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	0013588	A. BUILDING: _____ B. WING _____	C 12/19/2024

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A BETTER LIVING FAMILY SERVICES II LLC	7828 W KEEFE AVE MILWAUKEE, WI 53222

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M 000	INITIAL COMMENTS On 12/19/2024, Surveyor completed a standard survey and complaint investigation at A Better Family Services II. As a result, 9 deficiencies were identified. The complaint was substantiated. Census: 2	M 000		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 2 of 2 exits from the home were ramped to grade and doorways had a clear opening of at least 32 inches. The rear exit of the home contained a 2.25-inch rise between the interior floor and the	M 262		

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

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M 262	Continued From page 1	M 262		

threshold of the door. The front exit contained a 1-inch rise between the interior floor and the threshold of the door. From the threshold of the front door to the concrete patio was a 1.5-inch drop. From the concrete patio to the sidewalk pathway was a 2-inch drop.

Findings include:

The facility was licensed on 06/15/2011, to serve up to 3 residents.

On 12/13/2024, at 09:45 AM, Surveyors toured the facility and observed the following:

- The rear exit of the home contained a 2.25-inch rise between the interior floor and the threshold of the door. From the threshold of the door to the concrete to the ramp was a 1.5-inch drop.

- The front exit contained a 1-inch rise between the interior floor and the threshold of the door. From the threshold of the front door to the concrete patio was a 1.5-inch drop. From the concrete patio to the sidewalk pathway was a 2-inch drop.

- The front door had a clear opening of 30 inches.

- The rear exit had a clear opening of 30 inches.

- The bathroom door had a clear opening of 30 inches.

- Resident 1's room had a clear opening of 30 inches.

Surveyors observed Resident 1 in his/her room. Surveyors observed a 4 wheeled walker in Resident 1's room. Resident 1 confirmed s/he

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M 262	Continued From page 2 used the walker for mobility. On 12/13/2024, at 10:00 AM, Surveyor interviewed Caregiver B. Caregiver B confirmed both exits were emergency exits. On 12/19/2024, at 9:53 AM, Surveyor interviewed Licensee A. Licensee A confirmed the home was licensed to serve 1 non-ambulatory person. Licensee A reported s/he was unsure of how the home was licensed with incorrect door widths. Licensee A confirmed exits need to be ramped to grade for non-ambulatory residents. Licensee A reported they had not admitted a resident who required a wheelchair. Licensee A acknowledged Surveyor's concerns regarding Resident 1's walker.	M 262		
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 a safe, clean, and well-maintained homelike environment for 2 of 2 residents. Finding include: On 07/10/2024, the Department received a complaint alleging concerns with cleanliness within the facility.	M 276		

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M 276	Continued From page 3 On 12/13/2024, at 9:40 AM, Surveyor toured the facility and observed the following: Living Room - A television was on top of 2 metal banquet type chairs in front of the couch. - The couch had what appeared to be a blanket placed over the couch. Hallway - The hallway carpet was littered with whitish particle debris. Surveyor was unable to identify what the substance was. - The carpet by the bathroom door was frayed, which exposed approximately 26 inches of the subflooring. - There was a black cord which started in Resident 1's room, came out into the hallway, went across Resident 2's door, where it was taped down with what appeared to be a type of black tape, and out into the dining room. Bathroom - The toilet tank was missing a top to the tank. - There was a hole in the bathroom ceiling which measured approximately 4 inches by 3 inches. - The bathroom exhaust vent contained thick greyish material similar to dust. Resident 2's bedroom	M 276		

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M 276	Continued From page 4 - The flooring appeared to be heavily stained. The carpet appeared to be light tan in color. There was a black hard area which measured approximately 6-inches by 2.5 inches. The carpet contained similar whitish particle debris as the hallway. - The lower right-hand corner was cracked and contained 3 pieces of black tape. - The doorstop was missing on the lower right section. The section missing the door stop measured approximately 36 inches. Kitchen - The toaster oven did not contain a handle to open the door. The toaster oven contained a brownish sticky substance, similar to grease. This substance came off when Surveyor scratched it. The inside of the toaster oven contained black, brown, and gray debris similar to burnt food particles. - 2 ceramic type jars with lids were covered in brownish, grayish sticky substance, similar to grease and dust. - Inside the microwave, the top plastic piece appeared bubbled and peeling, exposing dark brown underneath, similar to rust. These dark brown areas were in the back of the microwave and under the turntable. - The refrigerator contained shelves which were not hanging, and just set on the bottom of the refrigerator. - 9 upper cabinets had a dark sticky substance, similar to cooking grease, around the edges of	M 276		

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M 276	Continued From page 5 the doors. The substance was able to be scratched off by Surveyor's nail. On 12/19/2024, at 9:53 AM, Surveyor interviewed Licensee A. Licensee A reported staff were required to clean on a daily basis. Licensee A did not offer any further explanation.	M 276		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure smoke detectors were located on the ceiling in 1 of 3 required areas. The smoke detector in the living room was located on the wall. Findings include: On 12/13/2024, at 9:45 AM, Surveyor toured the	M 334		

