STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013109	A. BUILDING: _____ B. WING _____	R 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGIAS PARADISE ASSISTED LIVING LLC	842 N 25TH ST MILWAUKEE, WI 53233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	INITIAL COMMENTS On 01/14/2025, with information gathered through 01/16/2025, Surveyors conducted a standard survey, and verification visit for SOD 76S713, dated 05/26/2023, at Georgia's Paradise Assisted Living LLC, an Adult Family Home (AFH) in Milwaukee, WI. Thirteen deficiencies were identified. One of the 13 violations was a repeat violation. See Statement of Deficiency (SOD) 76S712, dated 01/27/2022, and SOD 76S713, dated 05/26/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
M 130	88.03(5)(c) CHARGED OR CONVICTED OF CRIME 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the Department within 48 hours a service provider was charged with a crime related to caring for dependent persons. Caregiver D had pending charges of 940.198(2)(b) Physical Abuse of an Elder Person - Bodily	M 130		

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

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M 130	Continued From page 1 Harm. Findings include: The provider was licensed as a non-ambulatory adult family home (AFH) to care for up to 4 residents in the client groups emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, public funding, advanced aged, and developmentally disabled. On 01/14/2025, Surveyors reviewed Resident 3's record and identified the following: -Resident 3 was admitted to the provider's home on 11/04/2019. -Resident 3 had a guardian. -A letter from the Milwaukee County District Attorney's Office addressed to [Resident 3], dated 07/08/2024, stated the following: RE: State of Wisconsin v.[Caregiver D] Review Date: July 08, 2024 Offense: Physical Abuse of an Elder Person - Intentionally Cause Bodily Harm Offense Date: July 07, 2024 Dear [Resident 3]: "The Milwaukee County District Attorney's Office has reviewed the police reports and other evidence in this case in which you were a victim. Based on that review, the District Attorney's office has concluded that this case will not be prosecuted in criminal court." On 01/14/2025, Surveyors reviewed the Department's records and did not find documentation to indicate the provider notified the Department within 48 hours after Caregiver D had pending charges substantially related to caring for dependent persons.	M 130		

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M 130	Continued From page 2 On 01/16/2025 at approximately 8:35 AM, Surveyors interviewed Licensee C regarding if s/he reported to the Department Caregiver D had pending charges substantially related to caring for dependent persons. Licensee C stated s/he was aware of the pending charges. Licensee C stated s/he did not report pending charges to the Department. As of 01/16/2025, Licensee C had not reported the above charges to the Department.	M 130		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department, within 24 hours, when 1 of 1 resident (Resident 3) eloped and was reported missing. Resident 3 eloped from the facility on 4 occasions and the provider did not report to the department. Findings include: On 01/14/2025, Surveyors reviewed Resident 3's	M 134		

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M 134	Continued From page 3 record and identified the following: -Resident 3 was admitted to the provider's home on 11/04/2019 with diagnoses including chronic kidney disease, failure, hypertension, anxiety disorder, bipolar disorder, schizophrenia, dementia with behavior disturbance, lipid storage disorder, and anemia. Resident 3 had a guardian. On 01/15/2025, Surveyors reviewed Milwaukee Police Department (MPD) reports for incidents involving Resident 3 at the facility and identified the following: Incident on 06/07/2024 - On 06/07/2024, at approximately 12:30 AM, MPD officers were dispatched to a trouble with subject call at facility. -Upon arrival MPD officers spoke to [Caregiver E] who stated a resident (Resident 3) at the group home facility was having a psychotic episode and stating s/he was hearing voices. Caregiver E stated on 06/07/2024, at approximately 12:34 AM, Resident 3 walked away going southbound on N 25th St. toward W Wisconsin Ave. -Caregiver E stated Resident 3 is diagnosed with dementia and schizophrenia. Caregiver E stated Resident 3 has been reported in the past with most recent documented critical missing report is from 2022. -On 06/07/2024, at approximately 1:57 AM MPD officers were notified by a Marquette PD Squad had come into contact with Resident 3 and called medical for him/her. According to dispatch, Resident 3 had been conveyed to Mt. Sinai hospital. -MPD officers went to Mt. Sinai hospital where MPD officers spoke with Resident 3. Resident 3 stated s/he was upset because s/he didn't want to be around people she didn't know very well and	M 134		

