| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 200003 | A. BUILDING: _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

| (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 |
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| M 000 | INITIAL COMMENTS<br><br>On 12/11/2024, Surveyor completed a complaint investigation at Serenity Garden Adult Family Home. As a result, 7 deficiencies were identified. One complaint was substantiated.<br><br>Census: 0 | M 000 | | |
| M 130 | 88.03(5)(c) CHARGED OR CONVICTED OF CRIME<br><br>Within 48 hours, that the licensee or service provider has pending or has been charged with or convicted of any crime which is substantially related to caring for dependent persons.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the licensee did not notify the Department within 48 hours that Licensee A had pending charges substantially related to caring for dependent persons.<br><br>Licensee A was charged with s. 947.01(1) - Disorderly Conduct.<br><br>Findings include:<br><br>This provider is licensed as a non-ambulatory adult family home (AFH) to care for up to 3 residents in the client groups advanced age, developmentally disabled, physically disabled, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, traumatic brain injury, public funding, and terminally ill. | M 130 | | |

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

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| M 130 | Continued From page 1<br><br>On 10/01/2024 the Department received a complaint alleging caregiver misconduct by Licensee A with Resident 1.<br><br>On 10/14/2024, Surveyor reviewed WI Circuit Court Automation Program (CCAP), which revealed the following:<br><br>Milwaukee County Case Number 2024CM002824, State of Wisconsin vs. [Licensee A], Filing Date: 10/04/2024<br><br>Count No. 1<br>Statute: 947.01(1)<br>Description: Disorderly Conduct<br>Severity: Misdemeanor B<br><br>On 10/14/2024, Surveyor reviewed the Department's records and did not find documentation to indicate the provider notified the Department within 48 hours after Licensee A had pending charges substantially related to caring for dependent persons. As of 11/13/2024, Licensee A had not reported the above charges to the Department.<br><br>On 10/15/2024, at 2:54 PM, Surveyors attempted to conduct a complaint investigation at the home. Upon arrival, there were no residents or staff in the home. Surveyors contacted Licensee A via telephone and s/he reported s/he was at a training out of town, and no one was at the home.<br><br>On 10/16/2024, at 9:30 AM, Surveyors made a second attempt to conduct a complaint investigation at the home. Upon arrival, there were no residents or staff in the home. Surveyors contacted Licensee A via telephone and s/he reported s/he was at an appointment with a resident from her/his other home and s/he would | M 130 | | |

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| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

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| M 130 | Continued From page 2<br>not be able to respond for 45 minutes. Licensee A arrived at the home at 10:40 AM.<br><br>On 10/16/2024, at 10:45 AM, Surveyor interviewed Licensee A and s/he reported the following: S/He was arrested and charged with Disorderly Conduct on 10/01/2024, for an incident which occurred on 10/01/2024, with Resident 1. Licensee A reported s/he was not aware arrests/charges were required to be reported to the Department. Surveyor explained the self-reporting requirements for an AFH and provided information where the self-report forms could be located. Licensee A was unfamiliar with the self-reporting process. | M 130 | | |
| M 214 | 88.04(1)(c) RESPONSIBLE, MATURE AND REPUTABLE CHARACTER<br><br>The licensee and service provider shall be persons who are responsible, mature and of reputable character who exercise and display the capacity to successfully provide care for 3 or 4 unrelated adult residents as identified in the home's program statement.<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation, and interview the licensee did not demonstrate s/he was a person who was responsible, mature and of reputable character, and who exercised and displayed the capacity to successfully provide care for 3 vulnerable adult residents as identified in the home's program statement. The licensee was charged with a crime substantially related to caring for dependent persons and did not report it | M 214 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| M 214 | Continued From page 3 | M 214 | | |

to the Department; did not disclose prior history with the Department as a provider who had licenses revoked and denied; and did not ensure treatment of and services for Resident 1 were adequate.

Findings include:

This provider is licensed as a non-ambulatory AFH to care for up to 3 residents in the client groups advanced age, developmentally disabled, physically disabled, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, traumatic brain injury, public funding, and terminally ill.

On 12/11/2024, at 1:10 PM, Surveyor reviewed Department documents and identified the following:

License History

- On 10/16/2024, at 4:46 PM, Licensee A emailed Surveyor a copy of her/his background information disclosure (BID). Upon review of the BID, Licensee A listed Person J as an alias.

- Facility identification number (ID) 0013050, Life Care Senior Living, and facility ID 0014026, Life Care Senior Living - Hilbert were licensed under the name Person J and with the business name Life Care Senior Living Limited Liability Company (LLC). A license was issued for facility ID 0013050 on 04/01/2010. An application for facility ID 0014026 was received on 12/30/2011.

- The application for a license for facility ID 0014026 was denied on 08/27/2013.

- On 05/06/2014, the State of Wisconsin (WI)

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Division of Hearings and Appeals (DHA) made a decision relating to Person J's request to appeal the license revocation for facility 0013050.

The document stated the following:

"Findings of fact: 1. On or about April 1, 2010, [Person J] received a license from DHS (Department of Health Services) to operate an Adult Family Home (AFH) known as Life Care Senior Living - Wauwatosa (LCSL-Wauwatosa) . . . 3. On August 27, 2013, DHA issued a decision in Case No. ML-12-0125 affirming the Department's denial of a license to [Person J's] commission of fraud when seeking public benefits from Milwaukee Enrollment Services (MilES) and the Division of Workforce Development (DWD). The ALJ (Administrative Law Judge) in that decision concluded:

'Because the Department demonstrated by a preponderance of evidence that [Person J] committed fraud in applying for and receiving public benefits, [and] that [s/he] was not of "reputable character," . . . the Department properly denied [her/him] license application for LCSL-Hilbert pursuant to Wis. Admin. Code §§ DHS 88.03(2) and (3) and 88.04(1)(c).'

