| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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<br><br>From 06/19/2024 to 06/21/2024, Surveyor conducted a complaint investigation and standard survey at Hilltop Terrace LLC, an AFH in Milwaukee.<br><br>Eight deficiencies were identified. One deficiency was a repeat deficiency - See Statement of Deficiency (SOD) NLCY11, dated 12/22/2023.<br><br>The complaint was substantiated.<br><br>Census: 2 | M 000 | | |
| M 114 | 88.03(3)(b) CRIMINAL RECORDS CHECK<br><br>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 | 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 |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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<br>property of adults or minors or activities of the adult family home, 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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure a criminal records check was completed for 2 of 3 caregivers reviewed. The provider did not have a complete background check on file for Caregiver G and Caregiver E.<br><br>Findings include:<br><br>On 06/19/2024 at approximately 9:30 a.m. Surveyor requested employee records, including complete background checks, from Licensee A. A complete background check includes a background information disclosure (BID), report of findings from the Department of Justice (DOJ) and Integrated Background Information System letter from the Department of Health Services (IBIS).<br><br>On 06/20/2024 at approximately 12:30 p.m., Surveyor interviewed Licensee A. Licensee A stated s/he was still working on getting records to Surveyor, but that s/he knew s/he would not be able to provide some of Caregiver G's background checks. Licensee A stated s/he thought s/he did the check but was not able to | M 114 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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<br>obtain the documents from the DOJ website.<br><br>On 06/20/2024 at approximately 4:00 p.m., Surveyor received and reviewed records from Licensee A, which indicated the following:<br><br>- Caregiver G, hired 01/15/2024, did not have a DOJ check or IBIS letter in his/her record.<br>- Caregiver E, hired 11/10/2023, did not have an IBIS letter in his/her record.<br><br>On 06/21/2024 at approximately 12:00 p.m., Surveyor interviewed Licensee A. Licensee A confirmed s/he did not have additional background checks to provide at this time. | M 114 | | |
| M 232 | 88.04(2)(g)1 HEALTH SCREENING FOR STAFF<br><br>The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 3 caregivers reviewed had been screened for illness detrimental to residents, including tuberculosis, within 90 days before the start of providing | M 232 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 232 | Continued From page 3 | M 232 | | |

service. The provider did not have a communicable disease screen, including tuberculosis test, completed within 90 days prior to hire for Caregiver E and Caregiver C.

Findings include:

On 06/19/2024 at approximately 9:30 a.m. Surveyor requested employee records, including communicable disease screens, from Licensee A.

On 06/20/2024 at approximately 12:30 p.m., Surveyor interviewed Licensee A. Licensee A stated s/he was trying to provide Surveyor with Caregiver C's and Caregiver E's communicable disease screens.

On 06/21/2024 at approximately 12:00 p.m., Surveyor received and reviewed records from Licensee A, which indicated the following:

- Caregiver E, hired 11/10/2023, had a tuberculosis test completed on 06/26/2024, date which had yet to occur.
- Caregiver C, hired 12/15/2023, had a tuberculosis test completed on 04/20/2024, approximately 4 months after his/her date of hire.

