STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 07/09/2024, with information obtained through 07/23/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a standard licensing survey at All For 1 Inc, an adult family home (AFH) located in Brookfield, WI. As a result of the survey 5 deficiencies were identified. Census: 3	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 property of adults or minors or activities of the adult family home,	M 114		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 114	Continued From page 1 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 that a criminal records check was completed for 1 of 1 service provider, Caregiver B, at the time of hire. Caregiver B's background check did not include a Governmental Findings Report from the Department of Health Services (DHS) as part of his/her background check, until it was ran again on 07/12/2024 during the survey period and approximately 8 months after Caregiver B's hire date. Findings include: On 07/09/2024, at approximately 2:05 p.m., Surveyor requested from Administrator A the complete background check for Caregiver B, who was hired on 11/06/2023. On 07/11/2024, Surveyor reviewed the background check provided. The check showed a Department of Justice (DOJ) background check and a background information disclosure (BID), both dated 07/06/2023. There was no evidence of a DHS Governmental Findings Report.	M 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 114	Continued From page 2 On 07/11/2024, at approximately 3:31 p.m., Surveyor interviewed Administrator A. Surveyor requested any evidence from Administrator A of a DHS Governmental Findings Report having been completed for Caregiver B. Administrator A reported that s/he ran another background check on Caregiver B that day because s/he did not see the complete information. On 07/12/2024, Surveyor reviewed the updated DOJ/DHS background check provided by Administrator A, dated 07/12/2023 (approximately 8 months after Caregiver B was hired).	M 114		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, 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 ensure the adult family home was safe, well-maintained, and provided a homelike environment. Findings include: On 07/09/2024, Surveyor toured the environment with Caregiver B and observed the following: - At 11:40 a.m., an outlet in the kitchen area near the counter with the cover plate missing (Photo 1)	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 276	Continued From page 3	M 276		

- At 11:43 a.m., the overhead light fixture in the sole resident bathroom missing a lightbulb (Photo 2). The cover plate to the outlet left of the sink was missing, too (Photo 3).

- At 11:44 a.m., Surveyor observed Resident 1's bedroom. Both air vents located on the lower walls, one measuring approximately 1'x1' and the other measuring approximately 1.5'x1', were missing covers, exposing the entire area to the heating, ventilation, and air conditioning (HVAC) duct (Photos 4 and 5). The overhead light fixture in Resident 1's bedroom was missing its cover (Photo 6).

- At 11:51 a.m., Surveyor observed the laundry area. A box of dryer sheets, a letter, and a piece of white plastic was behind the dryer (Photo 7). The plug from the dryer into the outlet behind it appeared covered in dust and lint (Photo 8).

- At 12:09 p.m., a bottle of DayQuil, near completely full, was observed on a shelf in the kitchen's refridgerator (Photo 9).

- At 12:15 p.m., Surveyor tested the water temperature of the bathroom sink of the sole resident bathroom, which reached 122.5°F.

According to the Wisconsin Department of Health Services, "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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 276	Continued From page 4 instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." Sustained contact with water at or above 120°F and 127°F can result in second or third-degree burns in approximately 10 minutes and 1 minute, respectively. (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017). On 07/19/2024, at approximately 12:32 p.m., Surveyor interviewed Administrator A about the above concerns. Administrator A reported that the missing fixtures, cover plates, and vent covers were likely due to Resident 1, who was known to take things apart all the time. Administrator A replied, "Okay" when Surveyor discussed that the above concerns needed to be addressed.	M 276		
M 348	88.05(4)(d)2.c SEMI-ANNUAL FIRE DRILLS The licensee shall conduct semi-annual fire drills with all household members with written documentation of the date and the evacuation time for each drill maintained by the home. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a semi-annual fire drill was yet completed for 2024, and that the 2 fire drills completed in 2023 were done on a semi-annual basis. Findings include: On 07/09/2024, at approximately 2:05 p.m., Surveyor requested from Administrator A all the provider's fire drill records from 01/01/2023	M 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 348	Continued From page 5 through the current day. On 07/11/2024, Surveyor reviewed the fire drill records sent by Administrator A. Within the records, Surveyor observed the following fire evacuation drills for 2023: - 06/13/2023 at 4:30 p.m. - 09/19/2023 at 4:00 p.m. (approximately 3 months after the last drill) Surveyor did not observe any evidence of drills completed since 09/19/2023. On 07/19/2024, at approximately 12:32 p.m., Surveyor interviewed Administrator A. Administrator A confirmed that the only fire drills completed in 2023 were on the above 2 dates. Administrator A reported that s/he thought fire drills only had to be completed twice a year and that was why s/he didn't space the 2 drills in 2023 out semi-annually or conduct a fire drill yet in 2023. Administrator A reported s/he would have Caregiver B conduct a fire drill later.	M 348		
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	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 424	Continued From page 6	M 424		

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 record review and interview, the individual service plan (ISP) for 2 of 2 residents reviewed was not updated to reflect the resident's needs or was reviewed with the residents' legal representatives.

