STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019106	A. BUILDING: _____ B. WING _____	R-C 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLENS FAMILY HOME CARE LLC	8210 W HERBERT AVE MILWAUKEE, WI 53218

(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 02/20/2025 with information gathered through 02/21/2025, Surveyor conducted a complaint investigation and verification visit for SOD GD9011, dated 08/26/2024, at Ellens Family Home Care LLC, an Adult Family Home (AFH) in Milwaukee, WI. Five deficiencies identified. One of five deficiencies was a repeat deficiency. See Statement of Deficiency GD9011, dated 08/26/2024. Complaint substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a description of the services in the individual service plan (ISP) the licensee would provide to meet the assessed needs of 1 of 1 resident (Resident 2). Resident 2 had a history of ambulatory problems. Resident 2's ISP did not address Resident 2's utilization of a walker to ambulate.	M 412		

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

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M 412	Continued From page 1 Findings include: On 02/20/2025, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 08/01/2024 with diagnoses including, cerebral infraction, chronic viral hepatitis c, hyperlipidemia, hypokalemia, alcohol abuse with intoxication delirium, psychoactive substance abuse, major depressive disorder, recurrent depressive disorders, chronic pain syndrome, blindness right eye category 5, essential (primary) hypertension, asthma, acute pancreatitis without necrosis or infection, cervical disc disorder, lumbago with sciatica, frequency of micturition, suicidal ideations, dysarthria and anarthria, weakness, fracture of lumbar vertebra, initial encounter for closed fracture and personal history of traumatic brain injury. -Resident 2 was his/her own person. -Resident 2's ISP was dated 08/12/2024. Resident 2's ISP stated the following: -"Mobility and Transferring - Resident 2's needs/preferences: Independent." -Resident 2's ISP did not describe Resident 2's mobility needs. Resident 2's My Choice Wisconsin Member Centered Plan (MCP) was dated 10/01/2024. Resident 2's MCP stated the following: -"Mobility (In the Home): Level of Assistance - Independent (Member Strength). DME (Durable Medical Equipment) - Walker."	M 412		

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M 412	Continued From page 2 -"Mobility (Outside the Home): Level of Assistance - Independent (Member Strength). DME - Walker." On 02/20/2025 at approximately 3:00 PM, Surveyor interviewed Licensee C. Licensee C reported Administrator D was responsible for the creation of ISPs. Licensee C confirmed Resident 2's ISP did not reflect the above information. Licensee C stated Resident 2 utilized a walker to ambulate in the home and outside the home. Licensee C stated moving forward s/he would ensure Resident 2's ISP addressed his/her ambulatory problems and utilization of a walker.	M 412		
M 416	88.06(3)(d)3 SERVICES BY OUTSIDE AGENCIES Description of services provided by outside agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident individualized service plan (ISP) included a description of services provided by outside agencies for 1 of 1 resident (Resident 2) reviewed. Resident 2's ISP did not address home care services. Findings include: On 02/20/2025, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 08/01/2024.	M 416		

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M 416	Continued From page 3 -Resident 2's Discharge Summary from Froedtert and the Medical College of Wisconsin, dated 11/19/2024 indicated home care services through Horizon Home Care was ordered for physical therapy (PT), occupational therapy (OT) and speech therapy (ST). -Resident 2's Discharge-Transfer Summary Report from Horizon Home Care, dated 12/27/2024 indicated Resident 2 received home care services effective from 11/21/2024 to 12/27/2024 for PT, OT and ST. -Resident 2's ISP, dated 08/12/2024 did not address the home care services. On 02/20/2025 at approximately 3:00 PM, Surveyor interviewed Licensee C. Licensee C confirmed Resident 2 received home care services. Licensee C confirmed Resident 2's home care services was not added to Resident 2's ISP. Licensee C stated s/he was not aware of this requirement.	M 416		
{M 458}	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist.	{M 458}		

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{M 458}	Continued From page 4	{M 458}		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure every prescription medication was securely stored. Resident 2's medication was not secured in the home's refrigerator.

This is a repeat deficiency. See Statement of Deficiency (SOD) GD9011, dated 08/26/2024.

Findings include:

The facility is licensed to provide services for up to 3 residents with client groups of advanced aged, developmentally disabled, irreversible dementia/Alzheimer's, terminally ill, physically disabled, public funding and emotionally disturbed/mental illness.