On 06/21/2024 at approximately 2:15 p.m., Surveyor interviewed Licensee A. Surveyor reviewed concern with Licensee A that Caregiver E and Caregiver C did not have tuberculosis tests completed timely. Licensee A confirmed the documents Surveyor recieved were what s/he had in their files. Licensee A did not offer a response to what their system was to ensure staff were properly screened.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 244 | Continued From page 4 | M 244 | | |
| M 244 | 88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS<br><br>The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 2 caregivers reviewed had completed 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights, and treatment appropriate to residents served prior to or within 6 months after starting to provide care. Caregiver C had not received training for resident rights, first aid, fire safety and standard precautions. Caregiver E had not received training for resident rights.<br><br>Findings include:<br><br>On 06/19/2024 at approximately 9:30 a.m. Surveyor requested employee records, including trainings, from Licensee A.<br><br>On 06/19/2024 at approximately 12:15 p.m., Surveyor received and reviewed documentation provided by Licensee A and reviewed the Community-Based Care and Treatment Training registry, which indicated the following: | M 244 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 244 | Continued From page 5<br><br>- Caregiver C, hired 12/15/2023, completed 3 hours of training for diabetes, medications, and documentation. There was no evidence of training in resident rights, first aid, fire safety and standard precautions.<br>- Caregiver E, hired 11/10/2023, completed CBRF medication, first aid, fire safety, and standard precaution training, as well as 3 hours of training in diabetes, medications, and documentation . There was no evidence of training in resident rights.<br><br>On 06/20/2024 at approximately 12:30 p.m., Surveyor interviewed Licensee A and reviewed concern that documentation received indicated 2 of 2 caregivers had not received all required trainings. Licensee A stated s/he would send additional documentation if s/he had anything.<br><br>On 06/21/2024 at approximately 2:15 p.m., Licensee A stated s/he had caregivers enrolled for additional trainings, but did not offer an explanation why Caregiver C and Caregiver E did not have required training. | M 244 | | |
| M 332 | 88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS<br><br>Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire | M 332 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 332 | Continued From page 6<br>extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure 2 of 2 fire extinguishers were inspected annually by an authorized dealer or the local fire department. The fire extinguishers had not been inspected since November 2022, over 1 year ago.<br><br>Findings include:<br><br>On 06/19/2024 at approximately 9:30 a.m., Surveyor toured the provider's home. Surveyor observed 2 fire extinguishers, 1 in the basement and 1 in the kitchen. Surveyor observed the tags on both fire extinguishers indicated the fire extinguishers had not been inspected since November 2022, greater than 1 year ago.<br><br>On 06/19/2024 at approximately 10:00 a.m., Surveyor interviewed Licensee A. Surveyor shared observation that 2 of 2 fire extinguishers in the home had not been inspected in greater than 1 year. Licensee A replied, "Thank you for letting me know." | M 332 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 | | |
| M 424 | 88.06(3)(f) REVIEW OF ISP<br><br>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 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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 2 individual service plans (ISPs) reviewed were reviewed with the placing agency. Resident 2's and Resident 3's ISPs were not reviewed with their managed care organization case managers.<br><br>Findings include:<br><br>On 06/19/2024 at approximately 9:00 a.m., Surveyor reviewed resident records, which indicated the following:<br><br>- Resident 2 was admitted to the provider's facility on 12/13/2022. Resident 2's record did not include an ISP. | M 424 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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<br>- Resident 3 was admitted to the provider's facility on 12/13/2022. Resident 3's record did not include an ISP.<br><br>On 06/19/2024 at approximately 10:30 a.m., Surveyor interviewed Licensee A. Licensee A stated s/he had Resident 2's and Resident 3's ISPs with him/her for safekeeping and would email the ISPs to Surveyor.<br><br>On 06/20/2024 at approximately 12:00 p.m., Surveyor received the following:<br><br>- Resident 2's ISP, dated 01/13/2024, was not signed by his/her managed care organization case manager.<br>- Resident 3's ISP, dated 01/13/2024, was not signed by his/her managed care organization case manager.<br><br>On 06/20/2024 at approximately 12:30 p.m., Surveyor interviewed Licensee A. Surveyor asked if managed care organization case managers participated in the development of ISPs. Licensee A stated s/he developed the ISPs him/herself. Surveyor asked if the ISPs were reviewed with the managed care organizations. Licensee A replied, "No." Licensee A explained Resident 3's case manager had recently been to the home but Licensee A was unable to be present at the home and a review needed to be arranged for Resident 2.<br><br>On 06/21/2024 at approximately 12:00 p.m., Licensee A updated Surveyor that s/he had scheduled ISPs to be reviewed with Resident 2's and Resident 3's case managers on 06/24/2024. | M 424 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 448 | Continued From page 9 | M 448 | | |