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M 134	Continued From page 4 also want to smoke there. Resident 3 stated facility staff would not let him/her smoke and would not always be allowed to drink coffee. Resident 3 stated while s/he was gone s/he walked around his/her group home until s/he found an officer's who called medical for him/her. -MPD officer's spoke to Caregiver E informing him/her Resident 3 has been located at the hospital. Caregiver E informed MPD officer's s/he could not leave the residence. Incident on 07/07/2024 -"It should be noted that [Resident 3] has at least 2 prior missing reports filed (including one filed on June 7th, 2024), which [Resident 3] was listed as a critical missing, due to a dementia diagnosis." Incident on 07/23/2024 -On 07/23/2024, at 7:44 PM, Caregiver E reported to MPD Resident 3 was missing. -Resident 3 was last seen on 07/23/2024 at 7:30 PM. -Caregiver E reported to MPD officer Resident 3 goes missing a few times and usually ends up at the Joy House or Mt. Sinai hospital. -Caregiver E reported to MPD officer s/he is the only group home worker present so could not leave location. -On 07/23/2024 at approximately 8:15 PM, MPD officer's were notified by Marquette Police Department Resident 3 had been located at 2040 W Wisconsin Ave. Resident 3 was taken to Mt. Sinai. Incident on 08/08/2024 -On 08/08/2024, at 3:57 PM, Caregiver F reported to MPD Resident 3 was missing. -Resident 3 was last seen on 08/08/2024 at 3:50 PM. -On 08/08/2024, upon MPD officer arrival to the	M 134		

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M 134	Continued From page 5 critical missing, at 842 N 25th st, MPD officer observed Resident 3 to be sitting on the back porch on 08/08/2024 at approximately 4:40 PM. Resident 3 stated s/he left to go to church located at 631 N 19th but returned because the church was closed. Resident 3 stated s/he wanted to repent for his/her sins. On 01/15/2024, Surveyors completed a review of the Department facility folder. Surveyors did not observe any self-reports submitted to the Department in 2024. On 01/16/2025 at approximately 8:35 AM, Surveyors interviewed Licensee C. Licensee C confirmed s/he did not report Resident 3's elopements to the Department. Licensee C stated s/he has been dealing with a lot in his/her personal life.	M 134		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the provider did not ensure the home and its operation complied with this chapter and all other laws governing the home and its operations potentially affecting 4 of 4 residents. The provider has been unable to maintain compliance with Chapter 88 of the Department of Health Services-Licensed Adult Family Home regulations. At the time of this verification visit, the provider had 1 repeat violation. The provider	M 216		

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M 216	Continued From page 6 did not follow Special Orders which resulted from previous Statement of Deficiency (SOD) J6S712, dated 01/27/2022, and SOD 76S713, dated 05/26/2023. Findings include: On 11/07/2023, SOD 76S713 and a Special Orders Letter were issued to Licensee C via email with the following: Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Georgias Paradise Assisted Living LLC: 1. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., the licensee shall ensure the home is safe, and easily accessible for all residents. The licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency (SOD) 76S713. WITHIN 45 DAYS of receipt of this notice, the licensee's corrective measures shall address: A. Safe and Accessible Exits - The first floor of the home shall have at least 2 means of exiting which provides unobstructed access to the outside, for all residents of the home. - Ensure all residents shall be able to easily enter and exit the home, to easily get to their bedrooms, a bathroom, and all common living areas in the home. - 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	M 216		

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M 216	Continued From page 7	M 216		

unable to easily negotiate stairs without assistance, then at least two exits from the home shall be ramped to grade with a hard surfaced pathway with handrails.
- Pending completion of the forgoing requirements, the licensee will implement all necessary measures to ensure the safety of residents.

2. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for each current resident with a copy of Statement of Deficiency (SOD) 76S713 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the Department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the Department representatives upon request.

On 01/14/2025 with information gathered through 01/16/2025, Surveyors conducted a standard survey, and verification visit for SOD 76S713, dated 05/26/2023, at Georgia's Paradise Assisted Living LLC. As a result of the survey, the provider was issued 14 deficiencies. One of the 14 was a repeat deficiency. The following repeat deficiency was identified:

88.05(2)(a) - Difficulty Walking - This is a repeat deficiency.

On 01/16/2025 at approximately 8:35 AM, Surveyors reviewed SOD 76S713 and the Special Orders Letter with Licensee C. Licensee C confirmed the facility's 2 exits shared ramp did

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M 216	Continued From page 8 not have handrails. Licensee C confirmed s/he did not have documentation resident's legal representative and case manager was provided with a copy of SOD 76S713 and a copy of the Notice and Order Letter.	M 216		
{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 the ramps installed at 2 exits from the home were equipped with handrails. Resident 2 had difficulty walking and utilized a wheelchair for mobility. This is a repeat deficiency. See Statement of	{M 262}		

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{M 262}	Continued From page 9 Deficiency (SOD) 76S712, dated 01/27/2022, and SOD 76S713, dated 05/26/2023. Findings include: On 01/14/2025 at approximately 11:00 AM, Surveyors toured the home and observed the following: -The 2 side exits, located on the southwest side and southeast side of the facility, led to a shared ramp. There were no handrails on shared ramp. On 01/14/2025, Surveyors reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 11/26/2019 with diagnoses including adjust disorder with anxiety, bilateral primacy osteoarthritis of hip, chronic migraine w/o aura, intractable, w/o stat migraine, gastro-esophageal reflux disease without esophagitis, low back pain, muscle weakness, and paranoid personality disorder. -Resident 2's Resident Evacuation Assessment (RES), dated 11/26/2024, indicated Resident 2 was not physically able to start and complete an evacuation without physical assistance. Resident 2's RES stated, "Is in a wheelchair at this time by choice but can follow cues from the staff to proceed." Licensee C was listed as the evaluator of the RES. On 01/16/2025 at approximately 8:35 AM, Surveyors interviewed Licensee C regarding Resident 2's wheelchair and the facility's 2 exits shared ramp. Licensee C confirmed Resident 2 utilized a wheelchair for mobility. Licensee C confirmed the facility's 2 exits shared ramp did	{M 262}		

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{M 262}	Continued From page 10 not have handrails.	{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 clean, well-maintained and homelike environment for 4 of 4 residents (Resident 2, Resident 3, Resident 4 and Resident 5) in the home. The living room, bathroom, resident bedroom, exterior of home and hallways required cleaning and repairs. There was missing and dirty floor trimming throughout facility. The living room furniture was cracked and peeling. The living room had peeling floor tile. A resident bedroom needed repairs to the floor tile. Findings include: On 01/14/2025 at approximately 11:00 AM, Surveyors toured the home and observed the following: -Bathroom light fixture 2 of 3 light bulbs burnt out. -No toilet paper in the bathroom. -No toilet paper holder in the bathroom. -No hand towels in the bathroom. -No hand towels rack in the bathroom. -Bathroom wall vent brown due to being rusted. -Bathroom paper towel holder rusted and had	M 276		

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M 276	Continued From page 11	M 276		

dust caked all over.
-Bathroom wall trimming was dirty.
-Bathroom shower had brown substance on the floor and shower trimming base was dirty.
-Bathroom cabinets were cracked/broken and unable to close shut.
-Packages lined up against the wall near front entrance.
-Bedroom # 1 had missing floor tile throughout areas of room.
-Floor trimming was missing and dirty throughout facility.
-Living room had peeling floor tile throughout.
-Living room couch had peeling leather.
-Packages and computer desktop lined up against wall near front entrance hallway.
-Hallway near front entrance contained a black camera in the left ceiling corner
-Ceiling throughout facility was bubbling and peeling off (consistent with water damage).
-Black lawn chair close to exit 2 transition piece.
-Screen window crooked to the right of exit 3.
-Exit 3 screen door not closing completely.

