consists of the following: - A completed Background Information Disclosure (BID) form. - A report of findings from the Department of Justice (DOJ). - Integrated Background Information System (IBIS) letter from the Department of Health Services (DHS). Findings include: On 05/14/2024 and 05/15/2024, Surveyor reviewed caregiver records. The following was identified: Caregiver C was hired on 03/12/2024. The file contained evidence of a BID filled out. However,	M 114		

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M 114	Continued From page 2 the BID was not signed and dated by Caregiver C. Caregiver C's record contained no evidence of a background check. Caregiver D was hired on 04/26/2023. The file contained evidence of a BID filled out. However, the BID was not signed and dated by Caregiver D. Caregiver E was hired on 07/28/2023. The file contained evidence of a BID filled out. However, the BID was not signed and dated by Caregiver E. Caregiver F was hired on 08/16/2023. The file contained evidence of a BID filled out. However, the BID was not signed and dated by Caregiver F. Caregiver F's record contained no evidence of a background check. On 05/15/2023, at 2:15 p.m., Surveyor interviewed Licensee A regarding background checks of caregivers. Licensee A reported it was his/her responsibility to ensure each staff person had a completed background check. Licensee A confirmed there was no background check in Caregiver C's or Caregiver F's record. Licensee A confirmed BID forms for Caregiver C, Caregiver D, Caregiver E, and Caregiver F were not signed and dated. Licensee A looked up the form on the department website with Surveyor and discovered s/he was using the old BID form, dated 06/2018, which did not have a signature and date section. Licensee A stated, "I didn't even realize there was a new BID form dated 01/2022. I have it saved to my computer now."	M 114		
M 216	88.04(2)(a) RESPONSIBILITIES	M 216		

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M 216	Continued From page 3	M 216		

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 provider did not ensure the licensee and its operation complied with this chapter. During the survey and complaint investigations, 13 deficiencies were identified.

This is a repeat deficiency. See Statement of Deficiency (SOD) V9HK11, dated 01/12/2022.

Findings include:

Helping Hands Haven LLC was licensed 08/27/2020 to serve up to 4 residents within the client groups: advanced aged, developmentally disabled, irreversible dementia/Alzheimer's, physically disabled, emotionally disturbed/mental illness, terminally ill and traumatic brain injury.

From 05/14/2024 to 05/22/2024, Surveyor conducted a standard survey and three complaint investigations. Thirteen violations, including this violation, were identified during the time of the survey. The following citations were identified:

88.03(3)(b) Criminal Records Check
88.04(2) Responsibilities (repeat)
88.04(2)(h) Comply with OSHA
88.04(5)(a) Training - 15 Hours Within 6 Months
88.05(3)(a) Home Environment
88.05(4)(d)2a Fire Safety Evacuation Plan Review
88.05(4)(d)2b Fire Evacuation Annual Evaluation
88.06(2)(b) Service Agreement Except Respite

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M 216	Continued From page 4 88.06(3)(a) Individual Service Plan & Assessment 88.06(3)(f) Review of ISP 88.10(3)(b) Privacy 50.065(2)(bm) Out Of State Background Checks 13.05(3)(a) Entity Allegation Reporting Requirements On 05/14/2024 at 4:05 p.m., Surveyor interviewed Licensee A, who explained everything was so busy with the residents' behaviors and hiring staff that paperwork ended up being his/her last priority. Licensee A stated, "I have to figure out a better system. This is all so unorganized." On 05/22/2024 at 2:45 p.m., Surveyor conducted an exit conference with Licensee A regarding the above findings. Licensee A acknowledged an understanding of the requirements and confirmed, "We have a lot to work on. I've already gotten started redoing everything, one file at a time. I am glad you came. I needed the survey."	M 216		
M 235	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult family home shall comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 caregivers (Caregiver C, Caregiver D, and Caregiver F)	M 235		

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M 235	Continued From page 5	M 235		

reviewed received training in standard precautions as required in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens, prior to providing care to residents and annually. Caregiver C, Caregiver D, and Caregiver F did not receive training in standard precautions.