| M 448 | 88.07(2)(b)5 MONITORING HEALTH<br><br>Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed had their health monitored and changes documented in the record. The provider did not monitor and document changes for Resident 1's sacral wound.<br><br>Findings include:<br><br>On 01/25/2024, the department received a complaint regarding residents not receiving proper care.<br><br>On 06/19/2024 at approximately 10:00 a.m., Surveyor requested Resident 1's record from Licensee A. Licensee A stated s/he was unable to come to the provider's home and would need to send the records.<br><br>On 06/19/2024 at approximately 12:15 p.m., Surveyor received records that documented Resident 1 was admitted to the provider's home on 11/09/2023, with diagnoses including multiple sclerosis and diabetes. Resident 1's individual service plan (ISP), created 11/09/2023 and reviewed 12/06/2023, indicated s/he required assistance with bathing and Resident 1 had an open area to the sacral area that was to be assigned to an agency registered nurse (RN) upon discharge from the hospital. | M 448 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 448 | Continued From page 10<br><br>On 06/19/2024 at approximately 4:00 p.m., Surveyor requested documentation of any wound care and monitoring for Resident 1.<br><br>On 06/20/2024 at approximately 12:40 p.m., Surveyor received documentation indicating the following:<br><br>- Staff "cleaned and bandaged" Resident 1's wound 4 times a month with the most recent being 04/29/2024.<br>- Resident 1 had a telehealth appointment on 05/01/2024 for a change in condition - Decreased communication, decreased appetite, and rash on bottom. Appointment resulted in medication changes.<br>- Resident 1 had a telehealth appointment on 05/10/2024 for persistent confusion and lack of appetite. The appointment resulted in Resident 1 being sent to the emergency room (ER) for his/her sacral wound.<br><br>On 06/20/2024 at approximately 4:00 p.m., Surveyor reviewed Resident 1's hospital record (obtained by Surveyor). The record indicated Resident 1 had reported lethargy for 1 week prior to the ER visit and presented with a large, deep decubitus ulcer with purulent draining and foul smell. Resident 1 was diagnosed with severe sepsis, infected decubitus ulcer, and acute kidney injury. Resident 1 was treated with intravenous (IV) antibiotics, debridement, diverting colostomy, and a wound vac.<br><br>On 06/21/2024 at approximately 2:15 p.m., Surveyor interviewed Licensee A regarding Resident 1's wound. Surveyor asked if home health was assisting with management of Resident 1's wound. Licensee A stated home | M 448 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 448 | Continued From page 11<br>health had never been set up. Surveyor asked what the provider's staff did to care for the wound and if Licensee A had additional documentation regarding monitoring of the wound. Licensee A replied, "We bathed [him/her]." Licensee A did not have documentation regarding monitoring of the wound. Surveyor asked if the provider had documentation regarding the changes in Resident 1's appetite and cognition that led to physician appointments. Licensee A replied, "No."<br><br>Resident 1 resided at the provider from 11/09/2023 to 05/10/2024 and had an open area. The provider did not monitor and document changes in the open area. On 05/10/2024, Resident 1 was admitted to the hospital with severe sepsis, an infected decubitus ulcer, and an acute kidney ulcer. | M 448 | | |
| M 464 | 88.07(3)(d) MEDICATION- WRITTEN ORDER<br><br>Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure a written order from the physician who prescribed medications was | M 464 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 464 | Continued From page 12<br>received for 1 of 2 residents reviewed. The provider did not have a written order from Resident 2's physician to administer Resident 2's medications.<br><br>Findings include:<br><br>On 06/19/2024 at approximately 9:00 a.m., Surveyor reviewed Resident 2 and Resident 3's records, both of whom the provider's staff managed and administered medications for. Surveyor was unable to locate physician orders to administer medications in Resident 2 or Resident 3's record.<br><br>On 06/19/2024 at approximately 10:30 a.m., Surveyor interviewed Licensee A. Licensee A stated s/he didn't have all resident records at the house and would need to send Surveyor some of the records.<br><br>On 06/20/2024 at approximately 12:00 p.m., Surveyor received a physician order for the provider's staff to administer Resident 3's medications, but did not receive a physician order for Resident 2.<br><br>On 06/21/2024 at approximately 12:00 p.m., Licensee A provided all follow up documentation s/he was able. A physician order to administer medications for Resident 2 was not received. | M 464 | | |
| M 466 | 88.07(3)(e)1 MEDICATION- RECORD KEEPING<br><br>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 | M 466 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 466 | Continued From page 13 | M 466 | | |