Both of the ISPs created for Resident 1 since his/her admission on 08/04/2023 did not include a description of the services provided to meet his/her assessed needs or identification of the level of supervision that s/he required.

There was no evidence that Resident 2's legal representative reviewed Resident 2's last 2 ISP updates when his/her ISP was reviewed on 04/01/2024 and 10/02/2023.

Findings include:

Example 1 - Resident 1

On 07/09/2024, at approximately 12:20 p.m., Surveyor interviewed Caregiver B regarding Resident 1's needs. Caregiver B reported that Resident 1 spoke mostly Spanish and some non-fluent English. Caregiver B reported that because of this, Resident 1 communicated mostly by pointing, or providing other non-verbal indicators, or answering yes/no questions. Caregiver B reported that Resident 1 required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 424	Continued From page 7	M 424		

some staff assistance with showering and toileting but was able to dress, feed him/herself, transfer, and ambulate independently without staff assistance. Caregiver B reported that Licensee C arranges all medical appointments for Resident 1. Caregiver B reported that Resident 1 displayed some verbal aggression and was known to take different items from the house back to his/her room, which s/he frequently then broke. Caregiver B reported that staff typically have to go in his/her room to retrieve items that Resident 1 has taken from the home.

At approximately 2:05 p.m., Surveyor requested from Administrator A all of Resident 1's care plans since his/her admission.

On 07/11/2024, Surveyor reviewed records for Resident 1. Resident 1 was admitted to the provider on 08/04/2023 with diagnoses including autistic disorder, Down syndrome, and mild intellectual disability.

Surveyor reviewed Resident 1's current ISP, which was labeled as a "Member Care Plan" developed by his/her managed care organization (MCO) team and dated 04/01/2024. The following was documented in the care plan:

- Under the "Living Environment" goal: "[S/he] may or may not try to do some of [his/her] cares. Still needs reminders to do all the steps and follow through. [S/he] is doing some of the care when directed."

- Under the "Bathing" section: "[Adult family home (AFH)] staff" listed as being responsible. Nothing else was documented about how the provider's staff were meeting those needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 424	Continued From page 8 - Under the "Toileting" section: ""AFH staff" listed as being responsible. Nothing else was documented about how the provider's staff were meeting those needs. - Under the "Incontinence Care" section: "AFH staff" listed as being responsible. Nothing else was documented about how the provider's staff were meeting those needs. - Under the "Feeding" section: "AFH staff" listed as being responsible. Nothing else was documented about how the provider's staff were meeting those needs. - Under the "Supervision" section: "AFH staff" listed as being responsible. Nothing else was documented about how the provider's staff were meeting those needs. - Under the "Communication" section: "[Guardian]; AFH staff" listed as being responsible. Nothing else was documented about how the provider's staff were meeting those needs. - Under the "Obstacles or Risks" section: "-~Limited cognitive abilities - nonverbal - difficulty communicating..." Nothing else was documented about how the provider's staff were meeting those needs. There was no information about Resident 1's needs for dressing and grooming assistance. In reviewing Resident 1's admission assessment, dated 07/14/2023, it was documented that Resident 1 required clothing to be laid out or handed to him/her for dressing assistance and that "Someone must assist the participant to groom self."	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 424	Continued From page 9 Surveyor reviewed the only other ISP for Resident 1 created since his/her admission to the provider, dated 10/01/2023. This care plan was also labeled as a "Member Care Plan" developed by his/her managed care organization (MCO) team. The same information as above was documented in this care plan. On 07/19/2024, at approximately 12:32 p.m., Surveyor interviewed Administrator A. Administrator A confirmed that the provider used Resident 1's MCO care plans in place of developing their own ISP for him/her. In reviewing some of the activities of daily living (ADLs) from Resident 1's ISPs, Administrator A acknowledged Surveyor's concern that a specific description of services to meet Resident 1's needs or level of supervision required was not documented. Administrator A corroborated Caregiver B's report and stated that Resident 1 was independent in some self-cares but required staff assistance with others. Example 2 - Resident 2 On 07/09/2024, at approximately 2:05 p.m., Surveyor requested from Administrator A all of Resident 2's care plans since his/her admission. On 07/11/2024, Surveyor reviewed records for Resident 2. Resident 2 was admitted to the provider on 03/08/2023 with diagnoses including major depressive disorder. Resident 2 was documented as having a legal guardian. Resident 2's ISP was signed by Administrator A as reviewed on 10/02/2023 and 04/01/2024. There was no evidence that Resident 2's ISP was reviewed by his/her guardian.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 424	Continued From page 10 On 07/19/2024, at approximately 12:32 p.m., Surveyor interviewed Administrator A. Administrator A reported that s/he had signed off on the ISP reviews completed on the above 2 dates, but confirmed s/he had no evidence that the ISP was reviewed with Resident 2's legal guardian on those dates.	M 424		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that medication was stored correctly or residents were assisted with taking the correct dosage for 2 of 3 residents that required assistance with medication management. From 05/01/2024 through 07/17/2024, staff documented applying Resident 1's Eucerin cream daily - 78 days of administration. Upon observation, Resident 1's sole Eucerin container, which was dispensed on 08/03/2023, appeared 90% full. Two different PRN medications the provider had	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 462	Continued From page 11	M 462		

on hand for Resident 3, who had current prescriptions for those medications, were expired for at least 2 years.