The OSHA standard requires the employer train each employee with occupational exposure, "At the time of initial assignment to tasks where occupational exposure may take place" per 1910.1030(g) (2)(ii)(A); and "At least annually thereafter," per 1910.1030(g)(2)(ii) (B).

Findings include:

On 05/14/2024 and 05/15/2024, Surveyor reviewed employee records for Caregiver C, Caregiver D, and Caregiver F including training records. The following was identified:

Caregiver C was hired on 03/12/2024. Caregiver C's file did not contain evidence of standard precautions training before beginning to provide service on 03/13/2024.

Caregiver D was hired on 04/26/2023. Caregiver D's file did not contain evidence of standard precautions training before beginning to provide service on 04/26/2023.

Caregiver F was hired on 08/16/2023. Caregiver F's file did not contain evidence of standard precautions training before beginning to provide service on 08/19/2023.

On 05/15/2024 at 1:15 p.m., Licensee A provided copy of Caregiver C's certified nursing assistant

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M 235	Continued From page 6 (CNA) certification with the expiration date of 07/31/2018. On 05/15/2024 at approximately 3:30 p.m., Surveyor interviewed Licensee A. Licensee A confirmed s/he checked caregivers' CBRF and CNA training before the caregivers started working on the floor. Licensee A provided caregivers with a website to complete their training within 30 days and asked them to return the certificate of completion to him/her. Licensee A confirmed Caregiver C, Caregiver D, and Caregiver F did not receive training in standard precautions prior to providing care to residents. On 05/17/2024 at 4:30 p.m., Surveyor reviewed the University of Wisconsin Green Bay Training Registry. Surveyor confirmed Caregiver C, Caregiver D, and Caregiver F were not on the CBRF training registry. Cross Reference: M0244 88.04(5)(a) Training - 15 Hours Within 6 Months	M 235		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid.	M 244		

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M 244	Continued From page 7	M 244		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 3 of 4 staff (Caregiver D, Caregiver E, and Caregiver F) received the required training related to health, safety and welfare of residents, resident rights, fire safety, and first aid within 6 months after starting to provide care. Caregiver D and Caregiver F had no evidence of training in their files. Caregiver E did not have evidence s/he received the required training related to health, safety and welfare of residents and resident rights.

Findings include:

On 05/14/2024 and 05/15/2024, Surveyor reviewed employee records for Caregiver D, Caregiver E, and Caregiver F, including training records. The following was identified:

Caregiver D was hired on 04/26/2023. Caregiver D's file did not contain evidence s/he completed 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights, fire safety, first aid and treatment appropriate to residents served prior to or within 6 months after starting to provide care on 04/26/2023.

Caregiver E was hired on 07/28/2023. Caregiver E's file did not contain evidence s/he completed 15 hours of training approved by the licensing agency related to health, safety and welfare of residents and resident rights prior to or within 6 months after starting to provide care on 07/29/2023.

Caregiver F was hired on 08/16/2023. Caregiver

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M 244	Continued From page 8 F's file did not contain evidence s/he completed 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights, fire safety, first aid and treatment appropriate to residents served prior to or within 6 months after starting to provide care on 08/19/2023. On 05/15/2024 at approximately 3:30 p.m., Surveyor interviewed Licensee A. Licensee A confirmed s/he checked caregivers CBRF and CNA training before the caregivers started working on the floor. Licensee A provided caregivers with a website to complete their training within 30 days and asked them to return the certificate of completion to him/her. Licensee A confirmed Caregiver D, Caregiver E, and Caregiver F did not receive training prior to providing care to residents. On 05/17/2024 at 4:30 p.m., Surveyor reviewed the University of Wisconsin Green Bay Training Registry. Surveyor confirmed Caregiver D, Caregiver E, and Caregiver F were not on the CBRF training registry. On 05/22/2024 at 2:45 p.m., Surveyor conducted an exit conference with Licensee A regarding the above findings. Licensee A acknowledged having a misunderstanding of the requirements. Licensee A stated, "I thought that if the caregivers had the CBRF certification, that was enough training to get started. After you left, I looked at the code and saw that I was wrong. I have it on my list."	M 244		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe,	M 276		

