Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016620	A. BUILDING: _____ B. WING _____	R-C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1 VILLARD STREET MANOR	5277 N 29TH STREET APT 1 MILWAUKEE, WI 53208

(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 08/22/2024 with information gathered through 08/23/2024, Surveyors conducted a verification visit and two complaint investigations at 1 Villard Street Manor, an Adult Family Home (AFH) in Milwaukee, WI. Seven deficiencies identified. Seven of 7 deficiencies are repeat deficiencies. Two of 2 complaints unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
{M 216}	88.04(2)(a) RESPONSIBILITIES 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 observation, record review, and interviews, the provider did not ensure the home and its operation complied with this chapter and all other laws governing the home and its operations potentially affecting 3 of 3 residents. The provider has been unable to maintain compliance with Chapter 88 of the Department of Health Services-Licensed Adult Family Home regulations. At the time of this verification visit, the provider had 7 repeat violations. The provider did not follow Special Orders which resulted from previous statement of deficiency (SOD) LWDS14, dated 02/27/2024.	{M 216}		

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

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{M 216}	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) LWDS14, dated 02/27/2024 and SOD LWDS12, dated 10/20/2022. Findings include: On 03/29/2024, SOD LWDS14 and a Special Orders Letter were issued to Licensee A via email with the following: Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that 1 Villard Street Manor: CONSULTANT REQUIRED 1. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., effective immediately, the licensee shall ensure medication administration is safe, accurate, and appropriate to each resident's needs. The licensee will correct all deficiencies identified in Statement of Deficiency (SOD) LWDS14 in consultation with a registered nurse (RN), not currently affiliated with the licensee, at the licensee's expense. The consultant will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 88 and Wis. Stat. ch. 50) and knowledge of the client groups served by 1 Villard Street Manor. The licensee will provide the consultant with a copy of the SOD LWDS14, along with this Notice and Order letter prior to providing consultation services. In collaboration with the consultant, the licensee will develop (or review/revise) a written procedure to address: Medication Management and Administration Including how the provider will: (a) document	{M 216}		

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{M 216}	Continued From page 2	{M 216}		

medication orders, medication administration, and missed/refused doses; (b) administer medications to ensure residents receive medications at the intervals and dosages prescribed; (c) prevent medication errors; (d) respond to medication errors if they occur; and (e) monitor for adverse side effects. Resources are available at: https://www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm

ADDITIONALLY, WITHIN 45 DAYS of receipt of this notice, all service providers, with assigned duties for medication management and administration, will receive in-service training regarding the provider's written procedure required by Order #1. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training.

Consultation activities, including dates of consultation, will be documented, signed, and dated by the consultant.

A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request.

2. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for each current resident with a copy of Statement of Deficiency LWDS14 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the Department, to verify compliance with Order #2. Acceptable

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{M 216}	Continued From page 3 documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the Department representatives upon request. On 08/22/2024 with information gathered through 08/23/2024, Surveyors conducted a verification visit and complaint investigation at 1 Villard Street Manor. As a result of the survey, the provider was issues 7 deficiencies. Seven of the 7 were repeat deficiencies. 88.04(2)(a) Responsibilities - This is a repeat deficiency. 88.04(2)(g)(2) Communicable Disease - This is a repeat deficiency. 88.06(3)(d) Individual Service Plan - This is a repeat deficiency. 88.07(1)(e) Overnight Supervision- This is a repeat deficiency. 88.07(3)(a) Prescription Medications - This is a repeat deficiency. 88.07(3)(e)1 Medication - Record Keeping - This is a repeat deficiency. 88.10(3)(g) Medications-This is a repeat deficiency. On 08/22/2024 at approximately 11:00 AM, Surveyors reviewed SOD LWDS14 and the Special Orders Letter with Licensee A. Licensee A stated s/he did not read over the special orders when s/he received them on 03/29/2024 and was not aware of the requirements. Licensee A stated s/he did not follow the special orders.	{M 216}		
{M 234}	88.04(2)(g)2 COMMUNICABLE DISEASE The licensee shall ensure that no one	{M 234}		

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{M 234}	Continued From page 4 who has a communicable disease reportable under ch. HSS 145 may work in a position in the adult family home where the disease would present a significant risk to the health or safety of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each service provider was screened for illness detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service for 1 of 1 caregiver (Caregiver R) reviewed. This requirement is being cited for a fifth time. See Statement of Deficiency (SOD) LWDS14, dated 02/27/2024, SOD LWDS13, dated 04/24/2023, SOD LWDS12, dated 10/20/2022 and SOD LWDS11, dated 12/02/2021. Findings include: On 08/22/2024, at 10:30 AM, Surveyor reviewed Caregiver R's employee record. Caregiver R was hired on 07/31/2024. Caregiver R had a communicable disease screening questionnaire in her/his file. The communicable disease screening questionnaire was not signed. There was no evidence a TB test was completed. On 08/22/2024, at 10:35 AM, Surveyors interviewed Licensee A. Licensee A stated s/he thought Caregiver R went and completed his/her TB skin test. Licensee A stated s/he would send Caregiver R immediately to get his/her communicable disease screening and TB skin test completed.	{M 234}		