Findings include:

Example 1 - Resident 1

On 07/09/2024, at approximately 12:00 p.m., Surveyor reviewed the medication closet with Caregiver B. Surveyor observed the following medications for Resident 1:

- 1 container of Eucerin cream, 16 oz. The pharmacy label indicated the container was prescribed to Resident 1, dispensed on 08/03/2023, and contained instructions to, "Apply topically to entire body in the morning." The container appeared to be approximately 90% full (Photos 10, 11, and 12).

While reviewing the medication closet, Surveyor interviewed Caregiver B. Caregiver B reported that Resident 1 receives assistance with medication administration.

On 07/17/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 08/04/2023 with diagnoses including autistic disorder, Down syndrome, and mild intellectual disability. Surveyor reviewed Resident 1's current ISP, which was labeled as a "Member Care Plan" developed by his/her managed care organization (MCO) team and dated 04/01/2024. Under the "Assistance with Medications" section, "[Adult family home (AFH)] staff" were listed as being responsible to provide assistance.

Surveyor reviewed Resident 1's active prescriptions, which included "Eucerin (Minerin)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 462	Continued From page 12	M 462		

cream" with instructions to, "Apply topically to entire body in the morning." Surveyor reviewed Resident 1's medication administration records (MARs) from 05/01/2024 through 07/17/2024, where Licensee C documented applying Resident 1's Eucerin cream daily for each of the dates in the above range - 78 days of application.

On 07/19/2024, at approximately 11:32 a.m., Surveyor interviewed Representative D from the pharmacy that fulfilled Resident 1's prescriptions. Representative D reported that the only date Resident 1's Eucerin cream prescription was filled was 08/03/2023.

At approximately 11:51 a.m., Surveyor interviewed Case Manager E, who was the case manager for Resident 1. Case Manager E reported that Resident 1 was known to have skin eczema (a skin rash). Case Manager E confirmed that staff were to be applying Eucerin cream to Resident 1 daily.

At approximately 12:32 p.m., Surveyor interviewed Administrator A. Administrator A acknowledged Surveyor's concern that the most recent 78 days of documented application of Resident 1's Eucerin to his/her body did not seem consistent with his/her Eucerin container, most recently dispensed on 08/03/2023, being approximately 90% full. Administrator A reported s/he would have to follow up with Licensee C about it.

On 07/23/2024, at approximately 1:48 p.m., Surveyor interviewed Guardian F, who was Resident 1's legal guardian. Guardian F reported that Resident 1 was known to have a skin condition that affected his/her head and neck but s/he wasn't sure what it was called. Guardian F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 462	Continued From page 13	M 462		

reported that when Resident 1's skin "flared up" it was known to appear red. Guardian F reported s/he has had past conversations with care staff where s/he has asked them if they have been applying Resident 1's cream. Guardian F reported that in response s/he has received a "deer in the headlights" look from staff with no answer.

Example 2 - Resident 3

On 07/09/2024, at approximately 12:00 p.m., Surveyor reviewed the medication closet with Caregiver B. Surveyor observed the following 3 expired as-needed (PRN) medications for Resident 3:

- 1 medication card of diphenhydramine 50 mg capsules with instructions to, "Take 1 capsule by mouth at bedtime as needed (insomnia)." The printed information on the card indicated that it was dispensed on 06/15/2021 and documented, "Do not use beyond: 06/14/22" (approximately 2 years prior to the survey).

- 2 bottles of saline mist (deep sea) 0.65% nasal spray. One bottle contained instructions to, "Instill 2 sprays in each nostril twice a day as needed." The pharmacy label on that bottle indicated that it was dispensed on 05/18/2021 and documented, "Use by 11/14/21" (approximately 2.75 years prior to the survey). The other bottle contained instructions to, "Use 2 sprays in nostril(s) 2 times a day as needed." The pharmacy label on that bottle indicated that it was dispensed on 06/15/2021 and that it should be discarded after "6/2022" (approximately 2 years prior to the survey).

While reviewing the medication closet, Surveyor interviewed Caregiver B. Caregiver B reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018147	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 462	Continued From page 14 that Resident 3 receives assistance with medication administration and management. Caregiver B reported s/he was unaware that the above medications were expired. On 07/11/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 06/08/2020. Resident 3's current PRN prescriptions included diphenhydramine 50 mg capsules and saline mist (deep sea) 0.65% nasal spray - all with the same administration instructions as documented above. On 07/19/2024, at approximately 12:32 p.m., Surveyor interviewed Administrator A. Administrator A acknowledged Surveyor's concern regarding the provider having expired PRN medications on hand for residents with current prescriptions of those same medications. Administrator A reported s/he would have to follow up with Licensee C about it.	M 462		