On 02/20/2025 at approximately 8:54 AM, Surveyor toured the home with Caregiver E. Surveyor observed Resident 2's gabapentin 250 milligrams/5 milliliters solution on the shelf in a Sentry Safe black unlocked box in the home's common refrigerator, that all residents have independent access to; the medication was not securely stored.

On 02/20/2025 at approximately 8:54 AM, Surveyor interviewed Caregiver E. Caregiver E stated the Sentry Safe box has been broken for a few weeks.

On 02/20/2025 at approximately 9:05 AM, Surveyor interviewed Administrator D. Administrator D stated s/he was aware Resident 2's medication was not securely stored. Administrator D stated staff informed him/her that the lock box was broken today. Administrator D

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{M 458}	Continued From page 5 stated moving forward s/he will ensure every prescription medication is securely stored.	{M 458}		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 2) received prompt and adequate treatment when staff observed Resident 2 had left-sided facial droop, balance issues and slurred speech. On 11/15/2024 at approximately 10:00 PM Resident 2 had a change in condition and did not go to the hospital until 11/16/2024 at approximately 12:45 PM. Findings include: On 02/20/2025, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 08/01/2024 with diagnoses including, cerebral infraction, chronic viral hepatitis c, hyperlipidemia, hypokalemia, alcohol abuse with intoxication delirium, psychoactive substance abuse, major depressive disorder, recurrent depressive disorders, chronic pain syndrome, blindness right eye category 5, essential (primary) hypertension, asthma, acute pancreatitis without necrosis or infection, cervical disc disorder, lumbago with sciatica, frequency of micturition, suicidal ideations, dysarthria and anarthria, weakness, fracture of lumbar vertebra, initial encounter for	M 580		

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M 580	Continued From page 6	M 580		

closed fracture and personal history of traumatic brain injury.

-Resident 2 was his/her own person.

-Resident 2's "observation" note, dated 11/16/2024 at 7:45 AM, written by Caregiver F stated, "last night (11/15/2024) when I came in I was noticed that [Resident 2] fell 2 times and to check [his/her] blood pressure so I checked [his/her] blood pressure 4 times at 10:00 PM [Resident 2] blood pressure was 149/84 the next morning 158/94 that was at 12:23 AM the next one was 148/94 that was at 1:46 AM the next one was 173/93 at 7:00 AM."

-Resident 2's "observation" note, dated 11/16/2024 at 7:15 PM, written by Caregiver B stated, "On 11/15/2025 client [Resident 2] had two fall incidents back-to-back [Resident 2] was not complaining of any injury nor pain due to that we just observed [Resident 2] overnight and when observing [his/her] blood pressure notice [his/her] numbers kept going up so [s/he] was watch carefully throughout the night I came in at 8:00 AM and around 8:30 AM I checked [Resident 2] blood pressure it was still up so I started checking every 30 minutes to an hour and nothing change [Resident 2] was weak complaining of headache and the left side face was swollen as well I contacted the manager and called 911 and [s/he] was transported to the hospital."

-Resident 2's Emergency Department (ED) Provider Notes, dated 11/16/2024, stated the following:
-"Patient presents today from group home due to concern for stroke. Group home states that at 8:00 AM they noticed that [Resident 2] had a left-sided facial droop, balance issues, and some

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M 580	Continued From page 7 slurred speech, [s/he] was brought to the ED around 12:45 PM. [Resident 2] has a history of a stroke in the past with residual right-sided deficits. [Resident 2] uses a walker to ambulate at baseline. Per [Resident 2] [s/he] fell twice last night." -Resident 2's Froedtert and Medical College of Wisconsin (MCW) Patient Discharge Summary, dated 11/19/2024, stated the following: -Date of admit: 11/16/2024. -Date of discharge: 11/19/2024. -Reason for hospitalization: Left facial droop. On 02/20/2025 at approximately 3:30 PM, Surveyor interviewed Administrator D. Administrator D confirmed Resident 2 should have been taken to the hospital immediately following the change of condition. Administrator D stated s/he determines if 911 should be called or if a resident needs to seek medical attention. Administrator D stated Caregiver F did not notify him/her of Resident 2's two fall incidents and blood pressure issues.	M 580		
Z 055	DHS 13.05 (3) (a) ENTITY ALLEGATION REPORTING REQUIREMENTS 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	Z 055		

