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	0012075	A. BUILDING: _____ B. WING _____	C 10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY ADULT FAMILY HOME III	**1011 MAYFAIR DR RACINE, WI 53402**

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M 000	INITIAL COMMENTS On 10/07/2025, Surveyor concluded a complaint investigation at Destiny Adult Family Home III. Three deficiencies were identified. One complaint was substantiated. Census: 3	M 000		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 staff (Caregiver C) received the required training related to health, safety and welfare of residents, resident rights, and treatment appropriate to residents served prior to or within 6 months after starting to provide care. In addition, Caregiver C's fire safety training date was completed on 03/22/2023, over 2 months late and first aid training was completed on 03/08/2023, over 1 month late. Findings include:	M 244		

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

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M 244	Continued From page 1 On 10/03/2025 at 1:30 p.m., Surveyor reviewed employee records for Caregiver C, including training records. The following was identified: Caregiver C was hired on 07/30/2022. Caregiver C's file did not contain evidence s/he completed 15 hours of training related to health, safety and welfare of residents, resident rights, and treatment appropriate to residents served prior to or within 6 months after starting to provide care on 07/30/2022. Caregiver C's file did not contain evidence of resident rights training. In addition, Caregiver C's fire safety training date was completed on 03/22/2023, over 2 months late. Caregiver C's first aid training was completed on 03/08/2023, over 1 month late. On 10/03/2025 at approximately 11:35 a.m., Licensee A confirmed Manager G checked Caregiver C's University of Wisconsin Green Bay Training Registry trainings and certified nurse aid trainings before s/he started working on the floor. On 10/03/2025 at 2:23 p.m., Surveyor interviewed Licensee A and Manager G. They provided Caregiver C's the University of Wisconsin Green Bay Training Registry trainings. Manager G confirmed Caregiver C's fire safety training date was completed on 03/22/2023, over 2 months late. Manager G confirmed Caregiver C's first aid training was completed on 03/08/2023, over 1 month late. Licensee A acknowledged Caregiver C did not having all his/her training requirements met. Licensee A stated, "I thought s/he had those trainings done and in time." Cross Reference M 0548 DHS 88.10(3)(a) Fair Treatment	M 244		

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M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 resident's individual service plans (ISPs) was updated, in writing, when Resident 1's needs changed and when requested by the resident's guardian. Resident 1's ISP was not updated to accurately reflect her/his ability to be in the community independently. Resident 1's ISP did not reflect the guidelines his/her guardian had requested to be implemented on 11/01/2024, via email. Findings include: On 10/03/2025, Surveyor reviewed Resident 1's record and identified the following:	M 424		

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M 424	Continued From page 3	M 424		

-Resident 1 was admitted to the provider's home on 05/01/2015, with diagnoses including fetal alcohol syndrome, schizophrenia and intellectual disabilities.
- Resident 1 had a case manager (CM) from a managed care organization (MCO) and a guardian.
-Resident 1's individualized service plan (ISP) dated 06/01/2025. The following was identified:

Resident 1 required 24-hour supervision. Under wandering, the ISP identified, s/he, "wanders off." Frequency of service. "Daily. Staff monitors." Goals/outcomes. "To not wander off." Service provider responsible. "Destiny AFH/LLC." On 06/01/2025, the 6- month progress review and list for any changes read, "No changes."

On 10/03/2025, Surveyor reviewed a copy of an email sent by Guardian E on 11/01/2024, to Licensee A. It read, "I am writing to outline parameters for my ward, [Resident 1], in regard to [sic] leaving the facility. In an effort [sic] to keep him/her safe, I request and acknowledge s/he is able to [sic] leave the facility alone if s/he maintains sobriety from any form of drugs or alcohol while s/he is in the community. [Resident 1] should also check in hourly with the facility, for example: If s/he leaves for more than one hour [sic] s/he should return to the facility to 'check in' with staff on duty."

Resident 1's ISP was not updated per the request of Guardian E. The ISP did not indicate Resident 1 was able to leave the facility alone for up to an hour. The ISP did not indicate s/he was required to maintain sobriety from any form of drugs or alcohol while s/he was in the community. The ISP did not indicate Resident 1 was required to check

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M 424	Continued From page 4 in hourly with the facility staff. Interviews On 10/03/2025 at 11:15 p.m., Lead Caregiver B confirmed s/he wrote the ISPs. On 10/03/2025 at 12:05 p.m., Surveyor observed a hand-written note, dated 7/03/2024, that read, "[Resident 1] has permission to take walks by him/herself." Lead Caregiver B confirmed the note was written and signed by Guardian E. On 10/03/2025 at 12:40 p.m., Surveyor interviewed Licensee A and Lead Caregiver B, who confirmed Resident 1 had several items missing from his/her ISP. Lead Caregiver B reviewed the ISP and stated, "You are right. I don't have the permission to be in the community for 1 hour, the other information from the guardian or [Resident 1's] check in parameters. It should all be in here and it's not. I never added it after [Guardian E] sent the email." On 10/03/2025 at 12:45 p.m., Licensee A confirmed there was no specific plan for Resident 1, if s/he was gone for longer than 1 hour, but to call the police. However, they did have a general policy for elopement. Surveyor questioned how staff knew what to do when Resident 1 was gone longer than an hour. Licensee A stated, "They just call me or [Manager G]. We come and look for him/her." Cross Reference M 0548 DHS 88.10(3)(a) Fair Treatment	M 424		
M 548	88.10(3)(a) Fair Treatment	M 548		