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M 276	Continued From page 9 clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain a safe, clean, and well-maintained homelike environment for 2 of 4 residents in the home. The light fixture in the front foyer was missing, the light fixture in front of the bathroom was broken out, Resident 3's window screen was ripped, and Resident 2's glass in window was shattered. Findings include: On 05/14/2024 and 05/15/2024, Surveyor toured the facility and observed the following: First Floor: - Light fixture in front foyer has no cover. - Light fixture cover broken in hallway outside bathroom. - Rip in window screen, approximately 21 inches by 9 inches, in Resident 3's bedroom. -In living room, sectional couch with 6 separate cushions. One cushion completely sunk down, as if there was no support under the cushion. Second Floor: -Hole in wall, approximately 3 inches by 3 inches on second floor stairwell, underneath grab bar. - Resident 2's bedroom window was broken with a hole in the glass, approximately 13 inches by 9	M 276		

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M 276	Continued From page 10 inches. On 05/15/2024 at 12:55 p.m., Surveyor interviewed Resident 3 about his/her window screen. Resident 3 was unable to identify why his/her window screen was broken. Resident 3 stated, "It might have been the weather. I would like to be able to open my window without bugs getting in." On 05/15/2024, at 2:28 p.m., Surveyor interviewed Licensee A about the hole in the wall underneath grab bar, by the second-floor stairwell. Licensee A stated the maintenance person moved the grab bar up and it left a large hole. Licensee A stated s/he was unaware of when the maintenance person planned to fix the hole. On 05/15/2024, at 2:31 p.m., Surveyor interviewed Licensee A about Resident 2's bedroom window and the hole in the glass. Licensee A stated Resident 2 was currently hospitalized. Licensee A was working with the Managed Care Organization (MCO) to figure out best remedy for the window. Licensee A reported Resident 2 had a history of breaking windows before living in the facility. On 05/15/2024 at 3:30 p.m., Resident 4 sat down on the sectional couch in living room. Surveyor and Licensee A observed Resident 4 sink deep into the couch. Resident 4 stated, "I don't like this couch. What's wrong with it? It's hard to get up now." Licensee A explained to Surveyor s/he was working on getting a leather couch, since s/he had a bedbug outbreak in December of 2023. On 05/22/2024 at 2:50 p.m., Surveyor conducted an exit conference with Licensee A regarding the	M 276		

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M 276	Continued From page 11 above findings. Licensee A acknowledged Resident 3's window screen was broken. Licensee A stated, "I'll have to figure out how to handle that. [Resident 3] keeps breaking the screen out." Surveyor asked about Resident 2's broken window. Licensee A stated s/he was sending estimates to Resident 2's payee and they will send payment for the window repairs.	M 276		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents (Resident 1, Resident 2, and Resident 3) reviewed were evaluated immediately following placement, using the form provided by the department, to determine whether s/he was able to evacuate the home without any help within 2 minutes. Findings include: On 05/14/2024 at 12:30 p.m., Surveyor reviewed resident records and identified the following: Example 1: Resident 1 Resident 1 was admitted on 05/08/2022 with	M 344		

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M 344	Continued From page 12	M 344		

diagnoses including peripheral nerve disorders, dysuria, difficulty walking, and weakness. Resident 1's record contained the resident evacuation assessment document with the name of the facility, address, date of 05/11/2022, name of resident and evaluator filled out. No additional parts of the assessment were completed. Resident 1's record did not contain evidence an evacuation assessment was completed at the time of her/his admission.