On 01/14/2025 at approximately 12:00 PM, Surveyors interviewed Facility Manager A. Facility Manager A stated s/he was aware of the issues of the home environment. Facility Manager A stated Licensee C was aware of the issues of the home environment and is working with maintenance to fix the issues.

On 01/15/2025 at 5:34 PM, Surveyors interviewed Licensee C. Licensee C stated Facility Manager A provided him/her with an update regarding the home environment issues. Licensee C stated s/he will have the facility maintenance person take care of the issues of the home environment this week and weekend.

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M 380	Continued From page 12	M 380		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 2) reviewed received an admission health exam to identify health problems. Findings include: On 01/14/2025, Surveyors reviewed Resident 2's record. The following was identified: - Resident 2 was admitted to the facility on 11/26/2019. Resident 2's record did not include evidence of a health exam. On 01/14/2025 at approximately 12:00 PM, Surveyors interviewed Facility Manager A. Facility Manager A confirmed Resident 2 did not have an admission health exam. Facility Manager A stated information would have been in the resident's record if it was completed.	M 380		

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M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE 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 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 record review and interview, the provider did not ensure 2 of 2 residents (Resident 3 and Resident 4) had a service agreement completed prior to admission, signed and dated by the provider and guardian or designated representative. Resident 3's and Resident 4's guardians did not sign their service agreements. Findings include: On 01/14/2025, Surveyors reviewed Resident 3's and Resident 4's records and identified the following: -Resident 3 was admitted to the provider's home on 11/04/2019. Resident 3 had a guardian. Resident 3's record did not include a completed, dated and signed admission agreement. Resident 3's guardian did not sign the service agreement. -Resident 4 was admitted to the provider's home on 04/22/2022. Resident 4 had a guardian. Resident 4's record did not include a completed,	M 384		

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M 384	Continued From page 14 dated and signed admission agreement. Resident 4's guardian did not sign the service agreement. On 01/14/2025, at approximately 12:00 PM, Surveyors interviewed Facility Manager A. Facility Manager A confirmed Resident 3's and Resident 4's guardians did not sign their admission agreements. Facility Manager A stated s/he would contact Resident 3's and Resident 4's guardians to sign residents' service agreements.	M 384		
M 406	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents' (Resident 2 and Resident 3) individual service plans (ISPs) were developed, signed and dated by all persons involved in developing the plan. Resident 2's ISP was not signed by him/her and his/her managed care organization (MCO) care management team. Resident 3's ISP was not signed by his/her guardian. Findings include:	M 406		

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M 406	Continued From page 15 On 01/14/2025, Surveyors reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 11/26/2019 with diagnoses including adjust disorder with anxiety, bilateral primacy osteoarthritis of hip, chronic migraine without aura, intractable, without status migraine, gastro-esophageal reflux disease without esophagitis, low back pain, muscle weakness, and paranoid personality disorder. Resident 2 was his/her own person and made his/her own medical decisions. Resident 2 was enrolled in services with an MCO and had assigned case managers. Resident 2's ISP was dated 12/09/2024. Resident 2 did not sign his/her ISP. Resident 2's case managers' did not sign his/her ISP. On 01/14/2025, Surveyors reviewed Resident 3's record and identified the following: -Resident 3 was admitted to the provider's home on 11/04/2019 with diagnoses including chronic kidney disease, hypertension, anxiety disorder, bipolar disorder, schizophrenia, dementia with behavior disturbance, lipid storage disorder, and anemia. Resident 3 had a legal guardian. Resident 3's ISP was dated 12/12/2024. Resident 3's legal guardian did not sign his/her ISP. On 01/14/2025 at approximately 12:00 PM, Surveyors interviewed Facility Manager A. Facility Manager A stated Resident 2's and Resident 3's ISPs were current and developed by him/her. Facility Manager A confirmed Resident 2 and Resident 2's case managers' did not review and sign the ISP. Facility Manager A confirmed Resident 3's guardian did not sign his/her ISP.	M 406		