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M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 individual service plans (ISP) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 4's, Resident 6's and Resident 7's ISPs did not include a signed statement of agreement with all parties involved. Findings include: On 08/22/2024, at approximately 10:30 AM, Surveyors reviewed resident records and identified the following concerns: - Resident 4 was admitted to the provider's home on 12/12/2023. Resident 4 was his/her own person. Surveyor did not see evidence of an ISP. - Resident 6 was admitted to the provider's home on 04/26/2024. Resident 6 had an activated power of attorney. Surveyor reviewed Resident 6's ISP dated 05/09/2024. The ISP was blank and not signed by any parties involved. - Resident 7 was admitted to the provider's home on 04/10/2024. Resident 7 had a guardian. Surveyor reviewed Resident 7's ISP dated 05/15/2024. The signature page was blank and not signed by any parties involved. On 08/22/2024 at 11:00 AM, Surveyors	M 420		

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M 420	Continued From page 6 interviewed Licensee A. Licensee A stated s/he thought they could use the Managed Care Organization's (MCO)'s care plans so s/he did not create one for Resident 4. Licensee A then stated s/he did start one for Resident 6 and Resident 7 but it was not signed by their power of attorney or guardian. Licensee A acknowledged moving forward s/he would create their own ISP and have any parties involved sign off on the ISP.	M 420		
{M 434}	88.07(1)(e) OVERNIGHT SUPERVISION The licensee shall arrange for a service provider to be present in the home when the licensee is gone overnight or when the licensee's absence prevents the resident from receiving the services, training or supervision specified in the resident's individual service plan under s. HSS 88.06(3). This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not arrange for a service provider to be present in the home when a resident required services or supervision. The licensee shared staff between 2 provider homes and did not ensure the provider's home was staffed when 3 of 3 residents (Resident 4, Resident 6 and Resident 7) required continuous care. This is a repeat deficiency from Statement of Deficiency (SOD) LWDS14 dated 02/27/2024. Findings include:	{M 434}		

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{M 434}	Continued From page 7 On 08/22/2024, at 08:34 AM, upon entrance to the adult family home (AFH), Surveyors observed the building had 4 apartments, 2 on the upper level and 2 on the lower level. The apartment on the south side was labeled as Apartment 1, the apartment on the north side was labeled as Apartment 2. The front doors to the lower-level apartments were wide open. Surveyors followed Caregiver Q into Apartment 1. Caregiver Q confirmed Apartment 1 was the licensed AFH. Caregiver Q confirmed s/he was the only caregiver working for both sides (Apartment 1 and Apartment 2) of the home. Caregiver Q stated the other side was not a licensed home but s/he was providing cares to Apartment 1 and Apartment 2. Caregiver Q stated s/he was left alone to work both sides around 7:30 AM when the night shift caregiver went home and another caregiver should be coming in around 9:00 AM or 9:30 AM to help. On 08/22/2024 at 9:20 AM, Caregiver R arrived to work. Caregiver R stated it was usually his/her day off but s/he came in to help. Caregiver R stated sometimes there were two staff during the day shift but usually from 3:00 PM to 6:00 AM, there was only one caregiver for both Apartment 1 (which is a licensed AFH) and Apartment 2 (which is not licensed home). On 08/22/2024 at 10: 05 AM, Surveyors reviewed resident records and identified the following: -Resident 4's facility facesheet stated s/he was admitted on 12/12/2023, with diagnoses including cellulitis, amputee- (below knees, right arm, and below left elbow), early signs of mental illness present, and wounds. -Resident 6 was admitted on 04/26/2024	{M 434}		