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, observation, and interview the provider did not ensure record was kept of all medications administered or omitted. Resident 2's and Resident 3's Medication Administration Records (MARs) documented the administration of medications that were not available for administration.

This is a repeat deficiency. See Statement of Deficiency (SOD) NLCY11, dated 12/22/2023.

Findings include:

On 06/19/2024 at approximately 9:00 a.m., Surveyor reviewed resident records. Surveyor identified the following concerns regarding medication records:

Example 1 - Resident 2:

Resident 2 was admitted to the provider's facility on 12/13/2022. Resident 2's record included a physician order, dated 05/14/2024, to change his/her dose of atorvastatin to 80 milligrams (mg) 1 time (x) daily and gabapentin to 300 mg 2 tablets 3x daily. Resident 2's MAR, dated 05/21/2024 to 06/19/2024, documented the following:

- Atorvastatin 80 mg and atorvastatin 20 mg administered 05/21/2024 - 05/25/2024,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 466 | Continued From page 14 | M 466 | | |

05/27/2024 - 06/05/2024 and 06/05/2024 - 06/10/2024.
- Gabapentin 300 mg 1 tablet administered at 12:00 p.m. on 05/21/2024, 05/22/2024, 05/25/2024, 06/01/2024, 06/03/2024, 06/06/2024 - 06/10/2024.

On 06/20/2024 at approximately 12:15 p.m., Surveyor interviewed Pharmacist F. Pharmacist F confirmed both the atorvastatin and gabapentin dose changes on 05/14/2024. Pharmacist F stated the new doses were delivered to the provider's home on 05/14/2024 and previous doses removed, so documentation should have reflected atorvastatin 80 mg only (no atorvastatin 20 mg) and gabapentin 300 mg 2 tablets (rather than 1 tablet) were administered from 05/14/2024 to 06/10/2024.

Example 2 - Resident 3:

Resident 3 was admitted to the provider's facility on 12/13/2022. Resident 3's physician orders included loxapine 25 mg (Start Date: 08/10/2020) 2 capsules daily. Resident 3's MAR, dated 05/21/2024 to 06/19/2024, documented loxapine as administered each day. Surveyor interviewed Caregiver E regarding Resident 3's loxapine who stated the provider had been waiting for a refill of loxapine since at least 05/29/2024, indicating Resident 3's entries of loxapine being administered from 05/29/2024 to 06/19/2024, were incorrect.

On 06/19/2024, at approximately 9:30 a.m., Surveyor observed loxapine was not available in the home.

On 06/20/2024 at approximately 12:15 p.m., Surveyor interviewed Pharmacist F. Pharmacist F

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018942 | A. BUILDING: _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP TERRACE LLC | 6735 NORTH 55TH STREET MILWAUKEE, WI 53223 |

| (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 466 | Continued From page 15<br>stated Resident 3's loxapine was denied a refill by the physician in May 2021 and would not have been available in the home to administer 05/21/2024 to 06/19/2024.<br><br>On 06/21/2024 at approximately 2:15 p.m., Surveyor shared record keeping concerns with Licensee A. Licensee A stated s/he would ensure all MARs were updated and caregivers were double checking medications at the time of administration and documentation. | M 466 | | |