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M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a written order from the physician specifying who by name or position could administer medications for 1 of 1 resident (Resident 2) reviewed who required staff to administer his/her medications. Resident 2 did not have a written order permitting the provider staff to administer medications. Findings include: On 01/14/2025, Surveyors reviewed Resident 2's record. Resident 2 was admitted to the facility on 11/26/2019. Resident 2 did not have an order specifying who by name or position could administer his/her medication. Surveyors requested a written order from the physician for Resident 2 from Facility Manager A. On 01/14/2025 at approximately 12:00 PM, Surveyors interviewed Facility Manager A. Facility Manager A confirmed Resident 2 required staff to	M 464		

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M 464	Continued From page 17 administer his/her medication. Facility Manager A confirmed Resident 2's record did not contain evidence of a written order permitting the provider staff to administer medications from the physician for Resident 2.	M 464		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an accurate record of medication administration for 1 of 1 resident (Resident 2). The Medication Administration Records (MARs) for Resident 2 contained omissions in October 2024, November 2024, and December 2024. Findings include: On 01/14/2025, Surveyors reviewed Resident 2's record and identified the following: Resident 2 was admitted to the provider's home on 11/26/2019. Surveyors reviewed Resident 2's MAR for the months of October 2024, November 2024 and December 2024. The following entries	M 466		

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M 466	Continued From page 18 in Resident 2's MARs were blank: 8:00 AM: -Cephalexin 500 milligrams (mg) capsule by mouth 2 times daily for 10 days - 10/11/2024-10/13/2024 -Eliquis 5 mg tablet by mouth 2 times a day - 10/11/2024-10/13/2024, 11/08/2024-11/10/2024 and 12/06/2024-12/08/2024 8:00 PM: -Cephalexin 500 milligrams (mg) capsule by mouth 2 times daily for 10 days - 10/11/2024-10/13/2024 -Eliquis 5 mg tablet by mouth 2 times a day - 10/11/2024-10/13/2024, 11/08/2024-11/10/2024 and 12/06/2024-12/08/2024 On 01/14/2025 at approximately 12:00 PM, Surveyors interviewed Facility Manager A. Facility Manager A confirmed Resident 2 required assistance with medication administration for all of his/her medications listed. Facility Manager A confirmed the MARs should have been documented accurately. Facility Manager A stated the blank entries were due to medication being discontinued and staff were to indicate medication had been discontinued by still documenting on the MAR regarding why the medication was not administered.	M 466		
M 510	88.09(1)(d)11 RESIDENT FUNDS Records maintained by the licensee of the resident's finances, including written authorization from the resident of resident's guardian to control the resident's funds.	M 510		

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M 510	Continued From page 19 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident's (Resident 3) record had evidence of written authorization from the legal guardian to control the resident's funds. Findings include: On 01/14/2025, Surveyors reviewed Resident 3's record and identified the following: -Resident 3 was admitted to the provider's home on 11/04/2019. Resident 3 had a legal guardian. Resident 3's record did not contain written authorization from the guardian for the provider to control Resident 3's funds. On 01/14/2025 at approximately 12:00 PM, Surveyors interviewed Facility Manager A asking if the provider controlled any resident funds. Facility Manager A stated the provider managed funds for Resident 3. Facility Manager A confirmed s/he did not have written authorization documentation from Resident 3's guardian for the provider to control his/her funds.	M 510		
M 544	88.10(2) EXPLANATION OF RESIDENT RIGHTS EXPLANATION OF RESIDENT RIGHTS. The licensee shall explain and provide copies of the resident rights under sub. (3) and the grievance procedure under sub. (5) to the person being admitted, that person's guardian, family members involved in the placement and any designated representative of the person before the service agreement is signed.	M 544		