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Z 055	Continued From page 8 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 investigate allegations of neglect and abuse for 1 of 1 incident involving Caregiver B. Resident 2 alleged s/he was pushed down twice and pushed down on the bed three times, causing pain by Caregiver B on 11/25/2024. This allegation was known by Licensee C. No investigation took place into the alleged incident. Findings include: On 02/20/2025, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 08/01/2024 with diagnoses including, cerebral infraction, chronic viral hepatitis c, hyperlipidemia, hypokalemia, alcohol abuse with intoxication delirium, psychoactive substance abuse, major depressive disorder, recurrent depressive disorders, chronic pain syndrome, blindness right eye category 5, essential (primary) hypertension, asthma, acute pancreatitis without necrosis or infection, cervical disc disorder, lumbago with sciatica, frequency of micturition, suicidal ideations, dysarthria and anarthria, weakness, fracture of lumbar vertebra, initial encounter for closed fracture and personal history of traumatic	Z 055		

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Z 055	Continued From page 9 brain injury. -Resident 2 was his/her own person. -Resident 2's Froedtert and Medical College of Wisconsin (MCW) Admission History and Physical, dated 11/25/2024, stated the following: -Date of Service: 11/25/2024. -Chief Complaint: [Resident 2] presents with Domestic Violence. -History of Present Illness: [Resident 2] presents with a chief complaint of assault. Per [Resident 2] report, [s/he] was pushed by a caregiver (Caregiver B) at [his/her] facility. In [Resident 2's] words, "s/he pushed me down twice" and "pushed me down on the bed three times." When asked about the events surrounding the assault, [Resident 2] states, " I don't know why s/he did it." [Resident 2] endorsed leg and generalized body pain after the incident, which has now resolved. -Resident 2's Froedtert and Medical College of Wisconsin (MCW) Patient Discharge Summary, dated 11/29/2024, stated the following: -Date of admit: 11/25/2024. -Date of discharge: 11/29/2024. -Reason for hospitalization: Assaulted at group home. -SW (Social Worker) consulted for placement needs/further investigation. -Condition at discharge: [Resident 2] was discharged to group home in stable condition. On 02/20/2025 at approximately 3:00 PM, Surveyor interviewed Licensee C. Licensee C stated s/he was aware of the allegation of abuse. Licensee C stated Administrator D was responsible to conduct a thorough investigation for the alleged incident. On 02/21/2025 at approximately 8:21 AM,	Z 055		

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Z 055	Continued From page 10 Surveyor interviewed Administrator D via email correspondence. Administrator D stated the following: "On 11/25/2024 one of my members [Resident 2] complained that a staff member pushed [him/her] down on the floor. I was never told the situation until the hospital called me and told me I can't get information on [Resident 2's] stay. So the caseworker's finally called me and told me [Resident 2] was saying someone pushed [him/her] at the facility [s/he] went out and did a full investigation when [s/he] got there [Resident 2] didn't remember the situation [s/he] also did not mention nothing about a bruise either. The caseworker also stated this behavior happens when [Resident 2] don't get [his/her] way. It [sic] at another group home. I went there to the facility to check on [Resident 2] and get a statement from [him/her] verbally, I asked [Resident 2] what happened [s/he] didn't remember the incident [s/he] told me [s/he] don't remember [sic] only thing [s/he] remember [sic] was [s/he] wanted a cigarette and couldn't receive one. The staff that's involved in the situation is [Caregiver B]. I also went to [Caregiver B] and ask [him/her] what happened [sic] [s/he] stated [Resident 2] through [sic] [his/herself] on the floor because [s/he] wanted a cigarette but [Caregiver B] was with another client and when [s/he/] was done [s/he] will give [him/her] one. When the incident occurred [sic] I was called I told staff to send [Resident 2] out to make sure [s/he] didn't hurt [him/herself]. I did verbal investigation. I did not self report due to not knowing about it. I was not aware of the self-reporting or getting a police report. Moving forward I know now to self-report and file a police report." All entities regulated by DQA (Division of Quality Assurance) must conduct a thorough internal investigation and document the findings for all	Z 055		

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Z 055	Continued From page 11 allegations or incidents at the entity. A thorough internal investigation may include: Collecting and preserving any physical and documentary evidence including videos; Interviewing alleged victims and witnesses; Collecting other corroborating/disproving evidence; Involving other regulatory authorities who can assist (e.g., local law enforcement, elder abuse agency, Adult Protective Service agency, DQA, Board on Aging Ombudsmen, Client Right's Specialist, etc.); and Documenting each step taken during the internal investigation. These steps should be taken as part of the entity's initial attempt to determine what, if anything, happened and to determine the complete factual circumstances surrounding the alleged incident. (DQA publication P-00038, Wisconsin Background Check and Misconduct Investigation Program Manual, 03/2025.)	Z 055		