STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015924	A. BUILDING: _____ B. WING _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST COLETTA OF WI ST JULIAN AFH	2812 SUMMIT AVE WAUKESHA, WI 53188

(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 01/15/2025 - 01/21/2025, Surveyor conducted an abbreviated licensing survey at St. Coletta of WI St. Julian. Two deficiencies identified. Census: 4	M 000		
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 maintain a safe, clean, and home-like environment. Findings include: On 01/15/2025 at 8:03 AM, Surveyor toured the home, and the following was observed: - 3 resident room garbage bins were full, overflowing, and did not have visible garbage bags containing the trash. -In both resident bathrooms, the shelf next to the shower was covered with dried water spots/staining, and a dried residue that appeared to be the bottom of a glove or Kleenex box that adhered to the surface.	M 276		

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
	0015924	A. BUILDING: _____ B. WING _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST COLETTA OF WI ST JULIAN AFH	2812 SUMMIT AVE WAUKESHA, WI 53188

(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 1 -Many areas of the home contained dust and cobwebs including resident bedroom walls, a resident bedroom ceiling fan, and 1 of 2 resident bathroom fans. On 01/15/2025 at 8:50 AM, Surveyor interviewed Area Manager A and House Manager B regarding cleaning of the home. It was stated the residents and some of their families assisted in cleaning, and on Sundays staff were supposed to complete deep cleans of the home. They shared maintenance requests that explained why certain repairs had not been made yet but could not provide reason for the conditions described above.	M 276		
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 interview, the provider did not ensure 2 of 2 residents received all prescribed medications in the dosage and intervals prescribed by the residents' physicians. Resident 1 missed over 300 doses of fluticasone	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015924	A. BUILDING: _____ B. WING _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST COLETTA OF WI ST JULIAN AFH	2812 SUMMIT AVE WAUKESHA, WI 53188

(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 582	Continued From page 2 from January 2024 to January 2025. Resident 2 missed over 250 doses of fluticasone from January 2024 to January 2025. Findings include: Example 1- Resident 1 On 01/15/2025, Surveyor reviewed Resident 1's record and identified the following: Resident 1 admitted on 01/20/2016 with diagnosis including autism, severe intellectual disabilities, and sleep apnea. Resident 1's physician orders indicated Resident 1 was prescribed Fluticasone Propionate 50 mcg/actuation with instructions to use 2 sprays in each nostril daily. A review of Resident 1's medication administration record (MAR) from 08/01/2024 - 01/15/2025 documented that every dose had been administered. On 01/15/2025, Surveyor observed the medication storage and found 1 bottle of Fluticasone 50 MCG/ACT NSL SPR. The pharmacy label documented the bottle was filled on 01/17/2024 and belonged to Resident 1. The bottle was over half-way filled with medication. On 01/15/2025, Surveyor asked Area Manager A and House Manager B about the administration of this medication. House Manager B stated Resident 1 received the medication as prescribed, and that Resident 1 would alert staff if they missed 1 of (his/her) medications. Surveyor asked about the bottle being filled so long ago, and what the order process was like when it ran low. House Manager B stated the staff will	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015924	A. BUILDING: _____ B. WING _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST COLETTA OF WI ST JULIAN AFH	2812 SUMMIT AVE WAUKESHA, WI 53188

(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 582	Continued From page 3	M 582		

re-order things when running low, and that multiple bottles will come from pharmacy so (s/he) picks one and gives it to staff to use. Surveyor inquired about reviewing any additional bottles on hand, and any delivery record if available. The provider did not maintain medication delivery records beyond very recent orders. House Manager B was able to show Surveyor 3 additional bottles of Fluticasone in Resident 1's name that was being stored in the office until it was needed. The additional bottles were dated as filled on 03/07/2024, 04/11/2024, and 05/09/2024 and were all unopened. Surveyor obtained the previous contracted pharmacy, and the current contracted pharmacy's contact information to obtain additional delivery information. Area Manager A stated the provider switched pharmacy providers around October 2024.

