STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018852	A. BUILDING: _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A+ JUST LIKE FAMILY AFH	2611 VIRGINIA ST RACINE, WI 53406

(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 08/01/2023, Surveyor concluded a complaint investigation at A+ Just Like Family. As a result, 2 deficient practices were identified. The complaint was substantiated. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the licensing agency, within 24 hours, a significant change in 1 of 1 resident's status. Resident 1 eloped from the facility 3 times and her/his whereabouts were unknown. Findings include: On 07/25/2023, at 9:50 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 05/08/2023, with diagnoses including depression, schizophrenia, and intellectual disability. Resident 1 had a legal guardian.	M 134		

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

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M 134	Continued From page 1 Surveyor reviewed incident reports (IRs) and identified the following: -Incident report, dated 05/19/2023, stated "Resident had gotten redirected about grabbing cookies out of pantry without saying anything [sic] Resident got upset and slammed door when asked not to do that began to use profanity then stepped outside as if to catch some air and when check on was gone." The incident report indicated police were notified. -Incident report, dated 07/13/2023, stated "Resident left with transportation to take SSC to careers to possibly get hired [sic] came back with attitude and when getting out of the care said to not talk to [him/her] with profanity and then walked off saying call the police." The incident report indicated the police were notified. -Incident report, dated 07/14/2023, stated "resident [Resident 1] asked staff to order [him/her] food off [his/her] card staff told [him/her] no because the house lead told [s/he] cant [sic] so [s/he] went to [his/her] room and jumped out the window and took off running down the street." The incident report indicated the police were notified. Surveyor reviewed Resident 1's individual service plan (ISP), dated 05/25/2023. Resident 1's ISP reported Resident 1 required some supervision. Resident 1's ISP was updated on 07/18/2023. Resident 1's updated ISP did not indicate the level of supervision Resident 1 required. On 07/25/2023, at 10:30 AM, Surveyor interviewed Caregiver C. Caregiver C reported Resident 1 required supervision when out in the	M 134		

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M 134	Continued From page 2 community. Caregiver C reported when Resident 1 eloped from the facility, staff were to call the non-emergency police line to report Resident 1 was missing. On 07/25/2023, at 11:05 AM, Surveyor interviewed House Lead B. House Lead B reported Licensee A sent a report to the department regarding Resident 1's elopements from the facility. Surveyor inquired where Licensee A sent the report. House Lead B reported Licensee A sent the report to Resident 1's case manager, Resident 1's guardian, and called the crisis center. House Lead B confirmed Licensee A did not send a report to the department. House Lead B reported Licensee A thought s/he only had to send a report to the department if Resident 1 was missing for at least 24 hours. On 08/01/2023, at 2:00 PM, Surveyor interviewed Licensee A. Licensee A reported s/he was unaware Resident 1's elopements needed to be reported to the department. Licensee A reported s/he contacted Resident 1's case manager and adult protective service. Licensee A reported s/he has reviewed the code and will ensure all elopements are reported as required.	M 134		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications 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	M 466		

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M 466	Continued From page 3 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 maintain a complete record of medications administered. Medication administration documentation contained omissions for multiple administration times for 1 of 1 resident (Resident 1). Findings include: On 07/21/2023, the department received a complaint with concerns of Resident 1 receiving all prescribed medications. On 07/25/2023, at 9:50 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 05/08/2023, with diagnoses including depression, schizophrenia, and intellectual disability. Surveyor reviewed Resident 1's July 2023 medication administration records (MARs) and observed some medications were not signed out as given. The MAR sheets included the names of the medications administered to Resident 1, the date and time Resident 1 took the medication and the initials of the staff person who administered the medication to Resident 1. Resident 1's July 2023 MAR identified the following medications: 1. Fluoxetine 10 milligrams (mg) capsule taken daily at 8 AM. Missed documentation on 07/01/2023, 07/02/2023, 07/14/2023, 07/15/2023, and 07/16/2023. This medication was	M 466		

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M 466	Continued From page 4	M 466		

discontinued on 07/17/2023. The MAR indicated this medication was administered on 07/21/2023 and 07/22/2023.

2. Fluoxetine 20 mg capsule taken daily at 8 AM. Missed documentation on 07/01/2023, 07/02/2023, 07/13/2023, 07/14/2023, 07/15/2023, and 07/16/2023. This medication was discontinued on 07/17/2023. The MAR indicated this medication was administered on 07/21/2023 and 07/22/2023.

3. Aripiprazole 15 mg tablet taken daily at 8 AM. Missed documentation on 07/01/2023, 07/02/2023, 07/13/2023, 07/14/2023, 07/15/2023, and 07/16/2023.

4. Fluticasone 50 micrograms (mcg) taken daily at 8 AM. Missed documentation on 07/01/2023, 07/02/2023, 07/13/2023, 07/14/2023, 07/15/2023, and 07/16/2023.