Example 2: Resident 2
Resident 2 was admitted on 08/15/2023 with diagnoses including diverticulosis, adjustment disorder, intellectual disability, and hypertension. Resident 2's record contained the resident evacuation assessment document with the name of the facility, address, date of 08/18/2023, name of resident and evaluator filled out. No additional parts of the assessment were completed. Resident 2's record did not contain evidence an evacuation assessment was completed at the time of her/his admission.

Example 3: Resident 3
Resident 3 was admitted on 03/22/2023 with diagnoses including bipolar disorder, cognitive communication deficit, epilepsy, and schizophrenia. Resident 3's record contained the resident evacuation assessment document with the name of the facility, address, date of 03/25/2023, name of resident and evaluator filled out. No additional parts of the assessment were completed. Resident 3's record did not contain evidence an evacuation assessment was completed at the time of her/his admission.

On 05/14/2024 at 12:50 p.m., Surveyor interviewed Licensee A, who acknowledged s/he was aware of the requirement to assess each

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M 344	Continued From page 13 resident at the time of their admission. Licensee A acknowledged the assessments had not been completed. Licensee A stated, "I must have intended to fill them out and I forgot."	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 3). Findings include: On 05/14/2024 at 1:30 p.m., Surveyor reviewed resident records and identified the following: Example 1: Resident 1 Resident 1 was admitted on 05/08/2022 with diagnoses including peripheral nerve disorders, dysuria, difficulty walking and weakness. Resident 1's record did not contain a fire evacuation evaluation form for 2023. Example 2: Resident 3 Resident 3 was admitted on 03/22/2023 with diagnoses including bipolar disorder, cognitive communication deficit, epilepsy, and	M 346		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS HAVEN LLC	2205 WEST BURNHAM STREET MILWAUKEE, WI 53204

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M 346	Continued From page 14 schizophrenia. Resident 3's record did not contain a fire evacuation evaluation form for 2024. On 05/14/2024 at 12:50 p.m., Surveyor interviewed Licensee A, who acknowledged s/he was aware of the requirement to assess each resident annually. Licensee A acknowledged the assessments had not been completed. Licensee A stated, "I must have intended to fill them out and I forgot."	M 346		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a service agreement was completed prior to admission for 3 of 3 residents reviewed. Resident 1, Resident 2, and Resident 3's service agreements were not signed prior to admission. Resident 1 had resided in the facility for 737 days with no signed service agreement. Resident 2 had resided in the facility for 273 days	M 384		

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M 384	Continued From page 15 with no signed service agreement. Resident 3 had resided in the facility for 418 days with no signed service agreement. Findings include: On 05/14/2024 at 2:30 p.m., Surveyor reviewed resident records and identified the following: Example 1: Resident 1 Resident 1 was admitted on 05/08/2022. Resident 1's record did not contain a signed admission agreement. Example 2: Resident 2 Resident 2 was admitted on 08/15/2023. Resident 2's record did not contain a signed admission agreement. Resident 2's member centered plan, dated 10/01/2023, identified Resident 2 had a guardian. Example 3: Resident 3 Resident 3 was admitted on 03/22/2023. Resident 3's record did not contain a signed admission agreement. On 05/14/2024 at 4:01 p.m., Surveyor interviewed Licensee A. Licensee A reported s/he was aware of the requirement. Licensee A reported Resident 1 was admitted "off the streets." Licensee A stated, "I thought I did all of the admission paperwork with [Resident 1] and his/her care team." Licensee A reported s/he could not remember if s/he provided a written service agreement to Resident 2's guardian. Licensee A reported Resident 2's guardian was not actively involved. Licensee A reported s/he did not follow up regarding the service agreement. Licensee A reported Resident 3 was her/his own person. Licensee A reported s/he did not remember if	M 384		