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M 334	Continued From page 6 facility. Surveyor observed the smoke detector in the living room was located on the wall. On 12/19/2024, at 9:53 AM, Surveyor interviewed Licensee A. Surveyor inquired if Licensee A was aware of the code requirement, Licensee A stated, "I am now."	M 334		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete an annual evacuation assessment review for 2 of 2 residents who lived in the facility beyond one year. Resident 1 did not have an evacuation assessment completed in 2024. Resident 2 did not have an evacuation assessment completed in 2023 and 2024. Findings include: On 12/13/2024, at 10:30 AM, Surveyor reviewed resident records and observed the following: -Resident 1 was admitted to the facility on 04/26/2021 with diagnoses including traumatic brain injury, dementia, seizure disorder, psychosis, and congestive heart failure. Resident	M 346		

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M 346	Continued From page 7 1's record contained a Resident Evacuation Assessment, dated 03/04/2023. Resident 1's record did not contain a completed or updated evacuation evaluation in 2024. -Resident 2 was admitted to the facility on 03/23/2018 with diagnoses including alcohol dementia, history of cerebrovascular accident and alcohol abuse. Resident 2's record contained a Resident Evacuation Assessment, dated 03/03/2022. Resident 2's record did not contain a completed or updated evacuation evaluation in 2023 and 2024. On 12/19/2024, at 9:53 AM, Surveyor interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported the house leads were responsible for ensuring the evaluations were completed. Licensee A reported Resident 2's care team just completed a house audit, and the missing evaluations were not on the list. Licensee A reported the evaluations were there. Licensee A reported s/he would send them to Surveyor by 12:00 PM on 12/19/2024. No further documentation was received.	M 346		
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	M 424		

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M 424	Continued From page 8	M 424		

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.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 residents' (Resident 1 and Resident 2) individual service plans (ISP) were reviewed every 6 months by the licensee, the resident or resident's guardian, and service coordinator. Resident 1's ISP was not reviewed in November 2024. Resident 2's ISP was not reviewed in October 2022, April 2023, October 2023, April 2024, and October 2024.

Findings include:

On 12/13/2024, at 10:30 AM, Surveyor reviewed resident records and observed the following:

-Resident 1 was admitted to the facility on 04/26/2021 with diagnoses including traumatic brain injury, dementia, seizure disorder, psychosis, and congestive heart failure. Resident 1's record indicated Resident 1 had a guardian. Resident 1's ISP was last reviewed on 05/06/2024. Resident 1's ISP was not signed by Resident 1's guardian. Resident 1's ISP was due to be reviewed in November 2024.

-Resident 2 was admitted to the facility on 03/23/2018 with diagnoses including alcohol dementia, history of cerebrovascular accident and alcohol abuse. Resident 2's record indicated

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M 424	Continued From page 9 Resident 2 had a guardian. Resident 2's ISP was last reviewed 04/13/2022. Resident 2's ISP was signed by Licensee A and the placing agency. Resident 2's ISP was not signed by Resident 2's guardian. Resident 2's ISP was due to be reviewed October 2022, April 2023, October 2023, April 2024, and October 2024. On 12/19/2024, at 9:53 AM, Surveyor interviewed Licensee A. Licensee A reported the house lead and Co-Owner D conducted the ISP reviews. Licensee A reported the reviews took place over zoom or in person with the case managers. Surveyor inquired about guardians. Licensee A reported the guardians participated over the phone and the ISPs would be faxed to the guardians for signatures. When Surveyor relayed concerns regarding the ISP reviews and no signatures from the guardians, Licensee A reported Resident 2 just had an ISP review, because Co-Owner D handwrote the ISP. Licensee A reported s/he would send them to Surveyor by 12:00 PM on 12/19/2024. No further documentation was received.	M 424		
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.	M 458		

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M 458	Continued From page 10	M 458		

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure prescription medications were securely stored for 2 of 2 (Resident 1 and Resident 2) residents. The door to the medication closet was unlocked.

Findings include:

On 12/13/2024, at 10:05 AM, Surveyor toured the facility's kitchen and observed the medication closet. The door to the medication closet was unlocked. The door had a latch with a combination lock. The combination lock was hung on the latch but was not locked. Surveyor was able to remove the combination lock and open the medication closet. Surveyor observed Resident 1's and Resident 2's prescription medications inside the unlocked closet.

Surveyor observed Resident 2 ambulating freely around the facility.

On 12/13/2024, at 10:20 AM, Surveyor reviewed resident records.