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{M 434}	Continued From page 8 -Resident 6's Managed Care Organization's Member Centered Plan dated 04/01/2024 stated s/he had diagnoses including adjustment disorder with mixed anxiety and depressed mood, alcohol dependence with alcohol-induced mood disorder, bilateral primary osteoarthritis of knee, chronic pain syndrome, paraplegia, pressure ulcer of left buttock stage 4 and pressure ulcer of right heel unstageable. -Resident 7 was admitted on 04/10/2024 -Resident 7's Managed Care Organization's Member Placement Referral dated 03/21/2024 stated s/he had diagnoses including hyperlipidemia, hyperglycemia, pre-diabetes, obesity, chronic pain, dementia; neurocognitive disorder, anxiety, depression, schizophrenia, delusional disorder and insomnia. Resident 7 needs total assistance with cares. -Resident 7's placement referral dated 03/21/2024 stated, [Resident 7] engages in wandering behaviors for the day and night time hours. Behavior includes unsafely leaving or attempting to leave an immediate area, such as a home, community setting. Triggers include attention seeking, internal stimuli, frustration, anger, expectations, limits, and boundaries, assistance with cares, and abrupt change in routine or schedule. On 08/22/2024, at 11:15 AM, Surveyors interviewed Licensee A. Licensee A confirmed there were times when there was only one caregiver for Apartment 1 (which is the licensed AFH) and Apartment 2 (which is not a licensed home). Licensee A confirmed if there was only one caregiver working and the staff were in Apartment 2 helping residents, that would leave Apartment 1 without any caregivers and all 3 of the residents require 24 hour supervision.	{M 434}		

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{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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 resident (Resident 4) prescription medications were securely stored. Resident 4's morning prescription medications were located in a small clear cup on a bedside table in Resident 4's bedroom. This is a repeat deficiency. See Statement of Deficiency (SOD) LWDS12, dated 10/20/2022 and SOD LWDS14, dated 02/27/2024. Findings include: On 08/22/2024 at approximately 9:00 AM, Surveyors toured the facility and observed the following: Resident 4's morning prescription medications were in a small clear cup on a bedside table in Resident 4's bedroom which contained the following medications:	{M 458}		

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{M 458}	Continued From page 10 - Clindamycin hydrochloride (Hcl) 150 milligrams (mg) (1 pill) - Clindamycin Hcl 300 mg (1 pill) - Omeprazole delayed release (Dr) 20 mg (1 pill) - Ondansetron orally disintegrating tablets (Odt) 4 mg (1 pill) - Oxybutynin chloride (Cl) extended release (Er) 15 mg (1 pill) - Vitamin C 500 mg tablet (1 pill) - Ariprazole 15 mg tablet (1 pill) - Diltiazem Hcl 120 mg capsules (1pill) - Loratadine 10 mg tablets (1 pill) - Metoprolol Succinate Er 100 mg tablet (1 pill) - Potassium Cl Er 20 milliequvalent (Meq) tablet (2 pills) - Tab-A-Vite Multivitamin with Iron (1 pill) On 08/22/2024 at approximately 9:00 AM, Surveyors interviewed Resident 4. Resident 4 explained s/he did not know why staff left her/his medications on the bedside table. Resident 4 stated that s/he had no arms and was unable to take her/his own medications. Resident 4 stated that s/he had to eat before taking medications or s/he would get nausea. On 08/22/2024 at approximately 11:00 AM, Surveyors interviewed Licensee A. Licensee A confirmed all prescription medications were to be securely stored. Licensee A stated that Resident 4 needed staff assistance with medication administration. Licensee A stated s/he did not know why Resident 4's prescription medications were on the bedside table in her/his room.	{M 458}		
{M 466}	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications	{M 466}		

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{M 466}	Continued From page 11 controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an accurate record of medication administration for 3 of 3 residents (Resident 4, Resident 6 and Resident 7). The Medication Administration Records (MARs) for Resident 4, Resident 6, and Resident 7 contained omissions in August 2024. This requirement is being cited for a fourth time. See Statement of Deficiency (SOD) LWDS12, dated 10/20/2022, SOD LWDS13, dated 04/24/2023, and SOD LWDS14, dated 02/27/2024. Findings include: On 08/22/2024, at 8:43 AM, Surveyors reviewed resident records and identified the following: Example 1 - Resident 4 - Resident 4 was admitted to the provider's home on 12/12/2023, with diagnoses including Celluitis unspecified, amputee (below knees and arms), and early signs of mental illness. Surveyors reviewed Resident 4's MAR for the month of August 2024. The following entries in Resident 4's MAR were blank:	{M 466}		