'[Person J]'s AFH license application for LCSL-Hilbert was properly denied pursuant to Wis. Admin. Code §§ 88.03(2) and (3) and 88.04(1)(c) because [s/he] committed fraud when seeking public benefits from MilES and DWD, and, as a result, was not of reputable character . . . '

5. On November 5, 2013 the Department issued a Notice and Order to the LCSL-Wauwatosa [facility ID 0013050] including a Notice of

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Violation, Notice of License Revocation, Order Not to Admit New or Additional Residents, Notice of Special Orders, and Notice of Right to Appeal pursuant to Wis. Stat. Ch. 50 and Wis. Admin. Code ch DHS 88. The notice included Statement of Deficiencies (SOD) #B42V11. The license revocation cites [Person J's] failure to meet minimum licensing requirements in DHS 88.04(1)(c) as the basis for the revocation.

6. On November 22, 2013, [Person J] filed an appeal of the license revocation action of DHS with the DHA.

Discussion: . . . In summary, whether [Person J] meets minimum licensing requirements to operate an AFH was litigated and decided in Case ML-12-0125 . . . Therefore, I conclude that DHS' motion to dismiss should be granted based on the doctrine of issue preclusion."

The Order issued by WI DHA was signed by ALJ K on 05/06/2014.

- The license for facility ID 0013050 was revoked on 07/13/2015.

- On 10/16/2017, the Department received an application for Serenity Garden AFH, which was assigned facility ID 0017025. The applicant listed was Licensee A.

On the application under the fit and qualified section, question 1 asked, "Has the licensee ever operated a residential facility, health care facility, or a day care program for adults or children in Wisconsin or in any other state?" Licensee A reported, "Yes. Life Care Persoal Care Agency LLC. 1370 S. 74th Street, West Allis, WI 53214, Matthew Adult Family Home, 2423 W. Custered

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| M 214 | Continued From page 6<br>Ave. Milwaukee WI 53219 [sic]."<br><br>Question 3 asked, "Has the licensee ever had a license, certification or governmental approval to operate a facility/program denied, revoked, suspended or not renewed?" Licensee A reported, "No." The "No" response omitted the revocation of the license for facility ID 0013050, and the application denial for facility ID 0014026.<br><br>Licensee A signed the application on 10/12/2017 under the following statement: "I attest, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to $10,000 or imprisonment not to exceed 6 years, or both (Wis. Stat. § 946.32)."<br><br>Licensee A signed a revised application for facility ID 0013050 on 03/23/2018, updating the licensing to non-ambulatory classification.<br><br>The application was reviewed, and a revisions letter was sent on 11/29/2017 to Licensee A requesting submittal of a background check, explanation of delinquent taxes, and documentation stating resolution.<br><br>After additional review of the application a license was issued on 05/01/2018.<br><br>- On 11/21/2022, the Department received an application from Licensee A, for Serenity Garden Adult Family Home, which was assigned facility ID 0019385.<br><br>On the application under the fit and qualified section, question 1 asked, "Have you ever applied for licensure for a residential facility, | M 214 | | |

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health care facility, or a day care program for adults or children and been denied licensure?" Licensee A reported, "Yes. I currently own and operate an Adult Family Home in Milwaukee County." Licensee A omitted the application denial of facility ID 0014026.

Question 4 asked, "Have you ever had any license, certification, or governmental approval to operate facility/ program revoked, suspended, or nor [sic] renewed in Wisconsin or any other state?" Licensee A reported, "No." The "No" response omitted the revocation of the license for facility ID 0013050, and the application denial for facility ID 0014026.

Licensee A signed the application on 11/21/2022 under the following statement: "I attest, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge. I understand that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to $10,000 or imprisonment not to exceed 6 years or both (Wis. Stat. § 946.32)."

The application was reviewed, and Licensee A was issued a license on 01/19/2023.

- On 10/04/2023, the Department received an application from Licensee A, for Serenity Garden Adult Family Home, which was assigned facility ID 0020003.

On the application under the fit and qualified section, question 1 asked, "Have you ever applied for licensure for a residential facility, health care facility, or a day care program for adults or children and been denied licensure?" Licensee A reported, "No." Licensee A omitted the

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| M 214 | Continued From page 8<br>application denial of facility ID 0014026.<br><br>Question 2 asked, "Have you ever operated a residential facility, health care facility, or a day care program for adults or children in Wisconsin or in any other state?" Licensee A reported, "No." Licensee A omitted 2 active licenses for AFHs (facility ID 0017025 and facility ID 0019385), and facility ID 0013050, which was previously revoked.<br><br>Question 4 asked, "Have you ever had any license, certification, or governmental approval to operate facility/ program revoked, suspended, or nor [sic] renewed in Wisconsin or any other state?" Licensee A reported, "No." The "No" response omitted the revocation of the license for facility ID 0013050.<br><br>Licensee A signed the application on 10/16/2023 under the following statement: "I attest, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge. I understand that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to $10,000 or imprisonment not to exceed 6 years or both (Wis. Stat. § 946.32)."<br><br>The application was reviewed. The fit and qualified review reported findings "of concern." The concerns listed were, "Criminal charges history in Wisconsin . . . delinquent taxes owed by applicant . . . determination of fit and qualified and financial stability." Licensee A was issued a license 05/08/2024.<br><br>The AFH biennial report, generated from the online application, requested "names of all persons, age 10 or older, who live in the facility | M 214 | | |

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and are not client residents." Licensee A did not list Person D, who was living in the home. During an interview with Licensee A, on 10/16/2024, Licensee A reported s/he lived at Serenity Garden AFH "sometimes" and her/his spouse "comes every now and then." Police reports dated, 06/23/2021, 03/19/2024, 05/30/2024, and 10/01/2024, obtained by Surveyor, reported Licensee A and Person D resided at the address for Serenity Garden AFH. Resident 1 reported Licensee A and Person D resided in the basement at Serenity Garden AFH.