-Resident 1 was admitted to the facility on 04/26/2021 with diagnoses including traumatic brain injury, dementia, seizure disorder, psychosis, and congestive heart failure. Resident 1's record indicated Resident 1 was prescribed the following medications: atorvastatin 20 milligrams (mg), carvedilol 6.25mg, cetirizine 10mg, citalopram 10mg, clotrimazole 1% cream, Entresto 24/26mg, fluticasone spray, guaifenesin 600mg, lacosamide 100mg, lamotrigine 150mg, levetiracetam 1,000mg, polyethylene glycol

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M 458	Continued From page 11 powder, risperidone 2mg, senna 8.6-50mg, topiramate 200mg, and warfarin 6mg. -Resident 2 was admitted to the facility on 03/23/2018 with diagnoses including alcohol dementia, history of cerebrovascular accident and alcohol abuse. Resident 2's record indicated Resident 2 was prescribed the following medications: atorvastatin 40mg, diclofenac gel 1%, ferosul 325mg, folic acid 1mg, guaifenesin 200mg, lurasidone 40mg, melatonin 3mg, meloxicam 15mg, methocarbamol 750mg, multivitamin, omeprazole 20mg, prazosin hydrochloride (HCL) 5mg, proctozone 2.5%, sertraline 100mg, sertraline 50mg, tamsulosin 0.4mg, tramadol HCL 50mg, vitamin B1 100mg, vitamin C 250mg, and tizanidine 2mg. On 12/19/2024, at 9:53 AM, Surveyor interviewed Licensee A. Licensee A confirmed prescription medications were to be securely stored at all times. Licensee A reported staff were trained to ensure the medications are securely stored at all times. Licensee A was unsure why the medications were not securely stored.	M 458		
M 530	88.09(2)(a)8 TRAINING DOCUMENTATION Documentation of successful completion of the training requirements under HSS 88.04(5). This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain and keep up to date a personnel record for each service provider which included documentation of successful completion of the training requirements under s. DHS 88.04(5) for 1 of 2 employees reviewed	M 530		

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M 530	Continued From page 12 (Caregiver C). DHS 88.04(5)(a) states "(5) TRAINING. (a) 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." Findings include: On 12/18/2024, at 12:30 PM, Surveyor reviewed employee records and identified the following: - Caregiver C was hired on 11/18/2019. Caregiver C's staff record did not contain documentation of 15 hours of training approved by the licensing agency related to the health, safety, welfare, rights, treatment of residents, fire safety, and first aid. On 12/19/2024, at 9:53 AM, Surveyor interviewed Licensee A. Licensee A reported s/he sent the orientation training to Surveyor. Surveyor relayed the information on the paperwork Licensee A sent to Surveyor indicated an acknowledgement for policies and procedures in the facility. Licensee A reported s/he would send them to Surveyor by 12:00 PM on 12/19/2024. Surveyor did not receive training documentation for Caregiver C.	M 530		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall	M 570		

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M 570	Continued From page 13 have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe physical environment by ensuring water temperatures were kept at a safe temperature for 1 of 1 resident bathroom. The hot water temperature in the resident bathroom was 141.3° Fahrenheit (F). Findings include: On 12/13/2024, at 10:00 AM, Surveyors tested the water temperature in the resident's bathroom sink faucet. The water temperature was 141.3°F. "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 instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017)	M 570		

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(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 570	Continued From page 14 On 12/19/2024, at 9:53 AM, Surveyor interviewed Licensee A. Licensee A reported a plumber recently put a new gauge on the water heater. Licensee A reported s/he would look into the hot water temperature.	M 570		
Z 005	50.065(2)(b)intro ENTITY BACKGROUND CHECK REQUIREMENTS 1. A criminal history search from the records maintained by the department of justice. 2. Every entity shall obtain all of the following with respect to a caregiver of the entity: Information that is contained in the registry under s. 146.40(4g) regarding any findings against the person. 3. Information maintained by the department of safety and professional services regarding the status of the person's credentials, if applicable. 4. Information maintained by the department regarding any final determination under s. 48.981(3)(c)5m. or, if a contested case hearing is held on such a determination, any final decision under s. 48.981(3)(c)5p. that the person has abused or neglected a child. 5. Information maintained by the department under this section regarding any denial to the person of a license, certification, certificate of approval or registration or of a continuation of a license, certification, certificate of approval or registration to operate an entity for a reason specified in sub. (4m)(a)1. to 5. and regarding any denial to the person of employment at, a	Z 005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013588	A. BUILDING: _____ B. WING _____	C 12/19/2024

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Z 005	Continued From page 15 contract with or permission to reside at an entity for a reason specified in sub. (4m)(b)1. to 5. If the information obtained under this subdivision indicates that the person has been denied a license, certification, certificate of approval or registration, continuation of a license, certification, certificate of approval or registration, a contract, employment or permission to reside as described in this subdivision, the entity need not obtain the information specified in subds. 1. to 4. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 service providers had background check upon hire. Caregiver B did not have a completed background check until 524 days after her/his hire date. Findings include: On 12/18/2024, at 12:30 PM, Surveyors reviewed Caregiver B's record. Caregiver B was hired on 07/17/2018. Caregiver B's record contained a Background Information Disclosure (BID) dated 08/01/2019. Caregiver B's Department of Justice (DOJ) background check and Integrated Background Information System (IBIS) check were dated 12/23/2019. Caregiver B's record did	Z 005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z 005	Continued From page 16 not contain evidence of a background check being completed within 60 days of employment. On 12/19/2024, at 9:53 AM, Surveyor interviewed Licensee A. Licensee A reported Caregiver B was hired to work at the facility after high school, but ended up going to college. Caregiver B came back in the summer and filled out the BID. Licensee A confirmed the DOJ and IBIS were not completed within 60 days after the BID was filled out.	Z 005		