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M 384	Continued From page 16 s/he attempted to obtain a signed service agreement with Resident 3.	M 384		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents (Resident 1 Resident 2, and Resident 3) had a written assessment and individual service plan (ISP) completed and developed within 30 days after admission. Findings include: On 05/14/2024 at 2:30 p.m., Surveyor reviewed resident records and identified the following: Example 1: Resident 1 Resident 1 was admitted on 05/08/2022. Resident 1's record did not contain a written assessment. Resident 1's record contained the first page of an unsigned ISP dated 5/2022. The ISP was not completed and developed within 30 days after admission. Example 2: Resident 2 Resident 2 was admitted on 08/15/2023. Resident 2's record did not contain a written assessment. Resident 2's record contained an	M 404		

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M 404	Continued From page 17	M 404		

unsigned ISP dated 10/05/2023.
Resident 2's ISP was not completed and developed within 30 days after admission.
Resident 2's ISP was developed 22 days late.
Resident 2's member centered plan, dated 10/01/2023, identified Resident 1 had a guardian.

Example 3: Resident 3
Resident 3 was admitted on 03/22/2023.
Resident 3's record did not contain a written assessment. Resident 3's record contained the first page of an unsigned ISP dated 10/05/2023.
The ISP was not completed and developed within 30 days after admission.

On 05/15/2024 at 1:12 p.m., Surveyor interviewed Licensee A. Licensee A reported s/he was aware of the requirement. Licensee A reported Resident 1 was admitted "off the streets." S/He met with Resident 1, but it was an informal meeting. Licensee A stated, "I did not do a formal, written assessment and I only began the first page of his/her ISP."

Licensee A stated s/he met Resident 2 at the hospital and took some written notes. "Nothing formal. The staff gave me a verbal report." Licensee A stated s/he did not recall if s/he sent the ISP to Resident 2's guardian. The ISP in Resident 2's file was unsigned.

Licensee A stated s/he had intended to do Resident 3's assessment and ISP. When Licensee A arrived at Resident 3's former home, s/he had left. Licensee A stated s/he spoke briefly with Resident 3's family and took some notes. Licensee A stated s/he did not know where the notes were. Licensee A acknowledged the blank ISP in Resident 3's file. Licensee A stated, "I need to figure out a better system to get all of this

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M 404	Continued From page 18 done." On 05/22/2024 at 2:50 p.m., Surveyor conducted an exit conference with Licensee A regarding the above findings. Licensee A acknowledged needing a better system for initial assessments. Licensee A stated, "After you were here, I purchased a PDF pre-assessment document that I can use moving forward. It's very detailed. I think it will work well." Cross Reference: M0424 88.06(3)(f) Review of ISP	M 404		
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 review of resident records and	M 424		

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M 424	Continued From page 19	M 424		

interviews, the provider did not ensure 3 of 3 residents (Resident 1 Resident 2, and Resident 3) individual service plan (ISP) was reviewed at least once every six months by the licensee, the resident's guardian, and the service coordinator for 3 of 3 residents reviewed.

Resident 1's ISP should have been reviewed and updated at least 4 times since admission.
Resident 2's ISP should have been reviewed and updated at least 1 time since admission.
Resident 3's ISP should have been reviewed and updated at least 2 times since admission.

Findings include:

On 05/14/2024 at 2:30 p.m., Surveyor reviewed resident records and identified the following:

Example 1: Resident 1
Resident 1 was admitted on 05/08/2022 with diagnoses including peripheral nerve disorders, dysuria, difficulty walking and weakness.
Resident 1's record contained the first page of an unsigned ISP dated 05/2022. Resident 1's record did not contain evidence of ISP reviews. Resident 1's ISP was due to be reviewed in November 2022, May 2023, November 2023, and May 2024.

Example 2: Resident 2
Resident 2 was admitted on 08/15/2023 with diagnoses including diverticulosis, adjustment disorder, intellectual disability, and hypertension.
Resident 2's ISP was dated 10/05/2023. Resident 2's record did not contain evidence of ISP reviews. Resident 2's ISP was due to be reviewed in January 2024.