Criminal History

On 12/05/2024, at 5:21 PM, Surveyor requested records from West Allis Police Department (WAPD). On 12/09/2024, at 11:53 AM, Surveyor received the records and reviewed them. The following was identified:

Police report written by Police Officer (PO) L, dated 05/30/2024, reported Licensee A was arrested for Criminal Damage to Property and Disorderly Conduct - Domestic Abuse. PO L's report stated, " . . . [Person D] stated [Licensee A] became extremely angry with [her/him] and kicked an outdoor table over. [Person D] stated the glass plate on the table fell over and shattered on the ground. [Person D] stated [Licensee A] then walked up to [her/him] and scratched at [her/his] neck . . . Based on [Person D's] statement about [Licensee A] scratching [her/his] neck and smashing the table glass, [Licensee A's] admission to pushing the table over, [Person D's] obvious scratch mark to [her/his] neck, [Person D's] lack of consent to [Licensee A's] actions and the domestic relationship between [Person D] and [Licensee A], [Licensee A] was determined to be the

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predominant aggressor and was taken into custody."

Police report written by PO M, dated 05/30/2024, stated, " . . . Witness statement: Upon arrival, I made contact with a resident and witness to this incident. I identified [her/him] as [Person N]. [Person N's] caregiver, [Licensee A] had a verbal argument with [her/his] ex-[spouse] and other co-habitant, [Person D]. The context of the argument was unknown. [Person N] then observed [Licensee A] and [Person D] outside to the rear of the residence where [Licensee A] picked up and 'smashed' a patio table onto the ground causing the glass to break . . . "

Licensee A did not report the above incident to the Department.

On 10/01/2024, Licensee A was arrested for having a warrant through WAPD for the above Disorderly Conduct incident. S/He signed a personal recognizance bond for the warrant.

Police report written by PO F, dated 10/01/2024, reported police had been called to Serenity Garden AFH by Resident 1 for the report of Licensee A kicking her/him out of the residence. The police report stated, " . . .It was determined [Resident 1] would be let back into the residence. When officers went to leave, [Resident 1] could be heard screaming for help. Officers stood by the door and could hear [Licensee A] saying 'I'm gonna [sic] beat your [expletive].' [Licensee A] opened the door for officers, [Resident 1] said [Licensee A] grabbed [her/his] arms and neck which caused pain. Red marks were visible on [Resident 1's] skin. [Resident 1] also alleged [Licensee A] had wrapped [her/his] hand around [her/his] throat and impeded [her/his] breathing.

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| M 214 | Continued From page 11<br>[Licensee A] was arrested for strangulation and suffocation, along with intentionally abuse/neglect patient . . . "<br><br>Observation<br><br>On 10/23/2024, at approximately 10:50 AM, Surveyor reviewed PO G's body camera footage (Axon Body 3 X60A8620N, 10/01/2024, 17:43:57), and the following was observed:<br><br>Licensee A was speaking loudly at PO G. S/He was waiving her/his arms and pointing fingers towards PO G. Licensee A was concerned with why Resident 1 left the door to the residence open, and not with Resident 1's need for medical attention. Licensee A told PO G Resident 1 could not come back into the residence and if s/he did it would create a "hostile" situation. Licensee A told PO G s/he did not want to provide cares for Resident 1.<br><br>Interview<br><br>On 10/16/2024, at 10:45 AM, Surveyor interviewed Licensee A. Licensee A reported the following:<br><br>Licensee A admitted Resident 1 into the home knowing Resident 1 had a care plan, created by MyChoice, which required daily cares for Resident 1. Licensee A informed Resident 1's Case Manager B s/he would not be at the residence during daytime hours to provide cares for Resident 1. An agreement was made between Case Manager B and Licensee A in which Resident 1 resided at the home as a tenant, received room/board, and was provided with 3 meals per day. Licensee A stated s/he was not aware of many of the regulations of WI WI Ch. | M 214 | | |

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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 |
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| M 214 | Continued From page 12<br><br>DHS 88 defines an AFH as " . . . a place where 3 or 4 adults not related to the licensee reside in which care, treatment or services above the level of room and board but not including nursing care are provided to persons residing in the home as a primary function of the place . . . " Licensee A reported a care plan, communicable disease screening, including tuberculous (TB), and admission health exam were completed for Resident 1. Resident 1 had Nurse C 2-3 days per week to assist with medications and a transportation company to provide medical transport.<br><br>On 10/19/2024, at 6:40 PM, Licensee A sent Surveyor an email, which contradicted the above information regarding the admittance of Resident 1. The following was stated in the email:<br><br>" . . . [Resident 1] was admitted on September 4th, 2024, at 6pm [sic]. The TB skin test was scheduled by [Resident 1] after the 7 days. the [sic] doctor was able to see [Resident 1] later in the month. The [sic] was no availability . . . I know the TB screen should be done before the resident move [sic] in. The physical should be done with in [sic] 5-7 days after the move in. The primary care physician did not have any available until later in the month . . . I do not have a copy of an order to administer medications. [Case Manager B] indicated that [s/he] administered [her/his] own medication. [Case Manager B] also indicated the that was a nurse that come by to set up [Resident 1's] medication [sic]. That's how [s/he] had had it set up at [her/his] previously residents [sic]. Individual service plan I sent you from [her/his] Case manager [sic]. Serenity Garden has 30 days to develop ISP (individual service plan) [sic]." The above documentation was not provided to Surveyor. | M 214 | | |