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M 548	Continued From page 5 Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure each resident was treated with courtesy, respect, and full recognition of the resident's dignity for 1 of 1 resident. Staff did not treat Resident 1 with courtesy and respect after s/he arrived home late. Findings include: On 09/10/2025, the department received a complaint alleging the staff hit a resident in the face. On 10/03/2025, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's home on 05/01/2015, with diagnoses including fetal alcohol syndrome, schizophrenia and intellectual disabilities. - Resident 1 had a case manager (CM) from a managed care organization (MCO) and a guardian. On 10/03/2025, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 06/01/2025. The following was identified: -Aggressive/combative. "Whenever in disagreement, not getting attention." Frequency of service. "3 to 4 x a week." Goals/outcomes. "To reduce aggressive behavior." Service provider	M 548		

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M 548	Continued From page 6	M 548		

responsible. "Destiny AFH/LLC." On 06/01/2025, the 6- month progress review and list for any changes read, "No changes."

Resident 1's ISP did not call for any physical restraints to be used during behavioral episodes.

On 10/03/2025 at 7:10 a.m., Surveyor reviewed Racine Police Department incident report, dated 09/02/2025. The report read, "Contact was made with [Resident 1], who was being treated for a swollen right eye. [Resident 1] stated s/he was assaulted by his/her caretaker ...[Resident 1] stated s/he had gotten home later than expected. [Caregiver C] became frustrated with his/her late return. [Resident 1] stated the argument became heated and [Caregiver C] struck him/her in the eye ...[Police Officer I] made contact with [Guardian E], who explained parameters had been put in place regarding when and how s/he was to leave the house ....that [Resident 1] was to check in with caretakers at the group home every hour while away and that s/he should return no later than 2100 hours."

Police Officer I wrote, " ...contacted [Caregiver C] by telephone. [Caregiver C] confirmed [Resident 1] had parameters for going out and stated [Resident 1] returned approximately 10 to 15 minutes late. According to [Caregiver C], [Resident 1] returned agitated and aggressive, and s/he believed [Resident 1] may have been under the influence of drugs or alcohol. [Caregiver C] stated [Resident 1] became aggressive and [Resident 1] struck [Caregiver C] in the mouth. [Caregiver C] reported s/he restrained [Resident 1] by grabbing his/her arms and holding him/her down."

On 10/03/2025 at 11:06 p.m., Surveyor reviewed

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Resident 1's behavior support plan (BSP), dated 11/13/2014. Lead Caregiver B stated, "That's the BSP we use. The managed care organization (MCO) doesn't update it if there are no changes." Surveyor requested an email confirmation from Case Manager (CM) D if there had been any updates to the BSP.

On 10/03/2025 at 11:50 a.m., Surveyor reviewed Resident 1's managed care organizations (MCO) member centered plan (MCP) dated 09/01/2025. The following was identified:

- "Behaviors requiring intervention.
- Wandering/elopement: yes. Describe behaviors: Elopement during the day and night.
- Offensive/violent Behaviors yes. Describe behaviors. Property damage and biting.
- How are behaviors managed? PRN's (as needed medication), redirecting to other activities."

On 10/07/2025 at 4:06 p.m., CM D confirmed via email, "The BSP should be renewed every year and that is the only one we have on file, so essentially [Resident 1] does not have a BSP in place at this time and has not had one since this one "expired" in 2018, as his/her March 2019 assessment does not indicate that s/he has a BSP, and have not indicated that s/he has had one since."

On 10/07/2025 at 4:40 p.m., Surveyor reviewed adult protective services (APS) progress notes. The following was identified:

On 09/02/2025, Adult Protective Services Investigator (APSI) J wrote, "I spoke to [Guardian E] ...S/He goes out to see him/her every other month. [APSI J] stated that s/he has interacted

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M 548	Continued From page 8 with [Caregiver C] 2 to 3 times and has had to intervene because s/he and [Resident 1] have had verbal arguments." On 09/10/2025, APSI J emailed Licensee A and asked, "I wanted to know if staff is allowed to physically restrain [Resident 1] when s/he has behaviors. I did not see that in the BSP." Licensee A replied, "No, staff is not allowed to physically restrain any current resident member residing at Destiny AFH." On 10/03/2025 at 12:55 p.m., Surveyor interviewed Licensee A who stated Caregiver C called him/her the night of the incident and was upset Resident 1 was not back from his/her walk. Caregiver C stated Resident 1 was gone longer than 1 hour. Licensee A told Caregiver C if Resident 1 was not home by 9:00 p.m., Caregiver C should call the police. Resident 1 returned home at 9:01 p.m. On 10/03/2025 at 3:20 p.m., Surveyor interviewed Resident 1, who reported if s/he signed in and out, s/he could go out anytime. Resident 1 told Surveyor about the incident with Caregiver C. S/He stated, "I was out eating burgers. I knew I was late. I tried to hurry up ... I was only a couple minutes late ...[Caregiver C] was angry when I got home. S/He was yelling at me and calling me names. When s/he hit me, I told him/her s/he was going to go to jail for that. S/He kept calling me a drug addict and a drunk while hitting me. I punched him/her back. I tried to protect myself ... But I did not feel safe. I was being treated like [expletive], in my own home ...I never saw [Caregiver C] again." Cross Reference M0424 DHS 88.06(3)(f) Review Of ISP	M 548		

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