5. Propranolol 40 mg tablet taken twice daily at 8 AM and 8 PM. Missed documentation for 8 AM dose on 07/01/2023, 07/02/2023, 07/13/2023, 07/14/2023, 07/15/2023, and 07/16/2023. Missed documentation for 8 PM dose on 07/01/2023, 07/02/2023, 07/03/2023, 07/04/2023, 07/05/2023, 07/06/2023, 07/07/2023, 07/08/2023, 07/09/2023, 07/11/2023, 07/12/2023, 07/13/2023, 07/14/2023, 07/15/2023, and 07/16/2023.

6. Divalproex 250 mg tablet taken twice daily at 8 AM and 8 PM. Missed documentation for 8 AM dose on 07/01/2023, 07/02/2023, 07/13/2023, 07/14/2023, 07/15/2023, and 07/16/2023. Missed documentation for 8 PM dose on 07/01/2023, 07/02/2023, 07/03/2023, 07/04/2023, 07/05/2023, 07/06/2023, 07/07/2023, 07/08/2023, 07/09/2023, 07/10/2023, 07/11/2023, 07/12/2023, 07/13/2023,

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M 466	Continued From page 5	M 466		

07/14/2023, 07/15/2023, and 07/16/2023. This medication was discontinued on 07/17/2023. The MAR indicated this medication was administered on 07/21/2023 and 07/22/2023.

7. Benztropine 1 mg tablet taken twice daily at 8 AM and 8 PM. Missed documentation for 8 AM dose on 07/01/2023, 07/02/2023, 07/13/2023, 07/14/2023, 07/15/2023, and 07/16/2023. Missed documentation for 8 PM dose on 07/01/2023, 07/02/2023, 07/03/2023, 07/04/2023, 07/05/2023, 07/06/2023, 07/07/2023, 07/08/2023, 07/09/2023, 07/10/2023, 07/11/2023, 07/12/2023, 07/13/2023, 07/14/2023, 07/15/2023, and 07/16/2023.

8. Olanzapine 10mg tablet taken once daily at 8 PM. Missed documentation on 07/01/2023, 07/02/2023, 07/03/2023, 07/04/2023, 07/05/2023, 07/06/2023, 07/07/2023, 07/08/2023, 07/09/2023, 07/10/2023, 07/11/2023, 07/12/2023, 07/13/2023, 07/14/2023, 07/15/2023, and 07/16/2023.

Surveyor reviewed a second July 2023 MAR for Resident 1, dated 08/2023. This MAR contained medication changes and omissions in medication administration.

1. Fluoxetine 40 mg capsule taken daily at 8 AM. Missed documentation 07/21/2023, 07/22/2023 and 07/25/2023.

2. Aripiprazole 15 mg tablet taken daily at 8 AM. Missed documentation on 07/23/2023.

3. Fluticasone 50 mcg taken daily at 8 AM. Missed documentation on 07/23/2023.

4. Propranolol 40 mg tablet taken twice daily at 8 AM and 8 PM. Missed documentation for 8 PM dose on 07/17/2023, 07/19/2023, 07/21/2023,

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M 466	Continued From page 6 07/22/2023, and 07/23/2023. 5. Benztropine 1 mg tablet taken twice daily at 8 AM and 8 PM. Missed documentation for 8 PM dose on 07/17/2023, 07/19/2023, 07/21/2023, 07/22/2023, and 07/23/2023. 6. Olanzapine 15 mg tablet taken once daily at 8 PM. Missed documentation on 07/17/2023, 07/21/2023, 07/22/2023, and 07/23/2023. 7. Divalproex 500 mg tablet taken once daily at 8 PM. Missed documentation on 07/17/2023, 07/21/2023, 07/22/2023, and 07/23/2023. On 07/25/2023, at approximately 10:30 AM, Surveyor interviewed Caregiver C. Caregiver C reported Resident 1 had a medication change after a doctor visit. Caregiver C reported the pharmacy did not send out a new MAR for 07/2023, but the pharmacy did send out the 08/2023 MAR with the new medication changes. Caregiver C reported they started using the 08/2023 MAR for July's medication administration. When Surveyor inquired about the initials on discontinued medications, Caregiver C stated "The staff member was probably confused and initialed the wrong MAR." When Surveyor stated the staff member did use the correct month's MAR with incorrect medications, Caregiver C stated, "That's why we are using August's MAR." On 08/01/2023, at 2:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed staff were to document all medication administration. Licensee A reported a staff member was unable to see the lines to initial the MAR. Licensee A reported all staff had been retrained recently to ensure all medication documentation was completed at time	M 466		

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M 466	Continued From page 7 medications were administered. When Surveyor inquired what is the procedure for when a resident had a medication change, and the incorrect month was sent from pharmacy. Licensee A reported staff were to copy the new MAR with the medication changes, change the month at the top of the MAR, and use the MAR to ensure correct medications were being administered.	M 466		