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| M 214 | Continued From page 13<br><br>Attached to the email from Licensee A were 2 documents labeled, "Evacuation" and "resident service." The evacuation document was a Resident Evacuation Assessment for Resident 1, completed on 09/04/2024. The resident service document was a Resident Service Agreement, which identified Resident 1 as the resident. Signatures of the resident or representative, facility representative, case manager, and client rights specialist were not on the Resident Service Agreement. Under the "Services Provided" section of the document it stated, " . . . Beginning on 9/6/24 [sic] the Facility shall provide to the Resident the services, items and activities listed on Exhibit 1 at the Basic Services Rate described in (SECTION I) below . . . Services will be determined based upon a written Individual Service Plan (ISP) and obtained prior to the Resident's admission to the Facility." Exhibit 1 was not included in the documents sent to Surveyor.<br><br>Licensee A licensee did not demonstrate s/he was a person who was responsible, mature and of reputable character, and who exercised and displayed the capacity to successfully provide care for 3 vulnerable adult residents. The licensee failed to follow or attempt to understand the requirements of DHS 88. Licensee A's lack of knowledge of DHS 88, resulted in a facility that was not meeting code requirements, falsifying documents, abuse/neglect of a resident, and failure to self-report to the Department.<br><br>Cross reference:<br><br>M0130 - 88.03(5)(c) - Charged Or Convicted of Crime<br>M0572 - 88.10(3)(m) - Freedom From Abuse | M 214 | | |

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| M 380 | 88.06(2)(a) ADMISSION-HEALTH EXAM<br><br>Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) reviewed received a health exam, including a screening for communicable disease, including tuberculosis (TB), within 90 days prior to admission to the home or within 7 days after admission.<br><br>Findings include:<br><br>On 10/15/2024, at 4:03 PM, Surveyor reviewed Resident 1's records and identified the following:<br><br>Resident 1 was admitted to the home on 09/06/2024, without a health exam, or a screening for communicable disease, including TB.<br><br>On 10/16/2024, at 10:40 AM, Surveyor interviewed Licensee A. Licensee A reported Resident 1 was admitted as a tenant due to the | M 380 | | |

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| M 380 | Continued From page 15<br>home not having a contract with the managed care organization (MCO) Resident 1 was serviced by. Licensee A reported a health exam and communicable disease screening, including TB were completed for Resident 1. S/He reported the paperwork was at her/his office and s/he would send it to Surveyor.<br><br>On 10/19/2024, at 6:40 PM, Licensee A sent Surveyor an email, which stated the following:<br><br>"The TB skin test was schedule [sic] by the member after the 7 days. the doctor was able to see the member later in the month [sic]. The was no availability [sic] . . . I know the TB screen should be done before the resident move in [sic]. The physical should be done with in 5-7 days after the move in [sic]. The primary care physician did not have any available until later in the month [sic]."<br><br>On 10/22/2024, at 9:12 AM, Surveyor sent an email to Licensee A requesting the following documentation for Resident 1: an admission health exam and communicable disease screening, including TB. As of 11/13/2024, at 9:00 AM, none of the above paperwork had been received. | M 380 | | |
| M 384 | 88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE<br><br>An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any | M 384 | | |

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| M 384 | Continued From page 16 | M 384 | | |

change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any.
This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure a service agreement was dated and signed prior to admission for 1 of 1 resident (Resident 1). Resident 1 resided in the home for approximately 26 days without a signed service agreement.

Findings include:

On 10/16/2024, at 10:40 AM, Surveyor interviewed Licensee A. Licensee A reported Resident 1 was with MyChoice Wisconsin (MCWI) Managed Care Organization (MCO). Resident 1 was admitted on 09/06/2024 and had a signed service agreement. The service agreement included a start date, but no set end date. Licensee A reported the home was not contracted with MCWI, so special approval from the MCO's supervisor was needed to admit Resident 1. Licensee A reported the service agreement was at her/his office and s/he would send it to the Surveyor at a later time.

On 10/19/2024, at 6:40 PM, Surveyor received an email from Licensee A, which included an attachment titled, "resident service." On 10/22/2024, at 9:00 AM, Surveyor reviewed the document and identified the following:

Resident 1 was identified as the resident entering into the service agreement. A guardian or case manager was not identified. Services were to be

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| M 384 | Continued From page 17<br>provided beginning on 09/06/2024, at a rate of $1,300.00 per month, with food included. Serenity Garden AFH was to provide Resident 1 the services, items, and activities listed on Exhibit 1 of the document. Exhibit 1 was not included in the document nor was it provided at a later date to Surveyor. The signature section of the service agreement had not been signed by anyone, to include the resident or resident representative, the facility representative, or the case manager. As of 11/13/2024, Surveyor had not received a signed copy of the service agreement for Resident 1. | M 384 | | |
| M 436 | 88.07(2)(a) SERVICES<br><br>The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not ensure 1 of 1 resident (Resident 1) received services specified in the resident screening form and in MyChoice Wisconsin (MCWI) Managed Care Organization's (MCO) member centered plan.<br><br>Findings include:<br><br>On 10/16/2024, at 10:40 AM, Surveyor interviewed Licensee A and s/he reported the following: | M 436 | | |