On 01/16/2025 at 4:20 PM, Surveyor spoke with Pharmacy Director C. Pharmacy Director C reviewed delivery records for Resident 1's Fluticasone, and the physician order. There were no additional deliveries on file other than the 4 bottles the provider had on hand. Pharmacy Director C stated Resident 1 received 4 sprays daily, and that each bottle of Fluticasone contained 120 sprays. One bottle of Fluticasone should last 30 days if administered correctly.

On 01/16/2025 at 4:30 PM, Surveyor spoke with Pharmacy Tech D. Pharmacy Tech D reported 1 delivery on 11/26/2024 and confirmed 1 bottle was a 30-day supply.

In total, Resident 1 had record of 5 deliveries of single bottles of Fluticasone from January 2024 - January 2025. Out of those 5, only 1 bottle had been used in full. At 30 days per bottle, there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015924	A. BUILDING: _____ B. WING _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST COLETTA OF WI ST JULIAN AFH	2812 SUMMIT AVE WAUKESHA, WI 53188

(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 582	Continued From page 4 should have been about 12 deliveries if the medication was being administered correctly. Example 2- Resident 2 On 01/15/2025, Surveyor reviewed Resident 2's record and identified the following: Resident 2 admitted on 09/12/2022 with diagnosis including brain injury and seasonal allergies. Resident 2's physician orders indicated Resident 2 was prescribed Fluticasone Propionate 50 mcg/actuation with instructions to use 1 spray in each nostril daily. A review of Resident 2's medication administration record (MAR) from 08/01/2024 - 01/15/2025 documented that every dose had been administered. On 01/15/2025, Surveyor observed the medication storage and found 1 bottle of Fluticasone 50 MCG/ACT NSL SPR. The pharmacy label documented the bottle was filled on 10/10/2024 and belonged to Resident 2. The bottle was over half-way filled with medication. On 01/15/2025, Surveyor asked Area Manager A and House Manager B about the administration of this medication. House Manager B stated Resident 2 received the medication as prescribed. Surveyor asked about the fill process was like when it ran low. House Manager B stated the staff will re-order things when running low, and that multiple bottles will come from pharmacy so (s/he) picks one and gives it to staff to use. Surveyor inquired about reviewing any additional bottles on hand, and any delivery record if available. The provider did not maintain medication delivery records beyond very recent orders. House Manager B was able to show	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015924	A. BUILDING: _____ B. WING _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST COLETTA OF WI ST JULIAN AFH	2812 SUMMIT AVE WAUKESHA, WI 53188

(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 582	Continued From page 5 Surveyor 2 additional bottles of Fluticasone in Resident 2's name that was being stored in the office until it was needed. The additional bottles were dated as filled on 02/27/2024 and 04/12/2024 and were all unopened. Surveyor obtained the previous contracted pharmacy, and the current contracted pharmacy's contact information to obtain additional delivery information. Area Manager A stated the provider switched pharmacy providers around October 2024. On 01/16/2025 at 4:20 PM, Surveyor spoke with Pharmacy Director C. Pharmacy Director C reviewed delivery records for Resident 2's Fluticasone, and the physician order. There were no additional deliveries on file other than the 3 bottles the provider had on hand. Pharmacy Director C stated Resident 2 received 2 sprays daily, and that each bottle of Fluticasone contained 120 sprays. One bottle of Fluticasone should last 60 days if administered correctly. On 01/16/2025 at 4:30 PM, Surveyor spoke with Pharmacy Tech D. Pharmacy Tech D reported 1 delivery on 11/25/2024 and confirmed 1 bottle was a 60-day supply. In total, Resident 2 had record of 4 deliveries of single bottles of Fluticasone from January 2024 - January 2025. Out of those 4, only 1 bottle had been used in full. At 60 days per bottle, there should have been about 6 deliveries if the medication was being administered correctly.	M 582		