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M 544	Continued From page 20 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure newly admitted residents/legal representatives were explained and provided copies of the resident rights and grievance procedures for 2 of 2 residents (Resident 3 and Resident 4) reviewed. Findings include: On 01/14/2025, Surveyors reviewed Resident 3's and Resident 4's records and identified the following: -Resident 3 was admitted to the provider's home on 11/04/2019. There was no documentation acknowledging the provider went over the resident rights/grievance procedure with Resident 3's guardian. -Resident 4 was admitted to the provider's home on 04/22/2022. There was no documentation acknowledging the provider went over the resident rights/grievance procedure with Resident 4's guardian. On 01/14/2025 at approximately 12:00 PM, Surveyors interviewed Facility Manager A. Facility Manager A confirmed there was no documentation acknowledging the provider went over the resident rights/grievance procedures with Resident 3's and Resident 4's guardians.	M 544		
Z 055	DHS 13.05 (3) (a) ENTITY ALLEGATION REPORTING REQUIREMENTS Entity's duty to report to the department. Except	Z 055		

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Z 055	Continued From page 21 as provided under pars. (b) and (c), an entity shall report to the department any allegation of an act, omission or course of conduct described in this chapter as client abuse or neglect or misappropriation of client property committed by any person employed by or under contract with the entity if the person is under the control of the entity. The entity shall submit its report on a form provided by the department within 7 calendar days from the date the entity knew or should have known about the misconduct. The report shall contain whatever information the department requires. This Rule is not met as evidenced by: Based on record review and interview the provider did not investigate allegations of neglect and abuse for 1 of 1 incident involving Caregiver D. Resident 3 alleged s/he was punched one time on the left side of his/her face, causing pain, a laceration to his/her lower lip, and two of his/her upper teeth to become loose by Caregiver D on 07/07/2024. This allegation was known by Licensee C. No investigation took place into the alleged incident. Findings include: On 01/14/2025, Surveyors reviewed Resident 3's record and identified the following: -Resident 3 was admitted to the provider's home on 11/04/2019 with diagnoses including chronic kidney disease, hypertension, anxiety disorder,	Z 055		

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Z 055	Continued From page 22 bipolar disorder, schizophrenia, dementia with behavior disturbance, lipid storage disorder, and anemia. -Resident 3 had a legal guardian. -A letter from the Milwaukee County District Attorney's Office addressed to [Resident 3], dated 07/08/2024, stated the following: RE: State of Wisconsin v.[Caregiver D] Review Date: July 08, 2024 Offense: Physical Abuse of an Elder Person - Intentionally Cause Bodily Harm Offense Date: July 07, 2024 Dear [Resident 3]: "The Milwaukee County District Attorney's Office has reviewed the police reports and other evidence in this case in which you were a victim. Based on that review, the District Attorney's office has concluded that this case will not be prosecuted in criminal court." Resident 3's record did not include documentation of an investigation being conducted on allegations of staff to resident abuse on 07/07/2024. On 01/14/2025, Surveyors requested the police report and documentation of investigation for incident of staff alleged abuse from Facility Manager A. On 01/14/2025 at approximately 12:55 PM, Surveyors interviewed Facility Manager A. Facility Manager A stated s/he was aware of the allegations of abuse. Facility Manager A stated Caregiver D was not charged. Facility Manager A stated s/he would send the police report for the incident via-email by 5:00 PM.	Z 055		