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| M 436 | Continued From page 18<br><br>Resident 1 was admitted on 09/06/2024. A face sheet and service plan were completed for Resident 1, and s/he was provided with the house rules and the program statement. Prior to admitting Resident 1, Licensee A spoke with MCWI Case Manager B. Licensee A advised Case Manager B s/he was gone throughout the day and was not able to provide cares to Resident 1. Licensee A agreed to provide 3 meals per day. Nurse C was coming to the home to assist Resident 1 with medications, and a transportation company was in place to assist with medical transport. Licensee A provided Surveyor with Resident 1's file, which included a resident screening form and MCWI member centered plan.<br><br>On 10/17/2024, at approximately 9:00 AM, Surveyor reviewed Resident 1's records and the following was identified:<br><br>Resident 1 was admitted to the home on 09/06/2024, with diagnoses of schizophrenia and bipolar disorder.<br><br>A summary of Resident 1's needs/preferences indicated s/he required assistance with housekeeping, meal preparation, medications, dressing, speech, transportation, special diet, and social/emotional.<br><br>Resident 1's MCWI member center plan identified Resident 1 required the following:<br><br>- Dressing - cues to select weather appropriate clothing<br>- Eating - cues to eat<br>- Meal preparation - assistance with all meal prep<br>- Laundry/chores - assistance with laundry and | M 436 | | |

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| M 436 | Continued From page 19 | M 436 | | |

chores
- Help with getting to appointments
- Lactose free diet
- Medication administration - cues to take medications timely
- Medication management - assistance managing and monitoring medications
- Rep-payee to assist with money management
- Non-medical transportation
- Behaviors requiring intervention - verbal redirection
- Decision making - assistance required - no guardian was in place

On 10/22/2024, at 10:01 AM, Surveyor interviewed Resident 1 and the following is what s/he reported:

Resident 1 required assistance with medications. Nurse C came to the home 2 times per week to assist, but Resident 1 required assistance daily. Licensee A refused to assist her/him with her/his medications. Licensee A left food in the refrigerator for Resident 1, which included foods known to Licensee A Resident 1 could not, or preferred not to eat. Licensee A did not provide transportation. At some point during her/his stay, Resident 1 needed to go to Walgreens and did not receive transportation. S/He walked approximately 3 miles, fell during the walk, and called Licensee A. Licensee A told Resident 1 to get up and walk home. Licensee A dropped Resident 1 off at a laundry mat with her/his items for her/him to do her/his own laundry. Resident 1 was required to complete daily chores, including doing the dishes after s/he ate a meal.

On 10/22/2024, at 11:31 AM, Surveyor interviewed Nurse C and the following is what s/he reported:

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| M 436 | Continued From page 20<br><br>Nurse C had never met Licensee A, as s/he was not there during any of the visits with Resident 1. Nurse C was scheduled to go to the home once monthly but had been going there 1-2 times per week to assist with medications. Resident 1 was always alone in the home when Nurse C would show up. The medication closet was always unlocked, and the correct medications were not always available. Nurse C stated, "I'm afraid [Resident 1] had too much access . . . taking [medications] as [s/he] wanted."<br><br>In summary, Licensee A had information specific services were required for Resident 1. Licensee A did not provide assistance with the following required services: dressing, eating, laundry, chores, medication administration and management, non-medical transportation, behavior intervention, decision making, and social and emotional support. | M 436 | | |
| M 550 | 88.10(3)(b) Privacy<br><br>Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses contraband. The resident shall be | M 550 | | |

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| M 550 | Continued From page 21<br>present for the search.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure each resident had privacy in living arrangements for 1 of 1 resident (Resident 1) residing in the home. There was an electronic video and audio monitoring camera stationed in the kitchen.<br><br>Findings include:<br><br>On 10/15/2024, at 3:52 PM, Surveyor was met by Person D (Spouse of Licensee A) at the home. Once inside the home, Surveyor observed a camera on the kitchen table of the home. It was pointed towards the kitchen wall, overlooking the dining table area. Person D requested to record Surveyor's conversation on her/his phone. Surveyor pointed out the camera in the kitchen and Person D did not comment on the camera.<br><br>On 10/22/2024, at 10:01 AM, Surveyor interviewed Resident 1 and s/he reported the following:<br><br>The home had a camera in the kitchen near the sink. Licensee A spoke to Resident 1 through the camera. If Resident 1 made a mess in the kitchen or did not immediately wash the dishes after a meal, Licensee A made comments through the camera telling Resident 1 to clean up her/his mess. Licensee A was able to view the camera and audio from her/his Apple laptop. | M 550 | | |
| M 572 | 88.10(3)(m) Freedom from Abuse<br><br>Freedom from abuse. To be free from physical, sexual or mental abuse, | M 572 | | |

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| M 572 | Continued From page 22 | M 572 | | |

neglect, and financial exploitation or misappropriation of property.

This Rule is not met as evidenced by:
Based on record review, interview, and observation the provider did not ensure 1 of 1 resident (Resident 1) was free from physical and mental abuse. Licensee A had a physical and verbal altercation with Resident 1 where the police responded to the incident and witnessed red marks on Resident 1.

Findings include:

On 10/01/2024, at 10:14 PM, the Department received a complaint for caregiver misconduct. On 10/10/2024, at approximately 3:15 PM, Surveyor was assigned and reviewed the complaint. The complaint alleged Resident 1 was abused by Licensee A.

On 10/14/2024, at 10:47 AM, Surveyor requested records from the West Allis Police Department (WAPD). On 10/14/2024, at 3:45 PM, Surveyor received and reviewed the records. The following was identified:

Police Corporal (Cpl) E's report referred readers to the report s/he submitted to the Department. The following is a summary of the report:

On 10/01/2024, at 5:17 PM, Resident 1 called police dispatch and reported s/he was being kicked out of the home by Licensee A. Officers responded and attempted to relocate Resident 1. Resident 1's managed care organization (MCO) did not respond. Licensee A and Resident 1 agreed Resident 1 would stay at the home until her/his MCO contacted her/him in the morning. As the officers left the home, Resident 1 was

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heard screaming inside the residence. Officers stated they heard Licensee A state, "I'm gonna [sic] beat your [expletive]." Officers re-entered the home and Resident 1 reported Licensee A struck her/him in the arm with a stethoscope and blood pressure monitor, causing pain. Resident 1 also reported Licensee A grabbed her/his sheets off her/his bed, grabbed her/his arm, and pulled her/him into the living room. Resident 1 was told by Licensee A to sleep on the couch in the living room. Resident 1 attempted to run to the door to call for police and Licensee A grabbed her/him by the arm and threw her/him onto the couch. Resident was pulled by her/his arm and hair and was choked by Licensee A. Licensee A was arrested for strangulation and suffocation, and intentionally abuse/neglect a patient.