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{M 466}	Continued From page 12 clindamycin hydrochloride (HCL) 150 milligrams (mg), capsule 8:00 AM - 08/13/2024 clindamycin HCL 150 mg capsule 4:00 PM - 08/20/2024 clindamycin HCL 150 mg capsule 9:00 PM - 08/20/2024 clindamycin HCL 300 mg capsule 8:00 AM - 08/13/2024 and 08/15/2024 - 08/16/2024 clindamycin HCL 300 mg capsule 4:00 PM - 08/14/2024 and 08/19/2024 - 08/20/2024 clindamycin HCL 300 mg capsule 9:00 PM - 08/20/2024 Example 2 - Resident 6 - Resident 6 was admitted to the provider's home on 04/26/2024, Surveyors reviewed Resident 6's MAR for the month of August 2024. The following entries in Resident 6's MAR were blank: gabapentin 400 mg capsule 12:00 PM - 08/18/2024 and 08/21/2024 gabapentin 400 mg capsule 9:00 PM - 08/15/2024 and 08/20/2024 ropinirole HCL 1 mg tablet 12:00 PM - 08/15/2024 - 08/18/2024 and 08/21/2024 ropinirole HCL 1 mg tablet 4:00 PM - 08/15/2024 and 08/19/2024 - 08/20/2024 suboxone 8-2 mg firm place 12:00 PM 08/19/2024 - 08/20/2024 Example 3 - Resident 7 - Resident 7 was admitted to the provider's home on 04/10/2024, Surveyors reviewed Resident 7's MAR for the month of August 2024. The following entries in Resident 7's MAR were blank: olanzapine 5 mg tablet 9:00 PM - 08/20/2024	{M 466}		

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{M 466}	Continued From page 13 melatonin 3 mg tablet 9:00 PM - 08/15/2024 and 08/20/2024 memantine HCL 10mg tablet - 08/15/2024 and 08/20/2024 - 08/21/2024 On 08/22/2024, at 11:00 AM, Surveyors interviewed Licensee A. Licensee A confirmed the MAR's should have been documented accurately. Licensee A stated s/he needed to ensure all staff were documenting the medication administration properly.	{M 466}		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on observation record review and interviews, the provider did not ensure each resident received all prescribed medications in the dosage and at the intervals prescribed by the resident's physician for 3 of 3 residents (Resident 4, Resident 6, and Resident 7) reviewed. Resident 4 had a total of 11 medications not administered between 08/17/2024 and 08/20/2024. Resident 6 had a total of 9 medications not administered between 08/15/2024 and 08/19/2024. Resident 7 had a total of 4 medications not administered on	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016620	A. BUILDING: _____ B. WING _____	R-C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 582	Continued From page 14 08/20/2024. This is a repeat deficiency from Statement of Deficiency (SOD) LWDS12 dated 10/20/2022. Findings include: On 08/22/02024 at approximately 9:46 AM, Surveyors observed the locked medication closet. Inside the locked medication closet contained Resident 4's, Resident 6's, and Resident 7's bin of medication. Surveyors observed Resident 4's, Resident 6's and Resident 7's medications were in unit dose packaging. Resident 4's, Resident 6's and Resident 7's bin contained medications for past dates. Resident 4's, Resident 6's and Resident 7's bin of medications contained the following: Resident 4 - Clindamycin hydrochloride (HCL) 150 milligrams (mg) capsule was not administered on 08/17/2024 and 08/20/2024 (A total of 2 doses). - Clindamycin HCL 300 mg capsule was not administered on 08/17/2024 and 08/20/2024 (A total of 2 doses). - Acidophilus capsule was not administered on 08/19/2024 and 08/20/2024 (A total of 2 doses). - Vitamin C 500 mg tablet was not administered on 08/19/2024 (A total of 1 dose). - Melatonin 10 mg tablet was not administered on 08/20/2024 (A total of 1 dose). - Mirtazapine 15 mg tablet was not administered on 08/20/2024 (A total of 1 dose). - Prazosin 1 mg capsule was not administered on 08/20/2024 (A total of 1 dose). - Quetiapine fumarate 25 mg tablet was not on 08/20/2024 (A total of 1 dose). Resident 4 had a total of 11 medications not	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016620	A. BUILDING: _____ B. WING _____	R-C 08/23/2024

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M 582	Continued From page 15 administered between 08/17/2024 and 08/20/2024. Resident 6 - Gabapentin 400 mg 3 capsules were not administered on 08/15/2024 and 08/17/2024 (A total of 6 capsules/2 doses). - Ropinirole HCL 1 mg tablet were not administered on 08/15/2024, 08/17/2024 and 08/19/2024 (A total of 3 doses). Resident 6 had a total of 9 medications not administered between 08/15/2024 and 08/19/2024. Resident 7 - Melatonin 3 mg 2 tablets were not administered on 08/20/2024 (A total of 2 tablets/1 dose). - Memantine HCL 10 mg tablet were not administered on 08/20/2024 (A total of 1 dose). - Olanzapine 5 mg tablet were not administered on 08/20/2024 (A total of 1 dose). Resident 7 had a total of 4 medications not administered on 08/20/2024. On 08/22/2024, at 11:00 AM, Surveyors interviewed Licensee A. Licensee A stated that all residents required staff to administer medications. Licensee A confirmed past dates of Resident 4's, Resident 6's, and Resident 7's medications in unit dose packaging in residents' bins. Licensee stated that he did not know why staff did not give medications. Licensee A stated moving forward s/he would ensure each resident receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician.	M 582		