Example 3: Resident 3
Resident 3 was admitted on 03/22/2023 with

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M 424	Continued From page 20 diagnoses including bipolar disorder, cognitive communication deficit, epilepsy, and schizophrenia. Resident 3's ISP was dated 10/05/2023. Resident 3's record did not contain evidence of ISP reviews. Resident 3's ISP was due to be reviewed in September 2023 and March 2024. Cross Reference: M0404 88.06(3)(a) Individual Service Plan & Assessment	M 424		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses contraband. The resident shall be present for the search. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 residents had privacy in their home. The provider installed 3 cameras in the home, monitoring the living room, kitchen, and second level used by all residents. Findings include:	M 550		

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M 550	Continued From page 21 On 05/14/2024 and 05/15/2024, Surveyor toured the home and observed 3 cameras at the home. One camera monitored the kitchen and living room area of the home. The kitchen camera was mounted on the north corner ceiling above the exit door, pointing into the full kitchen. A second camera monitored the dining room and the dining room table. The dining room camera was mounted on the south corner of the room where residents could congregate and eat their meals. A third camera was on the second level, south wall, pointing down the hallway pointing towards a resident bathroom door and two resident bedroom doors. Residents would be captured walking down the hall, entering and exiting their rooms and the bathroom. On 05/14/2024, at approximately 12:25 p.m., Surveyor observed Resident 3 eating lunch in front of the camera. On 05/14/2024, at approximately 12:30 p.m., Surveyor interviewed Caregiver C, who stated, "The cameras are on." On 05/14/2024, at approximately 12:31 p.m., Surveyor interviewed Assistant Director (AD) B, who stated, "[Licensee A] receives the feed for the cameras on his/her phone. S/He can see and hear what we are doing at any time." On 05/15/2024, at approximately 1:35 p.m., Surveyor asked Licensee A about the cameras. Licensee A stated s/he installed the cameras to make sure the staff stayed awake for their shifts and to minimize stealing. Food was going missing.	M 550		

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M 550	Continued From page 22 On 5/22/2024 at 3:15 p.m., Surveyor interviewed Licensee A and asked if s/he was aware the use of video monitoring was an invasion of privacy. Licensee A informed Surveyor the residents knew the cameras were there and they had no problem being monitored. Licensee A stated all staff signed a company monitoring policy, indicating that Helping Hands Haven LLC, "may find it necessary to monitor work areas with security cameras." Licensee A stated the managed care organization said it was okay to have cameras in common areas. Licensee A stated s/he would evaluate the code for more clarity.	M 550		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search 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	Z 012		

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Z 012	Continued From page 23 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 ensure a good faith effort was made to obtain an out of state background check for 1 of 1 employee (Caregiver F) who indicated they lived out of state in the last 3 years on their Background Information Disclosure (BID) form. Findings include: On 05/14/2024 and 05/15/2024, Surveyor reviewed Caregiver F's record. Caregiver F was hired on 03/12/2024. Caregiver F's BID form identified Caregiver F resided in the state of Indiana between 2015 and 2020. Caregiver F's file did not contain an out of state background check. On 05/14/2024 at 3:45 p.m., Surveyor interviewed Licensee A. Licensee A confirmed an out of state background check was not completed. Licensee A reported s/he was responsible for ensuring background checks were completed. Licensee A reported s/he was unaware an out of state background check was required. Licensee A reported s/he would ensure out of state background checks would be completed in the future for those employees who had lived out of state in the previous 3 years.	Z 012		
Z 055	DHS 13.05 (3) (a) ENTITY ALLEGATION REPORTING REQUIREMENTS	Z 055		