Police Officer (PO) F, PO G, and Police Sergeant (Sgt) H also completed reports for the incident which occurred on 10/01/2024. The police reports included the following information:

- PO F observed red marks on Resident 1's skin
- Resident 1 was at the home alone during the day and requested an ambulance to take her to the hospital
- Licensee A refused to let Resident 1 into the home when s/he returned from the hospital
- Resident 1 had been waiting outside the home for Licensee A for over an hour
- Resident 1 denied making suicidal statements
- Resident 1 reported the day prior Licensee A yanked a blanket from her/him while she was laying down and s/he almost fell
- Resident 1 reported another incident when the toilet in the home backed up, Licensee A gave Resident 1 gloves and had her/him pick the feces out of the toilet
- Resident 1 reported feeling emotionally abused

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| M 572 | Continued From page 24 | M 572 | | |

in the home
- Licensee A reported Resident 1 left the door to the home open while gone at the hospital
- Licensee A reported s/he did not let Resident 1 back into the home due to suicidal statements s/he made
- Licensee A stated to officers s/he believed it would have created a hostile environment if Resident 1 continued to reside at the home
- Officers arranged for Resident 1 to stay at the home for the remainder of the evening and advised both parties to have no contact with one another
- Resident 1 entered the home through the front door and Licensee A grabbed her/his items from the officers and attempted to grab the items Resident 1 was holding
- Licensee A pulled at the bags around Resident 1's hand
- Licensee A's tone was loud
- Resident 1 exited the home and told officers Licensee A attacked her/him
- Resident 1 reported Licensee A assaulted her/him and threw her/him on the ground
- PO F observed the batteries from the blood pressure cuff in the bathroom, across from Resident 1's bedroom
- Resident 1 tried to get the officers attention at the front door, but Licensee A did not allow her/him to open the door
- Resident 1 tried to get to the door 4 separate times
- Licensee A wrapped her/his hand around the front of Resident 1's neck and squeezed, which cause Resident 1 to be unable to breathe for approximately 5 seconds
- PO F observed red marks on Resident 1's arms and on her/his neck
- Resident 1 received medical attention and was ultimately transported to the hospital

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 200003 | A. BUILDING: _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

| (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 |
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- Licensee A participated in a custodial interview with PO F and denied the allegations made by Resident 1
- A camera was inside the home
- Licensee A arrived home at approximately 5:00 PM, and observed Resident 1 walking down the street without shoes on
- Licensee A reported Resident 1 made suicidal statements and s/he offered to take her/him to Granite Hills Hospital for mental health treatment
- Resident 1 refused
- Licensee A told Resident 1 s/he could not stay at the home due to making suicidal statements and having left the back door open
- Licensee A told PO G, Resident 1 "disturbed the peace," and it was "creating a hostile environment."
- Licensee A placed Resident 1's property outside the home
- Licensee A was arrested for a disorderly conduct warrant with WAPD
- Licensee A yelled at Resident 1 upon letting her/him back into the home
- Licensee A forcefully grabbed bags from Resident 1's hands

On 11/05/2024, at approximately 5:00 PM, Surveyor interviewed PO F and s/he confirmed her/his police reports were true and accurate.

On 11/06/2024, at 4:13 PM, Surveyor interviewed PO G, and s/he confirmed her/his police reports were true and accurate.

On 10/14/2024, at 11:31 AM, Surveyor requested records from Aurora West Allis Medical Center. On 10/22/2024, at 3:25 PM, Surveyor received and reviewed the records. The following was identified:

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

| (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 |
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| M 572 | Continued From page 26<br><br>On 10/01/2024, at 11:35 AM, Resident 1 went to the emergency department (ED) for evaluation of chest pain. The medical screening exam notes stated, "[Resident 1] reports yesterday afternoon [s/he] developed chest pain. Has been constant since. [S/He] describes it as a dull ache. [S/He] states it is because [her/his] landlord was yelling at [her/him]. [S/He] was under increased stress." The following was also noted: "Psychiatric/Behavioral: Negative for suicidal ideas. The patient is nervous/anxious (increased stress)." A physical exam was completed in the emergency room and Resident 1's blood pressure was 185/93, which was noted with an exclamation point on Resident 1's medical chart. The ED provider wrote, "My differential diagnoses includes but is not limited to pneumonia, atypical acute coronary syndrome (ACS), pleurisy, pulmonary embolism, arrhythmia, dehydration, electrolyte abnormality."<br><br>On 10/16/2024, at 10:45 AM, Surveyor interviewed Licensee A. Licensee A reported the following:<br><br>Case Manager B requested Licensee A accept Resident 1 as a tenant. Resident 1 came to the home from a rental where s/he resided with her/his significant other. Resident 1 paid rent and was billed as a tenant, but a resident service agreement had been signed. Licensee A was unaware s/he could not have tenants in an adult family home (AFH). Resident 1 was admitted to the home on 09/06/2024. On admission, Licensee A was aware Resident 1 had diagnoses of schizophrenia and bipolar disorder. A care plan was not created for Resident 1. Licensee A advised Case Manager B s/he was gone throughout the day and would not be there to provide cares to Resident 1. Resident 1 had | M 572 | | |

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| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

| (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 |
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services in place with Nurse C and a transportation company, for assistance with medications and medical transport. Licensee A provided Resident 1 with 3 meals per day. Resident 1's last day at the home was 10/02/2024.