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Z 055	Continued From page 23 As of 01/14/2025 at 5:00 PM, Surveyors did not receive the police report and documentation of investigation for incident. On 01/15/2025, Surveyors requested the police reports involving Resident 3 from Milwaukee Police Department (MPD). On 01/15/2025, Surveyors reviewed MPD report, dated 07/07/2024, and identified the following: -On 07/07/2024, MPD officers interviewed Caregiver D. Caregiver D stated s/he is a caregiver at Georgia's Paradise Assisted Living LLC. -Caregiver D stated s/he knew Resident 3 because s/he was a resident at Georgia's Paradise Assisted Living LLC. -Caregiver D had pending charges for assault against Resident 3. On 01/16/2025 at 7:31 AM, Surveyor received a forwarded email from Facility Manager A that s/he sent to Resident 3's guardian on 07/08/2024 at 6:49 AM, stating the following: -"[Resident 3] morning started off rough when [s/he] realized [his/her] tablet charger [sic] a shortage in it. [Resident 3] asked for a cigarette. [Caregiver D] informed [Resident 3] [s/he] didn't have anymore. There will be some delivered. [Resident 3] walked up to [Caregiver D] and started looking around [him/her] requesting the staff cord. [Caregiver D] informed [Resident 3] once [his/her] phone [sic] done charging [s/he] will [sic] [Resident 3's] phone. A few minutes goes by [Resident 3] walked back in and tried plugging up his/her device without [Caregiver D]. When [Caregiver D] realized [s/he] redirected [Resident	Z 055		

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3]. [Resident 3] decided to go turn on the radio in the kitchen, then [sic] the volume, and then went to go sit outdoors with the door close. After [sic] few minutes goes by staff went to go turn it off because [Resident 3] was no longer in the kitchen area. When [Resident 3] realized [sic] was off [s/he] [sic] to [Caregiver D] and began screaming at him/her. [Resident 3] said, "there's no TV so [sic] listen to the radio." [Caregiver D] reminded [Resident 3] that s/he was outdoors not in the kitchen, and its to loud for everyone. [Caregiver D] also reminded [Resident 3] that [s/he] cut the cord on his/her TV and busted up the living room TV so that's the reason [s/he] [sic] not watching TV. [Resident 3] began cursing and yelling at [Caregiver D]. [Resident 3] walked back to the radio, [sic] it back on extremely high and walked back outside. While [Caregiver D] [sic] bent over [sic] [his/her] head down [Resident 3] walked up speaking [his/her] language and began attacking [him/her] while [s/he] was bent with [his/her] head down. [Resident 3] pulled [Caregiver D] [sic] and began beating [him/her] in the head for so long until [Caregiver D] was able to stand and get [Resident 3] off [him/her]. When [Caregiver D] was able to get away [s/he] called [MPD] and management. [Resident 3] heard [Caregiver D] on the phone with the police and ran out the door with [his/her] purse."

"When MPD found [Resident 3] and asked [him/her] questions [s/he] told them [s/he] didn't want to go back because [s/he] was [sic]. [Resident 3] told them [s/he] wanted to go to the hospital because [s/he] needs help. [Resident 3] informed them that [s/he] set [his/her] old house on fire that's how [s/he] ended up there. [Resident 3] kept saying [s/he] need help."

"[Resident 3] was seen at the ER and things were

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fine. 12th street hospital called the facility and stated [Resident 3] left the hospital roughly around 2[sic] before they could bring [Resident 3] back home."

"I currently don't have any updates since [sic]."

On 01/16/2025 at approximately 8:35 AM, Surveyors interviewed Licensee C. Licensee C stated s/he was aware of the allegations of abuse. Licensee C confirmed s/he did not conduct a thorough investigation. Licensee C stated s/he is not trying to make excuses but s/he has been dealing with a lot in his/her personal life.

-There were no interviews with facility staff/identified witnesses and residents and no attempt at obtaining a police report of the incident.

-Licensee C did not conduct an internal investigation on allegations of staff to resident abuse.

All entities regulated by DQA (Division of Quality Assurance) must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include: Collecting and preserving any physical and documentary evidence including videos; Interviewing alleged victims and witnesses; Collecting other corroborating/disproving evidence; Involving other regulatory authorities who can assist (e.g., local law enforcement, elder abuse agency, Adult Protective Service agency, DQA, Board on Aging Ombudsmen, Client Right's Specialist, etc.); and Documenting each step taken during the internal investigation. These steps should be taken as part of the entity's initial attempt to determine

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Z 055	Continued From page 26 what, if anything, happened and to determine the complete factual circumstances surrounding the alleged incident. (DQA publication P-00038, Wisconsin Background Check and Misconduct Investigation Program Manual, 10/2024.)	Z 055		