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Z 055	Continued From page 24 Entity's duty to report to the department. Except as provided under pars. (b) and (c), an entity shall report to the department any allegation of an act, omission or course of conduct described in this chapter as client abuse or neglect or misappropriation of client property committed by any person employed by or under contract with the entity if the person is under the control of the entity. The entity shall submit its report on a form provided by the department within 7 calendar days from the date the entity knew or should have known about the misconduct. The report shall contain whatever information the department requires. This Rule is not met as evidenced by: Based on record review and interview the provider did not report an allegation of misappropriation to the department within seven (7) days as required. Resident 1's debit card was used by Caregiver D for multiple purchases, without Resident 1's permission, and the provider did not report the allegation. Findings include: On 02/23/2024, the Department received a complaint alleging a potential financial exploitation to residents. On 05/14/2024 at 10:05 a.m., Surveyor interviewed Licensee A who stated the provider	Z 055		

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found out Caregiver D had been using Resident 1's debit card. Licensee A could not recall the specific dates of the events timeline but believe it was sometime around mid-February 2024. Resident 1 brought his/her concerns to Assistant Director (AD) B. Together, they reviewed Resident 1's bank statement, called the bank to report the fraud and to cancel his/her card, called Care Manager (CM) H, and took Resident 1 to the police station. Milwaukee Police Department (MPD) took a report and gave Resident 1 a case number.

Licensee A stated, "We did not know anything until [Resident 1] told us. [Resident 1] manages his/her own banking. S/He came to AD B and expressed concern. We reported it to CM H via telephone. S/he came to the facility and interviewed Resident 1. S/He provided the information to his/her supervisor. We did not report to the Department of Health Services because CM H said s/he would." Licensee A confirmed it was his/her responsibility to do the investigation. Licensee A stated, "I did not write up a final investigation. I was waiting on [CM H]. I did not look at the code for what to do when a situation like this occurred."

On 05/14/2024 at 10:49 a.m., Surveyor interviewed AD B, who explained Resident 1 came to him/her because s/he believed someone was using his/her credit card. Resident 1 told AD B that s/he let Caregiver D order some items for him/her once, on the computer, at Walmart (website). Resident 1 reported s/he noticed additional charges in the beginning of February. Resident 1 showed AD B his/her bank statement dated 02/13/2024 to 03/12/2024 and allowed AD B to take pictures of the bank statement.

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Z 055	Continued From page 26 AD B reported s/he assisted Resident 1 in calling the bank to report the fraud and to cancel Resident 1's credit card. AD B indicated that on 03/11/2024, there was a cash app withdrawal for fifty dollars with Caregiver D's first name noted next to the description of the transaction. AD B attempted to convince Resident 1 to file a police report. According to AD B, Resident 1 wanted to wait until s/he received the next statement in March to file a police report. On 03/27/2024, AD B took Resident 1 to MPD to file a walk-in theft report. AD B stated, "I did not write up any kind of report. I was waiting on the police department." On 05/14/2024, at 8:30 a.m., Surveyor reviewed department electronic files including the provider's self-report file. There was no evidence the provider submitted a self-report regarding Resident 1's misappropriation. On 05/14/2024, at 12:27 p.m., Surveyor received an email with Resident 1's bank statement dated bank statement dated 02/13/2024 to 03/12/2024. Surveyor observed a cash app withdrawal for fifty dollars on 03/11/2024, with Caregiver D's first name noted next to the description of the transaction. On 05/20/2024, at 8:13 a.m., Surveyor received an electronic mail from the Office of Caregiver Quality (OCQ). OCQ denied a misconduct report was completed for Caregiver D's misappropriation of Resident 1's funds. On 05/22/2024 at 3:22 p.m., Surveyor conducted an exit conference with Licensee A regarding the above findings. Licensee A acknowledged an understanding of the requirements and confirmed, "I tried to use the WAMS (Wisconsin Access Management System) system, but I got	Z 055		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS HAVEN LLC	2205 WEST BURNHAM STREET MILWAUKEE, WI 53204

(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 055	Continued From page 27 an error message. I also sent an e-mail to the help desk, but I never submitted a misconduct report. The managed care organization told me I should do it back in March 2024, but things have been so overwhelming. It's on the top of my priority list."	Z 055		