During the interview, Surveyor inquired why Resident 1 was no longer living at the home. Licensee A reported the following:

On 10/01/2024, Licensee A was not at the home and had left a key to the home for Resident 1. Resident 1 left the home for approximately 5 hours and had left the door to the home unlocked and open. Licensee A observed the live feed on the camera in the home and saw the front door had been left open. At 3:00 PM, Person D arrived at the home to drop off her/his truck and observed Resident 1's medications on the kitchen table and floor. Person D yelled for Resident 1, who was not at the home. Sometime after 3:00 PM, Resident 1 arrived at the home without any shoes on her/his feet and stated s/he had been at the hospital. Resident 1 made suicidal statements. Licensee A reported s/he refused to let Resident 1 into the home and offered to take her/him to a mental health facility to get help. Resident 1 refused to go with Licensee A. Licensee A stated, "I like dealing with advanced age people. They're calm and let you deal with them." S/He reported s/he never had to deal with someone like Resident 1 and did not typically admit residents with "outburst" behaviors. Resident 1 called the police due to Licensee A refusing to let her/him into the home. Resident 1 had a bruise on her/his wrist and Licensee A reported s/he did not know where the bruise came from. Police officers arrived on scene and Licensee A was arrested for what s/he reported

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

| (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 |
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as disorderly conduct. Licensee A reported s/he was falsely accused.

On 10/21/2024, at 2:58 PM, Surveyor interviewed Resident 1 and s/he reported the following:

On 10/01/2024, Resident 1 was at the home by her/himself. Her/His blood pressure was high so s/he called an ambulance. Licensee A usually left a key for Resident 1 but did not on this day. When s/he left with the ambulance s/he closed the door to the home. When Resident 1 arrived back at the home from the hospital the door was locked and s/he was unable to get in. When Licensee A arrived at the home, s/he tried to pull Resident 1 into her/his car. Resident 1 called the police to report Licensee A was refusing to let her/him into the home. After police came, Licensee A was physically abusive to Resident 1. Licensee A used Resident 1's stethoscope to hit her/him on the right arm. Resident 1 stated, Licensee A did a "Japanese strangle hold" on her/him. During the time Resident 1 resided at the home, Licensee A got upset on several occasions when Resident 1 woke up in the middle of night and used the bathroom. Licensee A grabbed Resident 1 by the arm and yelled at her/him about the noise s/he made. There was an incident when Resident 1 went to the bathroom and the toilet clogged. Licensee A had Resident 1 put on gloves and dig the feces out of the toilet.

On 10/22/2024, at 10:01 AM, Surveyor interviewed Resident 1 and the following was what s/he reported:

S/He resided at the home for approximately 1 month. S/He was accepted into the home as a tenant, paid $1250.00 per month, and was provided with a bedroom. Licensee A and Person

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| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

| (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 |
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D lived in the basement of the home. Person D had parties with alcohol at the home. Person D and Licensee A fought at night, which kept Resident 1 awake. Licensee A left food in the refrigerator for Resident 1 but provided foods s/he knew Resident 1 did not eat. The 2nd week of residing in the home, Resident 1 went to the bathroom and the toilet clogged. Licensee A gave Resident 1 a pair of gloves and told her/him to stick her/his hands in the toilet to remove the feces; Resident 1 did and was given a plastic bag to put it into. After that incident, Resident 1 never flushed toilet paper again, and instead threw it away in the garbage to avoid another incident. Another incident occurred when Resident 1 needed to get to Walgreens and was alone at the home without transportation. Resident 1 walked to Walgreens and fell during her/his walk. S/He called Licensee A and was told to get up and walk home. Resident 1 did not recall the day, but at 9:00 PM one day, Licensee A took the bedding off of Resident 1's bed and took it to the basement to wash. Licensee A gave the bedding back to Resident 1 soaking wet. The home was cooled by central air conditioning and Resident 1 was "freezing." Licensee A and Person D blamed Resident 1 for adjusting the temperature in the home. The home had a camera inside the kitchen. Licensee A talked to Resident 1 through the camera to tell her/him to clean and do the dishes. Licensee A got upset when Resident 1 had medications delivered and answered the front door to receive them. Resident 1 tried to get her/his mail from the mailbox and Licensee A "flipped out" on her/him. Licensee A was aware of a no-contact order between Resident 1 and her/his ex-friend and provided the ex-friend with the phone number to call the home.

On 10/23/2024, at approximately 10:50 AM,

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| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

| (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 |
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Surveyor reviewed PO G's body camera footage (Axon Body 3 X60A8620N, 10/01/2024, 17:43:57), and the following was observed:

Licensee A stated the following:

17:45:11 - "[S/He] needs to go get evaluated . . . [S/He] left the door wide open for 5 hours and walked away with no shoes on."

17:48:07 - "But I don't want [her/him] here. [S/He] can't be here."

PO G stated, "But the thing is [s/he] lives here."

Licensee A replied, "She does not!"

Licensee A moved towards PO G, raised her/his hands and stated, "Okay, you can take [her/him] with you, but I'm telling you [s/he] can't come back in my residence! I'm telling you that because [s/he] said that."

17:48:22 - Licensee A was pointing her/his fingers, raised her/his voice, and stated, "But [s/he] can't. I'm telling you why because if somebody says that they wanna kill theirself, they can't be around me [sic]. That's what I'm explaining to you. So that wouldn't be a good idea to leave [her/him] in my house tonight [sic]!"

17:48:35 - Licensee A stated, "[S/He] just have to stay outside [sic]! . . . But [s/he] can't come in here! [S/He] haven't paid to be here [sic]! I don't have to evict [her/him]! [S/He's] only been here for 3 we ...[s/he] can't come back in here [sic]!"

17:49:18 - Licensee A stated, "Okay you don't have to make [her/him] leave but [s/he] not coming back in this door [sic]! This is my house

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| | 200003 | A. BUILDING: _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

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and aint nobody finna sit here and tell me they gonna kill theyself and then you gonna tell them they can come back in here because then it'll be a problem [sic]! So why would you want to put [her/him] in a hostile situation?"

17:50:57 - Licensee A stated, "I'm telling you [s/he] can't come back in here . . . (Licensee A was clapping her/his hands together) If somebody's telling you that it's a hostile situation, why would you put somebody back in a hostile situation [sic]? Why would you do that if I'm telling you that? (Licensee A was pointing her/his fingers at PO G) I'm telling you that for a reason! . . . If [s/he] come back here and something happen to [her/him] then I'll say [PO G] said that [s/he] can be here in this hostile situation [sic]!

PO G replied, "Correct, why is it a hostile situation?"

Licensee A stated, " Because [s/he] can't be here!"

PO G replied, "Why?"

Licensee A stated, "Because [s/he] said what [s/he] said.

PO G replied, "But why does that mean [s/he] can't be here? Wouldn't you want to provide that care to [her/him]?"

Licensee A stated, "No! . . . I can't sit and babysit [her/him]!"

17:51:05 - Licensee A stated, "You can take [her/his] medicine outside!" Licensee A grabbed the bag of medications and placed it outside at the front entry of the home.

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| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

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| M 572 | Continued From page 32<br><br>18:04:53 - PO F requested Licensee A retrieve Resident 1's Gatorade from the home so Resident 1 could take her/his medicine. Licensee A stated to Resident 1, "Do you want to get your stuff or not? Do you want to get your stuff or not? Do you want to get your stuff or not?" Licensee A went inside the home. S/He came back outside and handed a bag to Resident 1 and stated, "Here's your Gatorade."<br><br>18:33:53 - PO I was talking with Licensee A. Licensee A stated, " . . . I'm so angry. Why would you want to put somebody in a hostile situation? I'm just letting you know that. I'm just being brutally honest with you! . . . Okay, well, listen, I don't want to be bothered with the foolishness [sic]. . . [S/He's] disturbing my peace."<br><br>18:44:53 - Resident 1 was escorted into the home by PO G. Licensee A met them at the front door and stated, "I can grab [her/his] stuff. I got it." Licensee A took the items from PO G. S/He then grabbed a purse from Resident 1's hands. Resident 1 stated, "Wait a minute you got my hand." Licensee A stuck her/his hand out towards PO G and stated, "okay, you all can go, I got this now [sic]." Licensee A started to raise her/his voice and stated, "I can do that . . . this is my house!" PO G attempted to calm down Licensee A, and Licensee A closed the door on officers.<br><br>18:46:25 - PO G and PO F approached the front door of the home and stood by listening. Surveyor observed yelling coming from inside the home. Resident 1 was heard screaming. PO G and PO F pounded on the door and ordered Licensee A to open the door. The door opened and Resident 1 quickly exited and stated, "[s/he] attacked me!" Licensee A was yelling and was placed into police | M 572 | | |

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| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

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| M 572 | Continued From page 33<br>custody.<br><br>On 10/23/2024, at approximately 10:50 AM, Surveyor reviewed PO F's body camera footage (Axon Body 3 X60A8174N, 10/01/2024, ), and the following was observed:<br><br>Resident 1 stated the following:<br><br>18:21:06 - "I have a pace maker . . . [Licensee A] could cause me a heart attack in an instant!"<br><br>18:22:21 - "[S/He'll] hit me . . . I'm real scared of her."<br><br>18:23:29 - "[S/He'll] jump in there and [s/he'll] push me. And [s/he'll] just attack me . . . Can I just say [s/he] abused me already."<br><br>18:27:19 - "[S/He's] just outrageously . . . [s/he] looses [her/his] temper. [S/He] goes into rage, after me. And then [s/he] doesn't want me talking to [her/his] [spouse] at all . . . even though s/he's the landlord."<br><br>18:27:34 - PO F asked Resident 1, "does [s/he] live here too?" Resident 1 responded, "[S/He] lives with [her/him] downstairs."<br><br>In summary, Licensee A was upset with Resident 1 on 10/01/2024, for leaving the door to the residence open while s/he was gone. Licensee A refused to let Resident 1 into the home. Resident 1 called the police. The police arrested Licensee A on a warrant from a previous disorderly conduct incident with their department. Licensee A was released from custody. Police advised Licensee A, Resident 1 was allowed to remain at the home. Resident 1 and Licensee A were advised by police to avoid contact with each other. Prior to | M 572 | | |

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| SERENITY GARDEN ADULT FAMILY HOME | 2916 S. 72ND STREET GREENFIELD, WI 53219 |

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| M 572 | Continued From page 34<br>police leaving the area of the home, yelling and screaming was heard coming from inside the residence. Police reinitiated contact with Licensee A and Resident 1 and determined Licensee A physically abused Resident 1. Licensee A was arrested for Strangulation and Suffocation, along with Intentionally Abuse/Neglect Patient. Red marks on Resident 1's arms and neck were observed by PO F. Resident 1 reported other incidents of physical and mental abuse by Licensee A, which occurred while residing at the home. Throughout Resident 1's contact with the police, s/he reported feeling scared, anxious, and the feeling of her/his heart racing. | M 572 | | |